DECEMBER 2017

ANZCA BULLETIN

Anaesthesiology

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Climate smart:
ANZCA driving change

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ANZCA Bulletin
The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional medical body in Australia and New Zealand that conducts education, training and continuing professional development of anaesthetists and specialist pain medicine physicians. ANZCA comprises about 6000 Fellows and 1500 trainees across Australia and New Zealand and serves the community by upholding the highest standards of patient safety.

Cover: In 2018, debate will intensify over whether Australia and New Zealand should align with most other parts of the world and refer to the profession as anaesthesiology rather than anaesthesia.

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President's message

Relationships locally and globally

This year has seen ANZCA engage across the globe with a number of sister organisations. Some of this has been the formalising of existing relationships, such as with the Royal College of Anaesthetists (RCoA) in the UK and the College of Anaesthetists of Ireland (CAI), and we have also strengthened existing relationships such as with the Royal College of Physicians and Surgeons of Canada, which is part of our Tri-nation Alliance with them and two other Australian and New Zealand colleges.

From these relationships come the ability to share knowledge and resources and opportunities.

The CAI link has helped us understand doctors' health better and informed our latest fellowship survey (which I hope you all completed!).

We are working with the RCoA and the *British Journal of Anaesthesia* to develop an opportunity for joint research funding, and the RCoA shares a number of policy areas of relevance to our members. The Tri-nation Alliance gives us access (and input) into world leading education and training initiatives for both trainees and Fellows. Shared discussions into competency-based medical assessment and entrusted professional activities will ensure that what ANZCA offers its trainees and Fellows will continue to be the equal of the best in the world. We have also worked with the World Federation of Societies of Anaesthesiologists to jointly promote the excellent FPM Essential Pain Management program, developed by Roger Goucke and Wayne Morriss that extends across dozens of countries now.

In Asia and the Pacific we have initiated new connections with the Chinese Society of Anesthesiologists, which has just given birth to its own College of Anesthesiology and is starting to consolidate the complex diversity of training programs across the country. They are particularly interested in learning about our research platform expertise and also safety and quality programs. In Hong Kong, we have signed a new memorandum of understanding with the HK College of Anaesthesiologists, which will progress education and academic resource sharing in years to come. We are also maintaining strong connections with our Malaysian and Singaporean sister colleges.

Closer to home, as was detailed in the last *Bulletin*, I had the privilege of joining with the Royal Australasian College of Surgeons and the Royal Australian and New Zealand College of Obstetricians to support the Medical Society of Papua New Guinea at their annual conference. Our colleagues there value our help and support which is focused on developing training, maintaining skills and expanding resources. It is an incredibly challenging environment both economically and socially, but the capacity that is brought by the enthusiasm and commitment of our Fellows who contribute, especially Michael Cooper and Chris Acott, and the local anaesthetists and anaesthesia scientific officers who work there, cannot be underestimated. The importance to the community of the training of specialist anaesthetists cannot be overestimated.

The value of our international relationships and engagement is significant. Our relationships are mutually beneficial in different ways, and unforeseeable ways in the future, to the College and its members. We live and grow in a global medical community and need to be active citizens to be able to deliver the best development of ourselves and the best care to our patients.

Indigenous healthcare

Health outcomes for Indigenous patients are significantly inferior than for the rest of the population.

In New Zealand for example, perioperative mortality is higher in Māori patients even after correcting for co-morbidities. This is just the tip of the iceberg. The provision of effective healthcare to Indigenous patients is recognised as a significant issue and has many components of course, including access to health services, cultural competence of doctors to facilitate patient engagement and a "safe" environment, and the development and maintenance of a diverse and inclusive workforce. There is significant under-representation of Indigenous doctors in both Australia and in New Zealand. In anaesthesia there is an even more significant gap.

To this end ANZCA is finalising the development of an Indigenous Health Strategy that will support all these processes in both Australia and New Zealand.

Interestingly, our colleagues at the royal college in Canada are also responding to their own national policy directives in enacting a number of key strategies to improve Indigenous healthcare, and we can share our approaches as we did when we met together in Melbourne to discuss these issues last year.

Cultural competence extends beyond Indigenous patients of course, and improves the quality of our care across the board. The Australian Medical Council is moving to strengthen requirements for doctors to be trained in cultural competence and ANZCA is considering practical ways to help our trainees and Fellows in this important area.

Professor David A Scott
ANZCA President

Chief executive officer's message

As we approach the end of another year I have been reflecting on the major achievements that have been delivered on behalf of our Fellows, trainees and the community.

Research continues to be a fundamentally important element of a medical college. A commitment to research built the safe environment that we now have in anaesthesia and it will be the foundation of the next major advances in anaesthesia, pain medicine and perioperative medicine. It is the basis on which we are able to build our public advocacy and the reason ANZCA and FPM are so well respected in government circles.

In 2017, a record $A1.74 million was allocated through the ANZCA Research Foundation to Fellows' research projects, including 27 new projects to commence in 2018. We are also aware that the next generation of researchers needs to be nurtured. This has led to the establishment of the new Emerging Investigators Sub-Committee, which is designed to increase support for new and emerging researchers among our fellowship.

Advocacy on safety and quality is also a key area of operations for ANZCA. This work is frequently conducted away from the media spotlight for many months before achieving success.

In 2017 we have represented the voices of Fellows and trainees in Australia and New Zealand in more than 45 submissions to external regulatory, medical and health agencies as well as governments. ANZCA led the development of an unprecedented joint position paper on day surgery with the Royal Australasian College of Surgeons (RACS) and the Australian Society of Plastic Surgeons. The position paper calls for tougher regulations and regular safety checks on day surgeries, including cosmetic surgery centres.

The recognition of National Anaesthesia Day on October 16 each year is growing in popularity each year. It represents one of the best opportunities for ANZCA to highlight to the community the valuable role of anaesthetists in their patients' surgery and recovery.

One of the features of college activity is the ANZCA Annual Scientific Meeting (ASM). This year's ASM in Brisbane was successful by every measure. It attracted in excess of 2000 delegates and included innovations that set the challenge to future regional organising committees.

It included the addition of an onsite crèche, gender balance in presenters, introduction of pop-up simulation, and a memorable social program.

The 2018 ASM is a collaborative meeting with RACS in the new Sydney Convention Centre. A satellite to the ASM will be run by the Obstetric Anaesthesia Special Interest Group.

The ANZCA Library continues to increase in popularity with Fellows and trainees. Library guides, literature searches and support for exam preparation are among the most frequently used services alongside the regular library functions. Over recent years the library has responded well to serving people's needs in more remote locations. So if you need assistance from the library regardless of location, just pick up the phone or send an email.

ANZCA continues to devote resources to preserving the history of the profession through the Geoffrey Kaye Museum of Anaesthetic History. During 2017 the museum won the award for the best small museum at the Museum Australia (Victoria) awards for its suite of online exhibitions. Three oral histories were launched during the year, celebrating ANZCA's 25th anniversary through interviews with the college's first president and the first deans of the Faculty of Pain Medicine and Joint Faculty of Intensive Care. These can be viewed at www.anzca.edu.au/about-anzca/anaesthesia-stories.

Plans for 2018 will showcase the women of anaesthesia and highlight the roles that these women have played and how their contributions are often the untold stories of the profession.

FPM has been very active in the organisation of consultative forums on medicinal cannabis and procedures in pain medicine.

Governments across Australia and New Zealand continue to move towards the legalisation of cannabis use for medicinal purposes, despite the lack of evidence with regard to efficacy. Following the consultative forum, the Faculty has reinforced its position that prescription of cannabis is appropriate within a research setting. Work will continue with governments to advocate on behalf of the community for safe and effective administration of cannabis. We are also mindful that Fellows need support in this area of uncertainty.

We are coming to the end of ANZCA's 25th anniversary as a college following 40 years as a faculty of the Royal Australasian College of Surgeons.

I thank the many Fellows, trainees and staff who have made it such a successful year. As one year closes, we prepare for 2018, which will be another milestone – the 20th anniversary of FPM.

John Ilott
Chief Executive Officer, ANZCA

Letters and awards

Marriage equality

ANZCA councillors are elected by Fellows based on their perceived commitment to standards and safety of anaesthetic practice. They are not elected to pursue random personally motivated ideological issues under the auspices of the College.

The Marriage Equality Statement promulgated by ANZCA councillors is such an ideological document.

A significant proportion of the membership of ANZCA would disagree with the opinions and supposition expressed in the statement. The open advocacy of the councillors under the imprimatur of the College shows an intolerance to the diversity of personal opinion of its Fellows and reflects an inherently discriminatory disregard towards the values of many of its members.

The ANZCA statement that "ANZCA Council considers marriage inequality to be clearly discriminatory" does not give the vaguest hint that it has insight into a more complex nuanced conversation.

In Australian law there is no difference between a same-sex couple and any other de facto or married couple.

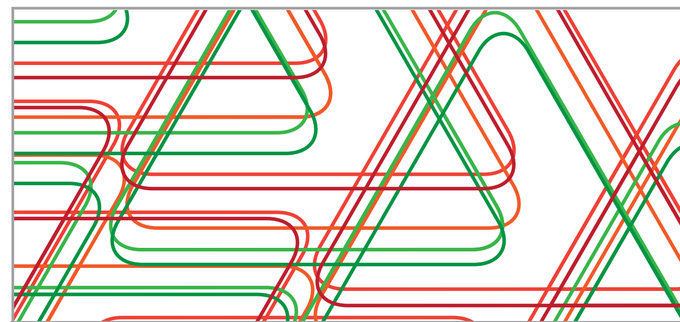
One definition of discrimination is the "recognition and understanding of the difference between one thing and another". The College gives no indication of the awareness of the view that the same sex marriage (SSM) debate is about a question of difference and not prejudicial discrimination. Where supporters of traditional marriage see the essence of marriage as primarily about affirmative action for the wellbeing of children, supporters of SSM would have marriage become something else.

As David Van Gend says in his book *Stealing from a Child* "if we redefine marriage, we redefine parenting and we redefine family. It is no small matter to revoke the definition of "family" in the Universal Declaration of Human Rights –'the natural and fundamental group unit of society'."

I encourage Fellows who are interested in science rather than advocacy to read https://critiqueama.files.wordpress.com/2017/07/medical-critique-of-the-ama-position-statement-on-marriage-equality.pdf.

Dr David Brooks, FANZCA
New South Wales

Correction
An article in the September *ANZCA Bulletin* included an incorrect title for William Woodhouse, one of the recipients of an ANZCA Citation. We apologise to Mr Woodhouse for the error.



Membership services

It's been a productive year for the College, and momentous, in celebrating our 25th anniversary. On behalf of the ANZCA CEO and council, we thank the many volunteers who have given their valuable time to participate in committees, organise continuing medical education events, participate as an examiner or supervisor of training, and in any other capacity for both ANZCA and FPM. We recognise the passion and drive you have to support your College and the future generation of anaesthetists and specialist pain medicine physicians. We wish you a safe and happy holiday season, and look forward to working with you again in 2018.

Did you know the College now has a dedicated membership services manager? If you have a query relating to your College or Faculty membership, why not touch base with Hannah Sinclair via Facebook, Twitter or email **membership@anzca.edu.au**

The 2017 Ray Hader Award for Pastoral Care

ANZCA Fellow Dr Antoinette Brennan, a visiting medical officer anaesthetist at Monash Medical Centre is the recipient of the 2017 Dr Ray Hader Award for Pastoral Care.

The award recognises Dr Brennan's commitment and dedication to ANZCA trainees and Fellows at Monash Health over the past 20 years where she has been a strong advocate for welfare support and counselling.

The 2017 award has special significance for Dr Brennan as Dr Hader was a friend whose "loss was deeply felt by many".

Reflecting on her commitment to welfare support and counselling she admits she is not sure where or when her interest in doctors' health began but "I feel like it has always been there".

"Very early in my anaesthetic training I was exposed to both suicide and substance abuse in anaesthetists, which are difficult to comprehend at any stage of one's career, but particularly so when young and inexperienced," she explained.

"At various times since medical school I have observed or personally experienced doctors with a kind, compassionate and nurturing approach to colleagues and I strongly believe that is the approach which ultimately encourages and achieves best performance and best patient care."

In nominating Dr Brennan for the award her colleagues in the anaesthesia department at Monash Health said she was "held in the highest of esteem by all members of our department, including the heads of department".

"Antoinette is a truly caring doctor, colleague and role model. Not only has she implemented so many excellent welfare programs … at Monash Health … but she is available to all members of the department for official or unofficial counselling. Antoinette has dedicated countless hours to ANZCA trainees and Fellows by listening to their stories, providing words of encouragement and helping people to find the support they need."

As the welfare officer for Monash Health she co-ordinates the welfare team across the multiple Monash Health campuses, regularly organises "R U OK?" days and is often the first port of call of advice for many welfare officers at hospitals throughout Victoria.

Dr Brennan said after a number of years working in the public hospital system she came to realise that she was "intuitive enough to recognise when some trainees or colleagues were experiencing difficulty, experienced enough in some of those transition points that cause problems, and interested enough to get involved".

Dr Brennan is also a motivated and enthusiastic member of the Welfare of Anaesthetists Special Interest Group and strongly supported the development of the Monash anaesthesia mentoring program, which for the past eight years has helped junior trainees access senior clinicians for advice and support.

She completed a masters in counselling at Monash University between 2011 and 2013 to ensure she was appropriately trained in the care and welfare of colleagues.

Dr Brennan also runs a small private counselling practice for doctors and medical students needing help with mental health issues such as anxiety, stress management and exam failure.

The Dr Ray Hader Award for Pastoral Care is awarded to an ANZCA Fellow or trainee who is recognised to have made a significant contribution to the welfare of one or more ANZCA trainees in the area of pastoral care. This may have been directly, in the form of support and encouragement, or indirectly via educational or other strategies.

The award is named after Dr Ray Hader, a Victorian ANZCA trainee who died of an accidental drug overdose in 1998 after a long struggle with addiction. The award was originally established in his memory by Dr Hader's friend, Dr Brandon Carp, to promote a compassionate approach to the welfare of anaesthetists, other colleagues, patients and the community. In 2012, Dr Carp agreed to continue his support in sponsoring the award and to a change which will also recognise the pastoral care elements of trainee supervision. The winner receives $A2000, to be used for training or educational purposes, and a certificate.

Carolyn Jones
Media Manager, ANZCA

Anaesthesiology

Time for change?

Anaesthesia is the second most important medical intervention – ever.

It sounds like a big call but consider for a moment that after the management of infectious diseases (that is, public health, antibiotics, vaccination/immunisation, and antisepsis/sterilisation), anaesthesia in its various forms enables life improving and life-saving interventions to be provided to tens of millions of patients annually, radically improving their quality and duration of life safely and effectively.

The pioneers of our specialty were predominantly medical practitioners who through innovation and the development of safer and more efficient techniques laid the foundations of what was to become today a specialty.

Our specialty is based on expert training and education, ongoing research and development, and a high level of professionalism. It is important for our continued ability to progress these attributes for the care of ever-increasingly complex patients, that these standards are maintained.

It is easy for the public, for politicians and decision-makers, and even for our professional peers, to underestimate how dependent safe and effective anaesthesia is upon skilled practitioners and ongoing research.

There are many ways this message can be communicated via formal advocacy and lobbying, but this lacks traction if the public view is ill-informed. Media promotion and programs such as ANZCA's National Anaesthesia Day are part of a strategy to enhance our profession's identity in the Australian and New Zealand communities.

We will continue to do these things. But maybe we need a more fundamental change to enhance our specialty's identity with the community while also aligning our specialty's name with a larger part of the global community.

The following article is provided to inform the discussion on whether we should change the name of our specialty from anaesthesia to anaesthesiology and us from anaesthetists to anaesthesiologists.

As I stated in my previous president's message – let's have the conversation, you will decide!

Professor David A Scott
President, ANZCA

What's in a name?

The time has come to explore – again – whether we should align ourselves with the majority and call ourselves "anaesthesiologists" or continue to be known as "anaesthetists", say the presidents of the three core groups representing the specialty in Australia and New Zealand.

Should we stay "anaesthetists" or could we become "anaesthesiologists"?

The most widespread term globally for doctors who practice the specialty of anaesthesia is anaesthesiologists (or anesthesiologists).

This is a widely understood term and differentiates doctors in many countries from non-specialist, or even non-medical "anaesthetists".

In Australia and New Zealand this distinction is not as essential because our protected name (by the Australian Health Practitioner Regulation Agency or the Medical Council of New Zealand) is specialist anaesthetist. No one else is able to represent themselves using this term.

On the other hand, a strength of the title anaesthesiologist is that an "–ology" represents a discipline based on scientific rigour and research. It is certainly our research that has led to the sophisticated, safe and effective anaesthesia that we practice today. In the community, an "–ologist" is more instantly recognised as a specialist or expert in the area of the "–ology".

In clinical practice we deliver anaesthesia. It has been historically the practice to call the provider of anaesthesia an anaesthetist. So, why should we even think about changing?

Some background

Discussion on the title anaesthetist versus anaesthesiologist is not new. The following examples highlight this:

1998

In 1998, "Terminology – Anaesthetist/Anaesthesiologist" was discussed at the October ANZCA Council meeting. The following is extracted from the minutes from this meeting:

"During consideration by the August Executive of the President's Report on the ASA Federal Executive Meeting … the revival of the anaesthetist/anaesthesiologist debate was highlighted. It was suggested that to widen discussion on this issue, information on the pro and con arguments could be included in the publications of the College, ASA and NZSA. It was agreed by the Executive that the matter of terminology should be (highlighted) at Council for further discussion.

"(It was noted) that this topic is being increasingly debated and suggested that it should be undertaken in an open forum. He noted that only the UK, Australia and New Zealand now use anaesthetist as opposed to anaesthesiologist. Following brief discussion, it was agreed that a case 'for' and 'against' should be published in the *Bulletin*. Dr Thompson undertook to compile an article with input from interested parties."

No change ensued.

2004

In 2004, the then-ANZCA President Professor Michael Cousins established a taskforce chaired by Professor Guy Ludbrook to research, review and discuss broadly with the fellowship a name change to the speciality of anaesthesia to anaesthesiology and a name change from anaesthetist to anaesthesiologist. This taskforce did not make a firm recommendation for change but produced a report for ANZCA Council in September 2005 with the following recommendations in summary:

- Scope of anaesthesia practice be clearly defined in our professional documents.
- A marketing or public relations group be consulted re the need for and impact of a name change.
- The marketing group advise on the best implementation of any such change.
- That the first item be reviewed every two years.

The relevance of the first item was that the scope of practice of anaesthesia extended beyond the operating room into preoperative assessment and preparation, and into postoperative care and management, that is, perioperative care. However, again, no change ensued.

2013

In 2013 the College undertook a survey that identified that one in 10 community members did not know that anaesthetists were doctors, and that 50 per cent thought that only some anaesthetists were doctors.

2017

In 2017 a name change for the speciality and specialists has been raised again by:

- The Australian and the New Zealand societies of anaesthetists following on from discussion at the World Federation of Societies of Anaesthesiologists (WFSA) 2016 conference and the European Society of Anaesthesiology in 2017.
- Informal discussions by ANZCA with the College of Anaesthetists of Ireland (CAI) and the Royal College of Anaesthetists (RCoA) in the UK.
- Feedback from ANZCA Fellows and trainees during the consultation period for the ANZCA Strategic Plan 2018-2022.
- A specific request from Dr John Crowhurst through correspondence to the Australian Society of Anaesthetists' (ASA's) *Australian Anaesthetist* magazine and formally to the ANZCA chief executive officer and president at the 2017 ANZCA Annual General Meeting in Brisbane.
- In social media, an active Twitter conversation is ongoing debating the merits of a name change.

(continued next page)

"It has been historically the practice to call the provider of anaesthesia an anaesthetist. So, why should we even think about changing?"

The international situation

A form of the words anaesthesiology and anaesthesiologist is used in more than 150 countries for specialists who practice anaesthesia.

In particular, it is used by the WFSA and most (but not all) of its member societies including the American Society of Anesthesiologists, the Chinese Society of Anesthesiology and the European Society of Anaesthesiologists. The Hong Kong college uses anaesthesiology, as do Singapore and Malaysia.

Anaesthesia remains for colleges and societies typically associated with English origins, that is, UK, Ireland, the South African college (not society), Australia and New Zealand as well as a few other countries.

Anaesthesiology is the most frequent term used in journal titles.

As an example of public perception, understanding of the role of anaesthesiologists in India was generally very poor in the population especially in those without university education, although the role of anaesthesiologists in the post-operative period and in pain management was also unclear to many medical undergraduates (Mathur 2009).

The Australian and New Zealand situation

Throughout Australia and New Zealand, hospital department names are very variable with uses of anaesthesia, anaesthesiology, perioperative medicine and pain medicine. This variety also applies to the names of private anaesthesia groups with "anaesthetic" or "anaesthesia" being the most common.

ANZCA in 2017

The draft ANZCA Strategic Plan 2018-2022 includes the exploration of adopting anaesthesiology and anaesthesiologist for Australia and New Zealand, acknowledging that to do this there are a number of issues that need to be considered and that the appropriate amount of time needs to be dedicated to such a task.

It is not a matter that can be decided quickly and does require due diligence. Also, with the College playing a leading role in the development of a perioperative medicine qualification it is timely to consider any change in name.

ASA in 2017

The statement made this year by the WFSA (representing 130 member societies in 150 countries) defined an anaesthesiologist as a qualified physician who has completed a nationally recognised medical residency training program in anaesthesiology.

Anaesthesiology includes pain medicine, trauma management, resuscitation, perioperative, critical and intensive care medicine. It goes on to note that in some countries anaesthetist is used, but this is a minority.

The future of the speciality importantly depends on us embracing this statement and expanding our routine clinical activities outside the operating room. Administration of anaesthesia is a vital part of what we do, however it is important that the role and perception of the anaesthesiologist is that of a wider function.

The ASA, like the College, understands this is a possibly contentious issue, and agrees that if a name change is to be made, it is best done together.

NZSA in 2017

A possible change in name to anesthesiologist aligns with the increased emphasis on the perioperative care aspect of our specialty; and growing recognition of the value this brings to elevating patient care outcomes.

It arguably better conveys our medical training and the excellence that underpins anaesthesia, highlighting the multidimensional nature of our role in medicine that goes beyond the administration of anaesthesia.

There is also a drive by our global body the WFSA to attain internationally consistent terminology. As a specialty we should all be engaging in discussion and debate with our colleagues, and exploring the possibility of a change.

The New Zealand Society of Anaesthetists (NZSA) believes that this is an issue in which it is vital that our three organisations work collaboratively, and if a name change is to occur, we need to do this collectively.

Pros and cons

Positives

The potential positives of changing to anaesthesiology as a name include:

- It reinforces for the community the breadth of the clinical nature of anaesthesia as a speciality, that is, that doctors practise and deliver anaesthesia and in a broader sense, perioperative care.
- Anaesthesiology encompasses more broadly the professional scope of the speciality including but not restricted to perioperative medicine, pain medicine, palliative care, hyperbaric medicine etcetera.
- It better reflects the academic and scientific basis of the speciality in line with cardiology, haematology and radiology.
- Negotiations with governments on the perioperative medicine care model and a name change to the speciality could be conducted concurrently. This would be a way of integrating both in the minds of governments who could then action health system change simultaneously.
- Using anaesthesiology would mean there is no need to change the acronym of the College or societies.
- A name change would be an opportunity for a marketing and communication campaign increasing the profile and knowledge of the speciality.
- The title specialist anaesthesiologist or anaesthesiologist would be distinctly applicable to a qualified specialist medical practitioner. Any other provider of anaesthesia services might then refer to themselves as an anaesthetist with less ambiguity (noting that the subtlety of this in the public's eyes would likely be lost without education).

Negatives

Potential negatives or challenges associated with a name change include:

External issues:

- Engagement with all anaesthetists across the College and the Australian and New Zealand societies of anaesthetists would be imperative in gaining a united voice and recommendation.

- Any debate about this change would need to be respectful and not disenfranchise or divide the speciality.
- Engagement with health services and clinicians would have to be comprehensive.

Organisational for ANZCA

- There would be a significant financial outlay on behalf of the College including widespread changes to resources including:
  - Policies and procedures.
  - Curriculum.
  - Continuing professional development.
  - Professional documents.
  - Other ANZCA documents and website references.
- Government and regulatory body changes would need to be formally made including:
  - Company registration.
  - Medicare.
  - Medical Board of Australia and the Australian Health Practitioner Regulation Agency.
  - Medical Council of New Zealand.
- A change to the protected specialist title to specialist anaesthesiologist would be required.

Organisational for the societies (ASA and NZSA)

- There would be some similar elements to the above with respect to websites, administration and resources including:
  - Policies and procedures.
  - Professional documents.
  - Company registration.

Other joint issues include:

- Grandfathering and transition plans.
- A comprehensive marketing plan as well as an engagement strategy tailored to a broad range of stakeholders should be developed and implemented.

Where to from here?

ANZCA, the ASA and the NZSA want to hear your thoughts and opinions.

This is not a trivial decision, and it is recognised that this should not distract us from many of the other large and important issues we are dealing with.

The three organisations have agreed to proceed down this line of inquiry together, noting that keeping the profession united is the most important thing for our external relationships and for our public perception.

A respectful discussion is the aim, and if the council and boards of all the organisations agree then we will proceed to finalise a decision with an online vote of the members of all the organisations by the end of 2018.

Consultation with our respective memberships, ANZCA trainees and other relevant stakeholders will occur over the next few months.

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Dr David Kibblewhite
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Reference:
Mathur et al Indian J Anaesth. 2009 Apr; 53(2): 179–186
https://www.wfsahq.org/images/UHC_Position_Statement_Final.pdf

"A form of the words anaesthesiology and anaesthesiologist is used in more than 150 countries for specialists who practice anaesthesia."

Definitions (Oxford Dictionary)

anaesthesia Insensitivity to pain, especially as artificially induced by the administration of gases or the injection of drugs before surgical operations.

anaesthetist A medical specialist who administers anaesthetics.

anaesthesiology The branch of medicine concerned with anaesthesia and anaesthetics.

anaesthesiologist See anaesthesiology

Safe sedation, codeine restrictions and NAD 17 lead media coverage

A diverse range of topics and issues involving ANZCA and FPM attracted strong media interest across broadcast, digital and print outlets since the last *ANZCA Bulletin*.

The College's pursuit of safe sedation controls, tougher regulations for day surgery and the release of its joint position paper on the issue with the Royal Australasian College of Surgeons and the Australian Society of Plastic Surgeons attracted more than 50 print, broadcast and online items in September and October.

ANZCA President Professor David A Scott featured in more than 20 broadcast, print and online articles and stories on October 19 and 20 following the release of the joint day surgery position paper. Highlights of the ANZCA-led media strategy included an editorial in the *Herald Sun* on October 23 supporting the College's stance which followed an earlier *Herald Sun* article about the position paper on October 19, a four-minute interview with Professor Scott on ABC News Radio and ABC radio interviews with Professor Scott that were aired in Melbourne, Sydney, Canberra and Hobart. These items reached a combined audience of 1.3 million people across Australia.

Professor Scott also featured in 32 broadcast, print and online articles and stories on September 1 and 2 after Australian Associated Press reported ANZCA's request to the NSW Health Minister Brad Hazzard calling for an urgent meeting to discuss safe sedation in the wake of the death of a cosmetic surgery salon owner after she had undergone a breast implant procedure.

Professor Scott was interviewed for ABC TV news bulletins in Sydney, Brisbane, World News Three in Wellington, New Zealand and radio stations including 2GB and 3AW. He was also quoted in a page one investigation article in the *Daily Telegraph* on September 23. These reached a combined audience of 1.5 million people across Australia and New Zealand.

National Anaesthesia Day received broad coverage across radio and print and online outlets in metropolitan and regional media including the *Herald Sun*, AAP, World News Australia, Newstalk ZB in New Zealand and *The Shepparton News*. In Australia, ANZCA distributed three media releases for National Anaesthesia Day: one "global" release with facts about older Australians and hospital admissions and how to best prepare for an operation, one on a frailty index being developed by ANZCA Fellow Dr Jai Darvall and another release quoting Professor Scott calling for more debate on futile surgery. Two media releases were localised for New Zealand media. In total, the National Anaesthesia Day coverage attracted an audience reach of nearly 800,000 people. (For more details on coverage see the feature on page 54.)

ANZCA's role in the landmark "Access to safe and affordable surgery and anaesthesia" conference in Port Moresby in early September was profiled by the ABC's Papua New Guinea correspondent Eric Tlozek in a four minute report for the ABC's national PM program on September 5 and featured an interview with Dr Cooper and local anaesthetists and doctors. The conference was also reported by Lauren Beldi of the ABC's *Pacific Beat* program on September 19. Radio New Zealand also broadcast an interview with Dr Cooper on September 11. These reached an audience of 300,000 people.

An AAP article on cancer admissions to hospital ICUs quoting intensive care trainee Dr Eamon Raith was syndicated to news.com.au, the *Herald Sun*, *The Australian*, World News Australia, the *Daily Telegraph*, the *Mercury*, Sky News, the *Cairns Post*, the *Geelong Advertiser* and the *Townsville Bulletin*.

FPM Dean Dr Chris Hayes was interviewed on the ABC's *The World Today* on October 18 in response to opposition by the Pharmacy Guild of Australia to codeine up scheduling in February 2018. Dr Hayes' comments were also reported in an ABC online story by reporter David Coady and these reached a combined audience of nearly 350,000 people. An AAP version of the story also quoted Dr Hayes and this was syndicated to 20 online mastheads across Australia including news.com.au and *The Australian* with an audience reach of 1.2 million people. Dr Hayes was the health segment guest for ABC Radio's Nightlife program on September 11. Dr Hayes spent 45 minutes with host Philip Clark discussing chronic pain and opioids and took questions from callers.

In Adelaide, FPM Vice-Dean Dr Meredith Craigie was interviewed by the ABC for a TV news report on October 5 about medicinal cannabis and the issues around prescribing the drug for chronic pain. The report reached an audience of 50,000 people.

FPM's Chair of the Professional Affairs Executive Committee Dr Michael Vagg featured in an eight minute panel segment on the Seven Network's *Weekend Sunrise* program on September 16 to discuss the opioid crisis and this attracted an audience of 520,000 people.

In Tasmania, ANZCA history consultant and retired anaesthetist Dr John Paull was interviewed by ABC Northern Tasmania's morning host Belinda King on September 15 about his new book on Dr William Ross Pugh, *Persistence Pays*. The segment was followed by an interview with ABC Hobart's morning host Ryk Goddard on September 21.

ANZCA issued three media releases on presentations given at the FPM Spring Meeting in Torquay in September including a call for an overhaul of pain medicine funding as more patients head for emergency departments.

The call for overhaul of pain medicine funding by Fellow Dr Jane Trinca featured on ABC radio news bulletins in Melbourne, Hobart, Launceston and 10 Victorian regional ABC stations and reached an audience of 110,000 people.

Carolyn Jones
Media Manager, ANZCA

Since the September 2017 edition of the *ANZCA Bulletin*, ANZCA and FPM have featured in:

- **15 print reports.**
- **140 radio reports.**
- **65 online reports.**
- **5 TV reports.**

Media releases since the previous *Bulletin*:

Thursday November 2:
Study reveals extent of cancer cases in hospital ICUs

Thursday October 19:
Leading medical groups call for tougher regulation of day surgery clinics

Monday October 16:
How significant is your age as a predictor of recovery after an operation?

Friday October 13:
New campaign advises older patients on how best to prepare for their operation

ANZCA calls for debate about the benefits and risk of operations on older patients

Thursday October 12:
Anaesthetists call for frank discussions about risks as well as benefits of operating on older patients

Saturday September 23:
Call for overhaul of pain medicine funding as more patients head for emergency departments

New Australian study to examine why some chronic pain patients won't listen to their doctor

Friday September 22:
Call to re-educate patients, doctors about limits of opioids for chronic pain

Wednesday September 20:
Opioid abuse, voluntary assisted dying, on agenda of annual meeting of pain medicine experts

Tuesday September 5:
Saving lives the goal of landmark safe surgery conference in Papua New Guinea

A full list of media releases can be found at www.anzca.edu.au/communications/media

Patient safety on the agenda

Australia

Putting patient safety and better pain services on the agenda of governments

ANZCA's Policy, Safety and Quality unit has been busy supporting the College advocacy activities with both federal and state health ministers and stakeholders regarding important Commonwealth of Australian Governments (COAG) doctors' wellbeing and education reforms, patient safety, quality of education and pain services.

