
ANZCA BULLETIN

CELEBRATING

25

YEARS
OF ANZCA
LEADERSHIP
1992-2017



**25 great years:
The College
celebrates**

**Trainee survey:
What we
learned**

**Ross Holland:
Farewell to
an icon**

**Choosing Wisely:
Our 5 things
to question**



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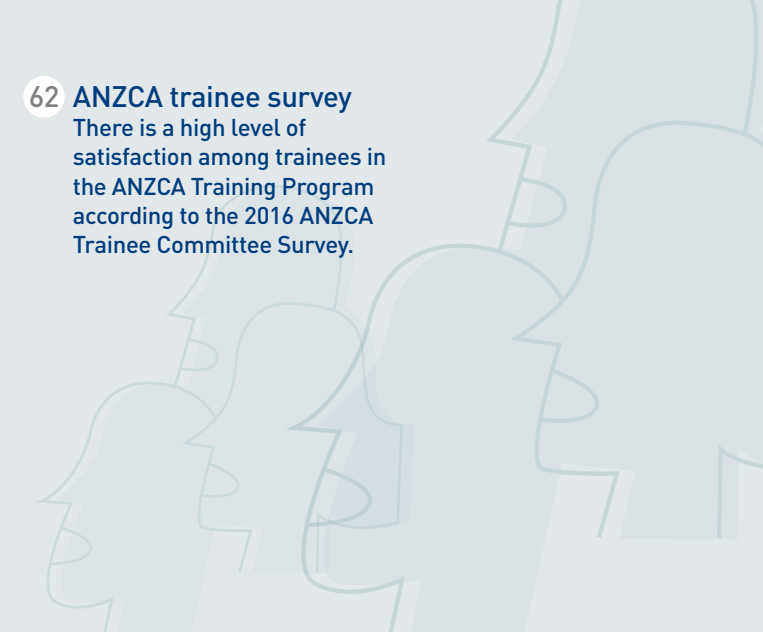


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ANZCA Bulletin

The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional medical body in Australia and New Zealand that conducts education, training and continuing professional development of anaesthetists and 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.
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President's message



25 years

By now you will be aware that this year marks 25 years since the formation of ANZCA as an independent specialist college. This was not a trivial undertaking and the background is outlined in the 25th anniversary book, *25 Years of ANZCA Leadership*, which has been sent to all Fellows.

Our separation from the Royal Australasian College of Surgeons after 40 years as a faculty was supportive, and has resulted in a positive, mutually beneficial and enduring relationship. The relevance of our engagement with our sister colleges cannot be understated.

Medical specialists in Australia and New Zealand do not practice in isolation from one another, and collaborative exchanges of ideas and policies helps set the standards for safe and effective practice – current examples include promoting standards for so-called “office-based” procedures, a consistent approach to bullying, discrimination and sexual harassment (our own working group report will be published very soon), and helping inform our response in policy areas such as the important consultation on Victoria's upcoming voluntary assisted dying bill.

The purpose of ANZCA is to train and

support specialists in anaesthesia and pain medicine, so that the best quality of care can be provided to the community. Every specialist anaesthetist in Australia and New Zealand has been trained or credentialed by ANZCA or the previous Faculty – it is our responsibility, given to us by national governments, to ensure that the standards of training, ongoing learning (continuing professional development) and practice are maintained.

As is often attested, we have the highest standards of anaesthesia care in the world, as measured by the respect for FANZCA membership world-wide, our incredibly significant research impact, and the high quality of safe care we provide daily. Policy advocacy is extensive, targeted, and an important responsibility of a mature College such as ANZCA.

Private practice

In Australia in particular, a question reasonably raised is “what is the relevance of ANZCA to anaesthetists who work predominantly in private practice?” This is important because ANZCA membership includes the overwhelming majority of anaesthetists who practice in private.

I believe that we provide value and significant benefit to members in private in a range of ways – but we recognise a need to do more. ANZCA sets the standards of practice for private and public practitioners alike. Every time you monitor oxygen delivery, saturation, end-tidal CO₂ or end-tidal agent levels – it's thanks to your peers considering and delivering the best and most thought-out standards of care in world. More recently, availability of depth of anaesthesia monitoring and soon new recommendations for neuro-muscular blockade monitoring will ensure that practitioners in public and private have access to, and guidance for, the safest practice.

The continuing professional development (CPD) standard legally applies to all practitioners, and based on



our consultations with the Medical Board of Australia (MBA) and Medical Council of New Zealand (MCNZ), will continue to meet regulatory requirements. ANZCA leads in this area, especially with practice evaluation (or regular practice review – RPR). In our first CPD triennium of the new program (almost 3000 participants), 99.2 per cent of members were fully completed. This is a great credit to our specialty, but it is not without individual effort – and ANZCA aims to support members as much as possible.

The College provides a wide range of learning and skills upgrade opportunities ranging from local meetings to our world-class annual scientific meeting (this year in Brisbane), but also directly accessible anytime with online modules (for example, major haemorrhage, and soon anaphylaxis), publications (for example, *Acute Pain*, the “Blue Book”, and the airway documents), apps (for example, the opioid calculator), library journals and the “gems” which are the Library Guides.

Probably the biggest challenge is practice review. We are ahead of the game in embedding it in the program but in recognition of the challenge to the many members in private practice we have offered a range of options for attaining satisfactory completion. We also provide online advice, examples, tools, forms and other resources to help with this.

We are constantly looking for ways to improve our support for all members, and are working to ensure that we optimise our offerings to Fellows in both private and public practise. Your feedback is welcome!

Professor David A Scott
ANZCA President

Chief executive officer's message



ANZCA's first 25 years

The first 25 years of ANZCA as an independent college have been well documented in the excellent publication, *25 Years of ANZCA Leadership* sent to all Fellows in early February. The themes that emerge for me are extraordinary vision, determination to be among the best in the world and thirdly, in a relatively short period, the breadth of services that ANZCA offers to trainees, Fellows and to our home communities in Australia, New Zealand as well as those abroad.

The vision of course includes the development of the world-class curriculum, continuing professional development (CPD) structure that is already demonstrating its robustness in the light of medical regulators' recertification initiatives, and the formation of the Faculty of Pain Medicine, the first faculty in the world to be multidisciplinary in its approach to education.

ANZCA's great vision includes a commitment to research which has underpinned the great advances in anaesthesia and pain medicine.

ANZCA's approach to practice standards demonstrates the determination that professional standards are the foundation of good clinical practice. Our standards are referred to many times each year as we advocate with governments and regulators to maintain standards of clinical practice that are evidence-based and are shown to be in the interests of the community.

The extraordinary breadth of services for a relatively small organisation is a credit to all who have led the College in different ways. Services range from the foundations in training curriculum, CPD, training site accreditation and training assessment to overseas aid projects in almost 50 countries, world-class annual scientific meetings and a busy calendar of continuing medical education and special interest

group activities which are organised in partnership with the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists.

On behalf of the staff of ANZCA I would like to acknowledge that it is a privilege to be a part of this wonderful organisation and I recognise the invaluable leadership contributed by Fellows, trainees and staff over the past 25 years.

Of course our history extends to 40 years beyond 1992 when we operated as a faculty of the Royal Australasian College of Surgeons (RACS). Then almost immediately after ANZCA become an independent college, the Faculty of Intensive Care was formed, which in turn became the College of Intensive Care Medicine (CICM).

ANZCA continues to enjoy close relationships with both RACS and CICM, particularly in areas of advocacy on standards.

Training program

During 2017 and 2018 ANZCA will be undertaking its largest project since the development of the new curriculum in 2013. The upgrades to the content and structure of the training program will result in a major improvement in service to trainees and supervisors. The key system improvements will include the following elements.

- Improved recording of time in basic training, introductory training and advanced training including clinical anaesthesia time and other clinical time.
- Improvements to recognition of volume of practice and use of log books.
- Improvements to recording the assessment of the scholar role and workplace-based assessments.
- Rules around interrupted training will be more easily understood by trainees.
- Greater clarity around recognition of prior learning.

We are confident that the proposed changes will produce an improved training program supported by service improvement in the way that the program is administered. Trainees, supervisors, assessors and staff will be the beneficiaries of the changes.

Website redesign

One of our larger projects in 2017 is a redesign of the ANZCA and FPM websites. The sites will be newly styled and will create a “new digital experience”.

The ANZCA and FPM websites receive around five million page views per year so it's critical that they are capable of interfacing with new technologies such as Facebook and Twitter.

We want to introduce better, more intuitive navigation, easier-to-locate information and remove a lot of unnecessary information. Ultimately we want to increase Fellow and trainee satisfaction and make sure our websites are using the most current technology.

We also want to greatly improve our information for the public so ANZCA and FPM are the go-to organisations for information about anaesthesia and pain medicine.

The result will be an appealing, highly professional looking website that is user friendly for everyone.

2016 in review

The 2016 annual report will provide more detail about the achievements of 2016. However I would like to acknowledge the efforts of staff, Fellows and trainees in the following.

- A highly successful Auckland annual scientific meeting.
- A record \$A1.7 million for 2017 research grants through the ANZCA Research Foundation.
- Four special interest group conferences, 18 regional scientific meetings, FPM's Spring Meeting and Refresher Course Day, Clinical Trials Network and ANZAAG meetings and more than 40 trainee courses run by ANZCA and FPM.
- More than 50 formal submissions to government, medical regulators and other bodies.
- Continued safety focus with webAIRS, professional documents reviewed and new resources.
- ANZCA Library introduced LibGuides and delivered 100 literature searches in a 10-month timeframe.
- World recognition for the Faculty of Pain Medicine.
- Successful completion of the Graduate Outcomes Survey for ANZCA and FPM.
- Forty hospital accreditation visits completed.
- Enhanced community engagement through social media.

The year was by all measures a successful one for ANZCA and the Faculty and I congratulate the many people who contributed.

John Illott
Chief Executive Officer, ANZCA

Awards

Australia Day honour

Dr James Francis Wilkinson, FANZCA, of Palm Beach, Queensland, was made a member (OAM) in the general division of the Order of Australia for service to medicine, and to choral music. Dr Wilkinson spent much of his anaesthesia career in Sydney. Outside of his medical career he served as a member of the St Mary's Cathedral from 1959 until the 1990s and then at the St Paul's Church in Burnwood from the 1990s until the mid-2000s. In 2005 he founded the Master Chorale which he served in until 2007.

New Year Honours

Dr John Hyndman, FANZCA, of Kaiapoi, near Christchurch, was made a Member of the New Zealand Order of Merit (MNZM) in the New Year Honours List for services to health and innovation. Dr Hyndman has won a number of other awards for helping to invent a compact, cheap and reliable anaesthetic machine for use in developing countries. His co-inventor, engineer Mr Ivan Batistich received the same New Year honour. Their work was featured in the September 2016 edition of the *ANZCA Bulletin*.

New Zealand Medical Association award

Dr Robin Youngson, a New Zealand anaesthetist known for his leadership in compassionate healthcare, was awarded the New Zealand Medical Association's Chair's Award last December. Dr Youngson is the co-founder of the organisation Hearts in Healthcare and the author of *Time to Care – How to love your patients and your job*.

ANZCA staff awards



Several ANZCA staff have been recognised for achievements in 2016 in the annual Staff Recognition Awards.

Certificates were presented during the annual Staff Recognition Awards by ANZCA President Professor David A Scott and councillor and awards judge, Dr Rowan Thomas, to:

- Virginia Lintott (Policy, Safety and Quality) and Shilpa Dumasia (HR) won the Staff Excellence Award for Customer Service. Highly commended was Alvin Choong (Strategic Projects Office and Technology).
- Hayley Roberts (Accreditation) won the Staff Excellence Award for Innovation or Process Improvement.
- The ANZCA Library Team (Laura Foley, John Prentice, Jenny Jolley and Loretta Schembri) won the Staff Excellence Team Award.

The individual staff excellence awards acknowledge service that is above and beyond the normal requirements of the position or a sustained high-level performance by an individual with a focus on outcomes and recognisable benefits to Fellows, trainees or the workplace.

The team award is for the team that delivers a project, program or work assignment that makes a significant contribution towards the achievement of the College's priorities and objectives, going beyond what is expected.

At the presentation, staff recognised for achieving 10 years of service were Kirsty Robinson and Daphne Erler. Those recognised for five years of service were Michelle Gully, Olly Jones, Mairead Jacques, Kirsty O'Connor, Colin Lynas, Maurice Hennessy, Eleni Koronakos, Sarah Chezan, Rob Packer and Barry Walker.

Above from left: Alvin Choong (Strategic Projects Office and Technology), Shilpa Dumasia (HR), Virginia Lintott (Policy, Safety and Quality), Hayley Roberts (Accreditation), Laura Foley and John Prentice (Library). Jenny Jolley and Loretta Schembri from the library are not pictured.

Correction

A picture on page 8 of the December edition of the *ANZCA Bulletin* was wrongly captioned. Dr Mark Fisher (right), who won the top prize in the new ideas category of New Zealand's 2016 Clinicians Challenge, is pictured with Giles Southwell, Chief Technology and Digital Services Officer at the Ministry of Health.

Chinese delegation visit



On Wednesday, February 22, ANZCA was pleased to welcome a delegation from the Chinese Society of Anesthesiologists (CSA) to the College. The delegation of 15, headed by CSA president-elect Professor Yuguang Huang, came from many regions of China. The majority were also heads of departments and most had a particular interest in regional anaesthesia.

The visit to ANZCA commenced with a tour of Ulimarua and the Geoffrey Kaye Museum of Anaesthetic History and was followed by a series of presentations by the ANZCA president, Fellows and staff. Presentations from the Chinese delegates focused on the overall state of anaesthesiology in China and regional anaesthesia including the 2014 statistics showing 38,000,000 anaesthesia procedures

performed and a total of 78,000 practising anesthesiologists. A memorandum of understanding was signed by ANZCA President, Professor David A Scott and Professor Huang with a focus on education and research and the sharing of information around quality and standards.

After the presentations and a lunch in the ANZCA House gardens, the delegates visited three Melbourne hospitals, The Alfred, St Vincent's and the Peter MacCallum. Thank you to Professor Paul Myles, Dr Rowan Thomas and Dr Jonathon Hiller and Dr Richard Smith for facilitating these visits.

To end a very successful day, dinner was hosted by Professor David Story at University House with further conversation on collaboration between ANZCA and the CSA.

Feedback from the delegation's visit has been extremely positive with Professor Lize Xiong, President of the CSA (who could not attend on February 22) conveying the impressions of the group.

"Although it's a pity that I couldn't be there, I did sense your warm welcome and enthusiasm through our delegates' positive feedback and beautiful pictures," he said. "I am sure that it was a successful visit and that we achieved our goals. Our delegates will never forget the meeting at ANZCA House, the ANZCA House tour, the hospital visit, and the dinner at Melbourne University House. All these considerations and professional arrangements greatly impressed our delegates."

Symposium attracts international audience

More than 190 delegates from around the world attended the Tri-nation Alliance's International Medical Symposium in Melbourne on Friday March 10.

Representing a broad range of specialties, the registrants came to hear sessions on leading change in:

- The culture of medicine – bringing an end to bullying, discrimination and harassment.
- Indigenous healthcare – strengthening the Indigenous specialist workforce and cultural safety.
- Medical education and technology – advancing competency-based medical education (CBME).
- Systems and practice – ensuring that the implementation of change is cost-effective and benefits patients and communities.

The Tri-nation Alliance is made up of five medical colleges spanning Australia, New Zealand and Canada – ANZCA, the Royal College of Physicians and Surgeons of Canada, the Royal Australian and New Zealand College of Psychiatrists, the Royal Australasian College of Physicians and the Royal Australasian College of Surgeons.

For the past six years, the alliance has met in Australia for three days each year with two days of by-invitation workshops followed by the one-day International Medical Symposium that is open to a wider audience and features local, national and international guest speakers. The members of the Tri-nation Alliance also meet in Canada later in the year for the International Medical Education Leaders' Forum (IMELF) and International Conference on Residency Education (ICRE).

The aims of the alliance are to drive collaboration, exploration, vision sharing and the continuous review and improvement of education, training and standards of clinical practice.

In the lead up to the symposium, ANZCA hosted a workshop on the evaluation of CBME and the potential for a CBME approach to continuing professional development for College Fellows



on Wednesday March 8. The following day, another workshop was conducted at the Koori Heritage Trust in Federation Square, Melbourne. This workshop examined strategies to strengthen the Indigenous specialist medical workforce and improve cultural safety across all health professionals and organisations. Representatives of the first peoples of Canada, New Zealand and Australia shared their perspectives and experiences on these crucial issues.