In September, College Policy representatives accompanied the College's Faculty of Pain Medicine Dean, Dr Chris Hayes, and Deputy Dean, Dr Meredith Craigie, at a meeting with the Australian Health Minister Greg Hunt to discuss opportunities for better pain medicine research, investment in training and services across Australia.

At this meeting the minister committed to working with the College on improving responses to management of chronic and acute pain in the community given the rising rate of chronic conditions in Australia (see also page 16).

FPM forums

In October, Policy unit members supported and attended two FPM forums with external stakeholders that encouraged College members, government representatives, university representatives and researchers and private industry to meet and discuss use of medicinal cannabis for chronic pain and medical device interventions. Both topics are critical patient safety public policy matters and the unit will play a role in advocating the College position in coming months.

Day surgery

Above right: NSW Regional Committee Chair Dr John Leydon with NSW Health Minister Brad Hazzard and ANZCA President Professor David A Scott.

In response to media coverage in September regarding the alleged death of a patient as a result of a procedure in a private cosmetic surgery clinic in NSW, the College wrote to all state health ministers requesting meetings and strongly advocating for further reform of regulatory frameworks for day surgery in private health facilities.

Throughout October the Policy unit supported ANZCA regional committee representatives and the ANZCA President, Professor David A Scott, who met to discuss safe sedation with state government and territory representatives in Tasmania, Victoria, New South Wales and Northern Territory.

Their discussions were informed by a joint position paper on day surgery in Australia led by ANZCA and endorsed by the Royal Australasian College of Surgeons (RACS) and the Australian Society of Plastic Surgeons (ASPS). The position paper defines day-stay procedures and outlines the minimum standards upon which national, state and territory regulations for day surgery facilities should be based.

The joint paper can be found on the ANZCA website (www.anzca.edu.au/documents/day_surgery_in_australia.pdf). The College will continue to liaise with state government health departments to ensure that regulatory frameworks uphold patient safety and the College's Professional standards for safe sedation.

COAG meeting

At the final COAG Health Council meeting for 2017 in November, state and federal health ministers considered a number of important issues for the College including the introduction of nationally consistent mandatory reporting laws for health practitioners and the draft report of the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme (NRAS).

Australian submissions:

- Australian Health Ministers' Advisory Council – Mandatory reporting under the Health Practitioner Regulation National Law.
- COAG Health Council – Draft report of the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professionals.
- All State Health Ministers – Safe Sedation in day surgery letters.
- Therapeutic Goods Administration – Rescheduling of codeine from S3 to S4.
- NSW Ministry of Health – Regulatory Impact Statement, Private Health Facilities Regulation.
- Joint Select Committee on End of Life Choices (Western Australia) Inquiry into End of Life Choices.
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists – Maternity care in Australia.

The health and wellbeing of our members is a headline issue, so the College submitted a response to inform COAG's deliberations in November on mandatory reporting. ANZCA has also been participating in the NRAS review throughout 2017 through submissions to a discussion paper, the draft report and through the Council of Presidents of Medical Colleges.

Voluntary assisted dying

The issue of voluntary assisted dying (VAD) and end of life choices continues to gain attention across state jurisdictions. A draft VAD bill was released in NSW for public consultation, a VAD bill was introduced to parliament, debated and supported in Victoria and the WA parliament established a Joint Select Committee on End of Life Choices and called for submissions. ANZCA was invited to make submissions in NSW and WA, and throughout October the Policy unit developed submissions in consultation with ANZCA members and committees.

All submissions are available on the ANZCA website.

New Zealand

Election advocacy for pain medicine

Above from left: Former Associate Minister of Health Peter Dunne; Deputy Chair, FPM NZNC, Dr Tipu Aamir, ANZCA Senior Policy Advisor, Virginia Mills, former New Zealand First spokesperson for health, Ria Bond and Chair, FPM NZNC, Professor Edward Shipton.

In the lead up to New Zealand's general election on September 23, FPM's New Zealand National Committee engaged in advocacy meetings with politicians, with the support of the Policy unit's New Zealand-based Senior Policy Advisor, Virginia Mills.

Members of the Faculty's National Committee met with Dr Jonathan Coleman in March (then Minister of Health, and National Party MP); and in August met with Peter Dunne (then Associate Minister of Health, United Future MP) and Ria Bond (the New Zealand First Spokesperson for Health). Health spokespeople from the Labour and Green parties indicated they would like to meet with the Faculty after the election.

The committee presented a number of key issues to the politicians, in particular that:

- 20 per cent of New Zealand adults suffer from chronic pain, causing a significant burden of disease. The consequences of chronic pain are severe, resulting in lost employment, reduced ability to work, depression and anxiety, long-term opioid use, and poverty.
- Multidisciplinary pain management services can manage the most severe and complex cases of chronic pain, but these services are under-funded in New Zealand, and there is a shortage of specialist pain medicine physicians.
- Increased resourcing for pain management services is a critical issue for the health agenda, and would support an adequately sized workforce; reduced waiting lists and unmet need; and improved rehabilitation so patients could improve their quality of life and participate more fully in society.

Overall, the politicians appeared interested in gaining a better understanding of the burden and causes of chronic pain in New Zealand, and hearing about the Faculty's biopsychosocial model of care and how this could help rehabilitate patients.

The committee also highlighted the Faculty's stance on cannabis-based medicinal products to politicians, urging a cautious approach and emphasising that more evidence on safety and efficacy is required. Committee members discussed the lack of evidence for the therapeutic role of cannabinoids in chronic pain, and raised concerns that cannabis-based products may be detrimental for patients, especially young people, with side effects such as impaired respiratory function, psychotic symptoms and disorders and cognitive impairment.

New Zealand submissions:

- Medical Council of New Zealand – Statement on doctors and complementary and alternative medicine.
- Ministry of Health – Proposed format change to National Health Index numbers.
- Pharmac – 2017/18 Invitation to Tender.
- Royal Australasian College of Surgeons – Review of New Zealand's Trauma System.

The election advocacy also resulted in a Faculty representative being invited to a Green Party meeting facilitated by Julie-Ann Genter to discuss her member's bill on medicinal cannabis. Dr Paul Vroegop (FPM NZNC member) attended, and was able to highlight concerns about lack of evidence for treatment of chronic pain, potential for misuse, and risks of adverse side effects.

NZ election outcome

A Labour-led coalition government with New Zealand First has been confirmed, with support from the Green Party with a confidence and supply agreement. Dr David Clark (Labour Party), right, will be Minister of Health, with Jenny Salesa (Labour Party) and Julie-Ann Genter (Green Party) as Associate Ministers of Health.

The Labour Party has promised an additional $NZ8 billion investment in health over the next four years, and areas of overlap between Labour, New Zealand First and Green Party health policy indicate there will be a strong focus on mental health, aged care, cancer treatment and primary care, including increasing the number of general practitioners.

Cannabis will be high on the agenda, as Labour and the Green Party both campaigned on making medicinal cannabis accessible for terminally ill patients, or those with chronic pain. A public referendum on personal use of cannabis is likely to be held by 2020, as part of the confidence and supply agreement between Labour and the Green Party.

Voluntary assisted dying is also on the agenda, with David Seymour's End of Life Choice Bill still to be debated. However, as part of New Zealand First's coalition agreement with Labour, MPs will be able to have a conscience vote in Parliament about whether there should be a public referendum on the bill.

Jo-anne Chapman
General Manager, Policy, Safety and Quality

Australian Health Minister meets with FPM

Australian Health Minister, Greg Hunt, has committed to working with FPM on improving community access to chronic and acute pain services.

Mr Hunt met with FPM Dean, Dr Chris Hayes, Vice-Dean Dr Meredith Craigie, and General Manager, Policy Safety and Quality, Jo-anne Chapman in September.

He said chronic pain and mental health were two areas that needed a different management approach.

Mr Hunt, who is eager to visit a pain clinic, said he broadly supported the inclusion of chronic pain in the National Strategic Framework for Chronic Conditions and FPM's role in educating patients and the wider community about pain. FPM offered to advise and support the government in addressing chronic pain, work across sectors, and helping reduce the burden and cost to the health system.

He was also supportive of research that supports best practice and results in improved health outcomes, including the effectiveness and efficacy of medical devices. He committed to ongoing discussion about a registry of pain devices.

Better training in pain medicine in regional areas was also discussed.

More recently, Dr Hayes, Ms Chapman and NSW Regional Committee Chair Dr Marc Russo met with the NSW Health Minister Brad Hazzard to discuss codeine policy and the Pharmacy Guild's suggestion of creating exemptions to upscheduling.

Also discussed was real-time prescription medication monitoring. In Victoria, $30 million has been allocated for its introduction.

Left: Meeting with Australian Health Minister Greg Hunt (middle) are FPM Vice-Dean Meredith Craigie, and FPM Dean Chris Hayes.

Professional documents – update

The professional documents of ANZCA and FPM are an important resource for promoting the quality and safety of patient care. They provide guidance to trainees and Fellows on standards of clinical care, define policies, and serve other purposes that the College deems appropriate. Government and other bodies refer to ANZCA's professional documents as an indicator of expected standards, including in regards to accreditation of healthcare facilities. Professional documents are subject to regular review and are amended in accordance with changes in knowledge, practice and technology.

Recent releases:

During the September 2017 ANZCA Council and Safety and Quality Committee meetings the following professional documents and their accompanying background papers were approved:

- *PS62: Statement on Cultural Competence (final version).*
- *PS07: Guidelines on Pre-Anaesthesia Consultation and Patient Preparation (final version).*

Professional documents now in pilot:

- *PS15: Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery*
- *PS51: Guidelines for the Safe Management and Use of Medications in Anaesthesia.*
- *PS58: Guidelines on Quality Assurance and Quality Improvement in Anaesthesia.*

The professional documents of ANZCA and FPM guide trainees and Fellows on standards of clinical care and define policies of the College. Government and other bodies refer to them as indicators of expected standards.

Feedback is encouraged during the pilot phase for all professional documents. All comments and queries regarding professional documents can be sent to profdocs@anzca.edu.au.

All ANZCA professional documents are available via the ANZCA website – www.anzca.edu.au/resources/professional-documents. FPM professional documents can be accessed via the FPM website – fpm.anzca.edu.au/resources/professional-documents.

What would you do?

Dr Peter Roessler explains ANZCA's professional documents using practical examples.

You and 'prof docs': A marriage made in ANZCA

As with many relationships and marriages, things don't always run smoothly as a result of parties having different opinions, goals, or aims. However, differing opinions offer the opportunity to communicate and strengthen relationships through the prospect of learning from each other, and then adopting more considered behaviours and actions.

Recently I was faced with the situation where in an accredited metropolitan private day-stay facility, the 70 per cent alcohol swabs used for skin prep prior to inserting intravenous cannuale, had been replaced by chlorhexidine swabs. No big deal! This occurred after a visit from the pharmaceutical representative to the local infection control officer, but without consultation with either the medical advisory committee or anaesthetists.

What would you do?

It is quite likely that this seemingly insignificant change might have gone unnoticed.

Would you accept this change or would you insist/suggest reverting back to alcohol swabs?

It is acknowledged that chlorhexidine may be a better disinfectant than 70 per cent alcohol.

However, reference to *PS28: Guidelines on Infection Control in Anaesthesia*, indicates that 70 per cent alcohol alone, is suitable for short-term cannulation as per item 4.3.1. Clearly, there may be a preference for chlorhexidine by "Infection Control", to be used in most cases. However, the evidence does not support the use of chlorhexidine in situations of short term intravenous cannulation. In isolation, the changeover may not appear sufficiently significant to warrant any action.

However, when considered in the context of ramifications, such a change may not be as innocuous as first appears. Enter, *PS60: Guidelines on the Perioperative Management of Patients with Suspected or Proven Hypersensitivity to Chlorhexidine*. While chlorhexidine anaphylaxis is relatively rare, the incidence appears to be increasing, and it can be delayed in onset and prove fatal. Recall that this was a private facility that does not have 24-hour onsite medical staff. Delayed anaphylaxis could evolve into a catastrophic outcome in a day-stay hospital without skilled medical practitioners immediately available.

My chosen course of action may be different from others. After discussing the issues with the administrators and director of nursing, and referring to *PS28* and *PS60*, there was unanimous enthusiasm to revert back to 70 per cent alcohol. This occasion provided the opportunity to disseminate individual "prof docs" relevant to the situation with the intent of averting a rare but major complication. It achieved two things apart from addressing safety and quality concerns, that included enhancing awareness of ANZCA prof docs and their relevance to everyday clinical practice, and making me look clever (no mean feat)!

The development of ANZCA professional documents is a rigorous process that involves a relationship between parties whose perceptions and perspectives may differ, and at times appear to be opposite. Prof docs serve as an interface between stakeholders including ANZCA, Fellows, trainees, specialist international medical graduates, jurisdictional and regulatory authorities, healthcare institution administrators, patients, and the community, which means everybody.

Needless to say, that within that group there are differing objectives and views. It is for this reason that the process of development and review of our prof docs requires consultation with relevant key stake holders. *A01: Policy for the Development and Review of Professional Documents provides the framework and process that ensures our prof docs remain contemporaneous.*

During the "pilot phase" the proposed drafts are published on the website for 12 months during which feedback is invited from all Fellows, and anyone else that accesses the website. Feedback during this stage is collected and then used to inform the final iteration for approval by ANZCA Council, after which it is published on the website in the definitive version. Your input into this is "relationship" enriching, and invaluable. It is how the College becomes aware of matters that may either have been overlooked (none of us is perfect), or where there is lack of clarity, or matters are identified that are open to interpretation.

Historically, the prof docs were developed to promote safety through the ability to negotiate with administrators of training hospitals for the purposes of anaesthesia departments acquiring the necessary equipment and facilities.

These were, and still are used by Training Accreditation Committee inspectors during accreditation visits. The role of the prof docs, however, has expanded to promote safety and quality throughout all healthcare institutions in both public and private settings, as well as guiding anaesthetists in their practices. They cover a broad area and are not intended to be overly prescriptive.

Awareness of variability within healthcare facilities and Fellows' practices has played an important role in ensuring that the content of the prof docs is relevant and considered, while not compromising standards. Appreciation of the intent of prof docs is central to their interpretation, and now improved through the provision of accompanying background papers, which clarify intent and provide insights into the decisions underpinning recommendations. The development of accompanying background papers facilitates the use of prof docs allowing them to be reasonably succinct and practicable.

In my experience I cannot recall any criticism of professional documents as an entity, however, I am aware of the occasional criticism of individual professional documents, or more frequently specific aspects of the documents. Your continued input is greatly appreciated and gratefully accepted, and pivotal to ensure that our prof docs remain contemporaneous and relevant.

Dr Peter Roessler
Director of Professional Affairs, Policy

Planning our next five years

ANZCA: Strategic plan 2018-2022

How we got here

ANZCA's Strategic Plan 2018-2022 will be launched in early 2018.

ANZCA Council approved the plan at its November 2017 meeting with acknowledgement of the engagement and contribution of the ANZCA community in the formation and finalisation of this new strategic plan. Congratulations to FPM who have also developed and launched a new strategic plan for 2018-2022 with detailed pain medicine specific goals, measures and key strategies (see the dean's message on page 70). Both plans were developed using a similar and consistent consultation and engagement process and are designed to increase and promote collaboration and joint projects.

Over the past 12 months, a broad consultation process has been undertaken with surveys, workshops, interviews, focus groups and one-on-one discussions part of this consultation. We thank the many Fellows and trainees, members of ANZCA and FPM committees, ANZCA staff, representatives of colleges and societies across a number of disciplines and individual stakeholders who gave their time and provided input and feedback. The plan is a result of this engagement and is reflective, at a high level, of the collective ideas of all our contributors.

ANZCA's mission remains the same: To serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine.

ANZCA's vision now recognises its role in and the multidisciplinary approach to perioperative medicine: ANZCA will be a recognised world leader in training, education, research and in setting standards for anaesthesia, perioperative medicine and pain medicine.

What is the strategic plan?

The ANZCA Strategic Plan 2018-2022 outlines the College's focus on new initiatives and sets the direction for ANZCA to build on its achievements over the last five years.

It is important to note that the plan concentrates on the development of emerging initiatives and activities beyond the substantive "business as usual" work of the College, its members and staff; work that plays a vital role in the success of the College.

The plan is based around four main goals and supported by key strategies with evaluation embedded in a section on "how we will measure success".

As a snapshot, the four main goals are as follows:

- **LEADING professional identity and perioperative medicine:** ANZCA will LEAD the promotion of the professional identity of anaesthesia and pain medicine specialties and the development of an effective, integrated and collaborative perioperative care model.
- **GROWING lifelong education, training and professional support:** ANZCA will GROW education, training and professional support for Fellows, specialist international medical graduates and trainees by investment in resources and technology and key collaborations.

"The plan concentrates on the development of emerging initiatives and activities beyond the substantive 'business as usual' work of the College."

- **DRIVING research and quality improvement:** ANZCA will DRIVE a culture of research and quality improvement through funding and supporting research, academic anaesthesia and researchers across Australia and New Zealand and sustaining ANZCA's global leadership in high quality research.
- **SUPPORTING our workforce and wellbeing:** ANZCA will SUPPORT the sustainable growth of a diverse, high quality and healthy anaesthesia and pain medicine and staff workforce so all communities in Australia and New Zealand have access to high quality anaesthesia, pain medicine and perioperative services, provided by clinicians who are supported both personally and professionally.

What to expect next

The ANZCA Strategic Plan 2018-2022 will be online at www.anzca.edu.au from early 2018. A limited number of hard copy versions will be available.

It will consist of an introduction from the ANZCA president, a complete version of the plan inclusive of the goals, key strategies and also how we will measure our success.

A dedicated webpage will allow for regular updates and reporting on the progress of the plan as well as a mechanism for the membership to provide feedback.

The strength of the strategic plan is that it has benefited from the input of the membership of ANZCA, our trainees, our staff and our external stakeholders. It represents a direction that we will work to achieve together.

With new initiatives supported by our core skills, expertise and experience the future years look very exciting, challenging and rewarding.

Jan Sharrock
General Manager, Fellowship Affairs

Indigenous doctors' conference

"The AIDA conference represented just one small way in which ANZCA can demonstrate its renewed commitment to Indigenous health."

With more than 350 attendees, the 2017 Australian Indigenous Doctors' Association (AIDA) conference was the largest to date and ANZCA was well represented.

ANZCA was a key participant at the 2017 annual conference of the Australian Indigenous Doctors' Association (AIDA) informing aspiring specialists about anaesthesia, emphasising the College's commitment to equity and our role in the national Indigenous health strategy.

President Professor David A Scott, Senior Policy Advisor Anthony Wall and Policy Officer Kate Davis attended the annual conference in the Hunter Valley from September 20-23.

Professor Scott was able to speak with dozens of budding specialists (above, second from left) about anaesthesia as a career, the life of an anaesthetist and the training pathway to fellowship.

In addition to presentations on a range of topics including cultural safety and workforce development, 20 workshops were conducted during the conference. Of these, a highlight was the Growing our Fellows workshop that provided an opportunity for AIDA members to have direct engagement with medical colleges to discuss pathways and career goals.

Following a "speed dating" format, each of the 15 specialist medical colleges represented was allocated a table with aspiring doctors invited to rotate tables every 10 minutes to interact with different colleges.

This year's conference celebrated the 20th anniversary of AIDA, which was established in 1997 as a professional association contributing to equitable health and life outcomes, and the cultural wellbeing of Aboriginal and Torres Strait Islander people. The theme of the event was "Family. Unity. Success. 20 years strong" and provided an opportunity to reflect not only on the successes that have been achieved over the past 20 years but also look to the future to consider how to achieve the work that still needs to be done.

ANZCA acknowledges that equitable health outcomes for Aboriginal, Torres Strait Islander and Māori people should be a priority for all Australians and New Zealanders. A key component of addressing inequities in Indigenous health is to improve Indigenous representation in the health workforce and this naturally represents an area where specialist medical colleges have the potential to make a meaningful impact, through initatives such as supporting the training of Indigenous doctors. However, workforce development involves more than the recruitment, retention and support of Indigenous health practitioners. It also involves ensuring that non-Indigenous practitioners are equipped to practise in a culturally safe and responsive manner and improving the ability of mainstream health services to meet the needs of Indigenous people.

With more than 350 attendees, the 2017 conference was the largest to date and included a diverse mix of Indigenous medical doctors (18 per cent), Indigenous medical students (22 per cent), associate AIDA members (23 per cent) and other stakeholders from all over Australia. Keynote speakers included the Minister for Indigenous Health and Aged Care, Ken Wyatt, the Consultant to Commonwealth Health, Professor Tom Calma, AO, the Deputy Dean Māori, Tumuaki, University of Auckland, and Associate Professor Papaarangi Reid.

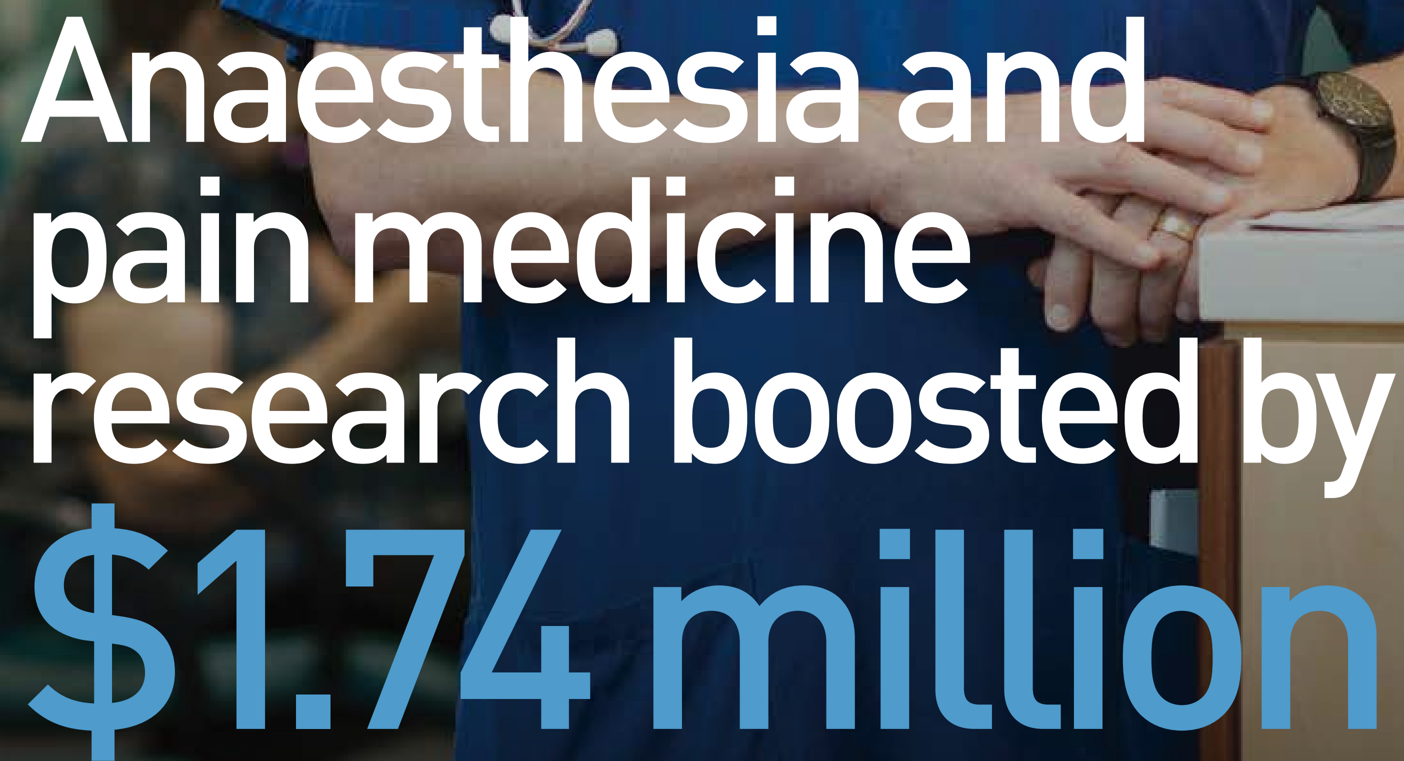
The AIDA conference represented just one small way in which ANZCA can demonstrate its renewed commitment to Indigenous health. In the September *Bulletin* we highlighted a new partnership for Indigenous health between the Australian government, the Council of Presidents of Medical Colleges and the National Aboriginal Community Controlled Health Organisation.

In the coming months the ANZCA Policy team and Indigenous Health Committee will be consulting widely with trainees, Fellows and external stakeholders for input into a new draft Indigenous health strategy developed for the College as we look to become a leader among medical colleges in supporting the Indigenous health workforce and redressing health inequity in Indigenous populations across Australia and New Zealand – watch this space!

Anthony Wall,
ANZCA Senior Policy Advisor

Kate Davis,
ANZCA Policy Officer

Anaesthesia and pain medicine research boosted by $1.74 million



Professor Guy Ludbrook.

The ANZCA Research Committee has awarded funding of nearly $A1.74 million through the ANZCA Research Foundation for research projects in 2018.

The funding supports the Academic Enhancement Grant, 20 new project grants, six continuing project grants, the Simulation/Education Grant, five novice investigator grants and the pilot grant scheme. These grants support important medical research initiatives that will be carried out in leading hospitals and universities in Australia, New Zealand and Hong Kong and are a vital part of ANZCA's continuing contribution to improvement in the safety and quality of patient care in anaesthesia, intensive care, perioperative medicine and pain medicine.

The foundation is very appreciative of its supporters and sponsors who have provided the named research awards: the Cole Family, the estates of the late Dr Robin Smallwood, Dr John Boyd Craig, Dr Lillian Elaine Kluver and CSL Behring.

Named research awards

Harry Daly Research Award – Professor Alan Merry

The Harry Daly Research Award was established by the Faculty of Anaesthetists, Royal Australasian College of Surgeons, in 1981. The Harry Daly Research Award may be made in any of the categories of research award made by the College provided the project is judged to be of sufficient merit. The award is made each year to the grant ranked most highly by the ANZCA Research Committee.

A bundle for anaesthetists to reduce postoperative infection: the Anaesthetists Be Clean (ABC) Study

Healthcare-associated infections (HAI) are a major, widespread problem in healthcare systems and create a substantial financial and human burden.

Surgical site infection (SSI) occurs in up to five per cent of so called "clean" operations. Pneumonia and septicaemia are also major complications associated with infection after surgery and may prolong intensive care unit and hospital stays or lead to readmissions, long-term complications, and an increased risk of death for patients.

This project is part of a substantial program of research with the overarching goal of improving the outcomes of patients undergoing surgery and anaesthesia through understanding and addressing human factors in anaesthetic practice. Specifically, the investigators wish to respond to work by our group and others that demonstrate that there is considerable room for improvement through a more systematic approach to key aseptic (clean) techniques.

Hand hygiene and the management of contaminated equipment may sometimes become secondary to the fundamental requirement to keep patients alive. Although most anaesthetists try hard to work using aseptic techniques, it is all too easy for contamination to occur due to hand hygiene, work surfaces, and in the drawing up and administration of intravenous (IV) drugs, and for bacteria and other micro-organisms to be transferred from one patient to another, or from the anaesthetist to a patient. During these anaesthetic tasks, there are many ways in which minor failures can occur in the maintenance of asepsis.

In this study, the investigators will firstly refine an already developed infection prevention bundle (IPB) of measures for improving key aspects of techniques used by anaesthetists in the drawing up and administering of IV medications, in hand hygiene, in maintaining a clean work space, and in reliably administering prophylactic antibiotics.

Secondly, they will determine the impact of implementing this IPB within whole units on days alive and out of hospital (DAOH). DAOH will be reduced by any infection serious enough to prolong hospitalisation or require readmission: other causes of increased DAOH are expected to be evenly spread between study groups. The rate of postoperative infection will also be measured in patients undergoing arthroplasty or cardiac surgery (groups for whom this information is readily available from national databases) as an explanatory secondary outcome. The investigators will also compare Māori and Pacific island patients (who are at increased risk for postoperative infection) with all others.

A finding that anaesthetists are contributing to postoperative infection through failures in simple aseptic practices would justify interventions to address this problem. Translation to practice would be readily achievable in collaboration with the relevant colleges (including ANZCA), government agencies and hospitals and could potentially save $20 million annually in New Zealand for hip and knee arthroplasties alone and much human suffering.

Professor Alan Merry, Professor Simon Mitchell, University of Auckland, New Zealand.

$A70,000

The Russell Cole Memorial ANZCA Research Award – Dr Daniel Chiang

The Russell Cole Memorial ANZCA Research Award was established following a generous ongoing commitment to the ANZCA Research Foundation from the family of the late Dr Russell Cole to support a highly ranked pain-related research grant.

The influence of genomic and neurophysiological factors on persistent pain after breast cancer surgery

Breast cancer is the most common cancer affecting one in eight women over their lifetime.

Surgery is the mainstay of treatment for more than 18,000 new Australasian breast cancer diagnoses annually. International data indicate that 35-60 per cent of all patients who undergo breast cancer surgery develop post-operative pain that lasts for more than six months. Of these patients, 14-25 per cent will experience moderate to severe pain that significantly impacts on their quality of life through physical disability and emotional distress. Furthermore, the proportion of persistent pain after breast cancer surgery (PPBCS) with a neuropathic component is estimated to be approximately 67 per cent.

Why some women are at greater risk of developing persistent pain after similar surgical intervention is still unclear. Psychosocial, demographic and surgical risk factors have traditionally been investigated as predictors for PPBCS. However, little is known about the genomic factors that underpin this condition, or whether alterations in preoperative quantitative sensory testing (QST) are associated with the chronic pain outcome.

Twin studies and human pedigrees estimate the heritability of chronic pain to be between 30-70 per cent, emphasising the importance of patient genetics. In the post-surgical population, preliminary genomic studies suggest that certain gene variants and genetic regulation may also be important as determinants in developing persistent post-surgical pain.

Neurophysiological risk factors (as assessed by preoperative QST) have been associated with the development of acute and persistent post-surgical pain in other surgical contexts. The success of these prospective studies suggest that an individual's propensity to develop post-surgical pain may be distinguished by assessing the function of their nociceptive pathways preoperatively. This has been inadequately assessed in PPBCS.

The investigators will perform an exploratory, prospective, observational study that focuses on genomic (in particular genes associated with the catechol-O-methyltransferase (COMT) pathway) and neurophysiological risk factors whilst comprehensively assessing psychological, demographic and clinical risk factors for PPBCS.

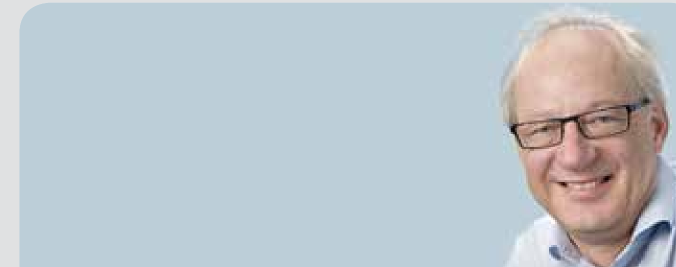
Data from this study will provide new evidence on the contribution of genomic and neurophysiological risk factors influencing PPBCS. These findings when combined with known demographic, clinical and psychological factors may improve the clinically-based prediction models for PPBCS to prospectively identify patients at risk of developing PPBCS.

It is imperative that we better understand the factors that contribute to the development of PPBCS to improve not only its treatment but also its prevention.

This study forms part of Dr Chiang's PhD project investigating the genetic and epigenetic influences on persistent pain after breast cancer surgery.

Dr Daniel Chiang, Associate Professor Michal Kluger, North Shore Hospital, New Zealand, Associate Professor Nuala Helsby, University of Auckland, New Zealand, Dr David Rice, Auckland University of Technology, New Zealand, Professor Andrew Somogyi, University of Adelaide, South Australia.

$A66,698 (including scholarship)



John Boyd Craig Research Award – Professor Paul Rolan

The John Boyd Craig Research Award was established following generous donations from Dr John Boyd Craig to the ANZCA Research Foundation to support pain related research by Fellows, particularly Western Australians.

Exosomal miRNAs in cerebrospinal fluid as objective descriptors of pain states

Pain is a significant global health problem with 20 per cent of the Australian population suffering chronic pain.

Fibromyalgia, complex regional pain syndrome, migraine and irritable bowel disease reflect the complexity and heterogeneity of pain patients. Based on the complexity of the disease, a significant number of patients are not treated with effective therapies and treatments are difficult to monitor.

Therefore new therapies are urgently needed and new diagnostic tools and targets for therapy are necessary to provide better treatment options. However, no objective measure has been developed that allows discrimination between the different pathologies that lead to more complex pain states and is able to complement clinical skills at the level of differential diagnoses.

Exosomes and micro RNAs (miRNAs) are present in many body fluids including cerebrospinal fluid (CSF) of pain patients. Exosomes as well as miRNAs are novel parts of many signalling pathways. The miRNA content of exosomes is tissue- and cell-type specific and changes under disease conditions such as cancer.

The investigators propose that the miRNA content also changes in response to complex pain conditions.

The aim of this study is to identify pain-specific miRNAs in exosomes isolated from CSF of patients with chronic pain to determine whether a test for chronic pain and complex pain syndromes is feasible and likely to be clinically useful. The team has expertise in the areas of exosome analysis, miRNAs, biomarkers, pain signalling, pain therapy and CSF acquisition, and has access to modern facilities that allow access to the most recent technologies to isolate and detect potential biomarkers.

The development of biomarkers for complex pain syndromes or pain subtypes will help to a) differentiate subtypes of pain b) monitor response to treatment c) support the diagnosis of pain in patients who are not able to communicate, and d) enable the identification of new targets for the development of novel drug therapies.

Professor Paul Rolan, University of Adelaide, South Australia, Dr Porhan Kang, Flinders Medical Centre, South Australia, Professor Rainer V Haberberger, Dr Michael Z Michael, Dr Dusan Matusica, Flinders University, South Australia.

$A32,433

The Robin Smallwood Bequest – Dr David Daly

The Robin Smallwood Bequest was established following a generous bequest from the late Dr Robin Smallwood to support a highly ranked grant in anaesthesia, intensive care or pain medicine.

Prospective Cohort Study of Pharmacokinetics of Cefazolin Prophylaxis in Cardiac Surgery with Cardiopulmonary Bypass

Surgical site infections are a devastating complication following cardiac surgery.

The administration of antibiotics at the time of surgery ("surgical antimicrobial prophylaxis") is a well-established strategy to reduce the incidence of these infections.

Despite this, the optimal dosing regimen for antibiotics at the time of cardiac surgery is still unknown. In addition, the best dose to use in obese patients is not well defined, but is increasingly relevant given the increasing number of obese patients undergoing cardiac surgery.

The investigators will test the hypothesis that the current therapeutic guidelines lead to sub-optimal antibiotic levels. They will examine the amount of antibiotic present in the blood, tissue and bone throughout the operation and in the post-operative period. These levels will be compared against the levels required to prevent the development of infection by common bacteria including *Staphylococcus aureus*. In addition, this research project will examine how obesity alters the antibiotic levels.

The research will be conducted at The Alfred hospital, Monash University and the University of Queensland. The research team undertaking this project is a multidisciplinary team including anaesthetists, cardiac surgeons, infectious diseases physicians, intensive care clinicians and pharmacists.

This research will characterise serum and tissue cefazolin levels, when the antibiotic is dosed according to current recommendations in patients undergoing cardiac surgery. This will inform national and international dosing recommendations.

This project will also provide seeding data for future larger category one funding applications for research into the optimal approach to antimicrobial prophylaxis in patients undergoing cardiac surgery.

Dr David Daly, Associate Professor Andrew Udy, Professor David McGiffin, Dr Stuart Hastings, Alfred Health, Melbourne, Dr Trisha Peel, Monash University and Alfred Health, Melbourne.

$A68,122

Named research awards (continued)

The Elaine Lillian Kluver ANZCA Research Award – Professor Guy Ludbrook

The Elaine Lillian Kluver ANZCA Research Award was established following a generous gift to the ANZCA Research Foundation from the estate of the late Dr Elaine Kluver to support a highly ranked pain-related research grant.

Extended Post-Anaesthesia Care – a feasibility study

In recent years, studies of patient postoperative outcomes have revealed a high incidence of adverse events in postoperative general wards. While many of these involve "high-risk" patients with serious co-morbidities undergoing major surgery, it has been more recently recognised that patients with less serious medical illnesses, such as diabetes, obesity, and hypertension undergoing certain surgeries also face a high risk of life-threatening complications in general postoperative wards in the early hours after elective surgery. Further, it is clear these events are to a degree predictable from preoperative assessment and risk scoring, and from the pattern of adverse events in recovery rooms.

Recent evidence from the UK suggests that providing these patients with enhanced treatment in the early hours after surgery may have sustained benefits in terms of postoperative complications, need for unscheduled intensive care unit (ICU) stays, length of stay, and overall costs.

Investment in upscaling ICU and high dependency facilities is challenging for hospitals. However, expanding the use of existing resources (recovery room infrastructure, recovery room nursing staff, anaesthetists and surgeons), both in- and after-hours, provides an immediate scalable flexible solution that may both reduce the number of medium-risk patients admitted to the wards or admitted to high-dependency.

The investigators propose a multi-centre feasibility study to examine the impact on in-hospital and post-discharge outcomes, patient management and overall health costs using an anaesthesia-led extended care service based in recovery rooms for patients for whom general ward care is standard practice.

If the results of this feasibility study show a potential benefit to patients and the healthcare system, funding for a large randomised trial will be sought to definitively answer whether anaesthesia-led extended recovery benefits both individual patients and the community. Such a finding would have importance for Australia and New Zealand and beyond.

The significance of this work is that, without a change in practice in a population with increasing age and co-morbidities, there will be an increase in postoperative morbidity, mortality, and costs, and/or an increase in untreated surgical conditions in the population.

Recovery room staff have high-level skills in early postoperative care which are now under-utilised.

Evidence of benefit from a co-ordinated team approach to provide extended care will allow future investment in such a healthcare model in both the private and public sectors.

Professor Guy Ludbrook, Royal Adelaide Hospital, South Australia, Professor Guy Maddern, the Queen Elizabeth Hospital, South Australia.

$A69,994

Academic Enhancement Grant

A haemodynamic and cardiovascular research program in obstetric anaesthesia and obstetric critical care at The Royal Women's Hospital, Parkville, Victoria

In August 2010 Associate Professor Alicia Dennis was appointed as the first Director of Anaesthesia Research in the Department of Anaesthetics at the Royal Women's Hospital.

This role was created to develop a new and innovative research program in obstetric anaesthesia based in a hospital department. Since 2010, Associate Professor Dennis has established an internationally recognised research program in obstetric haemodynamics and cardiovascular medicine, established transthoracic echocardiography teaching and research in pregnant women and developed cardiac magnetic resonance research at the Royal Women's Hospital.

In 2014 Associate Professor Dennis appointed a research midwife (0.4 full-time equivalent) and this role has been essential and integral to the successful development of this research program. The Academic Enhancement Grant will provide further research midwife support and expand the role into that of a co-ordinating research midwife to enhance and sustain the research program.

This midwife will co-ordinate the current local, national and international research projects including the Six-Minute Walk Test in pregnant women: a prognostic prediction model study that is the core study of the Academic Enhancement Grant application.

This international multicentre prospective cohort study will be performed at the Royal Women's Hospital, Parkville, Australia; Chelsea and Westminster Hospital, London, England; and Mowbray Maternity Hospital, Cape Town, South Africa.

The aim of this study is to develop and validate a clinical prediction rule using an exercise test, the Six Minute Walk Test, performed in women giving birth for the first time early in pregnancy, to discriminate between those women who will have low risk, uncomplicated pregnancies and those that will have high risk complicated pregnancies.

The investigators aim to implement this rule as part of clinical practice. The Six Minute Walk Test is commonly used in non-pregnant adults and advocated by the National Heart Foundation of Australia. It is used to determine cardiovascular fitness and as a prognostic test in adults with chronic medical conditions. Its utility has not been investigated in pregnant women.

It is hoped that this study, which builds upon the team's current international multicentre study determining reference ranges of this test in pregnant women, will enable the prediction of women who have a high risk of developing complications of pregnancy related to the cardiovascular system; specifically new onset hypertension in pregnancy (preeclampsia). If this test enables prediction of high risk women then closer cardiovascular system monitoring and earlier treatment interventions can occur in these women.

The use of this test to facilitate exercise training, as part of a pre-pregnancy exercise intervention program, may lead to a reduction in the likelihood of developing new onset hypertension in pregnancy. Furthermore, if decreased cardiovascular system fitness also predicts other adverse maternal or neonatal outcomes, improvement in cardiovascular fitness prior to pregnancy may lead to further improvement in maternal and neonatal health and a reduction in morbidity and mortality in these groups.

Associate Professor Alicia Dennis, The Royal Women's Hospital, Melbourne.

$A99,552

Novice investigator grants

Lumbar interspinous ligament scissure: a detailed anatomical and imaging investigation

This study is about fundamental anatomy, the bricks and mortar of our practice of epidural anaesthesia.

The interspinous ligament is a midline ligament that sits between the bony spinous processes that project backwards from the vertebral column. It is a ligament that is usually traversed when an anaesthetist chooses a midline approach to the epidural space.

Since most epidurals performed are in the lumbar portion of the spine this study will investigate the lumbar interspinous ligaments (LISL) and lumbosacral interspinous ligament, five ligaments in total per spine examined.

Every anaesthetist is expected to be able to accurately, gently and efficiently site epidural catheters in an adult. A greater proportion of these epidural candidates are severely morbidly obese due to the increasing prevalence and degree of obesity worldwide.

A LISL scissure (a narrow longitudinal fissure or cleft) may be populated by a significant amount of fat in these patients. If this is the case, an anaesthetist's ability to generate a working epidural in these patients may be reduced by simple catheter malplacement. Future investigations will focus on the change of this scissure with obesity and the performance of epidurals in the obese individual. These investigations will link back to this anatomical investigation via the imaging techniques used and fundamental knowledge gained.

Most anaesthetists are unaware of the structure of the LISL but every anaesthetist is prepared to pass a needle through it when they place an epidural. As they do so, they rely upon tactile feedback from the needle and "loss of resistance device" and match their perceptions with a mental image of lumbar anatomy.

The aims of this pilot study are to quantitatively describe the ventral portion of the LISL, and determine if it is universally a paired structure with a potential space. It will link various investigative techniques examining the LISL and determine the nature of tissue within the LISL scissure. Improved understanding of the anatomical structure of the LISL and its scissure may then be applied to the placement of lumbar epidurals.

This study is about basic science in the form of anatomy. The importance of this research is integral to the worldwide anaesthetic community's adaptation to heavier patients. Understanding human anatomy and the anatomical changes induced by severe morbid obesity will continue the excellent provision of safe and effective anaesthesia and analgesia provided by anaesthetists.

Dr Sue Lawrence, University of Queensland, Queensland.

$A19,951

Effects of low dose intravenous ketamine in severe obstructive sleep apnoea patients

Obstructive sleep apnoea (OSA) is a common disease affecting approximately 25 per cent of the population.

The prevalence is on the rise, associated with the increase in obesity among Australians. This patient group faces increased risks of postoperative complications with a high incidence of intensive care unit (ICU) admissions, some reports of death and a multitude of near misses. In addition to the patient cost associated with OSA-related complications, hospitals must absorb the increased financial cost of prolonged hospital stay and ICU care.

Ketamine is commonly used for postoperative pain management. A low dose ketamine infusion results in reduced opioid requirements, less sedation, a lower rate of postoperative nausea and vomiting with no change in breathing patterns. Previous trials, both in volunteers and postoperative patients, has shown improved oxygen saturations and a lower carbon dioxide level in the blood when ketamine was used with opioids.

The aim of this study is to evaluate the effect and safety of using low dose intravenous ketamine infusion in patients suffering from severe OSA. A ketamine infusion during sleep in these patients may improve ventilation resulting in reduced incidence of overnight oxygen desaturation compared to placebo. The investigators will administer either low-dose ketamine or a placebo (normal saline) as an infusion to volunteers suffering from severe OSA with a standard in-lab sleep study conducted to assess the blood oxygen level, breathing pattern and sleep pattern.

Evidence provided by well-conducted trials could lead to management guidelines that will pave the way to safer perioperative management of these patients. Due to the lack of high level evidence, current guidelines on the management of these patients are based on expert opinion and basic pharmacological action of medications in non-OSA populations. Studies performed using sedative/anaesthetic doses of ketamine suggests that ketamine could have a stimulant effect on patients' respiration, even in the presence of opioid and other sedatives. This study will add much needed evidence, for or against, the use of this commonly used medication in OSA patients.

Dr Viraj Siriwardana, Westmead Hospital, New South Wales.

$A19,244

Novice investigator grants (continued)

Comparison of ultrasound guided transmuscular quadratus lumborum (TQL) block catheter technique to surgical pre-peritoneal catheter for postoperative analgesia in abdominal surgery – prospective randomised study

Post-operative pain can pose significant challenges in the post-operative recovery of patients undergoing major abdominal surgery.

Traditionally opioids and epidural analgesia have been used in the management of postoperative analgesia, and more recently abdominal field blocks have been used. However, opioids can cause numerous side effects that can impact on the patient's wellbeing and on the length of their hospital stay. Although the epidural technique is seen as the gold standard after abdominal surgery, it has a certain failure rate and a very rare but serious risk of neurological side effects.

A recent development in this area of anaesthesia is abdominal myofascial blocks, where local anaesthetic (LA) either as a single injection or as a continuous infusion through catheters is infused between the muscle layers where the nerves run. This has been shown to provide good pain relief, while avoiding the opioid-related side effects.

Various forms of abdominal blocks exist: the so-called bilateral transversus abdominis plane (TAP) block and the more recently introduced trans-muscular quadratus lumborum (TQL) block. As an alternative technique, surgeons can insert catheters in the pre-peritoneal plane at the end of surgery and LA can be infused through these catheters.

In recent publications, TAP blocks and pre-peritoneal (PP) blocks have both shown to be effective in treating post-operative pain, comparable to the epidural catheter technique. The more recently introduced TQL block seems to be more promising in terms of pain control and reducing the need for opioids after surgery. However, they have not been compared to other techniques yet.

The investigators are conducting a prospective, randomised study of patients undergoing major abdominal surgery to compare TQL block catheters placed under ultrasound guidance versus surgically placed PP block catheters after LA infiltration.

The primary objective of the study is to compare the pain scores and analgesia used with the ultrasound guided TQL versus surgically placed PP catheter infusion techniques in abdominal surgery. A secondary aim is to assess the subjective quality of pain management (satisfaction score), bowel opening times, discharge times and cost analysis of the two methods of delivery.

Acute pain service (APS) personnel will independently assess the postoperative pain scores and analgesia used in 48 hours. Technical issues related to the insertion, time to insert these catheters, failure rates and complications will be noted. Patient satisfaction will be assessed on the second day after surgery and at one month.

The outcome of this study will contribute to the collective knowledge base around alternative regional anaesthetic techniques, avoiding the pitfalls of both primary opioid-based and epidural analgesia after abdominal surgery.

Dr Vasanth Rao Kadam, Clinical Senior lecturer, University of Adelaide, Queen Elizabeth Hospital, South Australia.

$A14,199

High flow humidified nasal oxygen to prevent desaturation during EBUS – a randomised controlled trial

Endobronchial ultrasound (EBUS) is a common procedure to extract tissue from the lungs of patients suspected of having lung cancer or infections such as tuberculosis or sarcoidosis.

Anaesthesia for EBUS aims to make the procedure tolerable for the patient to reduce or eliminate coughing to maximise safety and to protect the patient's physiology. To tolerate this procedure, patients require sedation which commonly causes hypoventilation and desaturation, necessitating the interruption of the procedure and occassionally putting patients' lives at risk. An intervention to reduce the rates of these problems may make the procedure safer.

The OptiFlow THRIVE device is a high-flow, trans-nasal oxygen delivery device that may allow an extension of the time until profound desaturation and may be able to limit the rise of carbon dioxide levels. The device has been used safely to assist in emergency and intensive care units in both adults and children with hypoxaemic respiratory failure. Its use in anaesthesia is relatively new and it has not been investigated in EBUS.

The aim of this study will be to evaulate the OptiFlow THRIVE's role in oxygen delivery during anaesthesia for EBUS with participants to be randomised to receive either oxygen therapy during sedation or OptiFlow THRIVE. The investigators will then compare the frequency of desaturation and hypercarbia (abnormally high levels of carbon dioxide) in the oxygen therapy using the OptiFlow THRIVE with that of standard oxygen therapy using a gutter mask.

If the use of the OptiFlow THRIVE device results in lower rates of desaturation than standard oxygen delivery, it will help to reduce the overall length of procedures as it will lessen the frequency with which procedures are interrrupted by the need to ventilate and re-oxygenate patients.

This will reduce potential risk factors and improve health outcomes for patients.

Dr Ned Douglas, Royal Melbourne Hospital, Melbourne.

$A16,253

Clinical and Health Economic Outcomes in Elderly Patients with an Operative Neck of Femur Fracture (CHIEF Study)

Fractured neck of femur (NOF) in the elderly is a leading cause of morbidity and mortality in orthopaedic surgery and imposes a heavy medico-economic burden on the health system.

Numerous studies have been carried out in this cohort, but due to significant diversity in measuring both outcome and management, the current evidence base is weak, particularly in relation to its financial implications. As such, a recent editorial has called for large observational studies in different countries so that comparative effectiveness research (CER) is possible in these patients.

In Australia, a research gap exists in this regard as local data on clinical and economic outcomes are limited in the literature for this population. Only a few small studies have reported mortality rates with little investigation into the health economics and with an ageing population hip fractures are forecast to reach 32,000 cases with Australian Medicare expenditure forecast to be over $1 billion by 2022.

These expenditure estimates do not include indirect healthcare costs, such as informal community care and productivity loss due to fractures, and most (72 per cent) are spent on hospital treatment.

This is a historical cohort study of fractured NOF patients aged 70 years or older, who were admitted to a Victorian metropolitan hospital from July 2011 to July 2015 for surgical repair.

After institutional ethics approval, the hospital's diagnostic related group (DRG) database has identified 1163 eligible patients, and provided total and activity-based hospital costs for each patient up to the study cut-off date (August 1, 2016). Mortality data has also been retrieved from the Victorian Registry of Births, Death and Marriages. Demographics and perioperative variables will be collected from electronic patient records.

The investigators will break down the data and assess the impact of perioperative variables on early (90-day) death after surgery, length of hospital stay (LOS) and associated hospital costs.

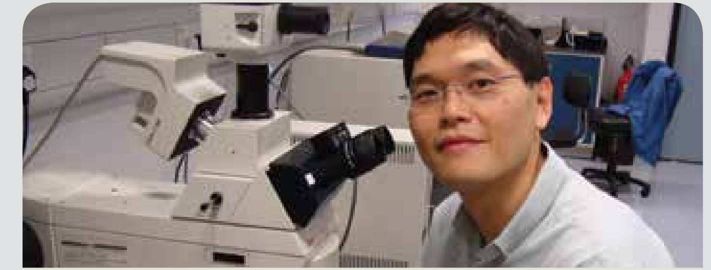
To achieve the study goals, the team will first clearly define the variables selected for examination, to address a lack of common definitions for certain variables (for example, early surgery is recommended in the current guidelines but its definition varies from 24 to 72 hours). This clarity of definition will support consistent interpretation and more conclusive results.

The study intends to improve health outcomes via establishing some potentially modifiable perioperative risk factors, and helping to fill an identified gap in the evidence base by providing valuable local data on outcomes for older people after surgical repair of a broken hip, and how much it cost the hospital to treat these patients.

Dr Aihua Wu, Maroondah Hospital, Eastern Health, Melbourne.

$A17,277

Project grants



Role of intestinal microbes in sepsis

Sepsis is a life-threatening condition characterised by the presence of harmful microbes or their toxic products in the blood.

These lead to systemic inflammation and are associated with disruption of the gut barrier, the single-cell layer separating our gut luminal microbes from the bloodstream. The incidence of sepsis and the number of sepsis-related deaths are increasing due to an ageing population and the emergence of drug-resistant bacteria.

Professor Chan and his team of basic science researchers are working on animal experiments to understand the role of resident gut microbes in sepsis. Using three mouse models of sepsis, fluorescently-labelled bacteria will be used to track the dissemination from the gut into the blood stream in the presence or absence of misoprostol – a prostaglandin E1 analogue. The severity of sepsis will be monitored using the mouse sepsis severity score. The relationship between sepsis severity and the bacterial load in the blood stream will also be investigated.

The team will also evaluate the therapeutic efficacy of misoprostol, which is known to provide protective effect in other digestive diseases against bacterial translocation from the gut to the bloodstream in sepsis.

The findings of this study will inform the underlying mechanism for bacterial translocation and will provide new insights on the use of the non-antibiotic drug misoprostol in preserving the gut barrier function to reduce the morbidity and mortality of sepsis.

Professor Matthew Chan, The Chinese University of Hong Kong, Prince of Wales Hospital, Hong Kong, China.

$A70,000

Project grants

Volatile Anaesthesia and Perioperative Outcomes Related to Cancer: The VAPOR-C Trial (feasibility study)

As the number of cancer diagnoses increase, more patients will present for surgical resection of primary and metastatic solid tumours.

It is now estimated that more than 80 per cent of patients with cancer require anaesthesia for definitive cancer resection or for diagnostic or supportive procedures. In Australia, more than 300,000 elective surgeries are performed each year for cancer resection, and this number is anticipated to increase substantially over the next decade.

While there is an urgent need to improve global surgical services it is important to recognise the mounting evidence that surgical therapy may adversely impact cancer outcomes.

This is likely due to surgery initiating an inflammatory and immunosuppressive stress response in patients. Anaesthetic agents also have immunosuppressive effects and may be cancer promoting (activating pro-angiogenic and anti-apoptotic pathways) within tumours or undiagnosed micro-metastatic disease.

Retrospective studies suggest that patients may have a poorer survival after cancer surgery if volatile-based anaesthesia is used instead of total intravenous anaesthesia. This is supported by our preclinical laboratory data, conducted in collaboration with Associate Professor Erica Sloan at Monash University, which demonstrates rapid breast cancer recurrence in mice when surgery is performed under volatile anaesthesia as opposed to propofol-based total intravenous anaesthesia.

The investigators plan to conduct an international, multi-centre, prospective randomised control trial to investigate the impact of anaesthetic technique on cancer-free survival and overall survival—the Volatile Anaesthesia and Perioperative Outcomes Related to Cancer (VAPOR-C) trial.

Before undertaking this multicentre trial, the investigators will conduct a feasibility study that will explore the ability to recruit patients, the ability to administer the anaesthetic technique during different major cancer surgeries, refine data endpoints in terms of postoperative complications that may impact the return to intended oncologic therapy (RIOT), and explore health economic endpoints. This feasibility study will also develop a biorepository to investigate potential biomarkers and investigate biological endpoints that have been identified in our mechanistic preclinical studies to better understand the impact of the perioperative period and anaesthetic technique on cancer outcomes. Studies will include advanced biochemical, immunological and genetic assessment of perioperative bio-specimens, including circulating tumour cells.

There are currently no evidence-based guidelines for the practice of onco-anaesthesia. The results of VAPOR-C will enable the development of such guidelines based on the high quality data collected via this randomised controlled trial. The results of this trial will better guide perioperative care for cancer patients, with rapid translation into clinical practice to ultimately improve long-term cancer outcomes globally.

Professor Bernhard Riedel, Peter MacCallum Cancer Centre and University of Melbourne, Melbourne, Dr Julia Dubowitz, Dr Jonathan Hiller, Associate Professor Erica Sloan, Monash University, Melbourne.

$A70,000

Capturing anaesthetic gases; an exploration of the chemistry and chemical engineering required to capture and potentially reuse sevoflurane

Inhalant anaesthetic agents are expensive and contribute to global warming emissions being hundreds to thousands of times as potent as carbon dioxide.

Their reuse has important financial and environmental implications and accordingly research into this area is of high priority. Although a few companies have devices that are capturing anaesthesia gases for reuse, they are rarely used due to cost and other technical constraints.

The investigators plan to examine the feasibility of capturing vaporised sevoflurane from the scavenging system of an anaesthesia machine by absorbing the gas to a metal organic framework or a carbon filter, or condensing it to a liquid.

This is the first project of a research program that will evaluate the capture and potential reuse of volatile anaesthesia agents.

The second part of the study will be to restore the sevoflurane to a gas. This should be relatively straightforward as it is an identical process to that now used in anaesthesia machines to evaporate the liquid sevoflurane in the bottle to be used by the patient.

This is an initial proof of concept study that does not involve patients. If the investigators are able to feasibly and inexpensively condense or absorb sevoflurane, further studies will be progressed to include patient trials.

The final aim is to allow for a feasible method to capture and reuse sevoflurane that could be used worldwide, preventing release of sevoflurane to the atmosphere and allowing for safe, inexpensive patient reuse of sevoflurane.

Dr Forbes McGain, Associate Professor Craig French, Western Health, Melbourne, Associate Professor Paul Donnelly, Bio21 Institute, Melbourne, Associate Professor Brendan Abrahams, Professor Sandra Kentish, Dr Keith Forrest White, Professor David Story, University of Melbourne.

$A34,039

A randomised non-inferiority trial of chewing gum versus ondansetron to treat postoperative nausea and vomiting in female patients after breast and laparoscopic surgery (the Chewing Gum Study)

Postoperative nausea and vomiting (PONV) is a significant complication of general anaesthesia, resulting in patient morbidity, delayed discharge and cost burdens of anti-emetic rescue therapy and unanticipated hospital admission.

Prophylaxis and treatment of PONV is effective but is costly and has side effects.

Chewing gum has been successfully used in the healthcare setting to hasten return of bowel function after major abdominal surgery.

Two prior prospective studies conducted by this research team on chewing gum treatment for PONV have confirmed its acceptability to patients and staff, feasibility of conducting a large multi-centre trial, and initial encouraging results compared to ondansetron in a single centre randomised trial (funded by an ANZCA project grant in 2016). Therefore chewing gum may have merit as a first-line, drug-free treatment for established PONV, thus potentially introducing a cheap, novel and safe therapy with important implications for patients undergoing general anaesthesia.

The investigators will conduct a multi-centre, randomised trial that will assess whether chewing gum is as good as ondansetron given intravenously (the standard of care) in achieving full resolution of PONV after administration to female patients aged ≥12 years with PONV in the recovery room after volatile anaesthetic-based general anaesthesia for breast and laparoscopic surgery.

The primary outcome is full resolution of PONV for two hours after administration of the intervention, defined as no nausea, retching or vomiting following treatment.

Secondary outcomes include acceptability of randomised treatment to patients and PACU nurses, time to full resolution of PONV, numbers of episodes of PONV after randomised treatment, numbers of rescue treatments after randomised treatment, duration of post-anaesthesia care unit stay, quality of recovery, functional health and wellbeing, duration of hospital stay, unplanned overnight admission in planned day cases, cost of randomised and rescue drugs, and hospital stay. Rescue antiemetics will be available at all times.

If chewing gum is shown to be non-inferior to ondansetron, it has the potential to change practice and improve clinical and financial outcomes for millions of patients as well as health services worldwide.

Dr Jai Darvall, Professor Kate Leslie, Dr Megan Allen, Royal Melbourne Hospital, Melbourne, Professor Andrew Davidson, Royal Children's Hospital, Melbourne.

$A70,000

Development of pharmacokinetic models for antibiotics prophylaxis in paediatric cardiac surgery

Surgical site infection (SSI) remains an issue in New Zealand. Development of infections postoperatively can lead to extended hospital stays, poor outcomes for patients and increased medical costs at a national level.

The problem is sufficient that a national SSI surveillance program has been established for hip and knee surgeries, with recent extension to cover cardiac surgery.

Ideally cardiac surgery should be associated with an incidence of infection (superficial and deep) of less than 5 per cent, which is not reached in many centres. While plenty of emphasis has been placed on giving the right dose of antibiotic at the right time in order to prevent postoperative infections, one factor that may contribute to persistent rates of SSI infection in children following cardiopulmonary bypass (CPB) is a lack of understanding about what the appropriate dose should be.

Failure to account for changes in antibiotic pharmacokinetics during support with CPB may mean that current dosing of some antibiotics is inadequate and desired concentrations in the body are not reached. Few studies have determined the pharmacokinetics of antibiotics in paediatric populations, and fewer still in neonates and children undergoing a procedure involving CPB.

The investigators aim to develop pharmacokinetic models that can be used to rationally select doses that achieve target antibiotic concentrations to help reduce postoperative infections in paediatric patients undergoing cardiac bypass at the Starship Hospital.

To do this, the project will involve both in vitro and clinical components. In the first (in vitro) stage, the disposition of the study drugs cephazolin and vancomycin will be studied in fully assembled CPB units without a patient to inform the modelling process to be undertaken in the clinical study. Other factors will also be investigated, such as impact of blood, albumen and clear primes, temperature change and modified ultrafiltration to quantify those factors that are likely to be important when developing pharmacokinetic models for children undergoing CPB. In the clinical component, antibiotic disposition will be assessed in neonates, infants and children by taking frequent samples for drug concentration analysis during and following CPB.

The development of robust pharmacokinetic models for vancomycin and cephazolin in children undergoing CPB will provide the tools needed to ensure that the right dose is given to each patient.

Ultimately this will translate into a reduction in postoperative infections, hospital stays and long-term mortality, as well as the emotional burden for the patient and family.

Professor Brian Anderson, Starship Hospital, New Zealand, Dr Jacqueline Hannam, University of Auckland.

$A25,804

Project grants (continued)

Prospective de-labelling of inappropriate antibiotic allergy for perioperative patients (CHAD-P, CHildren's Antibiotic De-labelling -Perioperative)

Children are often labelled "antibiotic allergic" when they develop a rash while being on antibiotics.

These rashes are rarely caused by the antibiotics and are more commonly unspecific viral rashes. It is estimated that less than 10 per cent of adult and paediatric patients with self-reported antibiotic allergy labelling (AAL) have a true antibiotic allergy.

AALs given in childhood impact on life-long clinical care. Adult studies have demonstrated a worse clinical outcome for antibiotic allergy labelled patients taken as a group, with aspects such as longer lengths of hospital stay, more admissions into the intensive care unit and a higher 30-day all-cause mortality compared to never labelled patients.

The most common antibiotic allergy reported concerns penicillin and beta-lactam antibiotics. AAL against beta-lactams are associated with the increased use of quinolones and vancomycin in the healthcare system, which are both linked to the rise in multi-resistant bacterial infections.

Current strategies of antibiotic de-labelling are time-intensive, painful and poorly validated in children.

Diagnostic strategies currently recommend skin prick testing then intradermal testing and finally provocation challenge. A reaction at any stage of the process is deemed to indicate allergy and further testing is not carried out.

However, data from the investigators' preliminary studies on paediatric AAL de-labelling suggest that this approach may lead to children inappropriately being identified as AAL and being unnecessarily excluded from the gold standard provocation challenge by false positive skin testing or immunoglobulin E (IgE) blood test results. As there is a genuine risk of life threatening allergy present within this labelled population, appropriate assessment is always warranted.

The Centre for Disease Control has recommended that everybody with an AAL, should be reviewed in order to confirm or dismiss their antibiotic allergy label. As yet there is no consensus on how to do this safely and promptly in the perioperative setting, a time when patients are likely to be exposed to antibiotics.

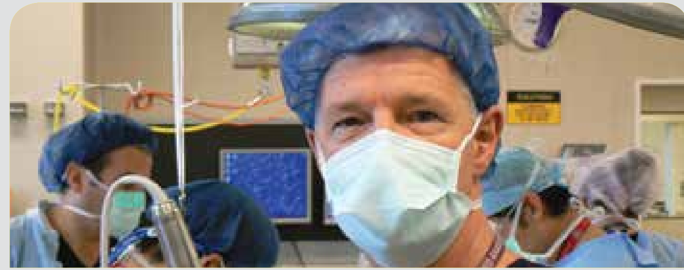
This study aims to develop evidence for a safe and timely method to de-label perioperative children with suspected antibiotic allergy. This research will help to determine if children with antibiotic allergy labels can be safely and effectively de-labelled.

Establishing a provocation challenge alone as safe and sufficient to preoperatively de-label children will mean children can be assessed quickly and with the avoidance of many needles, extra time and expense of skin prick testing and/or intradermal testing.

A systematic approach to de-labelling perioperative patients with AALs will lead to improvement in clinical care, including optimal choice of antibiotics and long-term health outcomes, both for those who are de-labelled and those whose AAL is verified.

Professor Britta Regli-von Ungern-Sternberg, Dr David Sommerfield, Associate Professor Michaela Lucas, Dr Kristina Rueter, Princess Margaret Hospital, Subiaco, Western Australia.