The symposium attracted extensive social media participations with more than two million "impressions", nearly 1000 tweets and nearly 200 people "joined the conversation" by using the hashtag. It was "trending" at #2 in Australia for a few hours and in the top five for most of the conference.

A more detailed report will appear in the June edition of the *ANZCA Bulletin*.

Dr Ian Graham
Dean of Education, ANZCA

Working with government and agencies

Australia

This year is set to be another busy year. A number of government departments and health agencies are due to consult on a number of issues relevant to ANZCA. In the next few months, ANZCA will be looking to engage on the following issues:

End of life choices (Victoria)

In February and March, ANZCA's Policy, Safety and Quality team co-ordinated feedback from ANZCA and FPM Fellows and trainees and specific College committees for the Victorian State Government's Voluntary Assisted Dying Bill Discussion Paper.

In late 2016 the Victorian government announced its intention to introduce new legislation in the later part of 2017. As part of the legislation development, the community has been invited to provide expert advice and guidance on the issue of voluntary assisted dying.

Feedback in relation to the Victorian legislation will help ANZCA develop a College-wide position on voluntary assisted dying.

The Victorian Parliament's Legal and Social Issues Committee has recommended that the Victorian Government should, in certain limited circumstances, legalise assisted dying. The committee's final recommendations (49) were for the implementation of an assisted dying framework.

The government has committed to undertaking further work on developing an assisted dying legislative framework, which will be supported by expert legal advice and a ministerial advisory panel that will provide advice on the practical and clinical implications of new legislation.

Key stakeholders will be consulted about the development and implementation of an assisted dying framework.

The report and summary booklet are available at www.parliament.vic.gov.au/lsc/article/2611.

ANZCA's submission to the "Simplifying medical treatment decision making and advance care planning consultation (June 2016)" is available at www.anzca.edu.au/communications/advocacy/submissions-2016.

The *Voluntary Assisted Dying Bill* discussion paper has been released for consultation.

The Policy, Safety and Quality unit will make its submission to the Victorian

government by April 10 2017.

Day surgery legislation

State legislation regarding day surgery is in various stages of development across Australia.

In NSW, amendment to the Private Health Facilities Regulation was made on June 3, 2016. The change to the regulation requires that any facility undertaking certain cosmetic surgical procedures (except dental procedures) must be licensed.

This means that facilities that carry out certain cosmetic surgical procedures will be subject to the same licensing standards that currently apply to licensed private health facilities.

The South Australian government has released the *Healthcare (Private Day Procedure Centres) Variation Regulations 2017* - draft for comment. In accordance with the amendments made by the *Health Care (Miscellaneous) Amendment Act 2016*, any facilities already declared by the Commonwealth Government and issued with a provider number under the *Private Health Insurance Act 2007 (Cth)*, upon a previous recommendation by SA Health will be deemed to be licensed in South Australia as a private day procedure centre at the commencement of the licensing regime on July 1, 2017.

ANZCA and the Royal Australasian College of Surgeons (RACS) are developing a co-badged position statement on cosmetic surgery safety issues that would include promotion of appropriate standards.

ANZCA recognises the value of a joint process to gain nationwide traction with health departments for a review of the broad variation in state legislation and to ensure patient safety.

MCNZ and MBA joint meeting with specialist colleges

ANZCA's CEO, John Ilott, and General Manager, Policy and Safety and Quality Jo-Anne Chapman attended the Medical Council of New Zealand (MCNZ) and Medical Board of Australia (MBA) joint meeting with specialist colleges in Melbourne on February 3.

The agenda included the following:

- Recertification (in NZ) and revalidation (in Australia).
- Cultural competence.
- Bullying and harassment.
- International medical graduates specialists (IMGs).

Australian submissions:

- TGA – Expedited pathways for prescription medicines.
- AMA Queensland – Expanded scope of practice.
- Dental Board Australia – Public consultation on proposed entry level competencies for endorsement for conscious sedation.
- TGA – Public consultation on medical device regulation in Australia.
- Australian Digital Health Agency – Enhancing Pathology and Diagnostic Imaging Reports in My Health Record.
- ACSQHC – Consultation on National Digital Health Strategy.
- TGA – Designation of Australian conformity assessment bodies for medical devices – Implementation.

Many ANZCA and FPM submissions can be found at www.anzca.edu.au/communications/advocacy/submissions.

New Zealand submissions:

- Pharmac – Proposal relating to tramadol hydrochloride oral solution in DHB hospitals.
- Health Quality and Safety Commission – Discussion paper: Anti-staphylococcal bundle to reduce surgical site infection in orthopaedic and cardiac surgery.

New Zealand

As well as building to a general election on September 23, government departments and health agencies are due to consult on a number of issues relevant to ANZCA. In the next few months, ANZCA will be looking to engage on the following issues:

Vocational training funding

Health Workforce New Zealand (HWNZ) intends to develop and introduce a new model for funding vocational training, by June 30, 2017.

It plans to adopt a funding model that will provide HWNZ with more leverage to invest strategically in training. HWNZ has committed to consulting with the medical colleges about any proposals it develops.

Dr Leona Wilson attended a workshop on this issue in December on behalf of ANZCA, and ANZCA Policy and New Zealand staff met with HWNZ staff in January to discuss progress on the proposals, among other issues.

Recertification

The Medical Council of New Zealand (MCNZ) is seeking feedback on proposals to strengthen recertification for vocationally registered doctors.

The proposals include that vocationally registered doctors would need to develop individualised Professional Development Plans (PDPs) based on performance and outcome data (e.g. from audit, multisource feedback, peer review), and to complete CPD activities that address their PDPs.

The MCNZ also wants stronger emphasis placed on career management planning for all doctors, and clear expectations set that doctors are familiar with the standards of practice outlined in the MCNZ's policy statements, and the Code of Health and Disability Services Consumers' Rights.

The ANZCA New Zealand National Committee will consider the proposals carefully and provide feedback.

Therapeutic Products Regulatory Regime

The Ministry of Health is still working on its "exposure draft" of the Therapeutic Products Regulatory Regime, designed to replace the Medicines Act 1981 and its regulations.

The exposure draft is now expected to be released for consultation in 2017. Key changes will include that the regime will regulate medical devices, cell and tissue products, hybrids of all three and future innovations, rather than only medicines. It will also change prescribing regulations, making it easier for health practitioner groups to add prescribing to their scopes of practice.

Anaesthetic consumables

Pharmac is progressing with its phased approach to managing hospital medical devices on behalf of district health boards. As part of its medical devices work, Pharmac has announced that anaesthetic consumables will be included in the next set of medical device categories that it works on.

Pharmac will be seeking proposals for national agreements for anaesthetic consumables in the first half of this year.

Jo-Anne Chapman

General Manager, Policy, Safety and Quality

Cultural competency

The populations in Australia and New Zealand are multicultural, representing people from many different backgrounds and cultures. Health inequities exist between different cultures, and the role of cultural competence is about challenging how as clinicians we practice – and what it is about our practice that maintains health inequalities.

Cultural competence involves ensuring the clinical environment is inclusive of the cultural needs of the patient, and their family/support network.

ANZCA's *Statement on Cultural Competence* is available via the ANZCA website – www.anzca.edu.au/resources/professional-documents. This document is in pilot phase until July 2017. Feedback is encouraged on all professional documents during the pilot phase.

CPD and cultural competency

Continuing professional development (CPD) credits are available for cultural competency activities.

These activities explore culturally different expectations for clinical communication and behaviour and help to develop strategies for responding effectively when expectations differ between colleagues, patients and their family members/carers. Being able to identify these diverse cultural perspectives will allow you to understand unexpected medical beliefs and behaviours, and where necessary, to guide others in adapting to the Australian or New Zealand context. Intercultural competency learning modules are available on ANZCA Networks.

Cultural competency activities can be claimed in the CPD portfolio under "Knowledge and skills" for one credit per hour. A certificate of attendance/participation/completion, written confirmation of course registration or a screen shot of online resources can be used as evidence.

Further resources

Medical Council of New Zealand – www.mcnz.org.nz/support-for-doctors/resources/%23Content-h2-5

Network for Indigenous Cultural and Health Education – www.nicheportal.org

Australian Indigenous Health Info Net – www.healthinfonet.ecu.edu.au/

Mauriora Health Education – <http://mauriora.co.nz/>

Centre for Cultural Competence Australia – www.ccca.com.au/

ANZCA Indigenous health resources – www.anzca.edu.au/fellows/community-development/indigenous-health.html



Continuing professional development

What would you do?

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



Whose College?

As Director of Professional Affairs, Professional Documents, one of my roles is to receive and attend to complaints, concerns, and queries from Fellows, patients, the community, and regulatory authorities.

I have found that practitioners on the receiving end of such concerns might be reluctant to seek support from the College. Indeed, some have indicated that colleagues initially advised them that it would be better not to contact the College.

What would you do?

If you were the subject of a complaint, would you seek assistance from the College? Or if a colleague sought your advice, would you suggest contacting the College?

So, for the first article of 2017, and at the risk of being labelled an "ANZCA-phile", I thought that I would try to present Fellows and trainees with an opportunity to consider what the College has to offer. A little history and some background on professional documents is included for context.

Professional documents represent an interface between the College and Fellows, as well as between the College and the community. Before the establishment of ANZCA, the then-Faculty of Anaesthetists' core role was dedicated to education, which included training, conferences, and research. It was also active in promoting the image of anaesthetists.

Professional documents were developed during that time to enhance safety and quality by making recommendations about equipment and facilities. These documents, along with accreditation, could then be used as levers by departments to negotiate with training hospital administrators to obtain essential equipment and facilities. This resulted in progressive improvements in care, as well as recognition of the importance of the varied roles undertaken by anaesthesia departments.

Now that ANZCA is an independent College accredited by the Australian Medical Council and the Medical Council of New Zealand, the core roles are still applicable.

However, with growth comes additional demands, and with recognition comes additional community interaction and expectations. ANZCA's mission statement encompasses that growth, now including not just anaesthesia but pain medicine and

"Given all the College's resources and experience, as well as its understanding of clinical practice and the compassion of senior Fellows, the decision whether to approach your College should not be a difficult one."

perioperative medicine (the Joint Faculty of Intensive Care Medicine having broken away to form its own college).

The roles of the College continue to expand, as do its responsibilities. The training curriculum has undergone several major revisions with consequent opportunities for Fellows to become involved in teaching, examining, and as supervisors. Ongoing education has progressed from conferences alone to include workshops and CPD. The museum and library have also grown and, with advancing technology, the resources available for trainees and Fellows have mushroomed. Research has progressed, as evidenced by the quantity and quality of studies by eminent Fellows recognised world-wide, as well as prominent research departments collaborating in large multi-centre trials.

Safety and quality is still first and foremost. Development and dissemination of guidelines and statements support this role with the aid of the Communications unit, which works to engage the media. In addition, alerts are issued through the Safety and Quality Committee via ANZCA's print and/or electronic media and social media.

As a result of its roles and activities, ANZCA has become a well-respected organisation, as shown by the fact that it receives many invitations to comment on a wide variety of submissions from government, medical boards, and jurisdictional authorities.

As Fellows of ANZCA, we are all members of this highly regarded College, but at times it appears that we forget that this is our College. We are the College. The perception of "academics sitting in ivory towers disconnected from reality", which is the way the College was not infrequently described in the past, has never been less accurate.

The College is run by Fellows. We elect councillors as our representatives onto ANZCA Council, as well as representatives on to regional and state committees. Our elected representatives come from varied practices including non-academic and private practices.

Stakeholders including the Australian Society of Anaesthetists, the New Zealand Society of Anaesthetists, regional and state committees, special interest groups, and Fellows are invited to participate in College matters.

Nowhere is this clearer than in the process of developing and reviewing professional documents, which includes the formation of a document development group from within the fellowship, internal stakeholder consultation, and a pilot phase during which all Fellows and other stakeholders are invited to provide feedback. The process is established in *Ao1 Policy for the Development and Review of Professional Documents*.

Despite the expansion and growth in roles and responsibilities, the College sincerely recognises the need to support Fellows and trainees in difficulty. I have witnessed strong empathy and compassion exhibited by our colleagues who voluntarily contribute their time to the College. The development of the Welfare of Anaesthetist SIG (WOAG) is a prime example of acknowledgement of the need and aim to support Fellows. The WOAG has developed valuable resource documents covering a range of issues, and may be found at www.anzca.edu.au/fellows/special-interest-groups/welfare-of-anaesthetists.

Finally, our ANZCA professional documents are a tool and a resource that can be used to good effect in many such instances.

So given all the College's resources and experience, as well as its understanding of all areas of clinical practice and the compassion of senior Fellows, the decision whether to approach your College should not be a difficult one.

What would you do?

Dr Peter Roessler
Director of Professional Affairs,
Professional Documents,
ANZCA

Guidelines designed to help colleagues in need

A new resource on the ANZCA website helps Fellows work through developing good practice and manage a colleague's poor performance.

There is a new resource on the ANZCA website titled "Promoting good practice and managing poor performance in anaesthesia and pain medicine" (www.anzca.edu.au/resources/doctors-welfare).

It has two purposes. The first is to identify the preventative and developmental actions that individuals, groups and departments can make to build resilience and capacity into lifelong excellence in clinical practice. The second is to provide an action plan when working with a colleague, friend or employee rumoured or reported as performing or behaving poorly.

It is very important that any concern should be managed quickly and well. Principles of natural justice, fairness and patient safety are important considerations that need to be ensured. Advice is given to assist in an evaluation of the seriousness of the problem and a number of external agencies are listed that may be able to help in the support, remediation or investigation of the practitioner.

The document is based on the Royal College of Anaesthetists' guideline, "Managing the poorly performing anaesthetist". A working group of ANZCA Fellows with affiliations that covered the Faculty of Pain Medicine, the Australian Society of Anaesthetists and the Welfare of Anaesthetists Special Interest Group recognised that the document would need to be re-written to suit the Australian context and we particularly wanted to explore systems and behaviours that prevent poor performance.

Poor clinical or behavioural performance is rare, but does occur. This can be for a variety of reasons and can occur at any age. There is an opportunity for us to establish and build personal habits and work environments that help to maintain skills and foster insight, capability and confidence to improve, review, retrain or retire from medical practice at a time that is right for the individual practitioner and safe for the community.

The Medical board of Australia expert advisory group on revalidation developed



an interim report that identified a two part approach². The report proposed:

- Maintaining and enhancing the performance of all doctors practising in Australia through efficient, effective, contemporary, evidence-based continuing professional development (CPD) relevant to their scope of practice ("strengthened CPD"), and
- Proactively identifying doctors at risk of poor performance and those who are already performing poorly, assessing their performance and when appropriate supporting the remediation of their practice.

While ANZCA has developed a CPD program that strongly aligns to the first part, the second part is problematic. Behavioural markers such as lack of engagement with CPD or a previous Australian Health Practitioner Regulation Agency (AHPRA) investigation may be useful. Proactive identification using simple demographic characteristics such as gender or age is not in keeping with current anti-discrimination legislation.

"Promoting good practice and managing poor performance in anaesthesia and

"Poor clinical or behavioural performance is rare, but does occur. This can be for a variety of reasons and can occur at any age."

pain medicine" serves as a guide to foster excellence, and also provides information for colleagues to identify, assess and manage the performance of themselves and their peers when required.

Dr Rowan Thomas
Lead author, ANZCA councillor

References:

1. Royal College of Anaesthetists (2013) Managing the poorly performing anaesthetist.
2. MBA (2016) Options for revalidation in Australia. Discussion paper. <http://www.medicalboard.gov.au/News/Current-Consultations.aspx> accessed Oct 2016.

College to develop guidelines on sustainability

“As an influential health organisation, ANZCA has an opportunity to be a leader in this area.”

ANZCA is developing a new environmental sustainability professional document that addresses an important global health issue.

In 2015, the Lancet Commission on Health and Climate Change described that not only is climate change the “biggest global health threat” but also the “greatest global health opportunity” in the 21st century¹.

It is extremely likely that anthropogenic greenhouse gas emissions are the dominant cause of observed global warming in the mid-20th century². Climate change will affect the health and well-being of population groups, including those living in low-lying small island states, the disadvantaged and people with pre-existing medical conditions.