$A69,953



A clinical trial to evaluate the antidepressant effects of nitrous oxide in people with major depressive disorder

Major depressive disorder (MDD) is a very common disease, occurring in around 15 per cent of people at least once in their lifetime.

It is associated with two-fold increased risk of death compared with non-depressed individuals and is predicted to be the leading cause of disability in Western countries by 2030. Severe depression is associated with a sense of ingrained hopelessness, high suicide risk, physical health decline, impairment in work, social and family life and increased healthcare utilisation.

The investigators propose a randomised clinical trial to evaluate the antidepressant effects of nitrous oxide in people with MDD.

Their preliminary work has identified a rapid onset and clinically important reduction in depression scores after a single treatment in those with treatment-resistant depression. This project will further evaluate these effects with four one-hour treatments of nitrous oxide over four weeks (once per week).

Patients will be monitored under the direct supervision of an anaesthetist-researcher. After the fourth weekly inhalation session, patients will undergo weekly assessments of depression.

The aim of this extension phase will be to characterise any persistent beneficial effect, and to explore for improved efficacy. The investigators will measure how well the patients respond and improve to this treatment, to identify an optimal dose and regimen to guide current practice, and to plan a future large pragmatic trial.

If nitrous oxide is proven to be effective, the investigators plan to further develop treatment regimens for a broader range of patients suffering from depression and bipolar disorders.

Nitrous oxide is inexpensive and can be simply and safely delivered by any trained clinician, and in more convenient locations, such as a ward, clinic or emergency room.

It is hoped that nitrous oxide can provide a rapid onset of antidepressant effect while the therapeutic benefit of any newly-commenced traditional antidepressant or non-drug treatment have their effect; it may also be a useful supplementary treatment for maintenance therapy, aiming to prevent recurrence of depression.

A potential clinical application of nitrous oxide may be as an immediately acting antidepressant in acutely suicidal patients where a week, or even two to three-day response would be advantageous and potentially life-saving.

Professor Paul Myles, The Alfred hospital, Melbourne, Professor Paul Fitzgerald, Professor Jayashri Kulkarni, Monash Alfred Psychiatry Research Centre, Melbourne, Professor Peter Nagele, Washington University School of Medicine, US, Dr Jessica Kasza, Monash University.

$A70,000

Improving Safety for children with Asthma undergoing General Anaesthesia (SAGA)

Perioperative respiratory adverse events (PRAE) are among the most common critical complications that children experience.

Approximately 15 per cent of children undergoing anaesthesia experience PRAE with rates as high as 50 per cent during some common surgical procedures. Previous research has reported PRAE to be highly correlated to increased airway reactivity. This association is strongest in patients with a history of asthma, eczema and recent upper respiratory tract infection (URTI).

Currently, anaesthetists rely on clinical histories to assess this risk. Symptoms such as asthma, wheezing, hay fever and a family history of allergies and asthma amongst others are all associated with a higher risk of respiratory complications under general anaesthesia. These respiratory complications can be minimised if children at risk are correctly identified preoperatively.

The use of new screening techniques that allow assessment of the risk for respiratory complications by measuring airway inflammation and changes in lung function would help anaesthetists to better assess this risk. This would then allow the anaesthetist to tailor a personalised anaesthesia management to minimise the risk for these complications.

This pilot study aims to assess the feasibility of an innovative personalised approach, easily applicable to young children to significantly improve the prediction of respiratory complications prior to surgery. Males and females aged four to 10 years of age will be recruited after voluntary informed consent and will complete two tests prior to their surgery.

Tests include measuring airway inflammation using the exhaled nitric oxide test and measuring lung mechanics using the forced oscillation technique.

Strong evidence of successful use of these screening techniques will pave the way to dramatically change in surgical and anaesthetic risk management prior to surgery and lead to improved health outcomes for children, their families and the broader healthcare system as the findings from this research can be directly translated into routine clinical care.

Professor Britta Regli-von Ungern-Sternberg, Princess Margaret Hospital, Subiaco, Western Australia, Associate Professor Graham Hall, Dr Anoop Ramgolam, Telethon Kids Institute, Subiaco, Western Australia.

$A67,332

Does MRGPRX2 activation produce life-threatening anaphylaxis during anaesthesia and can it be predicted and avoided?

The risk of anaphylaxis during surgery continues to concern clinicians, particularly since this adverse reaction is often unpredictable and life threatening.

Anaphylaxis, while rare, is an acute hypersensitivity response often occurring within minutes following exposure to a provoking agent. The clinical response is typically characterised by development of an erythematous rash and urticaria, airway swelling, bronchospasm and hypotension.

In severe reactions, cardiovascular collapse can result in cerebral injury and death. Provoking agents during anaesthesia are most commonly neuromuscular blocking drugs such as rocuronium. The systemic reaction results primarily from the exuberant release of mediators such as histamine from mast cells and basophils.

The presence of drug-reactive immunoglobulin E (IgE) in some patients is suggestive of a classic allergic mechanism of mast cell activation. However, in many, the adverse response occurs on first exposure to the drug and does not seem to be directly caused by an IgE-driven process.

New work has excitingly identified a mast cell receptor called MRGPRX2 that can be directly activated by common muscle relaxant agents (as well as other drugs that share related structures). These findings provide mechanistic support to an "anaphylactoid" or "pseudo-allergic" process being important in anaphylaxis mediated by muscle relaxants.

This project aims to answer the key questions as to why this reaction only occurs in a relative few, and secondly whether individuals can be identified who are likely to suffer these reactions. The investigators hope that establishing the importance of MRGPRX2 will lead to the development of a predictive test or biomarker to avoid occurrence of this potentially deadly adverse effect in the future.

The interdisciplinary nature of the investigators maximises opportunities for access to clinical specimens; utilisation of specialised cell lines and analytical equipment; and moreover a well-rounded perspective on the basic and translational research outcomes.

Associate Professor Paul Soeding, Dr Jeremy McComish, Royal Melbourne Hospital, Melbourne, Dr Graham Mackay, Department of Pharmacology and Therapeutics, University of Melbourne.

$A69,2199

Impact of non-anaemic iron deficiency correction on exercise capacity and perioperative outcomes in colorectal cancer surgery (ADEPT)

This study aims to determine the impact of correction of pre-operative non-anaemic iron deficiency on exercise capacity, total haemoglobin mass and patient-centred outcomes after major surgery for colorectal cancer.

Iron is an essential part of human physiology, integral to a variety of processes in the body. Most equate the presence of iron with the red blood cell haemoglobin, and the ability to carry oxygen. In truth, the role of iron is far broader; essential to the function of muscle and metabolic processes for the production of energy inside the cell.

Prehabilitation programs are being increasingly used as part of an optimisation strategy for patients undergoing major cancer surgery. In other populations, non-anaemic iron deficiency is recognised as reducing exercise capacity and inhibiting response to training. It is possible that given the high incidence of non-anaemic iron deficiency in patients presenting for surgery for colorectal cancer that non-anaemic iron deficiency could explain failure to respond to exercise training, and potentially worsen outcomes after cancer surgery.

Patients who are scheduled to undergo surgery for colorectal cancer and who have non-anaemic iron deficiency will undergo exercise testing, and then receive an infusion of intravenous iron or placebo before being tested again to see if their exercise capacity has improved.

They will be followed during and after their surgery to determine if important outcomes such as requirement for transfusion, physical and mental health and wellbeing and their ability to return to their cancer therapy (chemotherapy or radiotherapy) improves as a result of receiving the study drug. This project also involves a collaboration with the Australian Institute of Sport, utilising their expertise in total haemoglobin mass measurement as a means of measuring the erythropoetic response to iron infusion.

Patients who are iron deficient but not anaemic represent a relatively poorly studied group in perioperative medicine. Current guidelines advocating an analysis of iron stores pre-operatively for patients who are not anaemic are poorly followed, meaning that this group is chronically under-diagnosed. Identification of these patients and comparing the effects of correction of iron deficiency and placebo will determine if there is a case to intervene during pre-operative optimisation, to potentially improve outcomes, especially with respect to identifying non-responders to prehabilitation prior to surgery.

Dr Lachlan Miles, a staff specialist in anaesthesia at the Austin Hospital will co-ordinate this study which will form part of a PhD thesis through the University of Melbourne.

Dr Lachlan Miles, Ms Adele Burgess, Austin Health, Melbourne, Professor Bernhard Riedel, Dr Kate Burbury, Peter MacCallum Cancer Centre, Melbourne.

$A34,683

A prospective observational study examining the impact of iron deficiency on patient outcomes after cardiac surgery (IDOCS)

Pre-operative anaemia is associated with poor outcomes following cardiac surgery, manifesting as increased red cell transfusion, a longer hospital stay, and a higher incidence of acute kidney injury and 30-day mortality.

The most common cause is iron deficiency. Indeed, iron deficiency precedes anaemia and is associated with reduced functional performance and fitness in cardiac surgical patients due to reduced skeletal muscle aerobic metabolism.

The impact of non-anaemic iron deficiency on fitness and outcomes of patients undergoing cardiac surgery is not known. Early observational work suggests that this group have worse outcomes, with respect to transfusion requirements, length of hospital stay and possible mortality, and could be a potential target for intervention and risk modification in the pre-operative period.

Whereas anaemia may be multifactorial in its association with outcomes, iron deficiency can be defined with simple pre-operative tests and easily treatable.

The investigators plan to assess the outcomes of patients undergoing elective cardiac surgery, comparing those with iron deficiency relative to a control cohort of patients who are not anaemic or iron deficient.

Patients with non-anaemic iron deficiency before their operation will be followed during and after their surgery. This group will be compared to a cohort of patients with normal iron stores as a reference point to determine if patient-centred outcomes in patients who are iron deficient but not anaemic are worse, relative to those patients who are not anaemic or iron deficient. Identification of these patients, and comparing their outcomes to iron replete and non-anaemic patients will determine if there is likely value in intervening during the pre-operative period.

If iron deficiency is proven to increase patient risk and the demand on hospital resources, then the implementation of simple protocols of iron therapy may offer significant benefit to patients and ultimately improve patient outcomes.

Dr Lachlan Miles, a staff specialist in anaesthesia at the Austin Hospital will coordinate this study which will form part of a PhD thesis through the University of Melbourne.

Dr Lachlan Miles, Austin Health, Melbourne, Professor David Story, Melbourne Medical School, University of Melbourne, Dr Kate Burbury, Peter MacCallum Cancer Centre, Associate Professor Stephane Heritier, School of Public Health and Preventative Medicine, Monash University, Melbourne.

$A70,301 (including scholarship)

"OPTIMISE II" – AUSTRALIA. Optimisation of Perioperative Cardiovascular Management to Improve Surgical Outcomes II

Estimates suggest that more than 300 million patients undergo surgery worldwide each year with mortality reported between one and four per cent.

Complications and deaths are most frequent among high-risk patients, those who are older or have co-morbid disease and undergo major gastrointestinal surgery. Importantly, patients who develop complications, but survive to leave hospital, suffer reduced long-term survival.

Closely monitoring and augmenting a patient's cardiac output through goal-directed therapy (GDT) is an intervention that proponents say leads to a reduction in complications in major abdominal surgery.

However, the evidence base is inconsistent and not entirely persuasive leading to a patchy uptake of this intervention. The proposed OPTIMISE II trial aims to recruit 2502 patients and will be by far the largest and most definitive study of GDT performed to date in gastrointestinal surgery.

The aim of this large multi-centre randomised trial is to establish whether the use of minimally invasive cardiac output monitoring to guide protocolised administration of intra-venous fluid, combined with low dose inotrope infusion (GDT) will reduce the incidence of postoperative infection for patients undergoing major elective surgery involving the gastrointestinal tract.

Optimise II (http://optimiseii.org, ISRCTN39653756) will provide a definitive answer on the efficacy and safety of GDT.

Initiated by Professor Rupert Pearse, Queen Mary University of London, the trial is funded by the National Institute for Health Research (UK) and Edwards Lifesciences Corporation (UK). Australian sites including St Vincent's, the Austin and Alfred hospitals, will participate in this multicentre collaboration with funding from this ANZCA grant and seek to enhance the study internationally by recruiting an estimated 200 patients.

In addition, the Australian sites will initiate a biomarker sub-study, providing novel data on the mechanisms of harms and/or benefits of GDT. Biomarkers linked to the effects of GDT will be used to explore the endothelial and myocardial function, syndecan-1 and troponin-I respectively, in the first 48 hours after surgery.

The inclusion criteria are patients aged 65 years and over and ASA score ≥2 undergoing major elective surgery involving the gastrointestinal tract that is expected to take longer than 90 minutes. The intervention will commence from the induction of general anaesthesia and continue for four hours following surgery.

Cardiac output and stroke volume will be measured by a cardiac output monitor and allow for titration of fluid administration. In addition, a low dose dobutamine infusion will be used to augment cardiac output.

The usual care group will be managed with standard clinical monitoring and fluid administration according to local practice with the exclusion of the availability of cardiac output monitoring and/or GDT.

The primary outcome is postoperative infection within 30 days of randomisation. Secondary outcomes include mortality at 180 days, acute kidney injury, cardiac complications, quality of life and economic analysis.

We look forward to the international collaboration of a leading research group. The benefits include enhancing the design and conduct of future international trials and translation of findings to the local setting. Local researchers conducting the biomarker sub-study can build on their expertise in this area as well as adding to the scientific merit of the study.

Dr Tuong Phan, Associate Professor Lis Evered, Dr Robert Gotmaker, St Vincent's Hospital, Melbourne, Associate Professor Philip Peyton, Austin Health, Melbourne.

$A70,000

Project grants (continued)

Quantifying exposure to chlorhexidine after antiseptic cleaning of peripheral intravenous access ports

There is growing concern and mounting evidence that chlorhexidine can be a cause of anaphylaxis.

A recent literature review "chlorhexidine-induced anaphylaxis in surgical patients: a review of the literature" found 36 published articles (involving 68 patients) discussing chlorhexidine induced anaphylaxis in surgical patients. This review emphasised the increasing incidence of chlorhexidine as an allergen, with further support that it has the potential to cause severe and protracted anaphylaxis.

The current NSW policy for peripheral intravenous cannula (PIVC) access post insertion is to use 70 per cent alcohol to reduce unnecessary exposure to chlorhexidine. However, there are policy changes now being proposed that would standardise PIVC cleaning to be done with a chlorhexidine/alcohol solution.

Considering the significant number of patients receiving peripheral IV access, combined with the number of potential exposures to their access ports being cleaned and utilised, there is an exponentially increased potential for development of either sensitisation or triggering of an allergic reaction secondary to chlorhexidine exposure.

There is no current research investigating intravenous entrainment of chlorhexidine with routine swabbing of PIVC injection ports.

This research project aims to measure whether swabbing the injection ports on intravenous cannulas with chlorhexidine may result in clinically significant quantities of chlorhexidine being introduced when these ports are accessed for use.

The investigators will measure whether there is a difference when the injection happens immediately post swabbing, one minute post-swabbing (considered the recommended time), five minutes post swabbing, 15 minutes post swabbing and after repeated swabs. There is now no known lower limit of the amount of intravenous chlorhexidine established to cause an allergic/anaphylactic reaction.

While this study will not directly investigate the incidence of sensitisation or allergic reactions, it will help quantify the potential allergenic load that patients may be exposed to via a standardised protocol of chlorhexidine use. These results will help influence policy and practices surrounding antisepsis of intravenous ports, improving patient safety profiles for this very common medical intervention.

Dr Matthew Doane, Dr Christopher Kwong, Dr David Healy, Dr Sarah Green, Dr Michael Rose, Royal North Shore Hospital, NSW.

$A38,393

Does transfusion-related immune modulation occur following intraoperative cell salvage? A pilot study

Blood collected from volunteers, also known as allogeneic blood, is donated, processed and made available for patients requiring transfusion.

This is an expensive process; according to the National Blood Authority, the estimated cost associated with blood transfusion in Australia is over $A1 billion per year.

While the safety of allogeneic blood transfusions has improved over decades, life-threatening risks remain. These adverse events include wrong blood to wrong patient, transfusion-related lung injury, allergic reaction, infection, cancer recurrence, organ failure and death. Research has linked some of these outcomes to a post-transfusion impairment of the patient's immune responses.

An evaluation of transfusion-related immune modulation associated markers in intraoperative cell salvage blood has never been done in Australia. Considering that more than 2.4 million surgical admissions occur in Australia yearly, the potential impact is significant.

Resources and assays are now available in the laboratory at the Red Cross in Brisbane to study markers and investigate the potential of avoiding the increased infection and cancer recurrence risks associated with allogeneic blood transfusion by using intraoperative cell salvage.

Intraoperative cell salvage is a process where blood lost during surgery is collected, processed and given back to the patient. Use of intraoperative cell salvage may provide a cost-effective and safer alternative to allogeneic blood transfusion.

In particular, because patients are not exposed to blood from another person, it seems likely that the impairment of immune responses that occurs following allogeneic blood transfusion will be prevented.

Therefore, the aim of the study is to confirm that, by receiving intraoperative cell salvage instead of allogeneic blood transfusions, patients will have a lower plasma level of inflammatory markers and associated lower risk of transfusion related immune modulation, than when receiving allogeneic blood transfusion.

The debate about transfusion-related immune modulation has been ongoing in research literature. If this study confirms a lower level or absence of immunological markers within intraoperative cell salvage blood, there is significant potential to reduce the occurrence of major postoperative infections which will provide better patient care, decreased harm to patients and a more acceptable alternative to allogeneic blood transfusion.

Dr Michelle Roets, Associate Professor Kerstin Wyssusek, Professor André van Zundert, Royal Brisbane and Women's Hospital, Brisbane, Dr Melinda Dean, Dr John-Paul Tung, Professor Robert Flower, Australian Red Cross Blood Service, Brisbane, Queensland.

$A70,000

Validation of Clearsite finger-cuff in patients with problematic non-invasive blood pressure measurement undergoing elective bariatric surgery

Obesity can cause difficulties and inaccuracies in blood pressure measurement. Accurate blood pressure measurement is of fundamental importance in the detection and management of hypertension, and is an integral component of the delivery of high quality, safe anaesthesia and perioperative care.

With the rate of obesity in Australia continuing to rise, the challenge of accurately detecting and managing hypertension in obese patients will arise more frequently.

Use of an appropriately sized arm blood pressure cuff is important to reduce erroneous blood pressure readings. Standard arm cuffs for non-invasive blood pressure measurement often do not fit obese patients, which compromises the accuracy of their blood pressure readings. Significant aberrations of upper arm shape which occur when the BMI is 35 or greater is likely to contribute to this problem.

This study aims to compare three different blood pressure monitoring techniques in patients of BMI >45 with problematic noninvasive blood pressure measurement to improve the accuracy of measuring blood pressure in obese patients undergoing elective bariatric general surgery.

Continuous non-invasive blood pressure measured by Clearsite will be compared with the readings obtained from a traditional automated oscillometric arm blood pressure cuff, and continuous invasive blood pressure obtained from a radial arterial line.

The method under investigation is Clearsite which measures blood pressure using a finger cuff.

Despite being specifically recommended for obese patients under anaesthesia, the available studies on Clearsite have not been validated in morbidly obese patients. There are significant physiological changes that occur with obesity that may influence the accuracy and performance of the Clearsite finger cuff in this group, such as an increase in cardiac output and potentially an increase in adiposity or oedema in the soft tissues of the finger.

Bariatric patients in whom non-invasive blood pressure cuffs are poorly fitting, present a specific population in which the use of Clearsite continuous non-invasive blood pressure may be extremely useful.

Due to the unique physiological features of these patients, however, validation studies are required.

If shown to be accurate in the bariatric population, the finger-cuff method may be the ideal technique to optimise the accuracy of blood pressure surveillance in situations where invasive monitoring is not appropriate or when the risks, complications and cost of intra-arterial blood pressure monitoring and surveillance are to be avoided.

Dr Rebecca Christensen, Dr Victoria Eley, Professor Leonie Callaway, Associate Professor Kerstin Wyssusek, Professor André Van Zundert, Royal Brisbane and Women's Hospital, Queensland.

$A61,284

Simulation/Education Grant

Evaluation of an enhanced pulse oximeter auditory display: A simulator study

Since the pulse oximeter became standard equipment in operating rooms some 30 years ago, its auditory display has changed very little.

However, over the same time period the operating room environment has become increasingly more complex. Technology has advanced substantially with the result that more information (usually visual) is available to the anaesthetist; the number of alarms has increased and the types of patient have changed with sicker and older patients undergoing surgery.

The question arises as to whether the auditory display of the current pulse oximeter has achieved its maximum potential in supporting the anaesthetist in monitoring oxygen levels in the current operating room environment.

The aim of this study is to test the effectiveness of a new auditory display for pulse oximetry for detecting oxygen saturation (SpO2) parameters.

The pulse oximeter is widely accepted as essential for maintaining patient safety during anaesthetic procedures and is mandated as standard equipment in operating rooms in developed countries. It provides visual and auditory displays of a patient's heart rate and SpO2 levels.

Recent research shows the auditory display can be enhanced to provide better quality information about the patient's state. With the addition of extra sound dimensions such as tremolo (to give a vibrating sound) and brightness (to give a harsher sound) to the existing auditory display, people can identify different oxygen ranges, as well as when oxygen levels cross a clinically important threshold, more accurately than people using a sound display similar to that of current pulse oximeters.

The investigators plan to test their enhanced display in a high-fidelity patient simulator at the Lady Cilento Children's Hospital. Realistic scenarios for simulated patients undergoing anaesthesia will be designed to compare anaesthetists' ability to identify oxygen range and transitions between ranges using the enhanced display and the conventional display while they perform other anaesthetic tasks.

An effective auditory display would provide for more accurate identification of oxygen levels and transitions between ranges at a pre-attentive level, allowing the anaesthetist to engage safely in the many other tasks of anaesthesia that demand visual attention.

A more informative signal may allow for more accurate and time critical decisions about patient treatment, which could potentially enhance patient safety. The use of such a display may also alleviate the problem of too many alarms. This research may have implications for patient safety in other medical settings such as intensive care units, emergency medicine and patient transport.

Dr Neil Paterson, Lady Cilento Children's Hospital, Queensland, Professor Penelope Sanderson, Mrs Estrella Paterson, University of Queensland, Professor Robert Loeb, University of Florida, US.

$A30,657

Grant review process

Thank you to all reviewers (opposite) who reviewed a grant application, and in some cases two, for your invaluable contribution to the award process. The ANZCA Research Committee is very grateful for your assistance.

Much effort goes into ensuring that the process is as fair and rigorous as possible. It starts each year with ANZCA Research Committee members reading the grant applications. Three reviewers for each grant are then selected on the basis of their expertise and relevance to the project. Of these, one, the "spokesperson" is a member of the research committee, but the other two usually are not.

We select from a wide range of experts, including quite a number who are not Fellows of the College or its Faculty and where relevant to the content of the application, may not be anaesthetists. The reviewer comments are sent back to the researcher applicant for response, and the spokesperson then collates all this information (including the reviewer scores and the applicant's response – which is very important) into a synopsis with a score.

However, this synopsis and reviewer scores are not the end of the process.

Each grant is then discussed by the whole research committee during a day-long sitting, with final scoring done blind (so no one on the committee knows what score other committee members have given).

Conflicts of interest are declared and recorded and members of the committee are excluded from consideration of any grants for which they have a conflict. The presence of Dr Angela Watt, our community representative adds an extra safeguard in this regard as does our newly appointed member, Dr Jane Baker and our external member, Dr Andrew Klein, Editor-in-Chief of Anaesthesia. None of these three members actively compete for grants, and two are not eligible to.

At the end of all of this, funding is provided to the grants in order of final ranking, within the limits of the funds that are available. Inevitably, some applicants will be unsuccessful and end up disappointed.

We do provide feedback to novice investigators, but not to the other applicants unless directly asked because the reviewers' comments they have already received will reflect most of the factors. Most of the senior members of the committee have themselves had many unsuccessful grant applications both through the ANZCA process and through other granting agencies. Perhaps the thing that most characterises success in the pursuit of grants is persistence and the willingness to keep trying.

Fair process

While accepting that Australian anaesthesia has a fairly small pool of researchers and that among these will lie the best qualified judges of the relative merit of research projects up for grants, I was sceptical about the possibility of avoiding conflict of interest in the decision making. This scepticism found me on the Research Committee of ANZCA this year, a year in which the top scoring project was that proposed by the chairman of the committee!

It was certainly a busy day but I finished it convinced that the process is as fair as possible.

Those from the same department as the researchers are excluded from the process of assessment entirely as are those with close connections; voting is by secret ballot; discussion on the value and feasibility of the project is free ranging, sometimes very frank, and some projects are rejected at this stage. Perhaps some candidates over estimate their costs and some underestimate; however, in 2017 after all the funding was allocated, all but one of the 27 selected projects received the amount requested, but must justify the money as it is withdrawn. Some funding remains subject to ethics approval.

I think even the old cynics like me can be proud of the way the research grant applications are handled and of the way anaesthesia research has progressed in Australia over the last half century. We are all contributing to worthwhile projects in our donations to the ANZCA Research Foundation.

Dr Jane Baker

It will be appreciated that the committee and the reviewers put a lot of work into this process, entirely pro-bono. We would like to express our very sincere thanks to all of them, and to Susan Collins, ANZCA's Research Administration Coordinator and Rob Packer, General Manager, ANZCA Research Foundation for the amazing job they do in supporting the committee. We would also like to thank John Ilott, ANZCA's Chief Executive Officer and the ANZCA Council for their ongoing commitment to supporting research, which manifests in many ways including through the work of this committee.

Professor Alan Merry, Chair
Professor David A Scott, Deputy Chair

ANZCA-funded researchers deliver new knowledge and evidence

Research projects led by ANZCA Fellows are supported by grants through the ANZCA Research Foundation each year.

The following small sample of recent project outcomes is the start of an increased focus on the reporting of ANZCA-funded research outcomes and their implications.

Developing a pain modulation index in people with chronic pain: a pilot project (Professor Philip Siddall, Greenwich Hospital and University of Sydney)

This study designed and piloted a questionnaire as the first step in developing a self-report measure for assessing endogenous pain modulation, including altered modulation within the central nervous system.

After administering the questionnaire to test and control groups and comparing it to other pain-related physiological function questionnaires, the results showed it to be both valid and reliable for measuring features of central factors affecting pain modulation. With further refinement, the new questionnaire could be a useful clinical tool in the assessment of central contributors to the experience of pain, and the management of chronic pain.

Presentations: Australian Pain Society ASM (April 2017); IASP World Congress of Pain, Yokohama (September 2016).

Validity of performance in the anaesthesia patient simulator as a measure of performance in the operating room (Professor Jennifer Weller, University of Auckland)

In this study exploring the validity of the simulated environment, investigators hypothesised that anaesthetists would exhibit similar verbal communication patterns in routine operating room (OR) cases and routine simulated cases, and different patterns in crisis simulation.

Key communications relevant to teamwork were coded from video recordings in each setting. Investigators found no significant differences in communication patterns in the OR and the routine simulation, but did between the crisis simulation and both the OR and the routine simulation.

The similarity of anaesthetists' teamwork communications in simulated cases and the real setting supported the ecological validity of the simulation environment, and its value in teamwork training, while communication differences under the challenge of a crisis supported the use of simulation to assess crisis management skills.

Publications: Anesthesiology 2014; British Journal of Anaesthesia 2013.

REACT: Reducing anaesthetic complications in children undergoing tonsillectomies (Professor Britta Regli-Von Ungern Sternberg, Princess Margaret Hospital, WA)

Tonsillectomy surgery is associated with significant complications and in rare cases death. Children experience twice the adult rate of fatal respiratory events following tonsillectomy.

Previous studies by the Princess Margaret Hospital (PMH) group found a number of risk factors for perioperative respiratory adverse events, and a 48.2 per cent complication rate in children undergoing tonsillectomies.

As a strategy to improve outcomes for high risk children, this study explored preoperative inhaled salbutamol, recruiting 484 children aged one to eight years randomised to salbutamol or placebo.

Children receiving salbutamol preoperatively had significantly less breathing problems compared to the children who had the placebo.

The conclusion was that a drug such as salbutamol, a beta-2 agonist, before tonsillectomy can significantly reduce the risk of perioperative respiratory adverse events.

Presentations and publications: SPANZA, Perth (October 2017). Now being drafted for publication.

Malignant hyperthermia and exertional heat stress: the genetic and molecular connections (Dr Neil Pollock, Palmerston North Hospital and Massey University, NZ)

The investigators aimed to identify and characterise genetic variants causing malignant hyperthermia (MH), a potentially fatal disorder associated with potent volatile anaesthetic agents.

Their study showed that 13 different genetic variants are causative of MH, and demonstrated that two variants cause loss of function which is likely to cause the central core disease identified in families with these variants.

The team plans to submit these variants for acceptance as causative mutations to the European MH Group for adding to the existing list of 35 causative mutations; a significant 37 per cent increase on the current number.

This work will increase the diagnostic potential of DNA-based testing for MH and help reduce the requirement for invasive and morbid muscle biopsies, so that more individuals from families carrying these variants will only need to undergo a simple blood test to diagnosis MH susceptibility.

Publications: British Journal of Anaesthesia 2016; Temperature 2016.

Perth lunch promotes WA research

Building our research profile in Perth

On October 6, the ANZCA Research Foundation held a lunch meeting to further develop the foundation's network in Perth, and highlight the track record, achievements and current activities of ANZCA-supported researchers, focusing on those in WA.

ANZCA CEO Mr John Ilott opened the function, and ANZCA President Professor David A Scott presented core aspects of the successful ANZCA research support model including funding grants for basic science and pilot projects, support for emerging investigators through to senior researchers and clinical trial leaders, and vital research infrastructure support for multicentre clinical trials through the ANZCA Clinical Trials Network.

Perth-based Associate Professor Edmond O'Loughlin spoke about his personal career development including his role as a chief investigator on the current NHMRC-funded PADDI international multicentre trial on dexamethasone and surgical site infection, followed by discussion on the potential to further expand anaesthetist and pain specialist-led research in perioperative medicine in WA.

The 15 guests included Ms Shirley Bowen (CEO, St John of God Hospital, Subiaco), Ms Carolyn Williams (CEO, Centre for Entrepreneurial Research and Innovation), Professor Steve Webb (Director of Clinical Trials, St John of God Hospital), Mr John Gummer, CEO Bennet Family Company, Dr Lindy Roberts (Past ANZCA President), and Foundation Life Patron Associate Professor John Rigg.

Leadership Circle

The new ANZCA Research Foundation Leadership Circle is a special program for people who want to improve health outcomes for people having anaesthesia and surgery and pain patients by supporting more research in perioperative and pain medicine.

Leadership Circle members commit to donating $A10,000 or more annually over three or more years, reflecting the timeframe and minimum funding required for many medical research projects from design to completion and publication. The program is also intended to generate leadership gifts that help motivate significant further philanthropy for research in anaesthesia, pain and perioperative medicine to improving scientific knowledge for better patient outcomes.

Foundation Board of Governors member Mr Ken Harrison, chair of the new program, worked with the foundation to identify prospective members for the inaugural lunch, held at ANZCA on November 14.

Research support and grants for 2018

The foundation has been supporting the 2018 research grant round and the ANZCA Research Committee's grant review process. A new strategic planning meeting of the committee was initiated at the ANZCA Clinical Trials Network annual workshop in August to discuss issues such as the advancement of the new ANZCA Research Strategy, integrated support for new and emerging investigators, addressing barriers faced by researchers, and priority research areas.

New Emerging Investigators Sub-Committee

The new Emerging Investigators Sub-Committee has now been established to develop strategies to increase College-wide support for emerging researchers. Chaired by College President Professor David A Scott, membership includes ANZCA Research Committee Chair, Professor Alan Merry, ANZCA Trainee Committee members Dr Tabare Dione and Dr Jonathan Panckhurst, Dr Nico Terblanche from the Clinical Trials Network, Chair of the Scholar Role Committee Dr Scott Fortey, New Fellow Councillor Dr Scott Ma and members Dr Benjamin Piper and Dr Sophie Liang.

The new group is of strategic importance to ensuring that more novice and emerging researchers secure future ANZCA research funding, engage in research training, and progress to deliver world-class research and contributions to excellence in clinical practice.

Emerging researcher scholarship funding program

A vital component of assisting the development of emerging researchers is to provide more opportunities to pursue research higher degrees to prepare for successful research careers.

To support this, the foundation is looking for donors to support trainees and Fellows aiming to complete such degrees, by providing flexible scholarship funding that may be applied either to stipends or to fund research projects essential for degree completion.