The Lancet report cites climate change as a public health issue, that the health community has a central role in addressing, like other public health issues such as tobacco and obesity.

The report explains that the health effects of climate change can be categorised into events that directly impact health (storms, drought, floods and heatwaves) and that indirectly impact health (compromised water quality, spread of infectious disease, air pollution, insecure food supply and under nutrition, changes in land use, displacement, and mental ill-health).

Several health organisations and other medical colleges have taken steps to advocate for measures to mitigate climate change. Statements have been released by the Royal Australasian College

of Physicians, the New Zealand College of Public Health Medicine, the Australian Medical Association, the New Zealand Medical Association and the Association of Anaesthetists of Great Britain and Ireland.

As health organisations have become more involved in considering the health implications of climate change, ANZCA has been approached to provide its stance. ANZCA as an organisation already has a comprehensive sustainability program that reduces its carbon footprint and operating costs.

In September 2016, ANZCA Council approved the drafting of a new professional document on environmental sustainability for the following reasons:

- The practice of anaesthesia itself contributes to greenhouse gas emissions and waste.
- Climate change is considered by experts to be a serious public health issue that the health sector should participate in addressing. As an influential health organisation, ANZCA has an opportunity to be a leader in this area.
- The Lancet’s report outlines that climate change and sustainability are global health issues, likely to exacerbate health inequity in lower income countries with more vulnerable health systems. ANZCA is developing an international strategy, and climate change and sustainability issues may well be factors it is expected to have a stance on in the interests of being a good global citizen, and promoting the sustainable development of health systems internationally.
- Irrespective of views on whether climate change is modifiable by human

Sustainability document development group

Dr Scott Ma (SA, New Fellow Councillor), Dr Forbes McGain (Vic), Dr Eugenie Kayak (Vic), Dr Rob Burrell (NZ), Dr Vanessa Percival (WA), Dr Ingo Weber (SA), Dr Catherine Hellier (NT), Dr Andrew Weatherall (NSW) and Dr Peter Roessler (Vic, Director of Professional Affairs, Professional Documents).

intervention, the policy responses to reducing carbon emissions and pollution tend to have co-benefits for health independent of climate change (reduced air pollution and therefore respiratory disease; increased active transport and associated decreases in obesity and chronic disease). There are also other potential benefits such as cost savings for the health sector.

Dr Scott Ma, FANZCA
New Fellow Councillor

References:

1. Watts N, Adger WN, Agnolucci P, et al: Health and climate change: policy responses to protect public health. Lancet 2015 [https://doi.org/10.1016/s0140-6736\(15\)60854-6](https://doi.org/10.1016/s0140-6736(15)60854-6)
2. Intergovernmental Panel on Climate Change (IPCC), *Climate Change 2014: Synthesis Report. Contribution of Working Groups I, II and III to the Fifth Assessment Report of the Intergovernmental Panel on Climate Change*, ed. Core Writing Team, R.K. Pachauri, and L.A. Meys. 2014, Geneva, Switzerland: IPCC.

Research projects receive widespread coverage



Since the December 2016 ANZCA Bulletin, ANZCA and FPM have featured in:

- 13 print reports (most also ran online).
- 13 radio reports.
- Three online-only reports.

A number of stories describing ANZCA-funded research have received widespread media coverage over the past few months.

An ANZCA media release on a trial of ketamine to prevent chronic pain funded by the ANZCA Research Foundation resulted in Professor Phillip Peyton being interviewed in the *Herald Sun* (readership 317,517).

Another media release on foundation funding for a study into whether nicotine patches can help patients give up smoking before surgery led to Dr Ashley Webb being interviewed for eight minutes on ABC Radio Darwin's breakfast show (7000 listeners), and Sydney radio station 2SM ran his quotes in its news bulletin. The media release was also run verbatim in the *Fraser Coast Chronicle* and the *Donnybrook-Bridgetown Mail* (combined readership 7000).

An ANZCA-funded research study that found that chewing gum was as effective as drugs in treating post-operative nausea ran in *The Age* and the *Sydney Morning Herald* on January 12; Dr Jai Darvall's interview reached 191,000 readers. He also spoke on 3AW's breakfast show for four minutes the following morning (170,000 listeners).

On January 17, ANZCA Fellow Dr Paul Lee-Archer was interviewed on Territory Radio, Darwin, and on Radio 2SM about his ANZCA-funded study looking at ways to prevent small children developing long-term distress after anaesthesia and surgery. This followed an ANZCA media release.

The same day, anaesthetist Dr Debra Leung was reported in the *Centralian Advocate* (readership 3670) and on February 1, in the *Monaro Post*, following an ANZCA media release on her study into advance care planning.

ANZCA President Professor David A Scott was interviewed by the *Bendigo Advertiser* on January 27 about news that a group of anaesthetists had suspended neonatal anaesthesia services at Bendigo Hospital due to concerns about the expertise of anaesthesia assistants. He reached an audience of 8600.

Professor Scott was also quoted in a joint media release ANZCA issued with the Royal Australasian College of Surgeons on December 15 on the initiative to build respect in medical environments to counter bullying, discrimination and harassment. The release was run in full on the New Zealand website *voxy.co.nz*.

Another joint media release issued by

FPM, Pain Australia and the Australian Pain Society resulted in Professor Stephan Schug featuring in *The West Australian* on January 27 talking about the 2017 Global Year Against Pain After Surgery. The story reached 145,000 readers.

In November, FPM Vice-Dean Dr Meredith Craigie was on ABC Radio National's Counterpoint program, interviewed by Amanda Vanstone about why authorities should move cautiously on medicinal cannabis (31,000 listeners).

Also in November, anaesthetist Dr John Crowhurst was interviewed on the Ockham's Razor program on Radio National talking about the legacy of anaesthesia events at Pearl Harbour. The interview reached 90,000 listeners.

ANZCA Fellow Dr Megan Walmsley was interviewed in NSW's *Goulburn Post* on January 9 talking about her experiences working in Nepal in the aftermath of the avalanche (2786 readers).

Karen Kissane
Media Manager, ANZCA

Media releases since the December 2016 Bulletin:

January 25

Helping patients take control: Hoping for the best, planning for the rest

January 24

Persistent pain can affect half having major surgery: Global Year Against Pain After Surgery (joint release with Pain Australia and the Australian Pain Society).

January 18

Predicting which elderly patients will have serious disability after surgery: New study

January 17

Helping children recover from anaesthesia without distress: New study

January 9

Nicotine patches to help smokers cut risks of surgery: New study

December 21

Pain experts welcome new codeine restrictions

December 15

Anaesthetists join with surgeons to build respect

December 5

Anaesthetists win \$4.8m grant to study whether ketamine prevents chronic pain after surgery

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

Pain medicine story wins ANZCA Media Award

"When the drugs don't work: How prescription opioids have become the new heroin" by *Good Weekend* writer Stephanie Wood has won the ANZCA Media Award for 2016.



Ms Wood said she became interested in the topic after noticing the number of NSW coroner's findings delivered on deaths related to overdoses of prescription medicines, particularly opioids.

"It was a very difficult article to write," she said. "To balance the sensitivity required, especially given the fact that I was using the subjects' real names, with the need to vividly portray their situations; to explain the science of pain medication and addiction... and to settle on the appropriate emphasis, given the complexity of the subject."

The award, for the best news story or feature about anaesthesia or pain medicine, was judged by former ABC journalist, lecturer and media training expert, Doug Weller; anaesthetist and ANZCA Bulletin Medical Editor Dr Rowan Thomas; and former *Age* health editor and Ambulance Victoria media director Tom Noble.

The award is designed to encourage high-quality reporting on anaesthesia and pain medicine, and to raise the profile of the professions in the community.

The judges said, "This detailed, very

well researched article warned of the prevalence and misuse of opioids, used to ease chronic pain, and the impact this has on patients, particularly in terms of addiction. The investigation outlined the medical and human cost of this growing public health crisis.

"Stephanie Wood's beautifully crafted, engagingly written reportage highlighted the value of the work of the Faculty of Pain Medicine to promote the treatment of chronic pain without opiates. The article had high visibility, and its powerful message would have touched many in the community."

The article can be found at www.smh.com.au/good-weekend/the-painful-truth-behind-the-rise-of-prescription-opioids-20160602-gp9xl1.html.

Find out first on Facebook

In January, the number of people following us on Facebook hit the 1000 mark – an extraordinary result given we only launched our page last October and have done no paid promotion of the page. We're now sitting at just over 1200 followers, and have a healthy level of engagement (the number of people commenting on, sharing or liking our posts).

The most popular content, unsurprisingly, tends to be good news stories about research we've funded or initiatives our Fellows and trainees have been involved in. A great example is a recent post about a Fellow-led fundraising and safety initiative called Ettties. We originally ran the story in the December edition of the *Bulletin*, but felt it deserved to reach a far wider audience. So we turned it into web content – the first time we've digitised *Bulletin* content in this way – and shared it via Facebook. It reached nearly 18,000 people; got more than 150 likes; and was shared 76 times.

In addition to sharing news and feature stories, we will also be using Facebook increasingly to promote College activities, events and courses. So if you have a Facebook account, I would strongly encourage you to follow us.

Al Dicks

Digital Communications Manager, ANZCA

We'd love to see as many of our Fellows, trainees and international medical graduate specialists as possible using social media to learn, collaborate and advocate. So if you have any questions or suggestions please drop me a line at adicks@anzca.edu.au.



Twitter

About 20 per cent of ANZCA Fellows are on Twitter. They are part of a highly active, global community of anaesthetists using this "micro-blogging" platform. Our @ANZCA account now has more than 2500 followers. They get the latest College news, events and safety alerts, as well as stories of interest from across the healthcare sector.

Follow us at: twitter.com/ANZCA



YouTube

YouTube is the second biggest search engine after Google. Patients and healthcare professionals are increasingly using it to discover and share medical information. Video is a powerful tool for showcasing the College, telling our stories, and educating people about anaesthesia.

Subscribe to our channel at: www.youtube.com/ANZCAEduAU



Strategic planning: The next five years

Work is progressing well on the development of the ANZCA Strategic Plan 2018-2022. Importantly, all aspects of the current 2013-2017 strategic plan (www.anzca.edu.au/documents/anzca-strategic-plan-2013-2017.pdf) are being considered and tested including an assessment of the vision, the reworking of the strategic priorities and a substantial review of the strategic priorities.

The first phase of the development of the plan is focusing on hearing from Fellows, trainees, our external stakeholders and staff on what they believe:

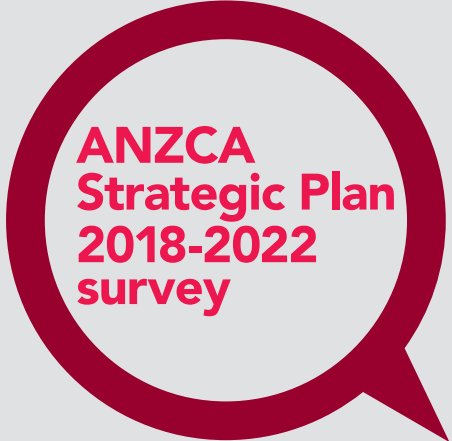
- ANZCA has achieved over the last five years.
- The challenges the College has faced during this time.
- The major influences on the College will be in the next five years?

Engagement activities to gather this

information are aimed at providing as many opportunities as possible for people to provide input to the development process for the plan. These activities include a broad-based survey, workshops at many ANZCA committee meetings, phone interviews and the running of focus groups. The Brisbane annual scientific meeting (ASM) in May will be another opportunity for people to talk with the chief executive officer and others on how they have viewed ANZCA's success and challenges since 2013.

The second phase (June through to August) looks at collating and analysing all the information gathered relating to the achievements, challenges and influences and categorising this information into themes and objectives that will inform the writing of the plan. There will be further opportunity for all people during this phase for engagement and input as part of the participatory nature of the Strategic Plan 2018-2022 process.

The final draft of the ANZCA Strategic Plan 2018-2022 will be presented to ANZCA

A graphic consisting of a large, dark red speech bubble with a white interior. Inside the bubble, the text "ANZCA Strategic Plan 2018-2022 survey" is written in a bold, dark red, sans-serif font. The bubble has a tail pointing towards the bottom right.

ANZCA Strategic Plan 2018-2022 survey

Council for endorsement and adoption at its November 2017 meeting. It is expected that its broader release will be in January 2018 supported by a communication campaign.

Development of the FPM Strategic Plan 2018-2022 is following a similar process and occurring in parallel with the development of the ANZCA plan.

If you have any questions or would like to discuss the strategic planning process please email ceo@anzca.edu.au or fellowshipaffairs@anzca.edu.au.

Clinical committee reviews MBS

On April 22, 2015, the Minister of Health and Sport announced that a Medicare Benefits Schedule (MBS) Review Taskforce would be established. The taskforce is considering how the more than 5700 items on the MBS can be appropriately aligned with contemporary clinical evidence and practice, and improve health outcomes for patients. The review is clinician-led and there are no targets for savings attached to the review. The taskforce recommendations will be made to the minister.

The Anaesthesia Clinical Committee (ACC) is part of the third tranche of clinical committees. It was established in September 2016 to make recommendations to the taskforce on MBS items within its remit, based on rapid evidence review and clinical expertise. The taskforce asked the ACC to review all anaesthesia-related MBS items.

The ACC consists of 12 members appointed by the taskforce. Seven are practising clinical anaesthetists and there is a consumer representative, a general practitioner and two surgeons, as well as an ex-officio representative from the taskforce. The taskforce and the ACC recognise that, as anaesthesia services are intended primarily to support surgical activity, any changes to anaesthesia MBS items may have unintended consequences for surgical providers and/or services, and hence for patients. The perspective of surgeons is therefore considered important. The perspective of patients is invaluable.

The ACC members cover most Australian states, and the anaesthetists involved have a mixture of metropolitan and regional, and public and private practice, reflecting the use of MBS items across sectors and regions. The ACC anaesthetists represent a broad range of clinical and other expertise, including healthcare quality, governance, policy and academic experience. The ACC is also fortunate to include the Immediate Past President of ANZCA, Dr Genevieve Goulding, as well as two former councillors (and one past president) of the Australian Society of Anaesthetists (ASA). The ACC

members were appointed individually, and not as representatives of nominating or other bodies. Members were appointed to provide a broad perspective on anaesthesia practice, and a willingness to share the insights of anaesthesia practice and MBS billing in the interests of the community, who (via taxpayers and MBS rebates, and health insurance) fund the majority of anaesthesia fees.

It is understood that the majority of the ACC members therefore share a common conflict of interest in reviewing items that are a source of revenue for them (that is, ACC members claim the items under review). This conflict is inherent in a clinician-led process, and having been acknowledged by the committee and the taskforce, it was agreed that this should not prevent a clinician from participating in the review.

The ACC was assigned 514 MBS items to review. The MBS Review and taskforce received public submissions prior to the establishment of the ACC (including a submission from the Australian Society of Anaesthetists, as well as submissions from individual anaesthetists). The work of the ACC has been undertaken via a number of face-to-face meetings and teleconferences, and is now concluding. The committee's work has been informed by data from the Department of Health, and by extensive secretariat support, including modelling of the supplied data, by McKinsey & Co.

The ACC draft report will be presented to stakeholders in the coming months, and the committee welcomes comments and feedback from all interested parties.

Associate Professor Joanna Sutherland
Chair, Anaesthesia Clinical Committee

Anaesthesia Clinical Committee members

Associate Professor Joanna Sutherland,
Chair (anaesthetist, NSW)

Dr Ruth Bollard (surgeon, Vic)

Dr Jim Bradley (anaesthetist, Qld)

Dr Penny Burns (GP, NSW)

Dr Genevieve Goulding
(anaesthetist, Qld)

Dr Jodi Graham (anaesthetist, WA)

Professor Michael Grigg
(Taskforce ex officio)

Ms Helen Maxwell Wright
(consumer representative, Vic)

Dr Mark Reeves (anaesthetist, Tas)

Associate Professor Margaret Schnitzler
(surgeon, NSW)

Associate Professor John Stokes
(anaesthetist/intensivist, Qld)

Dr Tim Weston (anaesthetist, NSW)

The ANZCA Council Citation was established in 2000 and is made at the discretion of the ANZCA Council in recognition of significant contributions to College activities. The scope of the award was recently broadened to include recognition of humanitarian work.