We have been able to initiate the program through the generosity of Dr Peter Lowe, who is funding a scholarship for a PhD students at the Melbourne Medical School, however we urgently need more similar donors willing to provide similar research project grant support for research degree students (ANZCA trainees or Fellows) at other institutions.

To discuss full or part funding a research scholarship, please contact the foundation.

Foundation subscriptions appeal

Each year many Fellows generously donate with their subscriptions payments to help the foundation provide more support to more trainees' and Fellows' projects.

Please consider such a gift to support our medical research or the work of the Overseas Aid Committee or Indigenous Health Committee. You will be contributing to anaesthetists' and pain specialists' ability to save and improve more lives well into the future. There could hardly be a better or more effective Christmas gift.

Wishing all of our generous donors and supporters, and all Fellows, your families and your patients a healthy, safe, happy and enjoyable Christmas.

Rob Packer
General Manager,
ANZCA Research Foundation

"Saving lives, improving life"

To donate, or for more information on supporting the foundation, please contact Rob Packer, General Manager, ANZCA Research Foundation on **+61 3 8517 5306** or email **rpacker@anzca.edu.au**. Gifts can be made via **www.anzca.edu.au/fellows/foundation**.

The art of making a good presentation

ANZCA CLINICAL TRIALS NETWORK

How a presentation is delivered is an important part of its success, writes ANZCA Research Committee Chair, Professor Alan Merry.

A highlight of this year's Clinical Trials Network (CTN) meeting at Coogee Beach, Sydney was the Novice Investigator's Prize Session.

The ANZCA Research Foundation Novice Investigator Prize was donated by Dr Peter Lowe who expressed a desire for the judging to include points for presentation as well as points for the scientific content of the work presented. Contestants were informed of this ahead of time.

Mr Max Evers, an experienced toastmaster, kindly judged the quality of the presentation, in consultation with the judges appointed to consider the science.

So what makes a good presentation? The following comments reflect the approach used in judging this session, but are slightly broader and deal with scientific presentations in general.

It is probably best to approach this question from the perspective of the objectives of the presentation. These are to convey the key points of the research project to an audience that has a general knowledge of anaesthesia and science but in general no specific expertise in the specific subject and to do this in a defined time frame (10 minutes in this instance).

In any presentation at any conference it is disrespectful to other presenters and to the audience to go over time, so timing is very important (and heavy penalties were imposed for running over time). The key to accurate timing lies in rehearsal.

Slides are generally expected, although there is no rule that says they have to be used. They need to be very clear and easy to read and understand. As a general guide, 24-point is the smallest easily legible font size. Larger is often better. It is amazing how often presenters use fonts that are simply not legible from even a modest distance. The key insight is that the slides are for presentation, not for publication.

It is best to keep decoration to the minimum, and to use bold clear colours. Black on white is very good, with different colours for headings or emphasis if desired. There should be no typographical or grammatical errors, but dot point and contracted sentence structures that are easy to follow are fine. The fewer words used on each slide, the better. Relevant illustrations and figures are very useful. Humorous slides should only be used if they assist to make a relevant point. Copyright is important – cite sources, and if in doubt about an illustration, don't use it.

Introducing a slide with words like "I know you won't be able to read this table but…" is a sign that the slide needs revision. If part of a table is of interest, extract or magnify that part.

There are various ways to structure the presentation, but one safe way is to follow the traditional formula of introduction (and background), methods, results and discussion, ending with a clear conclusion. It is important also to acknowledge those who have contributed to the study and it is not a bad idea to briefly explain your own contribution.

As to speaking itself, the fist point is to avoid "ums"and "ahs". They really are distracting, and in Toastmasters they are penalised. Learning to avoid them is a matter of practising in front of someone who can give specific feedback.

It is important to speak clearly, audibly and slowly enough for people to follow the content. It is perfectly acceptable to check, early on, that people at the back can hear you. It is better not to become stilted in the pursuit of clarity, but clarity is the most important thing. Some of your audience will probably be hard of hearing, so aim to be understood by them.

Ideally, one should vary the pace of the presentation, and also the volume, for the sake of emphasis. Pause is very important – a well-timed pause can build tension and add emphasis to key points, and can help to engage the audience.

It is critically important to speak to the audience and to try to engage them. A good trick is to choose one or two members of the audience, preferably not just in the front, and talk to them, watching their responses and modulating your pace and emphasis to keep them interested.

It is a courtesy to start every presentation with a formal acknowledgement of the chair and a short greeting to the audience. Something along the lines of "Thank you for that introduction, Dr Jones. Good morning everyone, I appreciate the opportunity to speak to you today…" is fine. It can be very effective to end on a strong point of conclusion, and it is not necessary to have a slide that says something like "Questions?" and not necessary to end by thanking the audience for listening (I think the trick here is to do that at the outset).

The question of what to wear is interesting. In general, it is important to dress tidily. If presenting at a major conference, particularly overseas, a suit, or a jacket and tie, is definitely safer, and is expected in the US. At the CTN meeting the emphasis is on casualness, but for a prize session it is still worth looking as if some effort has been made to dress smartly. At the CTN meeting ties are explicitly discouraged, but no one was marked down for overdressing (and that in fact is a reasonably safe way of considering the question of what to wear when speaking to audiences in general).

This point provides a segue into the idea that one should always try to understand one's audience and the context. A formal scientific presentation is just that. It is not primarily intended to be entertaining or humorous, although there is no harm in a little humour if it adds to a point that is being made. Gratuitous humour is not appropriate – it is simply a waste of time. At the Novice Investigator's Prize Session of the CTN meeting clear, well-paced, smoothly delivered presentations focused on conveying the key points clearly within the allotted time scored highly.

Professor Alan Merry
ANZCA Research Committee Chair

Above from left: Dr Kristine Owen, Dr Lachlan Miles, Dr Peter Lowe, Dr Viraj Siriwardana, Dr Jai Darvall.

Climate smart anaesthesia

ANZCA is driving change to reduce, reuse and recycle across the healthcare sector.

Dr Matt Jenks is living proof of what it means to be a "climate smart anaesthetist".

He has actively reduced his travel commitments, has cut back on his meat and dairy consumption at home on New Zealand's South Island and supports a robust public transport system.

As a specialist at Dunedin Hospital Dr Jenks is one of a growing number of Australian and New Zealand anaesthetists who are championing environmentally sustainable practices in their hospitals.

Dr Jenks outlined 10 steps anaesthetists can take to reduce their carbon footprint at the recent joint ANZCA and New Zealand Society of Anaesthetists 2017 Annual Scientific Meeting (ASM) in Rotorua and it was one of the more popular sessions at the conference.

"By making changes to how we use products and services in the sector, with a focus on simple strategies including reducing, reusing and recycling, we can reduce the carbon footprint of healthcare while also making cost savings," he explained.

At Dunedin Hospital anaesthetic circuits used to be changed daily but this was changed to weekly, which resulted in 856 fewer circuits going to landfill per year and a saving of $NZ13,000 per annum. General recycling was also set up in theatre, and PVC recycling, which diverted five tonnes of PVC from landfill over two years.

Dr Jenks says energy efficiency strategies can be simple but have a huge impact, such as turning off lights and unused equipment, using low-flow anaesthesia, using agents that have a lower impact on the environment such as sevoflurane and avoiding the use of nitrous oxide.

Ten things you can do to be a climate smart anaesthetist:

- Diet.
- Commute.
- Anaesthetic gases.
- Reduce and Reuse.
- Recycle.
- Conserve energy.
- Local CME.
- Divest.
- Offset.
- Advocate.

Source: Dr Matt Jenks, FANZCA, Dunedin, New Zealand.

ANZCA too is now taking steps to become an environmental champion. The ANZCA Council will soon be releasing its first professional document on environmental sustainability – *PS64 Statement on Environmental Sustainability in Anaesthesia and Pain Medicine Practice* – to Fellows and trainees with the aim of having a pilot document by early next year.

New Fellow councillor Dr Scott Ma, a consultant paediatric anaesthetist at the Women's and Children's Hospital in Adelaide presented the statement to council last month following a six month drafting process he led, with Rob Burrell (NZ), Eugenie Kayak (Vic), Forbes McGain (Vic), Vanessa Percival (WA), Andrew Weatherall (NSW), Ingo Weber (SA) and Peter Roessler (Vic) as Director of Professional Affairs, Professional Documents. The document has been released to stakeholders for consultation by the Fellows document development group.

It is estimated that operating rooms generate 20-30 per cent of total hospital waste and 20-25 per cent of this comes from anaesthesia services. Gases used daily by anaesthetists, such as sevoflurane and desflurane contribute to climate change but their impact differs dramatically.

Dr Jenks told the Rotorua ASM that using desflurane for one hour has the equivalent carbon footprint as driving a Toyota Corolla 380 kilometres. Sevoflurane's equivalent carbon footprint is only eight kilometres, which helps reduce hospital costs and carbon emissions.

Dr Ma says the environmental sustainability statement not only affirms ANZCA's commitment to reducing the health impact of climate change but will provide a resource for anaesthetists, perioperative specialists and pain medicine specialists to promote environmentally sustainable practices in the workplace and help healthcare facilities consider sustainable practice in the provision of safe patient care.

"It will guide us on how we can incorporate sustainable practice in the care we provide for our patients and provide some information for healthcare facilities about the benefits of sustainable practice. We're demonstrating that not only are there environmental benefits to sustainable practice but also financial and health benefits to patients and clinicians," Dr Ma told the *Bulletin*.

"This is quite a significant change for the College. We're now realising that our College as an organisation is not just about setting standards for our profession, education and training but also about setting standards on wider issues that directly affect the profession and the health and wellbeing of patients, our Fellows and our trainees.

"We're not dictating to Fellows how they should do things. The last thing we want to do is dictate that 'all Fellows should ride their bikes to work' but there are things we can change in our work environments that reduce waste."

Dr Ma said environmental strategies had also been found to reduce hospital costs, sometimes by hundreds of thousands of dollars.

"Financial benefits can be significant so if we can improve the efficiency of how we do things and reduce waste this can improve the economics of what we do."

In addition to the more obvious recycling and reusing anaesthetic equipment where possible, the strategies also extend to Choosing Wisely advice such as rationalising the number of patient blood tests and prescriptions as these too can help reduce waste.

> "Using desflurane for one hour has the equivalent carbon footprint as driving a Toyota Corolla 380 kilometres. Sevoflurane's equivalent carbon footprint is only eight kilometres."

The rollout of environmental sustainability programs in the healthcare sector is extremely patchy. Some hospitals embrace recycling programs such as those run by the Vinyl Council of Australia (VCA) and its major sponsor Baxter Healthcare.

Epworth HealthCare in Melbourne and Baxter Healthcare have joined forces to divert an estimated 12 tonnes of hospital waste from landfill each year with Epworth Richmond the first hospital in Australia to recycle aluminium and PVC hospital products as part of a new sustainability program.

Baxter, in partnership with the VCA, works with hospitals to collect and recycle intravenous fluid bags. This year Baxter expanded the recycling in hospitals program to aluminium bottles of its gas anaesthesia products.

The VCA launched the PVC Recycling in Hospitals initiative in 2009. The program now operates in 119 hospitals in Australia and New Zealand. High quality PVC products including Baxter IV fluids, oxygen masks and oxygen tubing are collected and recycled in Australia. The PVC hospital waste is recycled in Australia and New Zealand where it is used to make garden hoses and outdoor playground matting.

Helen Millicer, the VCA's recycling strategy manager said the program was designed to cost less than sending general waste to landfill.

"What hospitals have found is that a consequence of better sorting for PVC also results in lower clinical waste with considerable savings for hospitals, plus better staff motivation and good will."

At Ballarat Health Services in Victoria, the Deputy Director of Anaesthesia Dr Sanjay Sharma has been leading his department's recycling program. Ballarat Health is one of 60 Victorian hospitals involved in the PVC Recycling in Hospitals initiative.

"I was aware of the work being done by Dr Forbes McGain at Western Health in Melbourne and it seemed a good idea to start exploring what we could do here. Initially there was some reluctance but the department was very supportive. We thought we needed to do more and approached the hospital executive and they were enthusiastic."

A sustainability officer was appointed and Baxter now collects discarded plastic bags, lines, oxygen tubing and masks each week from Ballarat Health.

"Once you have that awareness with simple things such as knowing where the recycling bins are placed it just becomes a habit," Dr Sharma said.

"The anaesthetic nurses have been really instrumental in making the department staff aware of the program. It's not quite hospital-wide yet but we are hopeful that the wards will also become involved.

"Hospitals use a lot of disposable items and most of it goes to landfill. It is a big concern but if, as anaesthetists, we can provide leadership on an initiative such as this for the hospital and staff it just becomes part of normal practice and that's a good thing."

Carolyn Jones
Media Manager, ANZCA

For further information and to register your interest visit www.vinyl.org.au/pvc-recycling-in-hospital.

Above clockwise from left: Dr Matt Jenks in the anaesthesia department at Dunedin Hospital; recycled PVC hosing; recycled playground matting; IV bags ready for recycling. Recycling images courtesy of the Vinyl Council of Australia.

Day of celebrating anaesthesia continues to grow

"Our key message for patients encouraged them to talk to their anaesthetist about their medications and any medical conditions that may affect their anaesthesia."

Dozens of hospitals across Australia and New Zealand embraced ANZCA National Anaesthesia Day with its focus on ageing and anaesthesia.

Ageing and anaesthesia was the theme of ANZCA National Anaesthesia Day (NAD) 2017 campaign and we had a record number of public and private hospitals in Australia and New Zealand taking part.

With the aim of National Anaesthesia Day being to lift the profile of the speciality in the community, our key message for patients encouraged them to talk to their anaesthetist about their medications and any medical conditions that may affect their anaesthesia.

The poster we designed for 2017 noted that as we get older the more likely we are to need a procedure that may require anaesthesia and this prompted many hospitals to incorporate these messages in their foyer displays and activities on October 16.

National Anaesthesia Day has grown each year, with very strong Fellow, hospital and community participation, accompanied by widespread media coverage. Some hospitals and clinics set up comprehensive foyer displays, others simply display the ANZCA National Anaesthesia Day posters and patient information.

This year we had 56 hospital "champions" (well up on the 36 last year) who were personally thanked by the President, Professor David A Scott. There were 35 in Australian hospitals and 21 in New Zealand (out of a possible 26), with some hospitals appointing two champions, and there were also a number of other hospitals who participated. The surgical bus in NZ even promoted National Anaesthesia Day!

A great deal of support was provided by Dr Rowan Thomas and Dr Peter Roessler who gave key clinical/messaging advice and Dr Phillipa Hore and family who starred in this year's NAD video (see www.anzca.edu.au/events/national-anaesthesia-day).

Auckland hospitals were again very active and special mention should go to Sunshine Coast University Hospital who installed a giant electronic version of our poster on the side of a building in the lead-up to National Anaesthesia Day. On the day, Health Minister Cameron Dick visited the foyer display and was filmed learning to intubate using a mannequin (see page 56 for the full story).

Another Queensland hospital, Mackay Base, not only set up an exhibition booth with anaesthesia equipment, videos and posters but also organised a bake sale. The hospital partnered with the Good Shepherd Lodge which is a local community aged care organisation. The proceeds from the bake sale went towards the Lodge's aged care diversion therapy program.

Participating hospitals in Australia included The Alfred, Rockingham General Hospital, Royal Hobart Hospital, Latrobe Regional Hospital, John Hunter Hospital, Ballarat Health, Monash Health, Princess Alexandra Hospital and Western Health.

In New Zealand, National Anaesthesia Day was featured at Auckland City Hospital, Christchurch Hospital, Counties Manukau Health, Dunedin Hospital, North Shore Hospital, Palmerston North Hospital, Tauranga Hospital, Wellington Regional Hospital and Whangarei Hospital.

There was an increased uptake from private hospitals with 11 in New Zealand requesting the National Anaesthesia Day kits after we approached the NZ Private Surgical Hospitals Association. In Australia private hospitals participating included the Chris O'Brien Lifehouse in Sydney, Calvary Bruce Private Hospital in the ACT, the Epworth in Melbourne and Hollywood Private Hospital in Perth, which created a new theatre award to coincide with NAD.

Media and social media

National Anaesthesia Day received broad coverage across radio and print and online outlets in metropolitan and regional media including the *Herald-Sun*, AAP, World News Australia, Newstalk ZB in New Zealand and *The Shepparton News*.

ANZCA distributed three media releases in Australia for National Anaesthesia Day: one "global" release with facts about older Australians and hospital admissions and how to best prepare for an operation, one on a frailty index being developed by Fellow Dr Jai Darvall and another release quoting Professor Scott calling for more debate on futile surgery. Two media releases were localised for New Zealand media. In total, the National Anaesthesia Day coverage attracted an audience reach of nearly 800,000 people. For more details on coverage see the media news article on page 12.

The media campaign led to a 500 word piece in the *Sunday Herald Sun* "Specialists call for new methods to determine whether elderly patients will benefit from surgery" by the health editor Grant McArthur who interviewed Professor Scott and Dr Darvall and reached an audience of 370,000 readers. This story was syndicated to the *Gold Coast Bulletin* and *The Sunday Territorian* in Darwin.

The frailty study was also reported by Australian Associated Press medical reporter Sarah Wiedersehn and this was syndicated to World News Australia and an audience of 92,000 people.

Interviews were also aired on NewstalkZB and RadioLive/Newshub (TV3) networks, with RadioLive broadcasting an item in Auckland and 12 other stations around the country. *The Shepparton News* featured a profile on Goulburn Valley Health's clinical director of anaesthetics Dr Helen Roberts.

Pre-recorded audio grabs with Professor Scott also featured on morning radio news bulletins throughout regional Australia in Muswellbrook (2NM) and Orange (2MCE) in NSW, the Gold Coast (4CRB) and Capital Radio in Cooma. These broadcasts had a combined audience reach of 680,000 people.

Social media was very active. We collated 42 photos from 17 hospitals which can be seen on ANZCA's Facebook page. An estimated 28,000 accounts were reached via Twitter with the hashtag #NAD17. For the first time this year, we targeted key public audiences (based on age, location and interests) with a paid ad campaign on Facebook featuring the video. More than 1000 people in Australia and New Zealand have clicked on the ad to watch the video and another 4800 have taken some sort of action related to the ad (liked, shared, commented, visited the ANZCA Facebook page or visited the ANZCA website).

Carolyn Jones
Media Manager, ANZCA

Below: Highlights of Australian and New Zealand NAD 2017 celebrations.

Queensland hospital a shining star on National Anaesthesia Day

Just six months after the new Sunshine Coast University Hospital opened its doors near Caloundra in Queensland the department of anaesthesia and perioperative medicine swung into action to celebrate National Anaesthesia Day 2017.

For provisional Fellow Dr Galina Gaidamaka, who had only arrived in August, National Anaesthesia Day (NAD) 2017 was the perfect introduction on how to navigate around the hospital's various departments and administration. With the support of the Sunshine Coast Hospital and Health Service's acting director of anaesthesia and perioperative medicine, Dr Tanya Kelly and deputy director Dr Morgan Sherwood she became the hospital's "go to" person for the day.

By the end of Monday October 16 the hospital's activities had been filmed for the local WIN-TV news with special guest, the Queensland Minister for Health Cameron Dick (who tried his hand at intubation) and a giant electronic screen displayed the pink-hued NAD 2017 poster in all its glory on one of the hospital's exterior walls.

Dr Gaidamaka, who is one of six provisional anaesthesia Fellows at the hospital said in addition to the support of Dr Kelly, Dr Sherwood and consultant anaesthetist Dr Ralf Brachold the involvement of the hospital's media and communications team was crucial in making the hospital's support of National Anaesthesia Day 2017 such a success.

"National Anaesthesia Day is such a fantastic opportunity to promote our speciality here at the hospital and it's great for us as a department too. Having that hospital-wide support really made a difference," Dr Gaidamaka explained.

"Our hospital management is very interested in promoting the hospital and healthcare so we were able to showcase our promotion of NAD with a display that included equipment, a mannequin, ultrasound and of course, a cake!"

Carolyn Jones
Media Manager, ANZCA

Above from left: Queensland Health Minister Cameron Dick (right) is shown how to intubate a patient at the Sunshine Coast University Hospital; Billboard displaying NAD at the hospital.

Surfing and organising medical teams all in a day's work

"It's certainly a very uncommon thing and we've never had a shark attack a surfer in an event but there's a lot going on behind the scenes so we're prepared for anything."

Above from left: Dr MacKillop with his favourite surfboard; On the job with LifeFlight.

Dr Allan MacKillop combines his passion for the surf and the outdoors with leadership roles in retrieval and emergency medicine

Living on Queensland's Gold Coast means Dr Allan MacKillop has the best of many worlds. As a leader in retrieval and emergency medicine he has a work and life balance that many medical specialists would envy.

With the Gold Coast beach on his doorstep he often starts his day with a morning surf. Then it's into his office where as chief medical officer for LifeFlight Dr Al, as he is affectionately known by staff, manages a raft of air ambulance medical teams as they respond to medical emergencies throughout Queensland and offshore.

He's also medical director of the World Surf League and for the past 20 years has been a specialist with the Health Reserves of the Royal Australian Air Force (RAAF) as clinical director emergency and aeromedical services. He also manages an anaesthesia practice on the Gold Coast organising weekly theatre lists and is also involved in a pain medicine practice.

But such is his passion for the surf that any spare time he has he spends in Fiji or Hawaii catching the next wave with a group of mates.

Since 1983 when he completed his provisional anaesthesia fellowship Dr MacKillop has not only adapted to the changing requirements of his speciality but has also been a key player in the development of pre-hospital and retrieval medicine (PHRM) in Australia through his leadership at LifeFlight.

The rapid pace of technological change and Queensland's massive population growth has placed the not-for-profit emergency helicopter and fixed wing retrieval service at the forefront of the emerging specialty of emergency and retrieval medicine.

LifeFlight, formerly Careflight Queensland, was established 35 years ago on the Gold Coast with one surf rescue helicopter donated by a local real estate agent and the pilot as its only paid employee. Since then it has grown to a 24/7 operation with more than 350 staff including medical and aviation specialists, engineers and support crew. Several fixed wing jets have been fitted out as mobile mini intensive care units, including two based in Singapore, and 13 helicopters fly out of Brisbane, Toowoomba, Roma, the Sunshine Coast, Bundaberg and Mount Isa.

When Dr MacKillop first started with the then Careflight as a volunteer most of the callouts were to rescue people in car accidents.

Now, the sophisticated mobile emergency medicine equipment means complex retrievals can be deployed at a moment's notice such as in 2015 when Dr MacKillop played a key role organising a LifeFlight intensive care retrieval in Japan for a Cairns father of three who had contracted an aggressive strain of influenza while in Japan on holiday with his family. The patient's condition had deteriorated so rapidly that he was in an induced coma and on life support with a heart-lung bypass machine in a hospital outside Tokyo.

Working with Queensland's Prince Charles Hospital and The Alfred in Melbourne Dr MacKillop and a team of intensive care specialists organised for the evacuation team to bring the patient home on a 10-hour flight hooked up to a heart-lung bypass machine in a Challenger 604 jet that had recently been fitted out as an air ambulance.

Reflecting on the reach and development of the service since the mid-1980s Dr MacKillop says the clinical skills of the medical teams have been crucial in improving patient outcomes.

"We started off treating one patient a week and now our doctors treat 5000 patients a year throughout Queensland. We're now both a medical rescue service and a big aviation company," he explained.

"We've now developed a very sophisticated, co-ordinated system and we now manage a large number of assets, aircraft and personnel very efficiently. It's extraordinary when you look up at the wall in the office and see the markers to indicate all the flights that are criss-crossing the state at any one time.

"We've taken critical care out to the patients in rural and remote areas. Half of Queensland's population live outside the main centres so the ability to take a fast efficient helicopter or jet to take critical care team to patients has made an enormous difference. Their road to recovery starts hours and hours earlier

and that makes a huge difference to the quality of their survival. The bottom line is seeing great outcomes for the patients.

"You can't have sophisticated medical facilities everywhere so our role is to get people to them as safely and quickly as possible."

LifeFlight is recognised by ANZCA as an advanced training centre for anaesthesia registrars for six months or for provisional fellowship training (with prior approval) for up to twelve months.

"We're now able to train senior registrars in their fourth or final year. We need to have them at that level when all their clinical skills have been developed because when they're working with us they're going to accident sites so they have to be very independent," Dr MacKillop said.

He singles out the advent of technology and tele medicine as now essential retrieval medicine tools that were not available during his early years with the service.

"This is one of the biggest changes I've seen over the last 30 years," Dr MacKillop told the *Bulletin*.

"It means a consultant anaesthetist, intensivist or emergency physician can be available via radio or satellite phone at all times during their flights. They can give the medical teams advice utilising tele medicine when they're on a flight. It's a very comprehensive training program.

"We have about 30 registrars working with us for six months at a time and train up to 60 a year. It varies from year to year and while many are now emergency medicine trainees it's also great training for anaesthesia trainees as it takes them out of their normal operating theatre and intensive care environments."

Dr MacKillop is enthusiastic about the growing interest in pre-hospital and retrieval medicine as a specialty.

(continued next page)

"We started off treating one patient a week and now our doctors treat 5000 patients a year throughout Queensland. We're now both a medical rescue service and a big aviation company."

Surfing and organising medical teams all in a day's work (continued)

"The aircraft we're using now have become so much more sophisticated and capable. The personnel are so highly trained as we have established formal training programs from the beginning when nothing was established and it's now developing into a specialty of its own. It's great experiences for the doctors and they develop a lot of skills for their anaesthesia and emergency medicine careers.

"But when they finish their training with us many continue to have a part time role with retrieval medicine either here or overseas."

The international mix of registrars working with LifeFlight reflects the best practice reputation of the air ambulance teams. At any one time forty per cent of the registrar level staff are from overseas – either anaesthetists or emergency or intensive care specialists from South Africa, Europe, Canada, the US, Scandinavia and New Zealand.

"They come to work with us because it's quite a unique training experience that they can't get back home. In Germany for instance they have a lot of rescue helicopters but the average flight time is 11 minutes – here it's about one and a quarter hours."

In his other role with the US-based Word Surf League Dr MacKillop plans and co-ordinates medical response teams for the world championship surfing tour events in Australia, Fiji, Hawaii, Portugal, France and South Africa.

The skills he's honed at LifeFlight are effortlessly transferred to the surf world.

As the league's medical director he has to ensure there are evacuation plans which will either involve road ambulance, jet skis and helicopters and an international evacuation plan if needed.

"It's basically utilising the same skills we use in pre-hospital and retrieval medicine," he explained.

Thankfully, Dr MacKillop's work with the World Surf League has not involved shark attacks but he says it is something that the event response teams are prepared for.

"You do have to be aware. It's certainly a very uncommon thing and we've never had a shark attack a surfer in an event but there's a lot going on behind the scenes at events so we are prepared for anything.

"When we're in some of the more remote surfing areas the retrieval medicine side of things kicks in. I visit all the venues and help set up the medical infrastructure – I'll go to two or three events a year and act as the event doctor. I've developed a cohort of critical care physicians here in Australia, South Africa, the US and Europe who are now all trained up and we have standardised equipment and care," he explained.

"There's a significant risk because of the size of the surf and surfing on shallow reefs. We have very similar equipment on our rescue helicopters as at these events – a lot of what we do is more primary healthcare. We have a tour staff of more than 200 people for these events globally so we also have to make sure they're looked after too.

"Many of the events have thousands of spectators so we have a responsibility to provide emergency care for them and if any of the crew or surfers or support staff need medical treatment we are responsible for managing that and in some cases for evacuation for more advanced care cases.

"The surfers are elite athletes so they rarely have major injuries but we have had significant head injuries, lumbar spine and pelvic fractures, significant ankle and knee injuries and dislocations. We also cover the 'big wave' tour where the world's elite surfers come in with less than 24 hours notice to surf waves that are 30 feet high.

"That has its own risks because of the sheer size and power of the surf so we also have to make sure we have a dedicated medical response for that."

In his two decades with the RAAF reserve as a clinical specialist Dr MacKillop is used to the unpredictable nature of the role and having to deploy at extremely short notice to incidents in Australia and other countries.

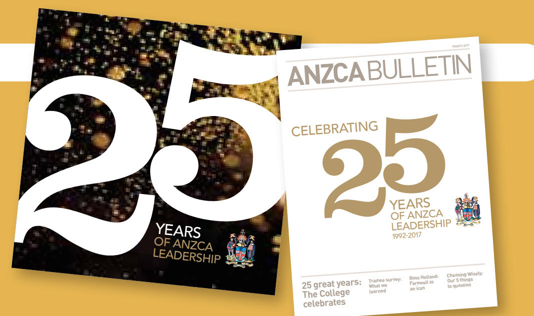
Dr MacKillop was one of the RAAF flight physicians deployed in October 2002 when the Bali bombing killed 202 people. He was part of the extensive medical response team that transported 60 seriously injured patients, many of them with severe burns, from Denpasar to Darwin, Perth and on to other hospital burns units in Australia for treatment.

In 2004 he worked as part of a group of RAAF medical teams who were deployed to Banda Aceh in Indonesia in the aftermath of the deadly tsunami that killed 170,000 people and destroyed entire villages. Dr MacKillop spent three weeks in the region co-ordinating medical supply deliveries and evacuating injured and displaced people to nearby Medan.

Carolyn Jones
Media Manager, ANZCA

Above: Dr MacKillop administering the first blood transfusion in a LifeFlight rescue helicopter in 2001.

A year of celebration



ANZCA 25th anniversary celebrations around Australia and New Zealand.

It has been a year of celebration for ANZCA in its 25th anniversary year.

With ANZCA's 25th anniversary year drawing to a close, the College celebrated with a special event on November 17 that was attended by 10 of its presidents since 1992.

Attending the function hosted by current ANZCA President, Professor David A Scott, were Dr Peter Livingstone, Dr Michael Hodgson, Dr Michael Davies, Dr Neville Davis, Dr Dick Willis, Dr Wally Thompson, Dr Leona Wilson, Professor Kate Leslie and Dr Genevieve Goulding.

ANZCA's Honorary Historian, Professor Barry Baker, spoke at the event about the College's growth over the past 25 years.

ANZCA was officially formed on February 7, 1992 and is now a world leader in anaesthesia.

On that day, 25 years later, a special edition *ANZCA E-Newsletter* was distributed and the College launched *25 years of ANZCA Leadership*, an 88-page reflection of ANZCA edited by Professor Baker. It looked at the College's place on the world stage, how the College has evolved, the evolution of equipment and drugs, a reflection of its high safety record and its role in the community. This book was sent to all Fellows and trainees of ANZCA. A copy was also given to all staff members with an invitation to take part in a "summer holiday selfie" competition.

Behind the scenes, a 25th anniversary logo was created and rolled out on stationery and other collateral including the ANZCA website, a 25th anniversary banner was created for each Australian region and New Zealand, and a video featuring Professor Baker's reflections on the past 25 years was made. We also promoted a Twitter hashtag – #ANZCA25 – to tag anniversary-related content.

The ANZCA Annual Scientific Meeting in Brisbane opened with a 25th anniversary video which was based on the meeting's "Think Big" theme. The video can be found on ANZCA's YouTube channel or via here – www.anzca.edu.au/about-anzca/our-25th-anniversary#Big.

The theme of the Gala Dinner at the ASM was "silver disco" that recognised the anniversary which was also featured in speeches and the ANZCA Lounge. In recognition of the anniversary, long-time ANZCA Research Foundation supporter, Professor Baker, donated $25,000 at the ASM, which tops up his $75,000 donation used to establish the Joan Sheales Staff Education Award and the Provisional/New Fellow Research Award.

More recently, the anniversary was also celebrated at the New Zealand Annual Scientific Meeting in November, adding to activities in all other Australian regions who have celebrated this event at meetings of Fellows and trainees.

The South Australia/Northern Territory Regional Committee, who met on February 7, celebrated the event. Other regions followed suit, many celebrating with presentations and specially made cakes.

The Geoffrey Kaye Museum of Anaesthetic History also supported the anniversary through its "Lives of the Fellows: 1992" project. Three new oral histories – with Dr Livingstone, Dr Felicity Hawker and Professor Michael Cousins – were uploaded.

The 25th anniversary has been marked in features of the *Bulletin* throughout the year, and was the cover story of the March edition, in which all past presidents of the College were profiled and articles from the ANZCA and Royal College of Anaesthetists – also celebrating 25 years as a College – were featured. A profile of 25 years of ANZCA Annual Scientific Meetings were featured in June and a feature on College medal winners was featured in September as well as a look back at some of the New Fellows Conference (now Emerging Leaders Conference) attendees over the past 25 years and where they are today.

Clea Hincks
General Manager, Communications

Above: Her Royal Highness The Princess Royal speaking at "Global anaesthesia: a platform for development".

Royal College of Anaesthetists celebrates 25 years

The 25th anniversary marked a special and momentous year for the Royal College of Anaesthetists (RCoA).

The RCoA's celebrations comprised of a program of events and activities that sought to further the key themes of the College's five-year strategic plan – enhancing membership engagement, working in partnership, and championing anaesthesia with the general public.

Across the UK – from Moray in the Scottish Highlands to Belfast and Cardiff, and throughout England – 10 regional bursary events took place, with a wide variety of workshops and presentations ranging in theme from perioperative medicine to engaging the next generation of anaesthetists. We were honoured to be joined by our Royal Patron, Her Royal Highness The Princess Royal, at RCoA Anniversary Meetings: "Landmarks in UK anaesthesia" (March 8), and "Global anaesthesia: a platform for development" (October 16).

Our ARIES talks (see www.rcoa.ac.uk/rcoa25/ariestalks) feature a variety of high-profile speakers delivering short informative talks on areas of relevance to anaesthesia, critical care and pain medicine. They range from "Do children feel pain?" by Dr Suellen Walker, to "Ebola and teamwork" by Dr Daniel Martin.

We also created a number of new awards especially for the anniversary year. The Trainer Award celebrated excellent training in anaesthesia, critical care and pain medicine, and Anaesthesia Trainee Representative Group members were invited with local trainees to nominate up to three local trainers for this award. The essay awards for medical students, Foundation Year doctors and trainees focused on what anaesthesia would be like 25 years into the future. Judges were impressed with the creativity and originality of the entries. We were also delighted to receive a selection of unique and interesting images on the theme of "In Safe Hands" for the photograph competition.

We are proud to have shared the past 25 years with ANZCA. As we look forward to the next quarter-of-a-century, we remain determined and steadfast in our commitment to continue to be motivated by the goals of the 25th anniversary – to improve outcomes for our patients and reduce pain.

Heather Rogers
25th Anniversary Programme Manager

News

ACGO alert

The following advice stems from both a recent ECRI Alert and a communication from an Australian healthcare facility. It is intended to emphasise the importance of understanding the design features of anaesthesia machines with an auxiliary common gas outlet (ACGO). One such machine is the Dräger Fabius MRI, and Dräger has issued a communiqué emphasising instructions for its use.

The ACGO outlet is a feature of a number of anaesthesia machines and is designed for use with T-piece or Magill circuits, commonly employed for paediatric cases. The position of the labelled switch/lever determines whether gas delivery is to the ACGO or circle system.

Anaesthesia machines that have piston-driven ventilators do not require fresh gas flow to function.

In these cases, connecting patients to the circle circuit while the lever is in the ACGO position may give the appearance that they are being ventilated with fresh gas entering the circle, when in fact the fresh gas is being diverted to the ACGO. In this situation there is risk of hypoxia and awareness.

With the lever switched to the ACGO, there is no audible or visual alarms to alert the user that flow is diverted to the ACGO.

Recommendations:

- Anaesthesia providers must be familiar with the ACGO mechanism on anaesthesia machines. This includes knowing where the ACGO and switch are located as well as whether the anaesthesia unit indicates that ACGO mode is enabled.
- Check the position of the ACGO switch and breathing circuit connections before the start of every case. The switch position should match the breathing circuit being used – the ACGO should not be activated for circle breathing circuits; the ACGO should be activated for non-circle breathing circuits.
- Perform a level 3 check of the anaesthesia machine before every case, as indicated in *PS31 Guidelines on Checking Anaesthesia Delivery Systems*, and ensure all relevant haemodynamic and anaesthetic agent/gas monitoring is attached to the patient. The pre-use check cannot be completed successfully if the ACGO switch is in the incorrect position for the breathing circuit in use.

Dr Phillipa Hore
Chair, Safety and Quality Committee

webAIRS case study report: What are we injecting with our drugs?

Case studies provide an invaluable opportunity to examine our clinical practice.

Within excess of 5000 cleansed reports, webAIRS offers a rich database of anaesthetic cases for analysis and learning.

Professor Alan Merry, Chair of the ANZTADC Publications Group, with DA Gargiulo and LE Fry, investigated a recent incident report to webAIRS that detailed contamination of a propofol ampoule.

This particular case study saw a glass shard fall into the solution.

The report provides insight into a situation thought to be quite common – contamination of drugs by particles introduced during the drawing up process. In this particular report, the shard of glass (presumed to be from a propofol ampoule) was found at the top of the drawing up needle. In such a situation, a two-fold increase in risk becomes apparent – from the glass and from potential micro-organisms on the particle. This is of particular concern with propofol as this short acting general anaesthetic is a medium in which rapid proliferation is likely.

Emerging technologies along with prefilled syringes and, where appropriate, use of plastic ampoules, will reduce the potential for contamination of injected drugs. While there are wider healthcare ramifications (such as cost) with these measures, there are steps that can be taken to reduce risk in every day practice.

Contamination incidents like these serve to remind that we need to exercise meticulous care in drawing up and administering intra venous drugs during anaesthesia. Aseptic techniques have an equally important place – hand hygiene, use of alcohol wipes and short retention times after drug draw up remain important steps in maintaining safe practice.

Sarah Walker
ANZTADC Co-ordinator/ANZCA Policy Officer

Reference:
What are we injecting with our drugs? AF Merry, DA Gargiulo, L.E. Fry. Anaesthesia and Intensive Care, Volume 45 Issue 5, 539-542 September 2017.

webAIRS
Anaesthetic Incident Reporting System from ANZTADC

Pajunk catheter reports

In October, webAIRS has received two reports relating to multiple cases where Pajunk regional analgesia catheters have become blocked.

In the first report, five cases have occurred in the last six weeks within the first day of use. In each of these cases the epidural catheter had worked well during the case and the block was effective in the immediate postoperative period. In at least one of the cases the filter also split.

The second report referred to the use of the long Pajunk catheters as rectus sheath catheters for postoperative pain relief. A number of these catheters have also become blocked within the first day after insertion.

It is not clear whether these incidents relate to a random cluster of cases, or a particular batch, or if there might be a design fault with these particular catheters.

We are appealing for any further reports either by using the webAIRS reporting system or alternatively notify the Safety and Quality Committee at ANZCA. Please note the batch number and also notify the Therapeutic Goods Administration.

Dr Peter Roessler
Communication and Liaison Portfolio
Safety and Quality Committee

Safety alerts

Safety alerts are distributed in the safety and quality section of the monthly *ANZCA E-Newsletter*. A full list can be found on the ANZCA website: www.anzca.edu.au/fellows/safety-quality/safety-alerts

SAFEty first in PNG

SAFE is an acronym for safer anaesthesia from education and is a series of 2.5 to three-day courses aimed at obstetric and paediatric anaesthesia.

These courses have become the model for low-resource anaesthesia teaching and were developed by the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the WFSA (see www.aagbi.org/international/safer-anaesthesia-from-education).

The first two SAFE Obstetric Anaesthesia courses in the Pacific region were held in Port Moresby, Papua New Guinea (PNG) and organised by Associate Professor Terry Loughnan from Victoria and his team. Two more have since been held in Samoa and then Kundiawa in the Highlands of PNG.

The first SAFE Paediatric Anaesthesia course in the region was held after the recent PNG Medical Symposium in September in Port Moresby where the theme was "Access to Affordable Safe Surgery and Anaesthesia in Papua New Guinea". This is the first time this recent World Health Organization-supported public health initiative has been the theme of a national meeting in a low-resource country.

The SAFE paediatric course attracted 25 participants of which 14 were anaesthetic scientific officers (ASOs) or trainees, and 10 were anaesthetic registrars. ASOs – are non-physician anaesthesia providers and provide the bulk of anaesthesia services in the 30 provincial and mission hospitals of PNG outside of the capital and receive no formal continuing education apart from attending these symposia.

Numbers were down a little this year due to an economic downturn and less funding in provincial hospitals to sponsor their staff to attend. Due to the mountainous terrain of PNG, flights are the only way to get to Port Moresby and are expensive.

The course was held at the School of Medicine and Health Sciences at UPNG and would not have been possible without the support of Professor Nakapi Tefuarani, Dean of the Faculty of Medicine, Dr Nancy Buasi, Director of Nursing Division, and Mr Modula, Executive Officer, SMHS.

The course requires a lot of the faculty to allow for small group workshops and interactive teaching and this would not have been possible without the PNG facilitators Dr Pauline Wake, Dr Keno Temo and Dr Arvin Karu; and from Australia Dr Yasmin Endlich, Dr Kirstie Morandell and Dr Chris Acott. Support was also received from Jayne Thompson of Karl Storz Endoscopy Australia and Lynette Hassall from Sonosite Australia.

Future courses are being planned for SAFE Obstetric Anaesthesia in Fiji and PNG, with paediatric courses yet to be determined.

A new course, the SAFE Operating Room course, is now being planned by the AAGBI, the World Federation of Societies of Anaesthesiologists, the Royal College of Surgeons, and the Association for Perioperative Practice.

This course involves the planning needed to run safe and efficient operating rooms in low resource settings. It involves training and education in such areas as reliable power, medical gases and water supply, sterilisation, appropriate equipment purchase and maintenance, drug supply and storage, teamwork, checklists and staff management. The aim is for all members of the operating room team to be involved in the course.

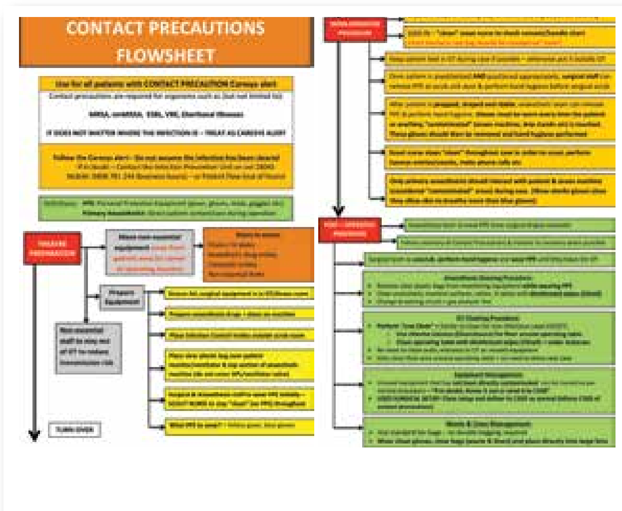
Dr Michael Cooper
Chair, Overseas Aid Committee

Left: A recent SAFE paediatrics course in Port Moresby, Papua New Guinea.

Infection control in operating theatres: Inventing the wheel?

Infection control system

Flow-sheets and associated documents are available at http://doctorsonthemove.com.au/infection-control-documents/.


CONTACT PRECAUTIONS FLOWSHEET

Royal Darwin Hospital has introduced a new system to manage infection control in the perioperative environment.

Infection control is a critical component of modern healthcare due to the ever increasing presence of multi-resistant organisms (MRO). The management strategies required to prevent the spread of infections are therefore paramount.

Fortunately, general infection control strategies such as hand hygiene and barrier protection are well established in Australian healthcare institutions.

However, these generalised approaches to infection control do not translate very well to the peri-operative environment.

Due to high patient turnover, frequent staff interaction with patient and surroundings and patient movement through multiple clinical areas, applying ward-based infection control strategies in theatres is impractical and unsustainable. These limitations inevitably lead to poor adherence to infection control measures and therefore risk of cross-infection.

Furthermore, attempting to interpret and apply these general policies to the operating theatre environment results in confusion and potentially unnecessary delays to operating lists.

To address these issues, we set out to develop an infection control strategy tailored to the perioperative environment. The aim was to maintain adequate infection control measures while minimising the disruption to operating theatre workflow. We contacted infection control departments at multiple Australian hospitals and were surprised to find that none of them had operating theatre specific policies.

Working side by side with the infection control department at our institution (Royal Darwin Hospital, Darwin, NT), we were able to produce a series of reference flow-sheets outlining the infection control requirements for each type of infection precaution.

The various pathogens are classified into five categories: contact, airborne, skin, droplet and carbapenem resistant enterobacteriaceae (CRE). These flow-sheets are stored on the infection control trolley (aka Buggy) with all the required personal protective equipment (PPE).

Staff members are able to bring the trolley to the specific operating theatre, refer to the relevant flow-sheet and prepare the theatre appropriately.

These flow-sheets provide specific and easy to understand management plans that include: theatre preparation, intra-operative requirements, recovery plan, cleaning, linen processing and waste disposal. It also provides clarification on how staff can remain "clean" or "contaminated" in the operating theatre environment during the various phases of the peri-operative process.

Above left: Dr Daniele Lazzari with the infection control trolley (Buggy).

"The aim was to maintain adequate infection control measures while minimising the disruption to operating theatre workflow."

The flowsheets were developed by analysing the perioperative movements and processes of the anaesthetic, surgical, nursing and theatre support staff. Specific areas of concern were identified, and working with the infection control department we established processes that facilitate theatre workflow while still minimising the risk of infection to patients and staff. Feedback from staff has been overwhelmingly positive, as it has provided a reference document and structured approach to the management of infection control cases.

Various factors have prevented us from auditing the impact of the new policy, but we believe that this approach is both simple to implement and robust from an infection control perspective, and would happily support its implementation at other institutions.

The flow-sheets and associated documents are available for free download, modification and implementation from http://doctorsonthemove.com.au/infection-control-documents/.

I want to thank Pamela Ann Boon, Infection Prevention and Management Unit Clinical Nurse Manager at Royal Darwin Hospital, for her expert contribution to the documents and processes described in this article.

For further information or comments you can contact me directly at dan.lazzari@nt.gov.au.

Dr Daniele Lazzari, FANZCA
Royal Darwin Hospital
Northern Territory

Faculty of Pain Medicine

Dean's message

The Faculty's 2018-2022 strategic plan was launched at the Torquay Spring Meeting in September 2017.

The plan represents the voice of our fellowship and follows extensive consultation about future direction. In addition to strategic planning the Faculty will continue to undertake the "business as usual" activities of the training program and professional education and support. The broad scope of the Faculty's activities require careful management of the finite resource available in terms of staff and Fellows. However skilled contributions from many dedicated people provides the strong foundation upon which we continue to build.

The strategic plan defines four major goals and I will use these as a framework to discuss current topics of interest.

Goal 1

Firstly, we aim to expand multidisciplinary pain services across New Zealand and Australia. A consultancy with expertise in the health sector has been contracted to undertake a workforce and economic evaluation in New Zealand.

International benchmarks suggest a target of one multidisciplinary pain centre per million population and one specialist pain medicine physician per 100,000 population. New Zealand with a population of almost five million people should therefore have five multidisciplinary pain centres and 50 pain medicine specialists. The current reality is well below that level. A survey of Fellows in April 2016 showed a total of approximately 11 full-time equivalents nationally and there are only three training units (in Auckland, Wellington and Christchurch) funded by district health boards. The need to build pain services in this setting is obvious.

In Australia we are better resourced relative to international benchmarks and the required workforce and economic analysis is more complex. There is a need to define the optimal model(s) of care particularly in terms of the interface between primary care and specialist practice. We aim to continue dialogue with Painaustralia, the Australian Pain Society, the Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine and other relevant organisations in this regard.

Goal 2

Secondly, we seek to position ourselves as trusted source of expertise. Our recent Melbourne forums addressing medicinal cannabinoids and procedural practice very much targeted this goal. Post forum email surveys will help us to refine strategic direction in these areas.

The success of the forums encourages us to plan further similar events as part of our ongoing leadership endeavours.

An opioid strategy forum is under consideration for 2018. This follows much recent activity in the opioid space. Marc Russo (NSW Regional Committee Chair), Jo-anne Chapman (GM Policy ANZCA) and I had a recent meeting with Brad Hazzard, the NSW Minister for Health to discuss codeine upscheduling. At this point he remains supportive of the Pharmacy Guild of Australia's "except when" proposal.

Our emphasis throughout the meeting was on evidence informed policy development and our support of a nationally consistent approach without exemption. This followed an earlier meeting in September with Greg Hunt, Federal Minister for Health, attended by Meredith Craigie (vice-Dean), Jo-Anne Chapman and myself in which opioid policy was part of a broader discussion of pain related issues.

Meredith Craigie also represented the Faculty at a recent meeting convened by Painaustralia to update key messages related to codeine upscheduling.

Kim Hattingh from Townsville has led the development of a document entitled "Statement on the use of sustained release opioids in the treatment of acute pain". This has been endorsed by the Faculty and also the Safety and Quality Committee of ANZCA. It raises the perhaps controversial idea that sustained release opioids should not be used routinely for acute pain. Implementation will raise interesting challenges.

Goal 3

The third goal targets leadership in pain medicine research.

The medicinal cannabinoid forum raised a number of possibilities. A strengthening of the links between FPM and the ANZCA Clinical Trials Network was discussed as Professor Phil Peyton presented on lessons learned from the ROCKET trial that might have relevance to cannabinoid research.

Another potential collaboration is with the Australian Centre for Cannabinoid Clinical and Research Excellence under the leadership of Professors Jennifer Martin and Nadia Solowij. Discussions are also underway with Professor Kathy Eagar at University of Wollongong about the possibility of adding cannabinoid questions to the ePPOC dataset which might facilitate clinical audit.

Arising from the procedural practice forum was discussion of adapting the ePPOC dataset for use in the procedural setting. A bundle of care incorporating a procedure could potentially be compared to a non-procedural care bundle. The comment was made by the ePPOC team that collection of registry type data was feasible alongside the standard dataset; recognising the requirement for appropriate resourcing.

Goal 4

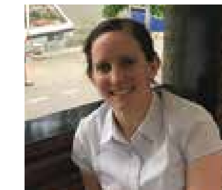
The final strategic goal relates to further development of the educational program particularly with a view to procedural practice and also the possibility of a certificate or diploma in clinical pain medicine based on six months training in multidisciplinary management. We continue to explore these opportunities.

The question arises of whether the six-month training option might assist in developing a primary care workforce with capacity to begin to meet pain medicine needs in rural and remote areas.

In closing I would like to take the opportunity to thank Fellows, trainees and staff alike for all that has been accomplished in 2017 and wish you all the very best for the upcoming festive season.

Dr Chris Hayes
Dean, Faculty of Pain Medicine

FPM examinations



The written section of the Fellowship Examination was held in 10 venues on October 27 with the viva voce section held at the Australian Medical Council National Test Centre, Melbourne on November 25. Twenty-three of the 27 candidates were successful. The Barbara Walker Prize was awarded to Dr Alix Dumitrescu (NSW) (pictured right) and merit awards were presented to Dr Hima Shailaja Venugopal (SA) and Dr Ilonka Meyer (Vic).

Successful candidates

The 23 candidates who successfully completed the Fellowship Examination and are listed below:

AUSTRALIA

New South Wales
Thor Timothy Chutatape
Alix Dumitrescu
Yuen Chuan Leow
Trudi Richmond
Abhilasha Sharma

Queensland
Alette Bader
Anju Tessa James
Joseph Kluver
Benjamin Manion
Michelle O'Brien

South Australia
Hima Shailaja Venugopal

Tasmania
Gurbir Kaur

Victoria
Gayathri Aravinthan
Eliza Beasley
Ilonka Meyer
Olivia Ong

Western Australia
Vishal Bhasin
Alireza Feizerfan
Vincenzo Mondello
Sonya Ting

HONG KONG
Chung Febbie Pui-Wah
Wong Sze Ming

NEW ZEALAND
Christopher Jones

News

2017 Distinguished Member Award

FPM Fellows Dr Meredith Craigie and Dr Tim Semple were awarded the prestigious Australian Pain Society Distinguished Member Award for 2017. Congratulations to Dr Craigie and Dr Semple.

New Fellow

- **Dr Willemena Ong**, FANZCA, FFPMANZCA (Vic).

Training unit accreditation

The following units have been accredited for pain medicine training:

- Sydney Spine and Pain, NSW.
- Northern Integrated Pain Management and Gosford, NSW.

FPM develops position on cannabis following forum

Considering research opportunities and the Faculty's strategic position around medical cannabis were two of the outcomes from FPM's forum, "Considering medical cannabis for chronic pain" attended by more than 80 FPM Fellows and trainees in October.

Gathering and using feedback from Faculty Fellows was another core aim of the forum, which featured excellent speakers who provided science and research summaries mixed with insights into the legislation and permit requirements.

Speakers included Professor Wayne Hall (Centre for Youth Substance Abuse, University of Queensland and Australian Advisory Council on the Medicinal Use of Cannabis); Professor Jenny Martin (Chair of Clinical Pharmacology, University of Newcastle); Adjunct Professor John Skerritt (Deputy Secretary for Health Products Regulation, Department of Health, ACT); Associate Professor Philip Peyton (Chair, ANZCA Clinical Trials Network Executive, Victoria) as well as specialists in addiction medicine, consumer representatives and Fellows of the Faculty.

After the forum, a follow-up survey was sent to attendees to gauge opinions on whether medicinal cannabinoids should be considered for patients with chronic non-cancer pain, restrictions to availability and what research projects were most needed.

In guiding future practice, FPM will update its position statement *PM10: Statement on "Medicinal Cannabis" with particular reference to its use in the management of patients with chronic non-cancer pain – 2015*.

A research strategy is also being developed. This includes:

- Basic pharmacology studies (pharmacokinetic/pharmacodynamics of individual cannabinoids).
- Current usage (surveying current use of recreational cannabinoids in the chronic non-cancer pain setting in pain clinic and community populations and auditing the clinical use of medicinal cannabinoids in pain services).
- Experimental trials and studies, such as seed development of multi-centre clinical trials.

Since the forum took place, the National Health and Medical Research Council (NHMRC) has awarded $A2.5 million funding to establish a world-first centre to co-ordinate research into medicinal cannabis use.

FPM position on the use of medicinal cannabinoids in patients with chronic non-cancer pain

Scientific evidence shows that, at best, there is marginal clinical benefit that does not outweigh the risk of harm.

- Medicinal cannabinoids can be considered for patients with chronic non-cancer pain, however this should be in the setting of an audit or research program.
- FPM will collaborate with professional organisations, including the Centre for Cannabinoid Clinical and Research Excellence (ACRE), and consumer groups, to develop a research strategy to further investigate the role of cannabinoids in chronic non-cancer pain.
- FPM emphasises the need for national pain plans in Australia and New Zealand that encourage education of the health workforce and community and facilitate multidisciplinary care and active self-management at all levels of the health care system. Any research investigating the use of cannabinoids or other medical treatments needs to be framed within this broader context.

The Australian Centre for Cannabinoid Clinical and Research Excellence (ACRE), will be co-led by Professor Jenny Martin from the University of Newcastle (UON) and Professor Nadia Solowij from the University of Wollongong (UOW).

Associate Professor Carolyn Arnold
Convenor, Cannabis Forum

Above left: Dr Chris Hayes, Dean, Faculty of Pain Medicine.

Spring meeting

The 2017 FPM Spring Meeting "Transcending pain: ride the next wave" was held at RACV Torquay in Victoria from September 22-24. The meeting was extremely successful with 156 delegates in attendance, who enjoyed the stunning scenery and beautiful coastal region while enjoying the varied scientific program.

The international invited speaker was Dr Luis Garcia-Larrea (pictured above right) from France, renown for his research in the field of neuroscience and integration of pain. He presented to the audience twice to discuss neuropathic pain and cortical integration of pain perception. The meeting also featured informative presentations by specialists on topics including surgery and placebo, acute pain, neuropathic pain and cancer pain. The meeting closed with a revealing session on assisted dying legislation.

New initiatives for the spring meeting this year included workshops, emergency response CPD activities and masterclasses. All workshops including emergency response activities were held at the University Hospital Geelong on Friday morning which were strongly attended. Masterclasses covered career progression, exam success, transition to retirement and mindfulness.

The meeting attracted media interest from ABC Radio in Melbourne with Dr Jane Trinca's presentation on nonpharmacological techniques receiving coverage on the prime 7.45am Melbourne news bulletin during the meeting. ABC journalist Melissa Brown subsequently interviewed Dr Trinca following the distribution of a media release about her presentation, the interview was reported by ABC Radio News in Melbourne, Hobart, Launceston and 10 Victorian ABC regional stations. These bulletins reached an audience of 110,000 people.

The FPM meeting media releases "Call for overhaul of pain medicine funding as more patients head for emergency departments", "New Australian study to examine why some chronic pain patients won't listen to their doctors", "Call to re-educate patients, doctors about limits of opioids for chronic pain" and "Opioid abuse, voluntary assisted dying, on agenda of annual meeting of pain medicine experts" can be found at: fpm.anzca.edu.au/communications/media

The Faculty is pleased to advise that the 2018 Spring Meeting will take place on October 19-21 at the Pullman Cairns International. A number of presentations were recorded and are available in Networks/pain medicine learning/pain medicine podcasts.

Faculty thinks strategically about pain procedures

More than 50 Fellows and industry delegates gathered in the ANZCA auditorium in Melbourne for the second of FPM's consultative forum days on Friday October 20.

The theme of the forum was "Procedures in pain medicine: How are they best done?" and speakers included Faculty leadership, representatives of professional and interest groups such as the Spine Intervention Society (SIS) and the Neuromodulation Society of Australia and New Zealand (NSANZ) as well as experts in outcome measurement, registries and big data.

The focus of the day was to assemble as much of the fellowship as possible to be informed about the strategic thinking of the FPM Board regarding the possible development of Faculty standard-setting and curriculum in the field of pain management procedures.

The day began with an outline of the strategic deliberations of the board relevant to convening the forum. This was followed by presentations from Fellows Dr Geoff Speldewinde and Dr Marc Russo highlighting the clinicians' view. Dr David Rankin from MediBank Private then spoke about how his organisation is interested in collaborating with providers to reduce unwarranted variations in practice between similar providers.

The second session saw presentations from former Dean, Professor Ted Shipton, Therapeutic Goods Administration Chief Medical Advisor, Associate Professor Tim Greenaway and Clinical Advisor to WorkSafe Victoria, Dr Lisa Sherry, who all discussed the types of evidence needed to provide regulatory and funding oversight of procedures.

After lunch, discussion turned to outcome measurements and "big data" projects for the Fellows to consider. Dr Diarmuid McCoy recounted the Faculty's Pain Device Implant Registry project, and Professor John McNeil from Monash University reflected on the characteristics of a high-quality registry data and how it could inform practice. Professor Kathy Eagar from the electronic persistent pain outcomes collaboration (ePPOC) spoke further about how the ePPOC data set could potentially be expanded and modified to include outcomes from procedures and even implantable device outcome data.

Above from left: Delegates attend the "Procedures in Pain Medicine" forum at ANZCA House; convenor Dr Michael Vagg and FPM Dean, Dr Chris Hayes at the meeting; Dr Vagg addresses the meeting.

The final session saw a review of current educational activities within the procedural pain medicine field and the question of hospital or Medicare credentialing for procedures. The day closed with presentations from Professor Shipton and forum convenor Dr Michael Vagg about what directions are open to the Faculty to proceed both in the near term, and over the next five-year strategic planning period.

Although technological limitations prevented many interested Fellows and trainees from participating online, the talks were all recorded and are available on the FPM website for Fellows to view. Survey questions were formulated to allow those who could not attend to have their say after watching the recorded talks and subsequent discussions.

I would encourage all Fellows and trainees with or without an interest in procedures as part of their scope of practice to watch the videos and be prepared to send in feedback, even though the official survey has now closed.

The Faculty leadership has resolved to tackle the sometimes vexed issue of procedures, and our deliberations and decision-making in this regard will have potentially profound consequences for our fellowship in the medium term. The more representative the feedback we receive from our fellowship, the more likely we are to proceed in a way that further enhances the world-leading position of our Faculty.

Dr Michael Vagg,
Convenor, Procedures in Pain Medicine Forum

Successful candidates

Primary fellowship examination

August/September 2017

One hundred and twenty two candidates successfully completed the primary fellowship examination.

AUSTRALIA

Australian Capital Territory

Mohamed Elasyed Ahmed Elkashash
Ryan Westwood McCann

New South Wales

Andrew Allan
Matthew John Baistow
Elise Victoria Butler
Ritchie Jacob Cherian
Laura Elizabeth Connell
Benjamin Patrick Dal Cortivo
Parya Ehteshami
Damien Gary Finniss
Michael Iskander
Christopher Kay
Nicole Angela Kemp
Peter John Langron
Lawrence Law
Richard Pearson Leaver
Samuel Robert Lewis
David Aladar Milder
Francoise Raphaele Jean Naeyaert
Ryan Oliver Mark Pedley
Kajan Hajumeanun Pirapakaran
Baraniselvan Ramalingam
Kartik Venkat Ramesh
Jam Sadullah
Natalie Anne Sim
Oliver John Snellgrove
Claire Ellen Strong
Angeli Jayesh Thakkar
Michael James Tobin
Satya Surya Shravan Varanasi
Mitchell Allan Warren
Darin David Westaway
Solomon Chelvanishan Yogendran
Weiting Lisa Zhao

Queensland

Lucas Charles Bailey
Hannah Rae Bellwood
Rosalyn Clare Boyd
Thomas Joel Chalk
Keembiyage Chamath Disna De Silva
Alice Jean Goldsmith
Benjamin John Yi-Hua Hew
Sam King
Lada Kordich
Henry Chi Hang Leung
Victoria Elizabeth Lingard
James David Marckwald
Linden James Lucas Martyr
Genevieve Rose McCreanor
Mark John Moll
Katarzyna Nowak
Sofia Padhy
Tyrone Daniel Paikin
Caydee Pollock
Swaminath Sadam
David Michael Samson
Mark Trembath
Ryan Lee Wheatley

South Australia

David Scott Barlow
Jennifer Mary Bird
Dustin Che De Jonge
Matthew Armando Matto
James Richard Murtagh
Doris Wai See Tang

Tasmania

Elizabeth Anne Judson
Alice Elizabeth Mulcahy
Jana Ludmila Vitesnikova

Victoria

Daniel Alban
James Lachlan Bainbridge
Emily Ruth Balmaks
Christopher Jake Barlow
Caroline Mary Bate
Louise Caroline Boyle
Alexander Edward Bradfield
Tristan Mark Coleman
Reece Raymond Cordy
Daniel Philip Creely
Luis Ruben Cuadros
Linden Anton De Ridder
Jane Thu Doan
Brendan James Flanders
Ron Glick
Yu-Feng Frank Hsiao
Grigor Indjeian
Jessica Louise Kay
Ezra William Keebaugh
Niketh Alex Kuruvilla
Lachlan James Kwa
Michael Hua Gen Li
David Yuan Yue Loo
Joshua Reid Lun
Marilyn Paola Menezes
Nicole Muir
Mark Gerard O'Donnell
Benjamin George Peake
Alan James Richard Peirce
Ambujaan Raviendran
Cameron Nathaniel Rush
Richard Seglenieks
Shi Hong Shen
Anna Elizabeth Steer
Angus Edward Patrick Thomson
Heath Alexander Tibballs
Ya-Chu May Tsai
Adam Joel West
Thomas Yang
Rebecca Beiyi Zhao

Western Australia

Nikki Lee Harmey
Gregory Leeb
Grant Damien O'Brien
Jing Shen Ong
Artur Proniewicz

NEW ZEALAND

Chen Chen
Elizabeth Ashleigh Dickie
Sarah Joanne Goodwin
Abraham Jacobson
Gareth Jones
George Syek Meen Lim
Manisha Mohanbhai Mistry
Natalie Hazel Paterson
Daniel Paul Ramsay
Jared Michael Smith
Michael Craig Waterhouse

Renton Prize

The Court of Examiners recommended that the Renton Prize at this sitting of the primary examination be awarded to:

Jana Ludmilla Vitesnikova, Tasmania

Dr Vitesnikova is currently undertaking her training at Launceston General Hospital as part of the Tasmanian anaesthetic training program. She studied at the University of Sydney and worked at Concord Hospital before moving back home to Tasmania. Her interests include pain medicine, teaching and welfare. Outside of medicine, she loves travel, bushwalking and exploring the outdoors. She hopes to become a well-rounded anaesthetist and work in either a rural or regional area.

"I see the Renton Prize as an acknowledgement of the wonderful support, encouragement and education I have received during my training and I am extremely grateful to my colleagues, family and friends."

The Court of Examiners recommended that the Renton Prize for the half year ended June 30 be awarded to:

Blagoja Alampieski, Queensland

A graduate of the University of Western Sydney Dr Alampieski is now with the southern network of the Queensland rotational training scheme. He is interested in regional anaesthesia and education. Away from anaesthesia he is a keen football (soccer) player and recently took up meditation. He became interested in anaesthesia during his surgical term as an intern in Wagga Wagga.