Everest avalanche hero awarded citation

Then-anaesthetic trainee Megan Walmsley was a doctor at Everest Base Camp during the challenging conditions immediately after the avalanche on Mount Everest in April, 2015. Now, she is to be awarded an ANZCA Council Citation “in recognition of her extraordinary efforts as a volunteer medical officer working at the Mt Everest Base Camp facility during the avalanche”.

Dr Walmsley, who qualified as an ANZCA Fellow last September, was at the base camp when the 7.8 magnitude earthquake struck Nepal. The quake triggered an avalanche, which swept across base camp causing widespread destruction.

It smashed parts of the basic clinic-in-a-tent that served the 1200 Nepalis and foreign climbers who lived and worked there. Crouching with a patient, Dr Walmsley survived the waves of snow and ice that washed over her. Seriously injured patients were soon arriving by stretcher.

It was never luxurious at the remote site, where equipment and supplies had to be transported in via porters and yaks. But conditions were even tougher as she ploughed on for the next 30 hours: “We were working in a tent. There was not really any electricity, and none of the monitoring or endless supply of equipment I was used to working with in Australia.

“Looking back afterwards, I realised I was lucky to have had such good training in Australia, which meant I was prepared for what had to be done. I think you can always do something, even if you’re not in a well-equipped hospital with an emergency department, ICU, theatres and scanners. We splinted and relocated limbs,

offered pain relief and fluids, and did our best to keep people comfortable, warm and dry – harder than it sounds in a place full of snow and ice.

“Myself, Dr Rachel Tullet, who was also working at the clinic, and a small group of volunteers with some medical training ended up assessing and treating around 80 patients.”

Dr Walmsley said the two times she has worked as a doctor in Nepal have been highlights of her career to date. The most crucial lesson she learned during the avalanche and its aftermath was how important teamwork is: “We had many people from different teams and different backgrounds come to help us – climbers, Sherpas, expedition leaders. Some of them had medical training, and some didn’t.”

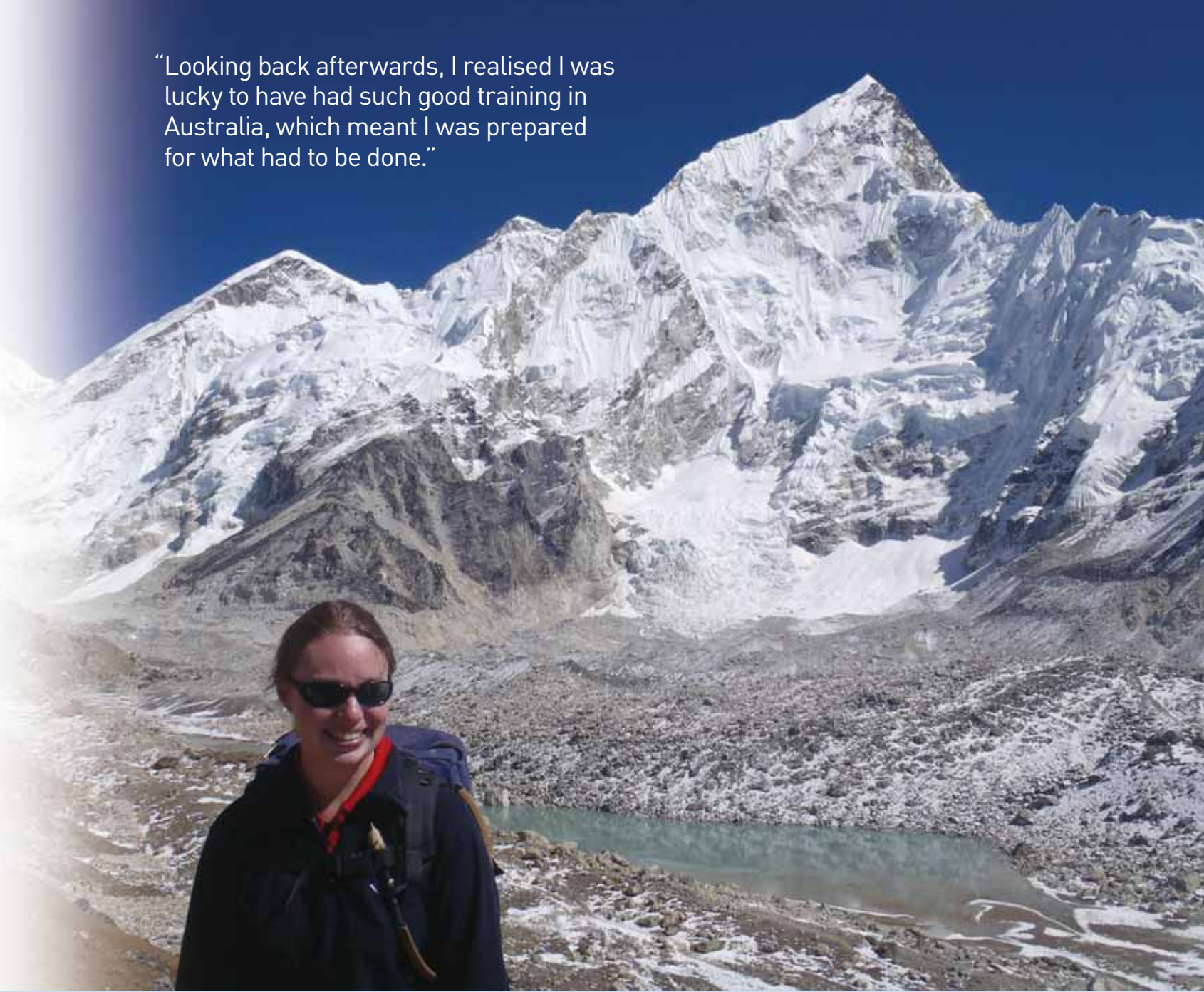
Dr Walmsley has now developed a longer-term interest in medicine in developing countries. She will soon return to Nepal for another three-month stint as a volunteer medical officer. Then, she will take up a six-month fellowship in Fiji offered by the Australian Society of Anaesthetists.

Dr Walmsley says, “Fiji will be more anaesthetic work, as opposed to Nepal. It will be part clinical and part teaching local doctors. This will be an exciting year, but hopefully Nepal will be less eventful than last time!”

For more information about the Mount Everest Base Camp clinic: www.everester.org.

Karen Kissane
Media Manager, ANZCA

“Looking back afterwards, I realised I was lucky to have had such good training in Australia, which meant I was prepared for what had to be done.”



Award for work on anaphylaxis

Anaesthetic anaphylaxis has been a key area of interest of Dr Elizabeth (Buff) Maycock, who has been awarded an ANZCA Citation for her work in that and other areas.

Dr Maycock obtained her fellowship in New Zealand in 1981 but since 1992 has lived and worked in Brisbane, where she set up an Anaesthetic Skin Testing Clinic at the Princess Alexandra Hospital. “This has involved investigating patients who have had anaphylaxis related to anaesthesia,” she says.

Flowing on from that work, in 2010 she helped found the Australian and New Zealand Anaesthetic Allergy Group (ANZAAG). The group has produced a website for anaesthetists and patients, as well as guidelines for the investigation and management of patients who have had anaphylaxis under anaesthesia.

She says, “I have always believed that it was important for Australia and

New Zealand to develop a network of anaesthetists and immunologists with experience investigating these patients, so that a standard of investigation could be established and reliable data could be collected for Australasia.

“The group is College-endorsed but not a special interest group (SIG). We decided to stand alone so that we could make changes to the ‘management’ and ‘investigation’ guidelines quickly, when needed. ANZAAG is made up of members from different specialties – principally anaesthesia and immunology.

“We have worked closely with immunologists in order to produce a recognised standard for the investigation of patients following anaphylaxis during anaesthesia. We are hoping that our article on perioperative anaphylaxis guidelines will be published this year. ANZAAG has also

been very successful in organising annual stand-alone meetings on topics related to perioperative anaphylaxis since 2012.”

Dr Maycock has also held portfolios at the Princess Alexandra Hospital Brisbane, managing the pre-admission clinic and in risk management. She also helped drive an initiative to train anaesthetists in communication skills.

“I have always felt that it is important for doctors to have good communication skills and when the Cognitive Institute started up here in Brisbane, I became a facilitator and got very involved in doing workshops for anaesthetists. I felt it was lacking in our training in the past, but in recent years the College has run a number Cognitive Institute workshops, thanks to the strong support of several presidents.”

Dr Maycock has now handed over the running of the Princess Alexandra Hospital Anaesthetic Allergy Clinic and plans to

spend the next three years studying the validity of the advice given by the clinic.

“I will contact all my anaphylaxis patients from the last 10 years and see what outcomes they had. Having set up the service, I feel I have an ethical responsibility to do this research audit and validate our skin test results and outcomes.”

Karen Kissane
Media Manager, ANZCA

25 years of ANZCA leadership

How the College has evolved

This year is an important one for ANZCA as we celebrate 25 years as a medical college.

Our College's vision is to be a recognised world leader in training, education, research and in setting standards for anaesthesia and pain medicine. I believe we have achieved all this and much more.

Throughout 2017, we will celebrate our 25th anniversary in the pages of the *Bulletin*. In this edition, ANZCA's Honorary Curator, Dr Christine Ball, reflects on the past 25 years of the College and we profile College achievements during the leadership of our 15 presidents.

We also hear from Dr Liam Brennan, President of the Royal College of Anaesthetists which is also celebrating 25 years as a college.

You should by now have received *25 Years of ANZCA Leadership*, edited by ANZCA's Honorary Historian, Professor Barry Baker, which provides an opportunity to reflect on our achievements since 1992 as we contemplate the next 25 years.

Professor David A Scott
President, ANZCA



In 1952, the Faculty of Anaesthetists was established at the Royal Australasian College of Surgeons (RACS) with 69 foundation Fellows. It came to represent the specialty in training, education and standards in both Australia and New Zealand.

The formation of an independent College took years of careful planning, and was finally achieved with the creation of the Australian and New Zealand College of Anaesthetists (ANZCA) in 1992.

Separating from a parent body is not simple for either organisation, something ANZCA discovered 20 years later when its own Joint Faculty of Intensive Care made the same decision. However, such growth and development is important – it could be argued that an important function of specialty medical organisations is to foster the development of subspecialty areas into independent bodies.

ANZCA has now grown to a fellowship of more than 6400 specialist anaesthetists and 1500 trainees. Of course now it supports another faculty, the Faculty of Pain Medicine, which has 400 Fellows and 80 trainees.

An important initial step for ANZCA was the development of a clear, simple "mission" or purpose, one which has expanded in scope and changed slightly over time: "to serve the community by fostering safety and high-quality patient care in anaesthesia, perioperative medicine and pain medicine".

Physical relocation from the RACS building in Melbourne was also required, and our current premises on the nearby prestigious St Kilda Road "boulevard" were purchased in 1993.

Initially the original stately home, Ulimarua, met our needs, but by the late-1990s it was clear that more modern, spacious facilities were needed. The seven-storey ANZCA House building, constructed at the rear of Ulimarua, opened in 2001.

This building contains the corporate offices, with the original 1880s Italianate building now functioning as an area for the Fellows and trainees; it houses important resources such as the library, the museum and the associated staff.

These facilities are most important, with the library providing 24-hour access to thousands of resources for trainees and Fellows. ANZCA now has offices or secretariats in the capital cities of all seven of Australia's training regions and in Wellington, New Zealand.

Training, an important role for the College, continues to evolve. Over the last 25 years, training has been extended from four to five years, part-time training has allowed for a variety of family circumstances and, more recently, the curriculum has been completely overhauled.

Technology has advanced in all areas of teaching, with most academic resources now available online and simulation courses, such as Effective Management of Anaesthetic Crises (EMAC), part of the training program.

The College has also developed a comprehensive continuing professional development (CPD) program, revised in 2014, which is a requirement of practice for all Fellows. This three-year program requires engagement in a number of activities. It is regularly audited, and is supported by courses held by the College in-house and at its annual scientific meeting (ASM), which can attract more than 2000 attendees.

Hands-on participation in workshops has been a major shift in focus of the ASM over the life of the College. While lectures still retain a place at these meetings, trainees and Fellows now expect more interactive education in order to hone and maintain their practical skills.

Possibly as a mark of its independence, the new College rapidly sprouted a number of special interest groups (SIGs).

There are now 17 SIGs, which share members across ANZCA, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists, including the important Welfare of Anaesthetists SIG. Founded in 1997, this SIG demonstrates the College's commitment to its Fellows beyond the academic and medical sphere.

The Faculty of Intensive Care was created in 1993, almost immediately after the formation of the College. In 2002 it became a Joint Faculty with the Royal Australasian College of Physicians (RACP), a step along the way to becoming an independent College of Intensive Care Medicine in 2010.

Collaborative faculties are not unusual but none are as complex as the Faculty of Pain Medicine, formed in 1999 with Professor Michael Cousins as the first Dean. This was the first such faculty in the world. Pain medicine is now recognised as a multidisciplinary speciality, and the Faculty embodies that spirit – a collaboration between ANZCA, RACS, RACP, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Australasian Faculty of Rehabilitation Medicine (AFRM) of the RACP. A fellowship in pain medicine can be obtained by specialists from any of these bodies.

Dr Christine Ball
Honorary Curator, ANZCA

Above from left:

The College mace was a parting gift from the Royal Australasian College of Surgeons when ANZCA became a college in 1992.

The inaugural ANZCA Council, February 1992 (from top left): Mrs Joan Sheales (registrar), Stewart Bath, Richard Walsh, Barry Baker, David McConnel, John Gibbs, Ian Reichtman, (from bottom left): Garry Phillips, Michael Davies, Peter Livingstone (President), Michael Hodgson (Vice-President), Neville Davis. Absent: Leigh Atkinson, James Watts.

ANZCA Council, July 2016: Dr Chris Cokis, Dr Michael Jones, Dr Rowan Thomas, Dr Genevieve Goulding (Immediate Past President), Dr Nigel Robertson, Professor David A Scott (President), Dr Richard Waldron, Dr Rod Mitchell (Vice-President), Dr Scott Ma (New Fellow Councillor), Dr Vanessa Beavis, Dr Patrick Farrell, Dr Chris Hayes (FPM Dean), Dr Sean McManus, Mr John Iott (CEO), Dr Simon Jenkins.



ANZCA'S PRESIDENTS

Since 1992, ANZCA has been led by presidents of the highest calibre. Here we paint a picture of how the College evolved under each.



Dr Peter Livingstone OAM
FANZCA

1992 (February-June)

Dr Peter Livingstone was the last dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons (RACS) and the first president of ANZCA. He oversaw the birth of the new college and its earliest days, with his presidency running from February to June, 1992.

ANZCA became a reality on February 7, 1992, when the board of Faculty meeting was told that the legal process to form the College was complete. The next morning, the board became the ANZCA Council and an election of office bearers, including Dr Livingstone as the inaugural president, was held.

The council communicated with all current Fellows of the Faculty, offering them foundation fellowship. Many early administrative matters were then addressed, including notifying other colleges, societies, state medical registration boards and health departments.

Then came the separation of the functions of the Faculty from RACS, with the administrative aspects handled by the registrar Mrs Joan Sheales and the financial matters by then-Treasurer Dr Michael Davies. This was achieved with the mutual respect that had existed between RACS and the Faculty for more than 40 years.

But it was clear that ANZCA would need its own space. A "search committee" was set up to find new quarters, and a second committee was asked to have a coat of arms designed. Other highlights of Dr Livingstone's presidency were the first examinations as a College and the first general scientific meeting.

Dr Livingstone later received a medal of the Order of Australia for services to medicine, as well as ANZCA's highest award, the Orton Medal.



Dr Mike Hodgson AM
FAMA, FANZCA

1992 (June) – 1993

Dr Mike Hodgson, the only Tasmanian to have been elected president of ANZCA, was involved in consolidating the position of the new College.

An offer to buy Ulmaroa was accepted on May 25, 1993. ANZCA Council agreed to a staged development.

Armorial bearings were approved by the College of Arms and the College foundation was established. It was agreed that the College support the writing of the History of Anaesthesia in Australia.

Many issues were considered by the Board of the Faculty of Anaesthetists, Royal Australasian College of Surgeons which progressed over subsequent years included intensive care medicine, pain management, overseas trained doctors and maintenance of professional standards.

The College became more involved in wider issues of the day such as increased involvement in south-east Asia, AIDS, entrepreneurial medicine, informed consent and hours of work.

In his term of office Dr Hodgson always strove and encouraged Fellows to become more active in the wider medical community.