"I would like to thank everyone who supported me but in particular my study group – Rob, Shaiyla and Terry. Finally I would like to wish all future candidates the best of luck."

Successful candidates (continued)

Final fellowship examination

August/October 2017

Ninety seven candidates successfully completed the final fellowship examination:

AUSTRALIA

Australian Capital Territory

Pallavi Kumar
Victor Kang-Lung Loa

New South Wales

Furqan Arshad
Gregory James Britton
Weiming Chiu
Tomasz Dzioba
Bernard David Frost
Lin Hu
Shirin Jamshidi
Marcus David Kornmehl
Gila Shoshannah Lepar
Sahil Kumar Mathur
Lachlan Andrew Nave
Niranjali Anuradha O'Connor
Michael Patrick Reid
Brenton James Sanderson
Peter Michael Simmons
Louisa Imogen Swain
Angela Marie Walker
David Benjamin Yong
George Zhong

Queensland

Sonia Andina Arwadi
Georgina Margaret Cameron
Daniel Keng-Cheng Chang
Conor Michael Dowdall
Clementine Amelia Hartl
Charles Andrew Herdy
Tiffany Ellen Holmes
Louisa Alice Kippin
Graham James Langerak
Peter Malcomson
Amos Peter Moody
Dasha Faith Tjanara Newington
Anna Fiona Pietzsch
Christine Marie Pirrone
Hanna Pyeon
Leah Rickards
Andrew Richard Souness
Sally Steele
Tiffany Shiu-Hin Tam
Justin Shih Sunn Ti
Michael Howard Toon
Andrew Godfrey Wright

South Australia

Tristan Roy Adams
Sean John Davies
Richard Branden Emmerson
Munib Kiani
U-Jun Koh
Kritesh Kumar
Louis Thomas Papilion
Haran Somehsa

Tasmania

Musdiyana Ishak
Adam Timothy Mitchell

Victoria

Lucy Hanna Barnett
Benjamin Biles
Jeremy David Broad
Patrick John Dunne
Matthew Wayne Jenke
Saleem Ibn Mohammad Khoyratty
Shu Ying Lai
Christopher John Moran
Victoria Ann Moulson
Reshma Pawar
Earlene Silvapulle
Dennis Eng Keat The
Daniel Trevena
Derrick Nathan Wong

Western Australia

Shruti Sanjeev Chitnis
Clare Victoria Frances Fellingham
Christopher James Kennedy
Brian Sun Lee

NEW ZEALAND

Louisa-Rose Bhanabhai
Robyn Louise Billing
Alexandra Claire Cardinal
Tze Ying Chan
Brian Ching-Hsueh Chen
Wei-Lyn Chung
Daniel James Cochrane
Simon James Davis
Illekuttige Malindra Clive Fernando
Daniel Reto Frei
Grant Matthew Frow
Shadi Gadalla
Kate Ida Hudig
Andrew James Johnson
Jee-Young Kim
Agnieszka Renata Lettink
Lynette McGaughran
Ravi N Mistry
Timothy Patrick O'Brien
Kathryn Helen Percival
Charles Besnard Richards
Stephen John Roberts
Orla Helena Ryan
Amanda Tsan Yue Siu
Dilraj Singh Thind

HONG KONG

Jaclyn Wai-Ming Wong

IMGS examination

Four candidates successfully completed the Specialist International Medical Graduate Exam:

AUSTRALIA

Queensland

Gilberto Walter Nogueira Arenas

Victoria

Guangjun Chen

Western Australia

Marcelo Epsztein Kanczuk
Betty Elizabeth Thomas

Cecil Gray Prize

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended December 31, 2017, be awarded to:

Dr Anna Fiona Pietzsch, Queensland

Dr Pietzsch studied medicine at Griffith University on the Gold Coast after completing a Bachelor of Physiotherapy at the University of Queensland. She is undertaking her first year of advanced training in Brisbane, currently at The Prince Charles Hospital. Anna has a special interest in anaesthesia for obstetrics and ear, nose and throat and is passionate about the education of junior doctors and trainees. She is a member of the Queensland Medical Women's Society and has a keen interest in gender bias in medicine. She wishes to acknowledge her husband Joel and children Felix and Darcey who kept her sane while studying for the exam.

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended June 30 be awarded to:

Dr Sarah Rose Skidmore, New South Wales

Dr Skidmore studied medicine at the University of New South Wales. She was first encouraged to study anaesthesia after meeting many of the inspiring and dynamic members of the specialty during her early training. The mix of procedural skills and interacting with patients and staff, combined with an application of fundamental sciences made anaesthesia an enjoyable and rewarding training program for her and she received a Merit Certificate in the Primary Exam. She is currently completing her training at St Vincent's Hospital, Sydney, where her interests include medical education and perioperative medicine.

"The Cecil Gray Prize is a high honour and testament to the sustained support from the St Vincent's Anaesthesia Department, my family and friends, and especially my husband Zdravko. I'm looking forward to the challenge of provisional fellowship in 2019."

Merit certificates

Merit certificates were awarded to:

Clementine Amelia Hartl, Queensland
Reshma Pawar, Victoria
Earlene Silvapulle, Victoria
Kate Ida Hudig, New Zealand

Advancing education at ANZCA

The ANZCA Education unit has been revised with a new staff structure and new functions to ensure that the evolution and expansion of education is effective and efficient. The General Manager, Education unit is Olly Jones.

Three new streams now exist within Education. Education Strategy and Quality stream is managed by the newly appointed operations manager, Teri Snowdon, Training and Assessments by the operations manager, Tamara Rowan, and the Learning and Development stream by operations manager, Helen Ho.

ANZCA's staffing structure is set up to ensure that the Fellows, trainees and others involved with the education committees are well supported, as are all education officers, supervisors, tutors, examiners and assessors contributing to College education and training.

Social media initiatives

Earlier this year, Digital Communications Manager Al Dicks met with the Trainee Committee to discuss the benefits and risks of using social media as a medical professional and to take them through some of the tools and platforms that they could use to create a sense of community among trainees.

Twitter hashtag

The Committee agreed that they'd like to establish a Twitter hashtag which trainees, Fellows, staff and other health practitioners could use to flag conversations and content of interest, such as news, events, resources, research, and anecdotes. The hashtag is really starting to gain momentum now, so if you're on Twitter it's definitely worth searching for **#ANZCAtrainees** to see how people are using it.

Facebook groups

There was also a strong interest in exploring closed forums where trainees could have honest and meaningful discussions with one another. Given that around 85 per cent of our trainees have a Facebook account, Facebook groups were a logical solution. Unlike Twitter or Facebook pages, groups are designed to be used as secure discussion forums for people with a shared interest. A sliding scale of privacy settings gives admins complete control over who can join.

So far, trainee committees in three jurisdictions have set up Facebook groups. Victoria was the first cab off the rank, with Dr Nick Lanyon setting up the "Victorian Anaesthetic Registrars" Facebook group in August. It now has almost 200 members. Dr Maryann Turner has recently launched the "Queensland Anaesthetic Registrars" group. And last week Dr Leesa Morton and Dr Jonathan Panckhurst launched the "NZ Anaesthesia Trainees" group. There are also plans afoot to set one up for New South Wales.

The College has no direct involvement in these groups. Its role is simply to provide advice and promotional support when needed. Each committee can set their own rules, although the Victorian model seems to work well and has been adopted by Queensland and New Zealand.

Case study: The "Victorian Anaesthetic Registrars" Facebook group

Age: Four months

Membership: 190

Criteria for membership: Anaesthetic registrars currently training in Victoria.

Because there are three well defined training schemes in Victoria, the Victorian Trainee Committee (VTC) felt that increased interaction between trainees on different programs could be useful when comparing and contrasting experiences or seeking advice. All of the VTC members are group admins and can approve new members. Anyone requesting to join the Group is asked a) which rotational program they are in and b) if they are willing to abide by the rules and guidelines posted. Each year, trainees who are becoming consultants are asked to voluntarily remove themselves, and new trainees will be invited to join.

Did you know..?

85% of ANZCA trainees are on Facebook

47% use Instagram

33% have a YouTube account

30% have Twitter and LinkedIn

All local trainee Facebook Groups are listed on the ANZCA website and in the *ANZCA E-newsletter*. You can also search for groups by name on Facebook.

If you want help setting up or promoting a group, please contact:

Al Dicks
Digital Communications Manager
adicks@anzca.edu.au

Boston meeting attracts Australian speakers

As the inaugural recipient of the Joan Sheales Staff Education Award, generously funded by an endowment from Professor Barry Baker, I used those funds to supplement attendance at the 9th International Symposium on the History of Anesthesia (ISHA) in Boston, Massachusetts.

Of course, Boston is the home of the first successful public demonstration of inhalational ether, and the symposium held its opening reception in the hallowed halls of the Ether Dome at Massachusetts General Hospital. It was certainly a thrill to be there.

The symposium itself consisted of three days of presentations, as well as a number of social activities. A highlight for me, and a first for ISHA, was the introduction of a series of sessions entitled "Museology". This gave a number of museums specialising in the history of anaesthesia the opportunity to discuss various projects they are working on, or ways in which they have integrated into their local communities, and thereby helped ensure their longevity.

We heard from the Geoffrey Kaye Museum, of course, as well as the Wood Library Museum, the Dräger Archives, the Mushin Museum, the Crawford W Long Museum, the Japanese Anesthesiology Museum, and the Anaesthesia Heritage Society. It would appear that the history of anaesthesia is in safe hands in these various museums.

These museums represent only a handful of museums worldwide that preserve, research and exhibit the history of anaesthesia. However, they stand apart from other museums because the history of anaesthesia is their core business. If you happen to be in, or travelling to, Australia, America, Germany, Wales, England or Japan, be sure to make time to visit any or all of these places. Each of them is doing wonderful work, and they have important stories to tell.

The introduction of these museology sessions gave the various curators, directors and workers a chance to meet, probably for the first time, and discuss their museums with like-minded individuals. This was a unique opportunity to find out about behind the scenes operations, projects that have worked, projects that haven't worked so well, and the various ways in which they are fulfilling their missions, and working with their communities.

The incredible Dr Christine Ball, honorary curator at the Geoffrey Kaye Museum, had a heavy workload, acting as mediator for each of these three sessions, as well as delivering two research papers herself.

Australia and New Zealand were well represented. In addition to Dr Ball, Professor Baker, Dr Michael Cooper, Dr Ron Trubuhovich, Associate Professor Ross Kerridge and Dr John Crowhurst also presented papers.

My first paper discussed the way in which accreditation has impacted the Geoffrey Kaye Museum, and I also presented a paper about early women anaesthetists in Australia and New Zealand. As part of my talk, I looked to the careers of Dr Janet Greig and Dr Emily Seideberg as examples of these pioneers, and drew from their personal experiences as medical students and doctors to create a social context through which the professional lives of other women anaesthetists could be viewed. It was gratifying that this presentation sparked as much discussion as my earlier one about museum practice.

The symposium concluded with the announcement that the 10th ISHA will be held in Kobe, Japan in 2021. If you have even the slightest interest in the history of anaesthesia, and think attending ISHA would be a good idea, now is the time to begin your research. Make sure you contact the museum – we're here to help.

Monica Cronin
Curator, Geoffrey Kaye Museum of Anaesthetic History

David M Little Jnr Book Prize

Michael Cooper, Chris Ball and Jeanette Thirlwell were awarded the David M Little Jnr Book Prize by the Anesthesia History Association for their "inspired editing" of the proceedings of the 8th International Symposium on the History of Anesthesia, which was held in Sydney in 2013. The ANZCA Library has a copy of the proceedings. Chris and Michael attended the 9th International Symposium on the History of Anesthesia in Boston in October, and were on hand to receive the award.

Above from left: The Ether Dome at Massachusetts General Hospital; Inaugural recipient of the Joan Sheales Staff Education Award, Monica Cronin, at the International Symposium on the History of Anesthesia (ISHA) in Boston, Massachusetts; Dr Christine Ball at the same meeting (images courtesy of ISHA).

Persistence paid in search for Pugh journal

Publishing books can be an expensive business. Earlier this year, ANZCA, in association with a Launceston charitable trust, agreed to provide funding to assist in the publication of a 180-year-old log and journal. The hand-written 62-page journal was written by the young English doctor, William Russ Pugh.

Pugh's place in the history of Australian anaesthesia was assured when, in 1847, he administered the first general anaesthetic for a surgical operation in Australia, at his private hospital in Launceston.

The late Dr Gwen Wilson, in her major work, *One Grand Chain*, wrote that she had become aware that Pugh had written this journal but commented, "… the Journal … has disappeared."

Not one to ignore a challenge, seven years ago I set out to see if I could find this journal.

Searches of historical archives in three states failed to provide any evidence of this journal or its location.

Finally, enlisting the aid of a skilled genealogist, Aileen Pike, of Launceston, and starting with a single mention of a name in a 1934 Hobart newspaper, we located a great, great granddaughter of Dr Pugh's sister. This woman, living in Berkshire, England, had eight siblings. She said that she had little knowledge of Dr Pugh but she would work her way through her siblings and inquire about the existence of the journal. Five years after the search started we finally heard that her youngest brother, living in Bristol, had it.

After lengthy negotiations with the family and the British Arts Council, the journal was handed to a courier company in Bristol on June 20, 2016 on the long journey to the Tasmanian Archive and Heritage Office (TAHO) in Hobart. On June 29, I received an email from TAHO simply saying "the eagle has landed".

That same day my wife and I travelled to Hobart and I had the exciting privilege of opening the parcel and holding the original document in my hand. My one regret is that I have not had the pleasure of telling my great friend Gwen Wilson that the journal had been found.

After 12 months transcribing and annotating the original manuscript, gathering illustrations, and securing the services of a quality printer, Pugh's remarkable document has now become available to everyone.

On Saturday September 16, 2017 the launch of *Persistence Pays* took place at the Queen Victoria Museum and Art Gallery's Inveresk Museum before an excited audience. Dr Eric Ratcliff, OAM, a psychiatrist and eminent and published architectural historian delivered a very entertaining launch address.

The very beautiful hardcover deluxe, numbered and signed edition and the softcover edition are available in Hobart and Launceston bookshops and at www.jdpaull.com.au.

Dr John Paull, FANZCA
Launceston, Tasmania

Above from left: Launch of Persistence Pays (from left): Dr Eric Ratcliff, OAM, who gave the launch address, Mr Martin George, Deputy Director of the Queen Victoria Museum and Art Gallery, and the author, Dr John Paull.

What's new in the library

"Giving AIRR to ANZCA and FPM research"

The ANZCA Institutional Research Repository (AIRR) has been developed to collect, preserve and promote the significant amount of important research published by ANZCA and FPM Fellows and trainees.

AIRR is an institutional repository that identifies, captures, stores and facilitates retrieval of the research and publication output of ANZCA, FPM and the wider ANZCA community (such as non-funded Fellows, trainees and staff) for the collaborative benefit of local and global clinicians, researchers and health educators. It is anticipated that, once launched, Fellows and trainees, will be able to self-submit their research publications and outcomes. The repository will provide a single access point of current and comprehensive research outcomes and a portfolio for ANZCA and FPM researchers/ authors on an international scale.

The ANZCA Library – working in conjunction with the ANZCA Research Foundation, FPM and the Emerging Investigators Sub-Committee – is now undertaking an initial test ingest of data including the most recent ANZCA Research Foundation's *Publication and research outcomes*.

Supporting documentation and library guides are also being developed, a selection criteria framework is to be finalised, and beta-testing with key target research groups has begun.

AIRR is expected to be ready for launch in early 2018.

Some of the benefits and opportunities AIRR will bring:

- Effectively communicate and disseminate research outcomes, especially published material (this will include dissemination via open access compliant systems such as *Google Scholar*).
- Increased awareness of ANZCA research grants.
- Support the FPM research community.
- Build and encourage ANZCA's research culture and strategy.

Content to be included in AIRR:

- ANZCA and FPM Fellow research grants (publications and outcomes).
- ANZCA and FPM Fellow publications (not related to research grants, for example, journal articles, theses, book chapters).
- ANZCA and FPM trainee research (published and unpublished).
- ANZCA Annual Scientific Meeting abstracts and presentations.
- ANZCA policy and background papers.

Register your interest or send any questions to the Library at library@anzca.edu.au.

ANZCA Library at the NZ ASM

New Zealand Fellows and trainees attending the NZ ASM at Rotorua took advantage of the opportunity to chat with the library manager, John Prentice, at the ANZCA stand. Many were pleasantly surprised to learn about the hundreds of journals and thousands of e-books that they can access remotely through the ANZCA Library. As always, the apps were popular, with many delegates downloading the library resources straight to their mobiles and devices.

From left: ANZCA Library Manager John Prentice and ANZCA Media Manager Carolyn Jones are pictured at the NZ ASM ANZCA booth with NSW Fellow Dr Wayne Carstens.

New and updated Library Guides

Library Guides

The ANZCA Library maintains a number of library guides that are designed to bring together key resources to support particular aspects of pain medicine.

There are guides are based around:

- Particular specialist/subject areas – for example, airway management, pain medicine, and many more.
- Guidance on searching specific databases – for example, *Ovid MEDLINE*.
- Supporting the growing number of ANZCA-subscribed apps including Read by *QxMD*, *ClinicalKey* and *BrowZine*.

The ANZCA Library Guides can be accessed at: http://libguides.anzca.edu.au/.

Paediatric pain

The library has recently developed a new guide on paediatric pain. This guide has been designed for specialist pain medicine physicians interested in paediatric pain to locate relevant resources on this topic, including those available through the ANZCA Library.

Examples of the sort of content that can be found in the guide:

European Journal of Pain. A multi-disciplinary, international journal that aims to be a global forum on all aspects of pain research and pain management. The journal publishes clinical and basic science research papers relevant to all aspects of pain and its management.

McGrath et, et al. *Oxford Textbook of Paediatric Pain*, 8e. Philadelphia, PA: Elsevier Saunders, 2015. A detailed and comprehensive resource that will be the standard reference in the assessment and treatment of paediatric pain. Case examples are used to illustrate the application of the knowledge.

PediPain app. The *PediPain* app provides support tools used in managing paediatric pain: including weight/age-based dosages for common medications, pain score tools, surgical pain management pathways, and recommended medication doses. This app is aimed at all health professionals managing pain in children.

Video 1 - Pain-Less Practice: Techniques to Reduce Procedural Pain and Anxiety in Pediatric Acute Care, ClinicalKey, March 1 2017

The NEW Paediatric pain guide can be accessed at: http://libguides.anzca.edu.au/paediatricpain.

New books for loan

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

Grit: why passion and resilience are the secrets to success
Duckworth, Angela – London: Vermilion, 2016.

Handbook of anaesthesia & peri-operative medicine
Mendonca, Cyprian [ed]; Vaidyanath, Chandrashekhar [ed] – Shrewsbury, UK: Tfm Publishing Limited, 2017.

Maori healing and herbal: New Zealand ethnobotanical sourcebook
Riley, Murdoch; Enting, Brian. – Fourth Printing 2010 – Paraparaumu, New Zealand: Viking Sevenseas N.Z., 1994.

Te Rongoa Māori: Māori Medicine
Williams, P.M.E. – Rosedale, New Zealand: Penguin, 2008.

Contact the ANZCA Library
www.anzca.edu.au/resources/library
Phone: +61 3 9093 4967
Fax: +61 3 8517 5381
Email: library@anzca.edu.au

New books

Updated eBooks access

A number of your favourite e-books available through the ANZCA Library have moved to a new platform – *Taylor & Francis eBooks*. Titles now available through *Taylor & Francis* include:

- The Clinical Pain Management four volume collection.
- The Get through the Primary FRCA collection.
- Principles of Physiology for the Anaesthetist.

You can still access them through the library's e-book page, as well as the library catalogue, database and library guides.

Follow the #ANZCALibrary on Twitter

Want to stay up to date with the latest news and resources from the ANZCA Library? Follow @ANZCA on Twitter and you will see weekly updates from the Library using the **#ANZCALibrary** tag.
The library spotlights online resources, new books and articles of particular interest as soon as they hit the collection.

New eBooks

eBooks can be accessed via the library website: www.anzca.edu.au/resources/library/online-textbooks

Cardiopulmonary bypass and mechanical support: principles and practice
Gravlee, Glenn P. [ed]; Davis, Richard F. [ed]; Hammon, John [ed]; Kussman, Barry [ed] – 4th ed –Philadelphia, PA.: Lippincott Williams & Wilkins, 2016.

Encyclopedia of pain
Schmidt, Robert F.; Willis, William D. – Berlin: Springer, 2007.

Goodman & Gilman's the pharmacological basis of therapeutics
Brunton, Laurence L.; Hilal-Dandan, Randa; Knollmann, Björn C. – 13th ed – [New York]: McGraw-Hill Medical, 2018.

Pediatric orthopedic trauma case atlas
Iobst, Christopher [ed]; Frick, Steven L. [ed]: Springer International Publishing, [2017].

Talley & O'Connor's clinical examination
Talley, Nicholas J; O'Connor, Simon – 8th ed – Chatswood, NSW: Elsevier Australia, 2018.

OSH Cardiothoracic critical care
Smith, Robyn [ed]; Higgins, Mike [ed]; Macfie, Alistair [ed] – Oxford: Oxford University Press, 2014.

Oxford textbook of cardiothoracic anaesthesia
Alston, R Peter [ed]; Myles, Paul S. [ed]; Ranucci, Marco [ed] – Oxford: Oxford University Press, 2015.

Oxford textbook of critical care
Webb, Andrew – 2nd ed – Oxford: Oxford University Press, 2016.

Ultrasound guided musculoskeletal injections
Allen, Gina M.; Wilson, David J. – 1st ed – Philadelphia, PA: Elsevier, 2018.

Challenging topics in neuroanesthesia and neurocritical care
Khan, Zahid Hussain [ed] – Switzerland: Springer 2017.

Comorbidities in headache disorders
Giamberardino, Maria Adele [ed]; Martelletti, Paolo [ed] – Switzerland: Springer, 2017.

Complications of regional anesthesia: principles of safe practice in local and regional anesthesia
Finucane, Brendan T [ed] – 3rd ed – Switzerland: Springer, 2017.

Monitoring the nervous system for anesthesiologists and other health care professionals
Koht, Antoun [ed]; Sloan, Tod B. [ed]; Toleikis, J. Richard [ed] – 2nd. – New York: Springer, 2017.

Anesthesiology: clinical case reviews
Aglio, Linda S. [ed]; Urman, Richard D. [ed] – Switzerland: Springer, [2017].

Orofacial disorders: current therapies in orofacial pain and oral medicine
Ferreira, João N. A. R. [ed]; Fricton, James [ed]; Rhodus, Nelson [ed] – Switzerland: Springer, [2017].

Herpes zoster: postherpetic neuralgia and other complications
Watson, C. Peter N. [ed]; Gershon, Anne A. [ed]; Oxman, Michael N. [ed] – Switzerland: Adis, Cham, [2017].

Groin pain syndrome: a multidisciplinary guide to diagnosis and treatment
Zini, Raul [ed]; Volpi, Piero [ed]; Bisciotti, Gian Nicola [ed] – Switzerland: Springer, [2017].

Urogenital pain: a clinicians guide to diagnosis and interventional treatments
Sabia, Michael [ed]; Sehdev, Jasjit [ed]; Bentley, William [ed] – Switzerland: Springer, [2017].

Comprehensive pain management in the rehabilitation patient
Carayannopoulos, Alexios [ed] – Switzerland: Springer, [2017].

Muscles, nerves, and pain: a guide to diagnosis, pain concepts, and therapy
Nix, Wilfred A. – Berlin/Heidelberg: Springer, Berlin, Heidelberg, [2017].

Orofacial pain biomarkers
Goulet, Jean-Paul [ed]; Velly, Ana Miriam [ed] – Berlin/Heidelberg: Springer, Berlin, Heidelberg, [2017].

Urological and gynaecological chronic pelvic pain: current therapies
Moldwin, Robert M. [ed] – Switzerland: Springer, [2017].

Vulvar pain: from childhood to old age
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Special interest group events

Joining together in Byron Bay

In early spring the Trauma and Neuroanaesthesia SIGs got together for a long weekend in Byron Bay to enjoy some time in the sun. With refresher sessions, information on the cutting edge and plenty of cat videos, there was something for everyone. There was also time to enjoy the delights of the Byron vibe and search around for a little haute-boho.

We kicked off with international visitor, neurosurgeon, London HEMS doctor of the year and all round good guy Professor Mark Wilson. He delivered his informative talk on pre-hospital care with typical wit, and along with the only other neurosurgeon in the room withstood all the predictable verbal jousting with good grace. He clashed swords/words with Dr Geoff Healey in a debate on the benefits (and dangers) of social media in medical education. Both speakers resorted to downright dastardly tactics at times to appeal to the masses but we emerged unscathed and entertained.

Invited speaker and ICU specialist Associate Professor Andrew Udy delivered his wisdom on caring for neurotrauma patients from a neurocritical care perspective, and day one ended with fascinating perspectives on consciousness and up to date aspects of mechanisms of anaesthesia and the effects of concussion from Professor Jamie Sleigh, Dr Doug Campbell and Dr Hamish Gray.

An eclectic day two started with information from Professor Kate Leslie, Professor Mark Wilson and Dr Ben Olesnicky on spinal cord trauma and spinal cord monitoring. The morning veered into a patient focused session on brain injury with Associate Professor John Moloney and then an impassioned and inspiring patient view from the executive officer of Brain Injury Australia, Mr Nick Rushworth. The day ended with delegates splitting themselves between emergency response training and simulation, stand up paddle boarding and a tour of local microbreweries. It has not been established which group ended up perspiring the most…

The final morning provided a chance to hear about various aspects at the frontier of both trauma care and neuroanaesthesia, with excellent talks from Dr Carolyn Deng, Dr Janette Wright, Professor Matthew Chan, Associate Professor David M Scott, Dr Don Campbell and Dr Kerry Gunn.

Many thanks to all the speakers and participants who made the meeting so educationally and socially enjoyable, and to Kirsty and Fran from ANZCA who allowed everything to run so smoothly.

Dr Kathryn Hagen, Chair, Neuroanaesthesia SIG
Dr Dan Holmes, Chair, Trauma SIG

Above from left: Workshops at the meeting; Guests enjoying themselves at the welcome reception.

Combined SIG meeting

"Confident competence – creating and maintaining our abilities" was the theme for the 14th combined special interest group (SIG) meeting held in Twin Waters from October 27-29. This year the Welfare SIG convened the meeting, where we hosted 138 delegates from around Australia and New Zealand. With lovely warm weather and stunning surroundings, the barefoot on the beach welcome drinks and conference dinner were a great chance to catch up with old friends, network and build future relationships.

Four workshops were on offer as part of the program including a mini-CRASH course looking at the management of returning to work from an individual and manager's perspective, two ANZCA Educator Program modules, and for the first time an emergency response workshop (CICO) which was early to book out.

Our international invited speaker was Mrs Carolyn Canfield, an honorary lecturer in the Faculty of Medicine at the University of British Columbia in Vancouver. Following the sudden death of her husband in the post-operative period Carolyn has investigated how our systems fail us and our patients, how happy workplaces are healthy for us and patients and this work led her to be recognised as Canada's inaugural individual Patient Safety Champion in 2014. Carolyn provided us with a small insight into the work that she has done over the years with the added personal elements as she has lived them.

Continuing in the theme of the "lived experience" Dr Andy Tagg, an emergency physician and co-founder of dontforgetthebubbles.com and Ms Jaelea Skehan, Director of Everymind, gave amazing presentations about physician mental health and, in particular, suicide. Given the continuing stigma associated with discussing our own mental health or discussing suicide in acute care medics, having two presentations with open, informed and frank discussion was a wonderful opportunity.

Dr David Sainsbury was pulled out of retirement for his reflections on how we encourage rather than enforce non-technical competencies. His engaging manner of presenting continued into his talk on retirement where he managed to quite literally have the audience tied up in knots and in fits of laughter. The self-proclaimed "Chris Rock" of conference presenting, Professor Carmelle Peisah, continued to keep us entertained as we moved towards looking at how and when we should look at retiring.

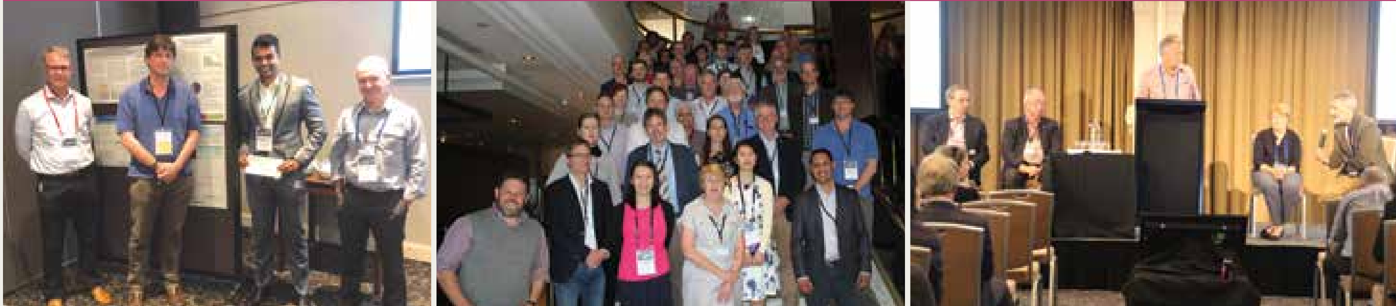
The meeting was a great success and we acknowledge the assistance from all the chairs of the SIGs, Dr Allan Cyna, Professor Guy Ludbrook, Dr Marion Andrew and Associate Professor Jenny Weller for helping put the program together, as well as the invaluable work done ANZCAs amazing events team, particularly Hannah Sinclair and Sarah Chezan.

Dr Cath Purdy and **Dr Anna Hallett**
Convenors

Above clockwise from left: Dr Andy Tagg presenting "The black dog runs at night"; Dr Vanessa Beavis and Dr Lindy Roberts attending the CICO workshop; Delegates taking a break at the meeting; The conference dinner.

Special interest group events (continued)

Perioperative Medicine SIG Meeting



Our meeting this year, “Cancer surgery and perioperative medicine: from prehab to rehab” was held in Manly, Sydney, overlooking the beautiful Manly beachfront. The second strategic meeting with more than 50 invited stakeholders in Perioperative Medicine (PoM) was held before the start of the main meeting. It was professionally facilitated by Jonny Schauder and has given us a strategic plan for PoM over the next 12 months.

The opening plenary was powerfully started by two inspirational women, both anaesthetists, who shared their personal cancer journey. Their journeys were moving and gave us a strong reminder that our patients must be at the forefront of our minds when dealing with cancer and perioperative medicine.

As always, the spirit of our meeting is one of collaboration and interdisciplinary teamwork. It was fantastic to see such a mixture of delegates from different specialties (476 in total) come together to learn more from and engage with one another.

A session on emergency laparotomy research from the UK, New Zealand and Australia was added to the program at short notice. This incorporated an introduction of the proposed binational emergency laparotomy audit and quality improvement project (ANZELA-QI), a combined ANZCA and RACS initiative. The project will also involve representation from the College of Intensive Care Medicine and the Australasian College of Emergency Medicine. It is one of the first intercollege research projects and has as ultimate goal to improve outcomes of emergency laparotomy patients.

Our international speakers were exceptional: Professor Lee Fleisher, the Robert D Dripps Professor and Chair of Anesthesiology and Critical Care, and Professor of Medicine at the University of Pennsylvania Perelman School of Medicine; Professor Henrik Kehlet, Professor of Perioperative Therapy at Rigshospitalet, Copenhagen University, Denmark; and Associate Professor Denny Levett, Consultant in Critical Care and Perioperative Medicine at the University Hospital Southampton.

Professor Fleisher explored the development of perioperative care in the US with the perioperative surgical home. He gave us useful insights into the pitfalls in its development and most importantly, emphasised how we must not forget the value of empathy and must always consider what is best for the patient.

Professor Kehlet, the grandfather of modern perioperative care, highlighted the importance of compliance to an evidence based bundle of perioperative measures to reduce complications, length of stay and improve outcomes.

Associate Professor Levett talked about prehabilitation and its effect on outcomes. She stressed the benefits of exercise not only with regards to cancer occurrence, recurrence and survival but also in more far reaching aspects of health, including quality of life. Exercise not only makes people feel good, but also turns out to be the best medicine… and it needs no TGA approval!

ANZCA President, Professor David A Scott, gave an excellent evidence based plenary on BIS, BP and outcomes. He also joined with Associate Professor Lis Evered to deliver a well-received workshop about postoperative cognitive dysfunction.