He was elected a Fellow of the Australian Medical Association in 1991, a life member of the Australian Council on Healthcare Standards in 2009 and was awarded the Australian Society of Anaesthetists President's Medal in 1996.

Dr Hodgson was president of the Tasmanian Club from 2012 to 2014 and was appointed a member of the Order of Australia in 1998.



Dr Michael Davies
MD, FANZCA

1993-1995

Dr Michael Davies was president from 1993 until 1995. Ulmaroa was purchased and beautifully renovated, supervised by the late Mrs Joan Sheales. It housed the College staff, our library and the Geoffrey Kaye Museum of Anaesthetic History. Fellows were surprised and proud of this wonderful asset, which enhanced our status among the medical colleges.

The first independent annual scientific meeting (ASM) in Launceston was a great success, attracting a record registration of more than 400 Fellows. The Royal Australasian College of Surgeons (RACS) recognised the formation of our College by the presentation of a magnificent mace, a symbol of our authority.

These events stimulated the council and its committees into a hive of activity. The Faculty of Intensive Care was formed, Maintenance of Professional Standards (MOPS) was established and a diploma of Chronic Pain Management was considered. In-training assessment and mandatory subspecialty training were introduced and the final exam was revised. A process to increase training positions by 20 per cent was started.

Research funding was increased and a communications consultant employed, resulting in more positive stories about anaesthesia in the press. National Anaesthesia Day started.

These years were productive for the College, a great credit to Fellows working hard on the ANZCA Council, its committees and Mrs Sheales and her staff of seven.

Dr Davies was director of anaesthesia at St Vincent's Hospital Melbourne from 1984 until 2009 and an associate professor at the University of Melbourne from 1999 until 2015.



Dr Neville Davis AM
FANZCA

1995-1996

The fourth president of ANZCA was Clinical Associate Professor Neville Davis.

During this period, a lot of work came to fruition with the introduction of the maintenance of professional standards (MOPs). This was somewhat controversial at the time with some Fellows being concerned that there was to be a recertification examination.

The Conference of International Reciprocating Examination Boards of Anaesthesia (CIREBA) meeting was held at the College in 1996, chaired by the president. This saw ANZCA hosting the presidents/ chairmen of the examining bodies of America, Canada, England, Ireland and South Africa.

The president chaired the joint liaison committee with the Royal Australian College of General Practitioners and guidelines were agreed on for the training of GPs. For the first time there was an organised program for anaesthesia training for GPs intending to go to country areas. This was prior to the formation of the Australian College of Rural and Remote Medicine.

At the beginning of 1996 the president became chairman of the Committee of Presidents of Medical Colleges, and ANZCA became the headquarters of the committee. This was the first time that the chairman was not from the Royal Australasian College of Surgeons or the Royal Australasian College of Physicians. Mrs Joan Sheales became secretary.

In 1998 Dr Davis was made a member of the Order of Australia.



Professor Garry Phillips AM
FANZCA, FCICM FACEM
(deceased)

1996-1998

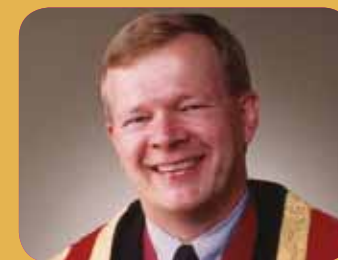
The late Professor Garry Phillips was ANZCA's fifth president, and during his tenure the first major reviews of ANZCA's structure and functions were undertaken. One result of this was the approval of an ANZCA mission statement.

Agreement was reached with the Australian Society of Anaesthetists (ASA) and New Zealand Society of Anaesthetists (NZSA) on overseas involvement in Papua New Guinea and the Asia-Pacific, and firm relationships were reached for training and examinations in Hong Kong, Singapore and Malaysia. ANZCA established a prize for the University of Papua New Guinea which was, many years later, named the Professor Garry Phillips Prize.

In New Zealand, submissions on the Crimes Amendment Bill and Medical Practitioners Bill led to important changes in the manslaughter regulations that better protected anaesthetists, who had previously been at risk of serious legal penalties. In 1996 the Welfare of Anaesthetists Group (later a special interest group) was formed.

A Pain Management Committee was set up and, at Professor Phillips' last ANZCA Council meeting as president, a motion to form the Faculty of Pain Medicine was carried. That last meeting also voted to extend Ulmaroa (ANZCA House) and to employ a director of professional affairs. Later Professor Phillips became ANZCA's first director of professional affairs (1999-2005).

Professor Phillips was appointed a member of the Order of Australia (AM) for service to medicine, and also an officer of the Order of St John. He was one of the founders of the Australasian College for Emergency Medicine (ACEM), who awarded him their Foundation 20 Medal, and he was awarded ANZCA's Orton Medal in 2005. ANZCA published his *Intensive Care Medicine in Australia – Its origins and development* in 2014. Professor Phillips died in July last year.



Associate Professor
Richard Walsh
FANZCA

1998-2000

Professor Richard Walsh, who worked on the transition from the Faculty of Anaesthetists, Royal Australasian College of Surgeons to ANZCA in 1992, was president from 1998 to 2000.

As College treasurer and then president, he guided College finances towards accumulation of enough money for the building of ANZCA House at St Kilda Road, Melbourne. He also oversaw the design and construction of the dramatically expanded College headquarters.

The Faculty of Pain Medicine was founded in 1998 under its inaugural Dean, Professor Michael Cousins, and this led to pain medicine later being recognised as a medical specialty in Australia and New Zealand.

During his presidency, Professor Walsh also launched the College's first national anaesthesia mortality report, *Anaesthetic mortality in Australia 1991-1993*, receiving positive media coverage regarding the safety of anaesthesia in Australia.

Meanwhile, the College continued to grow and flourish, including with the establishment of two new special interest groups (SIGs), the Obstetric Anaesthesia SIG and Diving and Hyperbaric Medicine SIG.

The influence of the College grew with the active involvement and regular hosting of meetings of the Committee of Presidents of Medical Colleges, as well as Professor Walsh's simultaneous membership on the Executive of the World Federation of Societies of Anaesthesiologists.

ANZCA'S PRESIDENTS
CONTINUED



Emeritus Professor Teik Oh AM
MD, FANZCA, FCICM, FRACP,
FRCP, FRCA

2000-2002

Emeritus Professor Oh's four strategic aims were advancing education, increasing services to rural areas, strengthening ties with Asia-Pacific, and serving Fellows.

The Education unit was founded and Trainee Selection, Supervisors of Training, and In-Training Assessment workshops established. Council adopted a new FANZCA program under Basic and Advanced Training, drafted by Emeritus Professor Oh and the Education unit. The Effective Management of Anaesthetic Crises course commenced, guidelines on assisting trainees with difficulties and a framework for postgraduate year 1 (PGY1) and postgraduate year 2 (PGY2) clinical training developed. ANZCA justified trainee selection to the Australian Competition and Consumer Commission (ACCC) and rebutted the National Competition Council's accusations of restricting trainee numbers for personal financial gain.

Maintenance of Professional Standards (MOPS) was revised and a new Continuing Professional Development Program initiated, to comply with proposed mandatory requirements. New policies on performance assessment of overseas trained specialists and services for areas of need were introduced. Some ANZCA Council meetings were held in the regions with local office-holders.

ANZCA's first annual scientific meeting outside Australasia was successfully held in Hong Kong in May 2001 with the HK College of Anaesthesiologists followed by a meeting in Beijing with the Chinese Society of Anesthesiology.

On August 4, 2001, the Governor General opened ANZCA House, the magnificent extension to Ulmaroa. The Joint Faculty of Intensive Care with the Royal Australasian College of Physicians was formalised in December 2001 by Council appointing the interim board. Emeritus Professor Oh was awarded the Orton Medal, CICM Medal, Dudley Buxton Medal of the UK College, fellowship *ad eundum* by the Irish and South African Colleges, and the Order of Australia.



Dr Richard Willis AM
FANZCA

2002-2004

Dr Richard Willis was one of the first three anaesthetists to be elected to the new college and oversaw much of the evolution from a Faculty within the College of Surgeons to an independent college.

During his presidency, the Australian Medical Council (AMC) developed a new process for accreditation of medical colleges involving on-site in-depth assessments, particularly in regard to education and training programs, continuing professional development, trainee support and assessment of progress. ANZCA was the first of the medical colleges to undergo the full accreditation assessment. The preparation involved was massive, involving review and upgrading of all college activities. The release of a new curriculum shortly before the accreditation visit helped the preparation. The overall report from the AMC was excellent.

Two new special interest groups were established, Anaesthetists in Management and History of Anaesthesia. The Joint Faculty of Intensive Care Medicine was founded with the Royal Australasian College of Physicians, a precursor for the College of Intensive Care Medicine.

The museum and library were upgraded, and changes were made to the assessment of international medical graduate specialists (IMGSS).

Dr Willis contributed to the executive of the College of Presidents of Medical Colleges (CPMC) and the Recognition of Medical Specialties Advisory Committee (ROMSAC) on behalf of the AMC. He was awarded member of the Order of Australia in 2015.



Emeritus Professor
Michael Cousins AO, AM
MD, DSc, FANZCA, FFPMANZCA

2004-2006

Major initiatives during Emeritus Professor Michael Cousins' time as president included the appointment of more than 100 ANZCA Fellows to 10 "taskforces" including perioperative care: quality and safety (a joint initiative with the Australian Society of Anaesthetists); a strategic plan to respond to evolution of nurse practitioners; development of the ANZCA Foundation and recruitment of prominent community leaders on the board (for example, Kieran Perkins, Olympian and the late James Strong, Australian businessman and philanthropist), accompanied by a marked increase in research funding.

After strong pressure from the president, funding for the ANZCA Trials Group (now Clinical Trials Network) was approved by ANZCA Council to provide "in-house" advice on clinical research design and statistical analysis, with emphasis on multi-site studies. ANZCA's standing was enhanced by the election of Professor Cousins to membership of the Australian Medical Council and as chair of the Committee of Presidents of Medical Colleges (CPMC).

ANZCA governance was enhanced at council level, including presence of both of the Faculty deans "ex-officio" on the council "executive" (arguably worth re-examination). Appointment of a new chief executive officer, Dr Mike Richards, paved the way for introduction of a "consultative" structure and operation.

ANZCA's role in pain medicine was enhanced by hosting the Intercollegiate Forum on Pain Medicine in 2005 and subsequently the National Pain Summit in 2010.

Subsequent to his presidency, Professor Cousins was awarded the ANZCA Robert Orton Medal (2008). He was appointed a member of the Order of Australia (AM) in 1995 and an officer in the Order of Australia (AO) in 2014.



Dr Walter Thompson AM
FANZCA, FCICM

2006-2008

The new millennium ushered in a period of rapid growth in the extent and range of the activities undertaken by the College. Dr Walter Thompson saw his presidency as a time of "review and consolidation".

This commenced with the prioritisation and implementation of the recommendations of the taskforces, followed by an "effectiveness review" of administrative functions, strategic planning and a review of the ANZCA Constitution. The outcomes included improvements in communication with Fellows and trainees; provision of additional educational resources; reorganisation of administrative processes at "Ulmaroa"; improvements in facilities for state offices and the NZ National Office; and enhanced co-operation with the Australian Society of Anaesthetists (ASA) and the New Zealand Society of Anaesthetists (NZSA) particularly in relation to continuing medical education, workforce issues and quality and safety.

Significant events and developments were the death of the College's first CEO, Mrs Joan Sheales; election of the inaugural new Fellow to ANZCA Council; introduction of continuing professional development (CPD); establishment of the Safety and Quality Committee and ANZTADC leading to the genesis of a bi-national incident reporting system (WebAIRS); the re-launch of the ANZCA Foundation; introduction of the ANZCA Code of Conduct; initiation of a performance review process for trainees; Australian Medical Council accreditation renewal; review of the ANZCA Training Program.

Dr Thompson was awarded honorary life memberships of the Australian Society of Anaesthetists (2009) and New Zealand Society of Anaesthetists (2009) and was appointed a member of the Order of Australia (2011).



Dr Leona Wilson ONZM
FANZCA, FAICD

2008-2010

Dr Leona Wilson was the first New Zealand president of ANZCA and the first woman, commencing in 2008.

Continuing professional development became mandatory in 2009 and a review of the training curriculum, the College's biggest project to date, also began. This culminated in the 2013 curriculum.

Much work went into the transformation of the Joint Faculty of Intensive Care Medicine to the new College of Intensive Care Medicine that started in 2010. Development of the Overseas Aid Committee occurred following the establishment of a working group in 2009, and the Ray Hader Award for Pastoral Care commenced.

Improved communications and advocacy were a feature of Dr Wilson's presidency through the introduction of regular e-newsletters and the establishment of a specialised media manager role. The first e-Learning podcasts were produced.

There was a strong focus on pain medicine through the 2010 National Pain Summit at Parliament House in Canberra and its resulting National Pain Strategy.

The directors of professional affairs (DPA) workforce within the College expanded, with employment of the first DPA Assessor Dr Steuart Henderson and DPA Policy Dr Peter Roessler joining Professor Barry Baker and Professor Garry Phillips. The DPAs provided much needed professional support for the Fellows who volunteer so much for the College.

Dr Wilson was made an officer of the New Zealand Order of Merit in 2010 and was awarded the Orton Medal in 2012 and honorary life membership of New Zealand Society of Anaesthetists (2010). She remains involved in College affairs in her role as the executive director of professional affairs.



Professor Kate Leslie
AO, FAHMS
FANZCA, FAICD

2010-2012

Professor Kate Leslie was president between 2010 and 2012. She was the youngest president to date and second woman to be elected to the role.

During her presidency revisions of the ANZCA constitution and terms of reference were commenced, and the Overseas Aid Committee, Indigenous Health Committee and Perioperative Medicine Special Interest Group were established.

A knowledge resources review was undertaken and a history and heritage strategy was developed, leading to refurbishment of the Geoffrey Kaye Museum of Anaesthetic History. The revision of the ANZCA training curriculum and the ANZCA Continuing Professional Development Program were in full swing during Professor Leslie's presidency. This coincided with an application for reaccreditation of ANZCA by the Australian Medical Council.

Many College processes moved online during 2010-2012 including in-training assessments and the Clinical Teachers Course. Professor Leslie worked closely with the Anaesthesia and Pain Medicine Foundation (now ANZCA Research Foundation) to raise funds for research and for LifeBox.

Dr Mike Richards retired as chief executive in 2011 and Ms Linda Sorrell was appointed. Subsequent to her presidency Professor Leslie was awarded the ANZCA Robert Orton Medal (2014) and the AMA Woman in Medicine award (2014), and was appointed an officer in the Order of Australia (2016).

ANZCA'S PRESIDENTS CONTINUED



Dr Lindy Roberts
FANZCA, FFPANZCA, FAICD

2012-2014

Dr Lindy Roberts was president for two busy years, working closely with new Chief Executive Officer, Linda Sorrell. The focus of her presidency was consultation with Fellows and trainees to improve College services.

Dr Roberts led development of the 2013-2017 strategic plan "Advancing anaesthesia, improving patient care".

Curriculum 2013, ANZCA's largest project ever, was introduced and achieved Australian Medical Council/Medical Council of New Zealand re-accreditation. As workforce concerns escalated, ANZCA initiated a Workforce Action Plan, informed by the inaugural new Fellow survey.

The College engaged with the Australian "revalidation conversation", revising the ANZCA/FPM Continuing Professional Development (CPD) Program with own-practice evaluation, emergency response training and a contemporary electronic portfolio. New Zealand granted specialty recognition to pain medicine and the College strengthened its relationship with FPM.

National Anaesthesia Day was relaunched to widespread media coverage. Relocation of the Geoffrey Kaye Museum of Anaesthetic History to Ulmaroa commenced, forming a knowledge hub with the library. The tripartite Communication Special Interest Group was founded, along with new groups for anaesthesia allergy, essential pain management and educational governance.

High-profile business and community leaders were recruited to the Foundation Board of Governors and, for the first time, the foundation awarded over one million dollars to research. The hugely successful Singapore annual scientific meeting (ASM) was held conjointly with the Royal Australasian College of Surgeons. In 2016, Dr Roberts was recruited as an ANZCA Director of Professional Affairs.



Dr Genevieve Goulding
FANZCA, FAICD, FCAI

2014-2016

Dr Genevieve Goulding was the fourth successive female ANZCA president. Her efforts centred on professionalism, workforce, advocacy, and strengthening services for ANZCA and FPM Fellows and trainees.

Chief Executive Officer, Linda Sorrell, retired and John Ilott was appointed. ANZCA released *Supporting Anaesthetists' Professionalism and Performance: A guide for clinicians* for piloting. Networks, a new online learning system was launched, along with an online ANZCA hospital accreditation system and the ANZCA Educators' Program.

The enhanced and relocated Geoffrey Kaye Museum of Anaesthetic History and new knowledge centre in Ulmaroa were opened, with the museum gaining accreditation by Museums Australia.

FPM launched an impressive redesigned curriculum, the European Pain Federation adopting parts of it for its new diploma in pain medicine. *Acute Pain Management: Scientific Evidence (4th edition)*, was published and an opioid calculator smartphone app was also launched.

The National Medical Training Advisory Network (NMTAN) report on the Australian anaesthetic workforce was released and NZ heads of department contributed to a snapshot analysis of NZ's workforce situation. Plaques acknowledging the traditional landowners were erected in all Australian ANZCA offices and the fellowship pledge was introduced at the College Ceremony of the ANZCA Annual Scientific Meeting. A joint ANZCA/FPM/Australian Society of Anaesthetists/NZ Society of Anaesthetists position statement on the health of asylum seekers was issued and a partnership with Interplast led to formation of Lifebox Australia & NZ, facilitating tax deductible donations.

Dr Goulding received an honorary fellowship from the College of Anaesthetists of Ireland in 2015. In 2016 she was appointed to the Queensland Board of the Medical Board of Australia.



Professor David A Scott
FANZCA, FFPANZCA

2016-

Professor David A Scott is approaching the half-way point of his two-year term and is focusing on professionalism, perioperative medicine and international and local organisation engagement as three important areas for the College to develop.

The *Supporting Anaesthetists' Professionalism and Performance guide* has been finalised and the College has adopted the codes of conduct of the Medical Board of Australia and the Medical Council of New Zealand. The important Bullying, Discrimination and Sexual Harassment Working Group report, acknowledging the extent of the problem and identifying actions to be undertaken, has been written and a policy to support Fellows, international medical graduate specialists and trainees is being prepared.

Support for perioperative medicine including development of a higher qualification, is now a clear focus that will require collaboration and to achieve cross-specialty support.

Externally, the College has signed agreements with the Royal Australasian College of Surgeons to share resources and we are also regularly meeting with colleges in Canada, the United Kingdom and Ireland, and value our ongoing relationships with Hong Kong, Malaysia and Singapore. A memorandum of understanding for academic engagement has been signed with the Chinese Society of Anesthesiology, and with the World Federation of Societies of Anaesthetists to promote Essential Pain Management.

An important overarching research policy is being finalised and we now have a new Diploma in Advanced Hyperbaric Medicine.

A lot has been achieved with a lot still to do.

THE ROYAL COLLEGE OF ANAESTHETISTS – ALSO 25 NOT OUT



Like ANZCA, the UK college also turns 25 in 2017. President Dr Liam Brennan looks back at its development.

The strong historical links between Australia and the UK are paralleled by developments in anaesthesia and of our two colleges. This year sees the 25th anniversary of the creation of the Australian and New Zealand College of Anaesthetists (ANZCA) and of the UK College receiving its Royal Charter.

The past quarter of a century has seen our specialty grow enormously in stature on both sides of the world. It is therefore timely to reflect on the past 25 years, combined with an overview of the Royal College of Anaesthetists (RCoA) today and a view of the future.

LOOKING BACK

The UK College developed at a remarkable pace in the early 1990s. In less than five years it transformed from being a Faculty of Anaesthetists to a fully independent Royal college, housed in independent premises. It took considerable effort – and courage – to leave the security of the Royal College of Surgeons, where the fledgling College and its preceding Faculty had been based since 1948. Leaving home is exciting but daunting, and contemporary records show that the new College needed to raise considerable funds to achieve its goals, which included buying its first home in Russell Square.

The RCoA in 1992 was very different from what it is now. With around 4000 Fellows and no associated faculties, it was considerably smaller than our current 17,500 membership. This is also reflected in staffing, with a team of just 20 when we moved into Russell Square, compared to nearly 100 today. This provision served the College well, as our work then predominantly revolved around delivering training and examinations. Professional standards were in the early stages of being defined; clinical audit was only just being talked about; and quality improvement science, which attracts significant resources today, was a concept far in the future.

In 1992 the College had the monopoly on constructing and delivering postgraduate curricula, approving training environments and delivering examinations. Some of this authority has long since been lost, and only recently have we regained some influence in these crucial areas of our activity. The FRCA was a three-part examination in 1992, oral examinations were just starting to be standardised and the OSCE was in an early stage of development. With pass rates at around 40 per cent, it was commonplace to pay several visits to the examinations before achieving the fellowship.

One aspect of the College that has certainly progressed is greater diversity in our representation. In 1992 our council and board of examiners were predominantly white and male. Today the demographic profile of those in College leadership roles much better reflects that of our membership. In 1992 fewer than 5 per cent of FRCA examiners were from Black, Asian and Minority Ethnic (BAME) backgrounds and fewer than 10 per cent female. In 2017 these figures are 17 per cent and 30 per cent respectively.

THE COLLEGE TODAY

Besides the expansion in membership and staffing, the College has developed new work streams with our Clinical Quality Directorate, recently established Communications & External Affairs Directorate, and not forgetting the faculties of pain medicine and intensive care.

Our research portfolio, coordinated by our Health Services Research Centre and amounting to some £4.5million, is leading the way in patient-centred quality improvement studies, which will undoubtedly be strengthened by our new Clinical Trials Network.

As in 1992, examinations and training remain core College business. These aspects of our work are highly regarded, by other Colleges and regulators in the UK and internationally, as being exemplars in education and assessment practice. The College estate is the envy of our UK peers with spacious, modern headquarters in Red Lion Square that we own outright.

AND THE FUTURE?

Perioperative Medicine (PoM) as a concept is gaining momentum with the specialty from the grassroots upwards and is a key part of the College's future direction (www.rcoa.ac.uk/perioperativemedicine).

Emphasising the pivotal role of the physician anaesthetist in managing increasingly frail, complex patients, this initiative aligns perfectly with current UK government policy and puts the specialty and College at a distinct political advantage. Our first College strategic plan, which foregrounds PoM, will hopefully keep us on course and prevent us being deflected by constantly reacting to external events (www.rcoa.ac.uk/strategic-plan-2016-2021).

The growing pressure on the anaesthetic workforce, as highlighted by our recent census (www.rcoa.ac.uk/document-store/rcoa-census-2015-final-report), is an issue we must address if our speciality is to meet future expectations. The same census also highlighted the problem of our increasingly ageing workforce, considered in the Association of Anaesthetists of Great Britain and Ireland's recent report "Age and the Anaesthetist" (www.aagbi.org/AgeandtheAnaesthetist).

A cultural change by employers is urgently required to facilitate portfolio careers for anaesthetists if they are to remain able to contribute safe and sustainable perioperative care late into their seventh decade. Alternative staffing options, including expanding the non-physician anaesthetic workforce, may need consideration, but this is only possible if accompanied by statutory regulation.

To finish with a cricketing metaphor, the RCoA innings has just started but despite hostile bowling we have defended well and are now starting to play some confident strokes with increasing frequency. At 25 we are confident of making 50 and then onwards to our first century!

Dr Liam Brennan
President, Royal College of Anaesthetists

This is an abridged version of an article published in the November 2016 edition of the RCoA Bulletin.

Remembering a doyen of patient safety

Professor Ross Beresford Holland AM MBBS (Syd), FFARACS, FANZCA, FHKCA

December 1, 1928
– February 25, 2017

The excellent worldwide reputation that Australia has for patient safety during anaesthesia is due to the many publications from the NSW Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) since its inception in 1960.

Professor Ross Holland, in 1959 as a relatively junior doctor and still a trainee, was the catalyst for the foundation of the NSW Ministerial Committee on Deaths Under Anaesthesia, which subsequently became SCIDUA.

He managed to persuade the then-NSW Minister for Health, the Honorable WF Sheahan, that such a committee was essential to improving the safety of anaesthesia and of surgery, which had adverse publicity at the time. He became the inaugural secretary (1960-75) and subsequently chair (1975-87, and again later acting chair 2008-9) to the committee.

This pivotal contribution to medical care was but one of a large number of Ross's contributions to the specialties of anaesthesia, intensive care and pain medicine, to medical education, to medical history and medical administration.

Ross was born in the Royal Women's Hospital, Sydney, to Ailsa (née Heinrichs) and Cyril Holland on December 1, 1928 as their first-born with a daughter a few years later. His early schooling was at Earlwood Primary and Erskinvale Opportunity Class, then with a scholarship to Sydney Grammar School (1940-44) leaving with a university exhibition.

He graduated in medicine in 1952 (final year 1951) from the University of Sydney, and joined the resident medical officer staff at St Vincent's Hospital for two years during which time he was rostered for nine months in anaesthesia.

Initially his ambition was to become a physician but failing to obtain a suitable training position he moved to Lidcombe Hospital as a medical officer (1954-7). As he had married Eileen Hocking in 1953 the main attraction of Lidcombe was comfortable housing accompanying the job!

The Holland family with three

children continued to live in hospital accommodation there for 23 years. Ross's main work at Lidcombe was as an anaesthetist and eventually he decided to become properly trained in the rapidly expanding specialty, so he moved on secondment to Royal North Shore Hospital obtaining his FFARACS in 1959.

He returned to work at Lidcombe Hospital initially as a specialist anaesthetist and later as senior specialist-in-charge, Schedule V Hospitals for NSW. Ross claimed his mentors at this time were Ken Macleod (St Vincent's), and Jim McCulloch and Ted Morgan (Royal North Shore).

On the opening of Westmead Hospital in 1978 Ross became the inaugural director of the Department of Anaesthetics and Resuscitation for nine years at which time he was appointed as the foundation professor to the Department of Anaesthesia in the University of Hong Kong until 1990 when he became the foundation professor and chair, Department of Anaesthesia and Intensive Care, University of Newcastle, NSW.

Professor Holland retired from this academic position at 65 though he continued to practice clinical anaesthesia part-time for another 15 years – mainly dental anaesthesia for the handicapped.

The bare bones of his life's professional work are in fact only a skeleton upon which Ross stretched a rich fabric of other activities.

During his time at Lidcombe he became known for his interest in old medical equipment with his teaching collection of discarded anaesthetic equipment that was continually added to from all specialties by "gifts" from all over NSW.

Eventually Ross recognised that the collection needed a more permanent home and he established the Society for the Preservation of Artefacts of Surgery and Medicine (SPASM) in 1979 in conjunction with Mrs Judith Cornell, and in 1996 the SPASM Museum at the old Gladsville Hospital. He was appointed patron of SPASM and its museum in 2013 in recognition of his foundation activities and longstanding support. He continued to attend the museum regularly twice a week until relatively recently. Ross had other historical interests on which he published and also, typically, contributed to with his administrative skills – at various times he has been chair of the Australian Society of Anaesthetists (ASA) History of Anaesthesia Library, Museum and Archives (HALMA) Committee; Chair of the History of Anaesthesia Special Interest Group; and

co-chair of the enormously successful 8th International Symposium on the History of Anaesthesia held in Sydney in 2013.

Ross was the 16th dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons (RACS) from 1984-6 and chair of its executive for the preceding five years. His deanship coincided with the contentious NSW Doctors' Dispute that saw mass resignations from NSW Public Hospitals by many surgeons and anaesthetists, particularly in Sydney.

This period was very difficult as there were real threats to specialist training in many hospitals as no qualified specialists were available to supervise trainees though the trainees were strongly encouraged by their employers to continue to provide clinical services unsupervised. Also there was a distinct possibility that the dispute would move to other states if the government won in NSW.

There were also fears that there might well be loss of College autonomy and influence as a registration and standards setting body for the specialty. As a dean, Ross had to tread a fine line between support for his resigning colleagues and support for the integrity of trainee teaching and supervision. During this period he was known by many as the "Red Dean", and although the dispute was eventually resolved with training integrity maintained there were many scars left.

Interestingly in the midst of this dispute a unique combined RACS Council and Faculty of Anaesthetists Board meeting was held to discuss the situation and the effects it was having on training and the College. This combined meeting led directly to the foundation of the Committee of Presidents of Medical Colleges (CPMC), and to formation of the Craft Groups representation on the Australian Medical Association Council.

In a *Bulletin* article on past deans in 2007 Ross recorded his thoughts on other major highlights during his time as dean mentioning the growing influence of the Faculty at the level of the RACS Council, and the excellent relations that he personally had with RACS presidents Mervyn Smith and Scotty McLeish.

Another highlight as dean was expansion of the Faculty's professional standards documents which gained widespread acceptance by health departments and hospitals around Australia and New Zealand. This recognition was another way in which major improvements were made in patient safety.

This interest in setting standards for

health led him on to the board of the Australian Council on Healthcare Standards (ACHS), and to chair of the ACHS Board (1982-3). The board in 2006 awarded him the ACHS Gold Medal for his contributions to the ACHS and to patient safety.

Other honours have been member of the RACS Court of Honour in 1989, honorary fellowship of the Medical Defence Union (UK) in 2003, and the ASA's Gilbert Brown Award in 2009.

In 1992 Professor Holland received the ANZCA Orton Medal, the highest award that the College bestows, recognising his major contributions to the College, to anaesthetic safety and teaching in particular. In 2015 he was made a member of the Order of Australia (AM) for "significant service to medicine in the discipline of anaesthesia, as a clinician, to health care standards, and to professional medical bodies".

Just prior to becoming dean, Ross was a relatively intimate bystander in the infamous Australian Security Intelligence Services (ASIS) botched practice raid on the Sheraton Hotel in Melbourne in November 1983, when, as a resident of the hotel while attending a meeting at the college of surgeons, ASIS carried out an armed raid on a room on the 10th floor as a practice for dealing with terrorists without warning hotel staff or anyone else. Fortunately there were no casualties though there were prolonged political ramifications as the culprits were apprehended by the police. Ross, who loved a party, would occasionally reminisce on this raid with good effect.

Ross was renowned as a teacher and positions in his tutorials were fiercely sought after. He had a wide knowledge of general medicine, a very good grasp of the basic sciences pertaining to anaesthesia and an excellent common sense approach to anaesthesia backed by long clinical experience, particularly in his roles overseeing anaesthetic complications, morbidity and mortality.

Although he was not directly involved in intensive care or pain medicine he supported those emerging specialties at Westmead and in his academic appointments in Hong Kong and Newcastle. On two occasions Ross contributed to overseas medical teams – in 1966 (January to May) he joined a St Vincent's Melbourne team at Long Xuyen in South Vietnam, and in December 2000 to January 2001 an AUSAID team to East Timor.

He received the 1945-75 Active Service Medal and in 1995 the Vietnam Logistic and Support Medal for his time in Vietnam. Professor Miles Little an inaugural surgical

colleague at Westmead remembers that "He had a very clear and comprehensive mind, great skill in practice and unequalled persuasive powers, with the ability to present issues starkly in relevant detail, and he knew precisely where he stood. He was quite prepared to deal fairly with those he disagreed with, without excessive compromise. I could never say 'he was my anaesthetist' – it would be more accurate to identify myself as one of his surgeons."

As mentioned earlier, Ross's major contribution was to SCIDUA from its foundation to his retirement in 2013. He remained a committed member for 50 years only being absent while in Hong Kong. In 2010 the NSW Clinical Excellence Commission (CEC) presented him with the CEC Lifetime Achievement Award for "his substantial contribution over 50 years to the SCIDUA and work in anaesthesia mortality reporting". He was also a member of both the AMA and the ASA for more than 60 years, and for almost that long a Fellow of the Faculty and College.

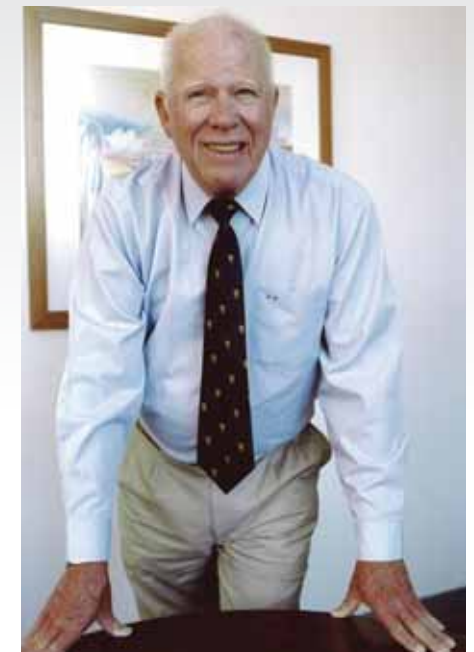
Ross retired to acreage in Kurrajong where he had many happy years, though sadly Eileen, who had so strongly supported him throughout his career, suffered a number of strokes necessitating residence in a nursing home where he was a very diligent daily visitor through to her death in January 2008.