Professor David Story yet again delivered an informative update on current perioperative evidence. He also chaired the session on future research directions in perioperative medicine. This involved Professor Jacqueline Close (geriatrician), Professor Lee Fleisher and Professor Bernhard Riedel. Professor Riedel finished off with an excellent video compilation of skype interviews with the thought leaders in perioperative research around the world, including Dr Rupert Pearse, Professor PJ Devereux, Professor Dan Sessler, Professor Bruce Biccard, to name just a few.

The debate about who should lead perioperative care was perfectly staged and resulted in much laughter. Anaesthesia won hands down thanks to the chair of the Perioperative Medicine SIG, Dr Jeremy Fernando.

On the activity front, many delegates enjoyed their early morning yoga with a view of the ocean. What better way to start the day! The setting for the conference dinner, Manly Pavilion, situated on the north harbour was just stunning and an absolutely perfect way to end a successful meeting.

Even though we were sad to leave Noosa, Manly catered nicely for the growing number of like-minded people who came together in such a collaborative spirit to improve perioperative care and outcomes for our patients.

Next year's topic will be about obesity and its many perioperative implications. Hope you can join us in 2018!

Dr Jill Van Acker, Specialist Anaesthetist
Perioperative Medicine SIG Meeting

Above from left: Mr Mike Hulme-Moir, Professor David Story, Dr Rukman Vijayakumar (poster presentation winner), Associate Professor Steve Smith; Strategic day; Professor Lee Fleisher (international guest speaker), Mr Phil Truskett (RACS), Associate Professor Ross Kerridge (Chair), Dr Rod Mitchell (ANZCA), Dr Catherine Yellard (RACP).

New Zealand news

2017 New Zealand Anaesthesia ASM

More than 300 delegates attended the 2017 New Zealand Anaesthesia ASM in Rotorua from November 8-11 which was jointly hosted by the ANZCA New Zealand National Committee and the New Zealand Society of Anaesthetists.

Fear and excitement proved to be a perfect theme this year with local and international speakers sharing their expertise and experience about facing fear and avoiding danger.

The stimulating and varied program saw delegates packing into presentations, workshops and exhibitions. There was a buzz in the air with space provided for networking with friends and colleagues, social activities including the dinner at the top of the Gondola, and the sights and sporting opportunities in and around Rotorua.

Delegates, organisers and keynote speakers were welcomed to the ASM with a Pōwhiri (Māori welcome). The opening presentation was a moving account by Waikato Hospital specialist anaesthetist Dr Tom Watson about how CPR, performed on him by a group of quick-thinking friends 12 months ago, saved his life.

The keynote speakers were: Professor Tim Cook a consultant in anaesthesia and intensive care medicine, Royal United Hospital and director of national audit projects and College advisor on airway, Bath, United Kingdom; Associate Professor Tony Roche, specialist anaesthetist, University of Washington, Harborview Medical Center, Seattle, US; Dr Karen Smith, specialist anaesthetist in adult and emergency anaesthesia, Auckland City Hospital, Auckland.

Sessions covered "Airway dilemmas in anaesthesia", "Conditions that make life difficult", "Ethical dilemmas in anaesthesia", "EEG in clinical practice", "Preadmission", "Dangers in everyday practice", "Overseas anaesthesia update" and "Our environmental impact". More information can be found on the ASM website www.nzanaesthesia.com.

A number of business meetings were held during the ASM: the AGM for NZ Fellows, a NZ Anaesthesia Education Committee, Health Care Industry liaison and ASM convenors. Immediately prior to the ASM, the ANZCA NZ National Committee met in Rotorua. Also the NZ Anaesthesia Technicians Society held their annual conference at the same time as the ASM, so those attending benefitted from the presence of the keynote speakers, the exhibition and some joint sessions.

ANZCA and the NZSA distributed four joint media releases. A number of media outlets ran stories on, or interviews with, Dr Charlie Brown on high risk patients, Dr Doug Campbell on the risk calculator and Dr Cam Bennett on environmental sustainability. Facebook and Twitter added to the chatter.

Next year's NZ Anaesthesia ASM and NZATS Conference will be held at the Cordis Hotel in Auckland, New Zealand from November 8-10, 2018.

Honouring Professor Alan Merry

Auckland anaesthetist Professor Alan Merry, ONZM, the Chair of ANZCA's Research Committee and a long-serving College councillor has been honored with an annual lecture in his name.

The New Zealand Anaesthesia Education Committee (NZAEC) Chair Dr Kerry Holmes announced that the Alan Merry Lecture would be a feature of the joint ANZCA New Zealand National Committee (NZNC) and New Zealand Society of Anaesthetists Annual Scientific Meeting (ASM).

Professor Merry served on the ANZCA Council from 2004 to 2016 and chairs the board of the Health Quality and Safety Commission in New Zealand. Professor Merry stepped down from ANZCA Council last year after 11 years. Prior to his council years, Professor Merry was on the New Zealand National Committee (NZNC) for 12 years from 1990 to 2002, serving NZNC for 24 years in total. He served as NZNC Chair for three years from 1996 to 1999.

The ANZCA NZNC members hosted a dinner to honour Professor Merry in Rotorua on the eve of this year's NZ ASM. College President David A Scott and CEO John Ilott attended. The event gave the NZNC the opportunity to thank Professor Merry for his distinguished service to the College.

Former ANZCA President Dr Leona Wilson spoke about Professor Merry's New Zealand and Australian anaesthesia achievements and highlighted the support of his wife Professor Sally Merry (pictured above).

Above: Dr Alan McKenzie presenting on the use of databases and quality assurance.

QAC Network looks into database technology

The challenge of improved health IT systems that would allow for national QA data to be collected dominated the second meeting of the Quality Assurance Coordinators' (QAC) Network in Wellington in October.

Existing electronic medical records do not link to patient management systems and vary between regions making national audits extremely difficult and complex. There also appears to be little clinician input and few details of a proposed New Zealand Health Strategy and Digital Health 2020.

A group of interested members has been established to progress the decisions made at the meeting. It is hoped that the laparotomy audit may be the first national audit. This would then be used to progress similar initiatives.

NZNC member Dr Rob Fry, who is one of the leads for the QAC Network, says improvements in process and patient care across the country would be facilitated with a national approach to data collection. "There is a real need for clinical information officers in each New Zealand hospital, reporting to a chief clinical information officer within the Ministry. This would help build a robust national clinical informatics IT platform for the country," says Dr Fry.

Toolkit for local maternal morbidity reviews

A toolkit is being developed for district health boards to support them to do local maternal morbidity reviews.

The toolkit is the work of the Maternal Morbidity Working Group (MMWG). This is a subgroup of the Perinatal and Maternal Mortality Review Committee (PMMRC) which operates under the umbrella of the Health Quality & Safety Commission. MMWG has representatives from anaesthesia, midwifery, obstetrics, maternal medicine as well as consumers and DHB management.

The aim is to provide a framework which includes highlighting excellent and high quality care as well as looking at opportunities for learning, creativity, innovation and improved resilience.

The toolkit is currently being tested by maternity services with feedback and final changes due in early 2018. It will be released in May 2018 on the Commission website.

Meanwhile regional panels have been busy reviewing cases in which women have been admitted to an ICU/HDU with either sepsis or an unplanned peripartum hysterectomy. MMWG has decided that sufficient information has been gathered over the 33 sepsis cases reviewed to identify opportunities for improvement. The sepsis reviews will be replaced in 2018 with review of hypertension/preeclampsia cases which result in severe morbidity. Because of their small numbers, reviews of unplanned peripartum hysterectomies will continue through 2018.

Dr Matthew Drake,
ANZCA representative on the MMWG

NZ's 2018 Research Workshop – top speakers line up

Top tips on research and getting published are drawcards for ANZCA's next New Zealand Research Workshop, to be held in Auckland on Friday, March 23, 2018.

The workshop promises to be a valuable opportunity to meet and chat with an impressive line-up of international and local speakers.

Guest speakers include Professor Hilary Grocott, the editor-in-chief of the *Canadian Journal of Anaesthesia*. He is exploring medical writing and how to get the reviewers and editors on your side

The other international speakers are Assistant Professor Jessica Feinleib, Yale University School of Medicine, speaking on the ins and outs of airway research and Professor Bernard Riedel, Director Peter MacCallum Centre.

The ANZCA NZ National Committee established the biennial event to provide an opportunity for emerging researchers to network. During the day, three novice researchers will present in a section titled "The Young and the Restless".

Above: Professor Hilary Grocott, the editor-in-chief of the Canadian Journal of Anaesthesia.

Australian news

Victoria

Victorian Registrars' Scientific Meeting

The Victorian Registrars' Scientific Meeting was held at ANZCA House on Friday November 17 and was very well attended by both trainees and supervisors.

The adjudicators were Professor Bernhard Riedel, Dr Jennifer Reilly, Dr Jai Darvall, Dr Lachlan Miles and each of their presentations was very well received.

The trainees presented a total of eight projects, which were divided into scientific and audit categories. The recipient of the prize for the scientific category was Dr Chad Oughton, and for the audit categories there were two winners – Dr Diana Abu-Ssaydeh and Dr Andrew Wooley. Each will soon be receiving a commemoration plaque and a book voucher.

There was a cake to celebrate the ANZCA 25th anniversary at the afternoon tea and the President's Christmas Drinks were held after the event where the winning awards were announced.

Above clockwise from top: VRSM chairs (Dr Tabara Dione, Dr Jeremy Broad, and Dr Christine Wu) and presenters (Dr Ruth Blank, Dr Andrew Goldberg, Dr Diana Abu-Ssaydeh, Dr Andrew Wooley, Dr Juan Sandoval, Dr Luke Willshire, Dr Ryan Juniper, and Dr Chad Oughton); Professor Bernhard Riedel presenting an award to Dr Andrew Wooley, with Professor David A Scott; Leading adjudicator, Professor Bernhard Riedel cutting the cake at afternoon tea.

Australian news (continued)

Victoria (continued)

Victorian Trainee Cocktail Ball

It started as a simple idea: To enhance the welfare of trainees through an inaugural social event independent of formative examinations and courses. What developed was a lesson in event management, distribution lists, running sheets, negotiation, extensive marketing via a multilayered strategy incorporating print and electronic media, and a significant amount of patience, flexibility and positivity in the process.

What resulted was an incredible evening in early November of Melbourne sunset views, mingling and elegant entertainment with trainees from Monash, Austin, Royal Women's, Royal Children's, St Vincent's, Geelong and the Alfred Hospitals, as well as ANZCA and ASA representation.

However, what eventuated was something far greater than we could have imagined. A realisation that we were creating an experience that embodied a spirit of hopefulness, positivity and collegiality. A true connectedness between inter-hospital colleagues that extended far beyond the physical presence of the trainees on the night. It was also an opportunity to create a new line of communication between the previously separate ANZCA trainee committee and ASA trainee committee, forging a path for future collaborations and planning across the wonderful work achieved in both organisations.

There are so many people to thank, but a list would start with the incredible support and hard work of the trainee committee, particularly Tabara Dione for her unwavering enthusiasm of the event. I would also like to thank Ramanan Rajendram for being our star recruiter at Monash hospital, Cathy O'Brien for her incredible worth ethic and behind the scenes support, Joannie Cheng for her stunning poster design and development, the management at Mon Bijou for their flexibility and second to none professionalism, the welfare advocates at all hospitals for their encouragement, our ANZCA college for their early support of the event and financial contribution and dually the ASA for their guidance, marketing and enthusiasm for the ball.

We are so lucky to be part of these organisations that consciously believe in a better future for all their trainees, who will continue to role model positive behaviours into their career, and we are excited for what the future holds.

Verna Aykanat
Event Coordinator, Victorian Trainee Ball

Trainee committee update

2017 has been a productive year for the Victorian Trainee Committee (VTC). Promoting registrar welfare and wellbeing has underpinned most of our work.

The committee aimed to increase interaction between trainees across Victoria and build a sense of community and support among ourselves. In light of that, the Victorian Anaesthetic Registrars Facebook page was launched in August. Any trainee in Victoria can request to join. It has been well received and we have 195 members. In fact, other trainee committees in Australia and New Zealand have followed suit and started similar groups!

On November 11 we held the first Victorian Anaesthesia Trainee Ball, with the ASA, which was a cocktail party held at Mon Bijou. It was fun and glamourous night, designed to bring Victorian registrars together to dress up and let their hair down! We hope it was the first of many more events like this.

The Victorian Registrars' Scientific Meeting (VRSM) provided an opportunity to celebrate research and audit performed by registrars across the state with some impressive presentations.

ANZCA has been celebrating its 25th anniversary, including the registrars, with cakes at the Trainee Ball and VRSM.

I look forward to more Victorian trainee involvement in 2018!

Dr Tabara Dione
Chair, Victorian Trainee Committee 2017

Western Australia

Update

The Autumn Scientific Meeting will be held at Joondalup Resort on April 7, 2018. The conference will focus on "being green" in anaesthesia as well as the importance of mental health in the workplace. A gala dinner will be held in the ballroom once the conference has closed.

On National Anaesthesia Day on October 16, Royal Perth Hospital held a display on the bridge and spoke to visitors to the hospital about the importance of anaesthesia using the ANZCA posters.

The Part 3 course was held on November 18 at Frasers Restaurant in Kings Park. Dr Bridget Hogan presented on consultant life in a tertiary hospital, Dr Wayne Reynolds spoke on getting started in the private sector and Dr David Borshoff and Dr Alex Swann spoke on the ASA and packing yourself to be successful in a public position. We thank the presenters for their time in making the Part 3 course a success once again and thank Dr Maya Calvert and Dr Natalie Akl for organising the day.

Above from top: Trainees enjoying the Part 3 Course; Dr Rob Storer presenting.

South Australia and Northern Territory

FPM CME

The SA FPM CME was held on November 7. Guest speaker, Tania Gardner, senior physiotherapist from the Department of Pain Medicine, St Vincent's Hospital, gave an informative presentation on the online pain management program "Reboot online". The aim of the program is to provide access to a multidisciplinary pain management program for those living in rural and remote areas who are unable to access programs in large metropolitan cities.

The evening was well received by specialist pain medicine physicians, trainees and allied health professionals.

Above clockwise from left: Dr Roelof Van Wijk and Dr Gary Clothier; Ms Lisbeth Woodroffe and Dr Bruce Rounsefell; Dr Irena Hollington and Dr Michelle Harris.

Australian news (continued)

South Australia and Northern Territory (continued)

Burnell-Jose Annual Scientific Meeting

The combined ANZCA/ASA South Australian Burnell-Jose Annual Scientific Meeting was held in the Barossa Valley on the weekend of September 9-10.

A successful scientific program was presented to delegates on the topics of human factors, optimising performance and improving systems. International and national speakers included Associate Professor Stuart Marshall, Clinical Director of the Australian Centre for Health Innovation (CHI) at The Alfred hospital, Professor Rick Iedema, Director of the Centre for Team Based Practice at King's College in London and Professor Alan Merry who practises in anaesthesia and chronic pain management at Auckland City Hospital and is also Head of the School of Medicine at the University of Auckland.

Emergency response workshop programs held on Sunday morning included an anaphylaxis workshop run by Dr Paul McAleer and Dr Nagesh Nanjappa and CICO workshops, facilitated by Dr Giresh Chandran and Dr Rob Young. Many delegates also were delighted to participate in the social program, which included wine tasting, social and serious bike riding, golfing and enjoying the world class dining experiences of the Barossa.

Professor Stuart Marshall also presented the Maurice Sando Memorial Lecture during the Barossa Valley meeting and as part of the triennial Burnell-Jose Visiting Professorship, Professor Marshall was invited to tour and speak to SA anaesthesia department meetings and attend registrar training sessions to foster education and research relationships.

The convenors, Dr Nathan Davis and Dr Tim Benny and the SA/NT CME Committee, thank all the speakers and delegates who attended and contributed to such a successful meeting.

The next planned Burnell-Jose Visiting Professorship will be held in South Australia in 2020. We look forward to seeing an even larger group of anaesthetists attending.

Above clockwise from left: Associate Professor Stuart Marshall; Associate Professor Stuart Marshall and Professor Alan Merry; Dr Gretchen Willis, Dr Brenton Millard, and Dr Richard Walsh; Wine tasting; Professor Bill Runciman, Dr Mike Goldblatt and Dr Tim Benny; and Dr Laura Willington, Dr Mary-Claire Simmonds and Dr Craig Morrison.

Australian Capital Territory

Art of Anaesthesia meeting

Under warm, blue skies the Art of Anaesthesia meeting was held over the weekend of September 23-24. This year's venue, the iconic Australian War Memorial, provided a wonderful backdrop for a meeting tinged with military themes. A wide range of speakers did us great service at the meeting, starting with the presidents of ANZCA and the ASA followed by our international speakers, Professor Girish Joshi from Dallas, Texas and Dr Ben van der Griend from Christchurch, NZ. In the afternoon, our local speakers provided much insight into various areas of research currently being conducted. There was much to ponder during the tea breaks and the convenors wish to thank all the speakers for their generosity and knowledge.

The beautiful venue, together with the outstanding program of experienced presenters, saw a record attendance of 135 delegates at the Saturday lecture series. Word must be getting out that Canberra is a pretty place to visit during springtime! We had 10 healthcare industry exhibitors join us for the meeting, and we would like to especially thank our major sponsors Medtronic and Seqirus.

We finished off the Saturday session on a more sombre and respectful note with the Last Post Ceremony read by ASA President Group Captain David M Scott RAAF. It was a very moving and touching way to end what was a wonderful meeting at the War Memorial.

Two workshops were held on the Sunday morning – Can't Intubate Can't Oxygenate (CICO) and Anaphylaxis Management. The CICO workshop was held in the Calvary Hospital theatres and was convened by Dr David Dao with assistance from Dr Salam Al-Khoury, Dr Ed Coxon, Dr Carmel McInerney and Dr Derek Potgeiter and Dr Chris van Leuvan. The anaphylaxis workshop was convened by Dr Melinda Ford with Dr Freya Aaskov, Dr Jennifer Myers, Dr Candida Marane and Dr Jennifer Moran assisting with the facilitation. Both workshops were fully subscribed and provided an opportunity for delegates to refresh their knowledge on these important topics whilst also providing a means for completing their emergency response requirements under the ANZCA Continuing Professional Development (CPD) Program. The feedback provided on each of the workshops was excellent with delegates praising both the facilitators and the content covered in each workshop.

Several social functions were offered for the delegates on Sunday including a private tour of the Australian War Memorial by Retired Wing Commander Sharon Bown (Sharon is Associate Professor David M Scott's ex-commanding officer). The tour was extremely well received and it was great to see delegates bringing their partners and children along for the morning. On Sunday afternoon, a small group of delegates and presenters enjoyed a scrumptious lunch at the nearby Mount Majura winery. The meeting was also held during the annual Floriade flower festival in Canberra, giving interstate and local guests the perfect opportunity to experience Canberra at its best. We hope all the delegates were able to get out and about and enjoy Canberra.

Thank you to the conference convenors, Dr Girish Palnitkar and Dr Carmel McInerney for their tireless efforts in bringing together a wonderful meeting.

Above clockwise from left: Associate Professor David M Scott, Professor Girish Joshi and Professor David A Scott; Delegates enjoying the morning tea break; Dr Ben van der Griend, Dr Andrew Davidson, Dr Girish Palnitkar and Associate Professor David M Scott enjoying a social lunch on Sunday; Professor Girish Joshi and Dr Girish Palnitkar; Group Captain David M Scott RAAF delivers the Last Post Ceremony reading; Dr Emma Lei delivering an engaging research presentation.

Australian news (continued)

Australian Capital Territory (continued)

Scan and Ski is back again in 2018!

After the immense success of our inaugural "Scan and Ski Workshop" in July 2016 we are delighted to announce that we will be running the event again in 2018! The workshop will be held from Friday July 13 to Saturday July 14 at the Thredbo Alpine Hotel in the Kosciuszko National Park. Dr Ross Peake will again convene the workshop, together with world-renowned ultrasound specialists Dr Alwin Chuan, Dr Peter Hebbard, Dr Andrew Lansdown, and Dr Brad Lawther.

The workshop will run over two days, using the morning and evening sessions for hands-on ultrasound scanning and instruction, and leaving the middle of each day free for skiing or sightseeing in the beautiful NSW Snowy Mountains. The workshop will cover upper limb blocks, lower limb blocks, trunk and spinal blocks, among other topics.

Online registration is now open via the ANZCA ACT website or if you would like to find out more please email Kym Buckley in the ACT office kbuckley@anzca.edu.au or phone +61 2 6221 6003. Places will be limited to 20 participants so don't delay!

Queensland

Update

The past few months in the Queensland Regional Office have been jam packed with events and meetings.

In October the Queensland Trainee Committee sent out nominations for the new 2018 committee and a postal ballot closed in early December. The FPM Directors and SOTs meeting was held at the office in October with five directors and five SOTs in attendance. Our Saturday lectures proved to be an ongoing success with seven particpants in the room and four participants dialing in to access the lecture remotely on Saturday October 14. The CME committee held a meeting on Tuesday October 17 with participation from the NSW regional office by teleconference. With the office down to two staff, the months end saw us at the Sofitel invigilating the Final Oral Exams with the team from Melbourne in October.

The Queensland Trainee Committee had their last meeting for the year and Christmas dinner on Tuesday November 7. "Five of the best" was the title of the CME dinner meeting on November 13 with five Provisional Fellows presenting their interesting cases.

The QARTS committee held a meeting on Thursday November 16 with representatives from Queensland Health to discuss the RMO Campaign and Pathway for the coming year. Friday November 17 saw the office transformed into a meeting workspace with the final SOT meeting for the year. A total of 38 SOTs travelled to the Qld Regional Office for their Business Meeting and a workshop titled "Preparing your trainees for the final examination" with presenters Dr Parag Nalavade, Dr Greg Moloney and Dr Jesse Gilson. The final Saturday Lecture for the year was well-attended and streamed remotely to four participants.

The FPM QRC meeting was held at the office on Tuesday November 21. The Queensland Regional Committee held its last meeting and Christmas dinner on Thursday November 23 at the Ecco Bistro in Brisbane's CBD; there were 17 committee members with ANZCA President Professor David A Scott in attendance.

Monday November 27 saw both the new State Manager Jo Sutton and the new Events Coordinator Julie Donovan starting in the office.

New South Wales

Part Zero Course

The Part Zero Course for new trainees was held at the ANZCA NSW Office at Crows Nest on October 21. Forty-two new trainees attended the day program which included sessions on training, navigating TPS, examination preparation, career options, welfare and ended with a session by partners of anaesthetists.

Many thanks to those trainees, consultants and non-anaesthetists who volunteered their time to take part. Thanks to the NSW Trainee Committee for organising a great day, which provided an opportunity for new trainees to meet and mingle with other trainees and consultants.

Thank you to Dr Moyle

A big bouquet to Dr Michelle Moyle for her work as ANZCA Education Officer NSW over the past years. Michelle has always been enthusiastic and caring in her role and committed to improving anaesthetic training, for both supervisors of training and trainees. We wish her well (but do retain her mobile number for future advice!). The new Education Officer for New South Wales is Dr Sally Wharton.

Annual FPM CME

The NSW FPM Regional Committee hosted their annual CME meeting on Thursday October 26 in the ANZCA Sydney office. The speaker was Professor Ian Harris, a practising orthopaedic surgeon and researcher who studies effectiveness of surgery but is interested in research methodology and the applying of the scientific method to reduce bias in the research and practice of medicine. His presentation "Determining the true effectiveness of pain interventions" was well received by the delegates who represented the various pain disciplines from around the Sydney metropolitan area.

Australian news (continued)

Tasmania

As 2017 draws to its conclusion, plans are well away for dynamic and challenging meetings in 2018. You are encouraged to register for the Tasmanian ASM in March and combine a meeting and golfing weekend or just check out the spectacular scenery overlooking Bass Strait while you gain those important CPD points at Barnbougle in August 2018.

Tasmanian Trainee Trauma Teaching Day

More than 20 registrars attended a trainee trauma teaching day held at the Launceston General Hospital on September 7. A busy program, including interactive sessions kept delegates engaged, including interesting presentations by Associate Professor Reny Segal from Melbourne, Dr Andrew Hughes from Queensland and local contributions by Dr Lucy Reed and Dr Bruce Newman. The meeting was convened by Dr Deborah Tooley with feedback on the day being very positive.

Saturday March 3, 2018 – save the date

Tasmanian Combined 2018 ASM "Out of the comfort zone" will be held in March next year.

The case appeared on your list yesterday
Its complex, high risk
A little scary
Maybe there's someone else? Surely...
But no, it's you
You read, research, plan
Now it's time
You are nervous
Your breath quickens
Your heart thuds a little
You straighten your back and walk into theatre
'Hello, I'm your anaesthetist'...

You are outside the comfort zone

If you have ever been in this position the Tasmanian Combined ANZCA and ASA Annual Scientific Meeting is for you.

The theme is anaesthesia outside of the comfort zone. It specifically explores those areas of anaesthesia that make us nervous, those complex high risk cases that we don't do very often.

The organising committee has put together a wonderful program of local and interstate speakers to challenge and intrigue you. We are delighted to welcome Dr Rani Chahal, Dr Lachlan Miles, Associate Professor Philip Ragg, Dr James Griffiths and Dr Catherine Olweny to Tasmania. In addition, we have an excellent local presentation led by Dr Bruce Newman on some of the issues of paediatric anaesthesia in regional and rural settings.

Now, if you aren't already feeling uncomfortable with thoughts of those tricky cases, we can take you to a place well beyond most reasonable definitions of comfort – Antarctica! Cold, windswept and desolate, yet stunningly beautiful. We are delighted to have a combined presentation from local anaesthetists including Dr Lizzie Elliot and Dr Jeff Ayton of the Polar Medicine Unit at the Australian Antarctic division on some of the challenges of medicine on the frozen continent.

The meeting will also provide opportunities to meet ANZCA CPD requirements with concurrent ALS and major haemorrhage workshops.

The Tasmanian Regional Committee for ANZCA and the ASA invite you to the Tasmanian ASM on Saturday March 3, 2018. A cocktail function will be held after the meeting at the Atrium of the Henry Jones Hotel. A trainee day precedes the ASM on Friday March 2, 2018. A Process Communication Model (PCM) workshop will also be held in association with the meeting on Sunday March 4, 2018.

The meeting is held in beautiful Hobart, the smallest, but in our opinion the best capital city. From the waterfront to Mount Wellington, Hobart is packed with natural beauty and attractions including Salamanca, MONA, everything from gentle bushwalking to hair-raising mountain biking and oodles of great restaurants and vineyards. We look forward to seeing you there.

Dr Lia Freestone, Convenor of the Tasmanian ASM

Saturday August 25, 2018 – "Traps and hazards"

Following on from the success of the 2017 August meeting, the 2018 ANZCA Tasmania Midwinter Meeting will again be at the stunning Barnbougle golf resort at Bridport, an hours drive north of Launceston. It will feature a range of interesting local and interstate speakers, on topics related to anaesthetic traps and hazards. Topics will include managing difficult airways for laryngeal and thyroid surgery, anaesthesia for bariatric, upper gastrointestinal and liver surgery, as well as bleeding management in trauma and obstetrics. There will also be opportunity available to attend an ANZCA accredited anaphylaxis CPD workshop. The resort is rated as one of the top 10 golf courses in Australia, and has a few of its own traps and hazards. A three-course delegates dinner at the Lost Farm Restaurant is also included. We look forward to seeing you there.

Dr Karl Gadd, Co-convenor of the August 2018 meeting

Obituary

Arumugam (Tony) Ganendran 1927-2017

Arumugam (Tony) Ganendran was born on April 1, 1927 and passed into eternal life on Monday September 18, 2017.

Tony was born in Kuala Lumpur, Malaysia and received his early education at the Pasar Road School and the Victoria Institution. He successfully applied to the University of Bristol to study medicine and qualified in 1956. In 1957 Tony moved to Singapore and took up a position as an anaesthetic trainee. In 1960 he received a two-year scholarship for Advanced Anaesthetic Studies and Training at the Liverpool Post-Graduate School of Medicine. In Liverpool he was mentored by several founders of the specialty of anaesthesia in the UK including Professor T Cecil Gray, Dr Gordon Jackson Rees, Dr Alan Stead and Professor John Utting. During this time Tony sat for the primary fellowship examination and was awarded the Nuffield prize. The following year, Tony passed the final fellowship examination and became a Fellow of the Faculty of Anaesthetists of the Royal College of Surgeons. Also in 1961, Tony sat and passed the exam to become a member of the Royal College of Physicians. This was an astonishing and exemplary series of academic achievements in a very short space of time and he was able to widen his experience in anaesthesia in various centres of excellence like the Nuffield Department of Anaesthesia in Oxford, Department of Anaesthesia in Cardiff, at the Great Ormond Street Children's Hospital in London and finally in Edinburgh.

Tony returned to Singapore as a Senior Registrar in 1962 and in 1963 was appointed as anaesthetist in charge of neurosurgery at the Thomson Road Hospital, Singapore. In 1965 Tony was invited to set up the anaesthetic department at the University of Malaya. Having established the first independent anaesthetic department in Malaysia and Singapore, he conducted research, including pioneering work on the treatment of tetanus in intensive care with the careful use of Gamma Hydroxybutyrate for deep sedation, for which the Singapore Academy of Medicine awarded him the Galloway Memorial Prize in 1963. Among his other milestones and achievements were the establishment of the first intensive care unit in Malaysia in January 1969 followed by involvement in the first successful open-heart surgery in Malaysia including Singapore. In 1973, he was elected as a Fellow of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons and as a Fellow of the Royal College of Physicians.

One of his finest achievements was obtaining full recognition by the Faculty of Anaesthetists of the Royal Australasian College of Surgeons for the University of Malaya Medical Centre as a training centre for six training positions. The first batch of anaesthetists fully trained in the University of Malaya Medical Centre graduated with the Australasian FFARACS in 1974.

Subsequently, he conducted research into the treatment of organophosphate insecticide poisoning which was common in the region at that time and ultimately led to his award of the degree of Doctor of Medicine by dissertation in 1975 from the University of Bristol. In 1976 the position of Chair of Anaesthesia was created at the University of Malaysia and Tony was appointed as the first Professor of Anaesthesiology in Malaysia and Singapore after a rigorous selection process in the face of international competition. In recognition of his contribution to the profession of anaesthesia, he was awarded the DPMT, a knighthood carrying the title of Dato by the Sultan of Terengganu in 1977.

Tony was a close friend of Professor Tess and Doctor Humphrey Cramond. When Tony was considering a move and the furthering of his career in 1978, he had two countries in mind – the US or Australia – both of which had offered positions. He discussed the options with Tess and she strongly encouraged Tony to choose the position as Director of Anaesthesia at Greenslopes Repatriation Hospital in Brisbane. After taking up the position, Tony reorganised the anaesthetic department using his previous experience and was responsible for the training of anaesthetic registrars and also medical students. In 1995 the hospital was sold to Ramsay Health Care and in 1996 was renamed as Greenslopes Private Hospital. Tony was appointed Director of Anaesthesia in the hospital under the new administration.

Tony also visited the dental hospital in Brisbane where he instructed dental students and, in recognition of his work in anaesthesia and dentistry, he was appointed as a Clinical Professor of Anaesthesia of the University of Queensland in 1993. He retired from his directorship at Greenslopes in 2002 but continued providing anaesthesia at Belmont Private Hospital until he retired from clinical practice in 2007. However, he continued his academic activities after retirement and completed an MA in Theology in 2005 at the Australian Catholic University.

As well as high achievements in anaesthesia, Tony also excelled in other complex activities such as becoming a registered owner builder and supervising the building of his own house in Carindale in 1984.

Tony was married for more than 58 years to his dear wife Cecilia. His four children Jaci, Billie, Frank and Tony all became professionals in their own right, following in their father's ethic of hard work and determination, and in Tony Junior's case, also following the specialty of anaesthesia. His 90th birthday party was a wonderful event, celebrated by family and many friends earlier this year, and Tony impressed yet again with his good health and sharp wit.

Tony was a devout Catholic and a Knight of Malta. He received Holy Communion and the Last Rites in his last few hours of life. He passed away peacefully in the early hours of Monday September 18, surrounded by family. He is survived by his dearly loved wife Cecilia, his four children and six grandchildren. He is sadly missed by his family, friends and colleagues. Tony brought joy and fulfilment to many, and his legacy will live on forever.

Dr Martin D Culwick
Friend and colleague with assistance from the Ganendran family.