Unfortunately later Ross suffered from back pain and a spinal operation did not give much relief. The final tragedy was the recent loss through fire of his treasured possessions. His health was also affected by smoke inhalation from the fire, and latterly he was cared for at her home by his daughter Beth. He died quietly on February 25, 2017.

Ross was a consummate debater on committees and worked hard and passionately for his causes, though he never brought any animosity out of the committee or debate as he well recognised that everyone was aiming for the same excellent result, and that there were other perspectives which could be held.

Among the great delights of Faculty board meetings during his time on the board were the splendid dinners that occurred in conjunction with the meetings. Ross loved the camaraderie and jovial discussion at these dinners and when he retired he left several boxes of fine port to be consumed at subsequent dinners when we could remember him fondly.

His family remember "his insatiable intellectual curiosity, love of books, music and fine wine, an excellent



conversationalist, a party lover and generous host" with which I concur, and I think it would be a fitting gesture for us all to raise a fine glass of red to his memory. His contributions are much admired and have been most influential in improving patient safety.

The College sends its sincere condolences to his children Beth, Susan and Paul, and to his three grandchildren and sister Jenifer.

Professor Barry Baker AM
Emeritus Professor of Anaesthesia,
University of Sydney
Honorary Historian, ANZCA

ANZCA joins Choosing Wisely

ANZCA has joined the international Choosing Wisely campaign

Choosing Wisely is based on improving outcomes for the individual – avoiding harm, making wise choices.

The emphasis is not on effective use of finite resources or sustainability, both of which may be important for the population but not necessarily for the individual. In fact, if cost is seen to be the driver of change, physician and patient engagement is understandably reduced. Improved quality of care is the core objective of the campaign. Financial benefits may be a welcome consequence of Choosing Wisely but they are not the goal.

The American Board of Internal Medicine Foundation and nine medical specialty societies launched the Choosing Wisely campaign in 2012 to encourage physicians and patients to have conversations about what care is truly needed and “debunk the notion that more is better”.

Choosing Wisely is a physician-led campaign with medical specialty colleges and societies creating a list of tests, treatments or procedures that may be of limited benefit or cause harm; suggestions about what not to do. After its origins in the United States, Choosing Wisely has been adopted and implemented in 12 countries including Australia, New Zealand, Canada, Denmark, Germany, Italy, Japan, the Netherlands, Switzerland and the UK².

In Australia, the Choosing Wisely campaign is administered by the national prescribing service, MedicineWise, while in New Zealand the Council of Medical Colleges is taking a co-ordinating role with colleges and professional bodies developing their lists of five Choosing Wisely items.

In an effort to facilitate engagement and promote the Choosing Wisely campaign, a

survey was sent to all ANZCA Fellows and trainees in mid-2016. A list of 10 possible recommendations was developed by an ANZCA working group. These were based on current concerns around best practice for optimal patient outcomes as well as reference to existing Choosing Wisely lists from the US and Canada and Australian groups such as the College of Intensive Care Medicine.

More than 1100 Fellows and trainees responded, allowing a quantitative assessment of preferences with some illuminating free text comments. This analysis was used to create a final list of five Choosing Wisely items (with support of Fellows and trainees) as the primary selection criterion. These now form the basis of the ANZCA Choosing Wisely campaign.

A number of the recommendations advocated by ANZCA could be considered to already be a part of our daily practice. It could also be argued that the patient does not usually have the necessary knowledge base to determine whether an investigation or even a blood transfusion is in their best interests. Choosing Wisely should not be seen as empowering patients to override reasonable clinical judgment nor should it be used by doctors to promote clinical biases. Choosing Wisely offers an opportunity to inform patients and discuss risks. It also offers the chance to educate others involved in a patient's care, such as residents and nursing staff, in the importance of ordering appropriate tests.

Recommendations 4 and 5, dealing with provision of anaesthetic services to patients with limited life expectancy and appropriate provision of perioperative care respectively, afford important opportunities for discussion with patients and their families. Goals of care discussions for the medically frail who are scheduled for surgery can often be initiated and led by an anaesthetist.

The anaesthetist has an understanding of the co-morbidities of the patient, the nature and risks of the surgery and often

the expected outcomes. Similarly, the specific perioperative care requirements of any patient are often best determined by the anaesthetist.

A discussion between the patient, family and treating medical practitioners may be required, particularly when a small or local facility may not be able to provide optimal infrastructure for a particular procedure in a given patient. This includes staffing, equipment and postoperative monitoring. Pre-operative discussion may result in modification of the surgical approach to accommodate the needs of a patient in a chosen facility, rescheduling to a more appropriate facility or even a decision not to proceed.

Choosing Wisely promotes the role of anaesthetists as clinical experts dealing with complex issues in an individualised way.

Dr Phillipa Hore, FANZCA
Chair, ANZCA Safety and Quality Committee

Professor David Story, FANZCA
Chair of Anaesthesia, University of Melbourne

References:

1. Daniel Wolfson, MHSA, John Santa, MD, MPH, and Lorie Slass, MA. Engaging Physicians and Consumers in Conversations About Treatment Overuse and Waste: A Short History of the Choosing Wisely Campaign. *Academic Medicine*, Vol. 89, No. 7 / July 2014
2. Levinson W, et al. “Choosing Wisely”: a growing international campaign *BMJ Qual Saf* 2015;24:167–174.



5 THINGS

CLINICIANS AND CONSUMERS SHOULD QUESTION

Developed by the Australian and New Zealand College of Anaesthetists



1. Avoid routinely performing preoperative blood investigations, chest X-ray or spirometry prior to surgery, but instead order in response to patient factors, symptoms and signs, disease, or planned surgery.
2. Avoid ordering cardiac stress testing for asymptomatic patients prior to undergoing low to intermediate risk non-cardiac surgery.
3. Avoid administering packed red blood cells (blood transfusion) to a young healthy patient with a haemoglobin of $\geq 70\text{g/L}$ who does not have on-going blood loss, unless the patient is symptomatic or haemodynamically unstable.
4. Avoid initiating anaesthesia for patients with limited life expectancy, at high risk of death or severely impaired functional recovery, without discussing expected outcomes and goals of care.
5. Avoid initiating anaesthesia for patients with significant co-morbidities without adequate, timely preoperative assessment and postoperative facilities to meet their needs.

For more information about ANZCA's Choosing Wisely submission go to www.choosingwisely.org.au/recommendations/anzca

ANZCA Choosing Wisely Working Group

Dr Phillipa Hore, Chair ANZCA Safety and Quality Committee
Professor David Story, Chair of Anaesthesia, University of Melbourne
Associate Professor Joanna Sutherland, Safety and Quality Committee
Dr Dick Ongley, immediate past chair Perioperative Medicine Special Interest Group

ANZCA issues joint statement on labelling standard

ANZCA and the Australian Commission on Safety and Quality in Health Care (ACSQHC) have published a joint statement on user-applied labelling in Australia (see <https://www.safetyandquality.gov.au/wp-content/uploads/2017/01/Joint-statement-supporting-user-applied-labelling-standardisation-for-all-injectable-medicines-and-fluids-January-2017.pdf>)

The perioperative poster (see <https://www.safetyandquality.gov.au/wp-content/uploads/2015/09/National-Standard-for-User-Applied-Labeling-Print-version-Aug-2015.pdf>) is embedded within the position statement and illustrates user-applied labelling in open and closed practice environments within the perioperative area. The poster is endorsed by ANZCA and the Australian College of Perioperative Nurses.

Note that with the changes in nomenclature to be introduced, labels will need to reflect these, for example, adrenaline and epinephrine.

Applied-Labeling-Print-version-Aug-2015.pdf is embedded within the position statement and illustrates user-applied labelling in open and closed practice environments within the perioperative area. The poster is endorsed by ANZCA and the Australian College of Perioperative Nurses.

National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines

Perioperative Labelling of Medicines and Fluids

Closed-practice environment (a single patient with established identity)

Label syringes containing medicines used during anaesthesia

For example:

Morphine mg/mL	Midazolam mg/mL	Atropine mg/mL
Ketamine mg/mL	Levosimendan mg/mL	Suxamethonium mg/mL

Use Anaesthetic Labelling Standard (ISO 26825:2008) compliant labels

Label containers on the sterile field

For example:

Medicine Conc (units/mL)	Sodium Chloride 0.9%	Povidone-Iodine
Adrenaline 1 in 1,000	Bupivacaine	Morphine

Use sterile labels and sterile marker pens

Open-practice environment (more than one patient in the same area)

Label all containers (including syringes) containing medicines to continue beyond the operating room

Label lines to identify route

SPINAL	INTRATECAL	INTRAVENOUS	INTRAVENOUS	CENTRAL VENOUS	CENTRAL VENOUS
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Label lines to identify medicine in a dedicated continuous infusion line – for example:

Medicine	Medicine	Morphine	Noradrenaline
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To be read in conjunction with the National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines
© Commonwealth of Australia 2015

ANZCA Endorsed by the Australian and New Zealand College of Anaesthetists
ACORN Endorsed by the Australian College of Perioperative Nurses
AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Conscious sedation – ANZCA’s response

Public consultation on proposed entry level competencies for endorsement for conscious sedation.

In March 2016 the Dental Board of Australia (DBA) sought feedback from key stakeholders regarding entry level competencies for endorsement of registration in an approved area of practice: conscious sedation. At this initial stage, ANZCA provided extensive feedback including very articulately defining the “sedation spectrum”.

In December 2016, ANZCA and FPM provided comment on the DBA’s Public Consultation on proposed entry level competencies for endorsement for conscious sedation. Some of the key response points are provided.

ANZCA supports the Dental Board in setting entry level competencies expected of dental practitioners who wish to be endorsed to administer conscious sedation. It is important that patients who require anxiolysis and/or amnesia while undergoing a dental procedure, and thus are in need of sedation, are under the care of an appropriately skilled practitioner. Patient safety is paramount. Implementation of practice competencies assists in setting practice standards.

As noted in ANZCA’s previous submission (preliminary consultation, April 2016), the sedation spectrum is a continuum from anxiolysis to general anaesthesia and patients may transition from one state to another unpredictably.

The term “conscious sedation” is used by the dental board in defining the proposed competency. This term implies that a patient is responsive to minimal stimulation but the ever-present possibility of inadvertent transition to deeper sedation requires that a practitioner has the appropriate airway and cardiovascular support skills to manage unintended complications. If verbal contact is lost, the

patient requires a level of care which in some respects approaches that needed for provision of general anaesthesia. Hence, the dental board’s proposed entry level competencies need to provide clear and unambiguous instruction to practitioners on the constraints around their intended scope of practice.

Further detail is required to define the practice of safe dental conscious sedation (separate from entry level competencies). This would include:

- Pre-procedure assessment including the use of risk assessment tools to ensure appropriate patient selection.
- The process of sedation including drug selection and delivery.
- Monitoring of the patient during and after the procedure.
- Adequate documentation of medication delivery, vital signs and monitoring used.
- Plans for discharging patients following sedation.
- The requirement for additional skills needed to deal with any complications.

With regard to these points, ANZCA has already developed guidelines that may assist the Dental Board of Australia in scoping and further refining the listed competencies. ANZCA would welcome the opportunity to assist, and invites the Board to access the relevant material.

In addition to ensuring safe conscious sedation skills, any endorsement should ensure that a practitioner has an understanding of a safe operating environment in terms of appropriately skilled staff, equipment and infrastructure. Dental practitioners should be cognisant of whether the facilities in which they practise comply with the appropriate licensing regulations. The principles of maintaining records and auditing personal practice should also be included in competency assessment.

ANZCA is of the opinion that all approved dental sedation competency-based courses must deliver the

requirements outlined in these entry level competencies. Thus, the accreditation body will need to ascertain whether the currently approved competency based courses, as well as any future courses, deliver these requisite skills.

For the sake of completeness, all definitions of the states of altered consciousness in the ANZCA professional document, *PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures* should be included so that these are clear to the practitioners seeking endorsement. Specific reference should also be made to section 2 of *PS09* (“Aims and Risks of Procedural Sedation and/or Analgesia”).

ANZCA regards this consultation to have high importance in ensuring that dental practitioners endorsed to provide dental sedation are suitably qualified. Consideration should be given to processes of monitoring and auditing a dental practitioner’s:

- Performance.
- Maintenance of conscious sedation skills and knowledge.
- Conscious sedation endorsement currency.
- Completion of the appropriate standard of CPD in dental sedation.
- Ability to demonstrate the capacity to adequately assess patients for risk and suitability and/or manage complications.

Dr Phillipa Hore
Chair, ANZCA Safety and Quality Committee

Respiratory issues the most commonly reported to webAIRS

webAIRS

The most common incidents reported to webAIRS were coded as respiratory, followed by medication, cardiovascular, and medical device/equipment, an overview of the first 4000 incidents shows.

Published in the January 2017 edition of *Anaesthesia and Intensive Care (AIC)*, this reporting milestone was achieved in July 2016.

The four main categories accounted for more than 70 per cent of the incidents reported. The outcomes data showed that no harm occurred in 70 per cent of the incidents, while 26 per cent and 4 per cent, respectively, resulted in harm or death.

While the no harm category accounted for the majority of incidents, it is extremely important to report these low harm incidents. Analysis can assist in developing strategies to prevent the less common, serious harm events or deaths¹.

A further series of articles is planned this year with themes including awareness, aspiration, airway, anaphylaxis, hypotension and medications. A preview of the anaphylaxis data will be presented at the 2017 ANZCA Annual Scientific Meeting (ASM) in Brisbane.

The ASM will also offer webAIRS workshops, which will provide delegates with the opportunity to learn about all aspects of webAIRS, from registration to incident review and analysis functions.

As of mid-January 2017, webAIRS has collected 4580 incident reports from 144 registered sites. This represents

If you are yet to register with webAIRS, it is quick and easy – just follow the link from the webAIRS landing page: www.webAIRS.net

considerable growth since the milestone of July 2016. If you haven't already registered with webAIRS, you can do so quickly and easily from the link on the site landing page (webairs.org.au).

Frequent reporting is an important component of the quality improvement process. Even data relating to incidents that did not result in harm provide unique opportunities for learning and identification of themes for advancing our practice. The aim of webAIRS is continuous improvement in care and positive patient outcomes – fundamentals in maintaining high quality care across our profession.

Dr Martin Culwick, FANZCA
Medical Director ANZTADC/webAIRS

References:

1. Gibbs NM, Culwick M, Merry AF. A cross-sectional overview of the first 4,000 incidents reported to webAIRS, a de-identified web-based anaesthesia incident reporting system in Australia and New Zealand. *Anaesthesia and Intensive Care* 2017;45(1):28-35 <http://www.aaic.net.au.ezproxy.anzca.edu.au/Document/?D=20160686>

Safety alerts

Recent alerts:

- Medtronic SynchroMed II infusion pump – hazard alert.
- Inadvertent use of Phenol to spray vocal cords.
- Update – New Zealand Remifentanyl shortage update – 2mg now available.
- Medtronic model 37751 recharger – used with neurostimulators.
- Update – New Zealand Ultiva injections supply delayed.
- GE Avance CS2, Avance and Amingo Anesthesia Devices.

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

Dr Peter Roessler

Communication and Liaison
Portfolio
Safety and Quality Committee

The ANZCA Safety and Quality Committee thanks Dr Peter Roessler, Communication and Liaison Portfolio, and staff from the ANZCA Policy, Safety and Quality unit, for sourcing and compiling these articles.

Keeping qualifications up to date



New ways of learning and novel group activities are among the changes being considered for CPD.

The revised ANZCA CPD Program turned three on December 31, 2016, with more than 2980 Fellows successfully completing the required activities. A total of 99.2 per cent of participants have successfully completed the 2014-16 triennium online portfolio requirements, which suggests that our colleagues are robustly engaged with the aim of life-time learning and skills training, regular assessment of practice and self-evaluation.

We should be proud of this achievement, as it demonstrates, particularly to the legislators, that the profession is responsible and is committed to improving the safety and quality of anaesthesia.

Several challenges are being considered by the CPD Committee and unit for some point in the future. There are new ways of learning and novel group activities that have real value as CPD activities that would only require minor changes to the category sections within the CPD framework. The CPD unit will look to develop more specific toolkits for different types of practice so that, for instance, Fellows can enter the CPD website, click on a “my type of practice” icon and see how to complete meaningful CPD activities and accrue credits for

their portfolio.

An online learning module will be available in 2017 for the anaphylaxis emergency response category and proposals have been made for a human factors module and for specific emergency response activities for FPM Fellows.

Revalidation/recertification

The Medical Board of Australia (MBA) and the Medical Council of New Zealand (MCNZ) are talking to the colleges and other stakeholders about how best to ensure doctors’ ongoing fitness to practise safely and effectively. Several other jurisdictions have introduced revalidation frameworks, notably the United Kingdom, Canada and New Zealand, which have had a recertification process for all doctors in place for some years.

The MBA has ruled out a UK-style revalidation model and commissioned an expert advisory group (EAG) that produced a draft framework proposal for further discussion with stakeholders, including ANZCA. A fundamental tenet of the proposal is that all recommended approaches should be integrated within existing systems and should not require any more time or resources to complete. Whether this is achievable, especially for practitioners in private practice, remains to be seen.

There are two parts to the proposed revalidation model:

“The CPD unit will look to develop more specific toolkits for different types of practice so that ... Fellows can ... click on a ‘my type of practice’ icon and see how to complete meaningful CPD activities.”

1. An enhanced, evidence-based CPD program for all doctors. Discussion so far indicates that the MBA views the ANZCA CPD program as already being suitable for the purpose of revalidation.
2. Identifying, assessing and assisting at risk and poorly performing doctors.

The second part is largely uncharted territory, and this is where the debate continues. It is clear that participating in a CPD program does not, in itself, ensure fitness to practice (although it is a good surrogate marker).

Research indicates that 4-6 per cent of doctors are at risk or underperforming at any one time; often this is temporary and is remediated quickly and without recurrence. A number of risk factors of poor performance have been identified internationally but considerable further work is required to understand these better in the Australian and New Zealand context.

The MBA proposes a three-tier system for assessing competence where concerns have been raised, starting with a specific multi-source feedback (MSF) exercise, elevating to a peer review of practice and, if serious safety concerns are raised, to a formal performance assessment. These would all be designed to be non-punitive, to encourage remediation, and ANZCA has strongly emphasised that they must not be part of the normal CPD cycle. The MBA and EAG appear receptive to this view.

These are proposals for discussion at this stage and the colleges are robustly debating roles, benchmarking, evidence and outcomes. Further consultation is scheduled for early 2017 and updates will follow.

Nigel Robertson
Chair, CPD Committee

The accidental greenie



David Hays, a Melbourne anaesthetist, often noticed the extravagant waste of the single-use little blue towels with which theatre staff dry their hands after a surgical scrub. Small, light-weight and pure cotton, the towels were dropped into waste bins and fated to be landfill.

Some were rescued by doctors, nurses and technicians, who found them useful in dozens of ways around the house, the shed, the garage or the laundry – washing cars, cleaning windows, camping and fishing.

Talking to a friend on the Murray Meander boating event that raises money for cancer, Dick Phillips from Echuca, Dr Hays floated the idea of recycling the towels in order to sell them and raise money for the Otis Foundation. The Otis Foundation provides free retreat accommodation to those living with breast cancer, letting guests relax, reconnect and take a break with family and friends.

The Little Blue Towels project, a registered charity, was launched in February 2016. The towels are laundered and packaged by adults with disabilities in Bendigo, Ballarat, Echuca and Kew, giving the workers meaningful employment.

More than 50 hospitals across Victoria now participate, contributing more than 20,000 Little Blue Towels a month, a total

of 250,000 a year, or the equivalent of more than 12 tonnes of landfill.

The towels are collected in specially labelled 240-litre blue wheelie bins supplied to each hospital’s operating suite or radiology department. Then they are collected and transported to the disability agencies where they are washed, ironed and packed for resale. Each pack contains five Little Blue Towels and sells for \$5. The project also produces a Little Blue Golf Towel for \$5.

On every pack of five towels sold, \$3 is earned.

“We sell to anyone who wants to buy,” Dr Hays says. “A pizza shop owner bought \$2000 worth and told customers they could have five towels for \$5 every time they bought a pizza.”

“A lady bought them for a garden party she was having to raise money for breast cancer research. Last October, during Breast Cancer Awareness Month, every regional branch of the Bendigo Bank sold the Little Blue Towels, generating \$30,000 for the project.”

Dr Hays would like to see the Little Blue Towel packs sold as widely as possible.

They are bought by transport companies and agriculture machinery businesses who use them in their trucks or give them away with every tractor sold. Dr Hays has

developed a version with a cleat on it that can attach to a belt for use by waiters and barmen, and golfers who can attach it to their buggies. And he is branching out with kits made up of Little Blue Towels, single-use surgical scissors and artery forceps, and plastic basins. He will market them as outdoor packs to horse-owners as useful kits for tending to their horses’ fetlocks on bush rides, as well as to dog owners, fishermen and campers.

Dr Hays and Mr Phillips would like to see a Little Blue Towels collection bin in every Victorian hospital within the next 12 months. They hope a large retail business will eventually sell them to a mass market.

Dr Hays said, “We have now started operations in Canberra and surrounding areas. Same model: hospital collection, disability services and local sales, with all proceeds going to the Otis Foundation. If we dream big enough, we will go national. You have to dream!”

For further information, go to www.littlebluetowels.com.au.

Karen Kissane
Media Manager, ANZCA

Above from left: Melbourne anaesthetist, Dr David Hays; Hospital theatre staff with packed up Little Blue Towels; Little Blue Towels and basin kit.

Assessment of overseas trained specialists changing

The revised process for assessing overseas trained specialists comes into effect on April 3.

The ANZCA and FPM processes for the assessment of overseas trained specialists have been combined and are now both governed by *Regulation 23: Recognition as a specialist in anaesthesia or pain medicine; and admission to fellowship by assessment for specialist international medical graduates (SIMGs)* which can be found via www.anzca.edu.au/resources/regulations/regulation-23.

This revised process will come into effect from April 3, 2017 and will apply to the assessment of anaesthetists and specialist pain medicine physicians in Australia and New Zealand.

It will then be referred to as the specialist international medical graduate (SIMG) assessment process.

International medical graduate specialist (IMGS) anaesthetists who are now participating in the process have been notified individually of the changes that may impact them and can apply for a new assessment under the revised regulation 23.

Those requesting a new assessment should be aware that their current assessment will be vacated and the outcome of the new assessment must be abided by. They should also be aware that a new assessment may result in being categorised as “not comparable” and being unable to continue in the SIMG assessment process.

Major changes to the processes for anaesthesia and pain medicine IMGs in Australia (specialist registration and fellowship pathways) and New Zealand (fellowship only pathway) are:

- If an applicant requires three or more

months of trainee equivalent time during their clinical practice assessment (CPA) they will be ineligible for the SIMG process.

- The criteria for assessment have changed. Please refer to the regulation for details on the assessment criteria.
- All SIMGs must participate in the ANZCA continuing professional development (CPD) program.
- CPA reports are due every three months instead of every six months. This change will also be applied to all existing IMGs and SIMGs.
- If an SIMG is assessed as substantially comparable and has previous appropriate experience in Australia or New Zealand the CPA time can be reduced by up to six months.

New Zealand

This information relates only to the ANZCA fellowship process in New Zealand. Any questions on vocational registration should be directed to the Medical Council of New Zealand (MCNZ).

It should be noted that the MCNZ vocational registration and ANZCA fellowship processes are separate and different, however there are some points where the processes may overlap. An assessment may be undertaken for either or both processes at the same time.

Applicants must inform the College if they would like an ANZCA assessment conducted at the same time as their MCNZ assessment. If they do not, only the MCNZ assessment will be conducted. They may opt to have the ANZCA assessment undertaken at a later stage which would require application directly to the College for assessment under regulation 23.

Associate Professor Michael Steyn
Chair, ANZCA IMGs Committee

Major changes – anaesthesia

The major changes that impact only the anaesthesia pathway include:

- All anaesthesia SIMGs who are required to complete an ANZCA exam will be exempted from the written sections of the exam. This does not apply to existing IMGs unless they are assessed under the revised regulation and their requirements are changed.
- SIMGs who are assessed as partially comparable and who have completed a comparable examination as part of their specialist anaesthesia training may be eligible to undertake a workplace-based assessment (WBA) in lieu of the ANZCA exam.

Major changes – pain medicine

The major changes that impact only the pain medicine pathway include:

- The assessment criteria has changed. Please refer to regulation 23 for full details on the assessment criteria.
- Any SIMG who has previously been assessed under by-law 16 may request a new assessment under regulation 23 noting that application for a new assessment vacates the existing assessment and the SIMG must abide by the outcome of the new assessment.

What I learned from receiving an epidural during labour

Anaesthesia registrar **Phuong Pham**, used to working with labouring women, learns what it is like to be one of them.

It is midnight in a busy tertiary obstetric hospital. You are the sole overnight anaesthetic registrar on call. It has been a constant evening so far and the birthing suite is packed to the brim. You receive yet another page: G1P0, 40+4/40, 5cm dilated, Plt 400, requesting epidural. Stomach grumbling from hunger, you resist a sigh and call the midwife to let them know that you will come as soon as the current caesarean is completed. It is going to be a long night.

Like most anaesthesia trainees, I have received many such pages. Tonight, this one is different. Instead of being the registrar receiving the page, I am the patient awaiting the epidural.

Being a patient for the first time since starting anaesthesia training was an unfamiliar but enriching experience. I was no longer the professional; my body was denied its usual civilised dignity and privacy. Normally, my confidence was underpinned by cool intellect. Not here. I lost complete control. I was shamefully reduced to a hysterical, howling mess, frantically battling nitrous-induced hallucinations while combating the out-of-this-world agony of labour. Vulnerable, obviously. Frightened, absolutely. A vulnerable and frightening experience for anyone, but perhaps even more so for the “Type A” personality typical of many anaesthetists.

Thankfully, I had a competent and compassionate team looking after me. My midwife was kind, efficient and safe. The midwife in charge was reassuring and supportive yet firm. The obstetric team was skilful, communicative and organised. However, saviour came in the form of the anaesthetic registrar, who brought the magical respite known as the epidural. Finally, after hours of nitrous madness and unbearable pain, I regained self-composure, rational cognition, emotional balance and physical relief.

I should emphasise here that I had every intention of having a natural birth and only opting for the epidural if necessary. In preparation for my labour during a straightforward pregnancy, I dutifully attended Calm Birth classes and practised meditation exercises. Unfortunately, I had one major risk factor - being a doctor. One's ability to calmly meditate through the contractions is somewhat limited after sixty-three hours of spurious labour, failure to progress, meconium liquor and prolonged foetal decelerations. Far from having the ideal natural birth, I was quickly accumulating all the ingredients for an emergency caesarean.

It is impossible to describe how grateful I am for the incredible team that looked after me. Throughout my hospital admission, I made a point of remembering the name of each staff member who looked after our little family. In fact, the first thing I did, when afforded sensible speech again thanks to the epidural, was tell my husband to write down the names of the birthing suite team. I never want to forget the kindness and care I received. I always want to remember those who helped me.

Reflecting on my day job as an anaesthesia trainee before maternity leave, I am filled with gratitude and humility. Gratitude for the right to practise anaesthesia. Humility for the ability to be of service to others. I have been one part of similar teams treating similar labouring women many times in the past. It has always been, and will continue to be, a privilege to have the skills to relieve patients' suffering. Though anaesthesia training is not always an easy journey, it is an honour to have a role in delivering positive outcomes for new families. It is a true gift.

My ordeal certainly reinforces my passion for obstetric anaesthesia. There is no doubt that our attention to seemingly mundane detail is important: the warm blanket, the gentle touch,

“Finally, after hours of nitrous madness and unbearable pain, I regained self-composure, rational cognition, emotional balance and physical relief.”



the soothing voice. These aspects are just as valuable as our scientific knowledge, efficiency and steady hand. Treating screaming labouring women, co-operating with multiple teams involved in a complex birth, and managing obstetric emergencies are not easy tasks. Tragedies yield deep sadness, but triumphs produce great joy.

As service providers, we may never receive a bottle of wine at Christmas from our patients. In fact, most patients may not remember or even realise our contributions. Yet, their experience of being cared for is undeniably determined by our work and the thoughtfulness we put into it. Perhaps it is precisely this aspect of anaesthesia that appeals to the quiet achiever within me.

Whatever my future career holds, my recent experience as a patient makes me incredibly proud to belong to this profession of carers. I am inspired and determined to provide the best service possible for each patient who comes my way.

Dr Phuong Pham
NorthWestern Training Rotation Scheme, Melbourne

Above: ANZCA trainee, Dr Phuong Pham with baby Riley Dharma Liddle.

“This assessment process will be referred to as the specialist international medical graduate (SIMG) assessment process.”

Anaesthetists play crucial Lorne Pier to Pub role



Each year over summer, anaesthetists emerge from the operating room to volunteer at the Lorne Pier to Pub swim and its associated Mountain to Surf run.

With perioperative medicine gaining momentum, it is pertinent to consider the wider role of anaesthetists. There is a perception that anaesthetists are confined to the operating theatre in the way chefs are confined to the kitchen.

Some of our non-anaesthesia colleagues have very little knowledge of anaesthesia and consequently little respect for what we do. Emerging from the operating theatre, and being seen outside that environment while involved in patient management, is critical to changing that perception. Engaging in wider medical consultation and management activities is also helpful.

Anaesthesia has already shown its abilities outside the operating theatre in the past, having ventured into and pioneered intensive care medicine (ICM). But then with the formation of the separate College of Intensive Care Medicine, anaesthetists withdrew back into theatre.

Similarly, the formation of the Faculty of Pain Medicine also helped to despatch anaesthetists back into the operating room (OR). This is despite the fact that we are all involved in managing acute life-threatening issues as well as acute pain on a regular basis, and that many Fellows are dual qualified.

While these advances have been great for the community and patient care, they do not present an accurate image of anaesthetists.

Over more than 15 years at a major sporting event, initially as a competitor and later as a medical practitioner, I have seen the commitment of anaesthetists to community welfare, and their value outside of theatre and surgery. Ensuring safety and a high level of medical care for the event has involved invoking a range of ANZCA Roles in Practice, including medical expert, advocate, leader and manager, collaborator, scholar, and professional.

The event is the annual Lorne Pier to Pub swim and associated Mountain to Surf run held by the Lorne Surf Life Saving Club (SLSC) in Victoria every January. To ensure the safety of almost 2000 runners and 5000 swimmers is no mean feat. The event is listed in the *Guinness Book of Records* as being the open-water swim with the largest number of competitors.

The first official swim was held in 1981, although many had swum from the pier to the club house previously, sometimes as a race between friends. Dr Peter Atkinson, a Melbourne GP, who was known to many club members and whose children were involved in the club Nippers program, was on the beach that day and was invited to attend to anybody needing first aid.

Entrant numbers doubled each year for several years. Bob Smith,

a Melbourne anaesthetist, athlete (and painter), often competed in the run and the swim, and was well known to Dr Atkinson. Around 1990 Dr Smith started to help once he had completed the swim event. At that time, the only other help was from a group of nurses from The Alfred hospital, who faithfully turned up year after year.

After the second race death in 1994, the race director invited Peter Atkinson and Bob Smith to discuss a letter received from another Melbourne anaesthetist, Dr Kevin Moriarty, who offered suggestions about assisting, and improving resources as well as the level of care.

Dr Moriarty's involvement then led to the establishment of facilities and care that are now "gold standards" for other similar events. Since this involvement, the anaesthetist's leadership of the medical team was formalised by the appointment of Dr Moriarty to the race committee for advice on competitor and spectator safety, a role recently handed over to another anaesthetist, Dr Mark MacLennan.

Lorne being a favoured holiday spot for doctors meant that there were plenty present at the time of the event, some of whom came to compete. Many were approached to help and they volunteer regularly. Similarly, the nurses have been effective in recruiting, and instrumental in maintaining the high standards. Mrs Val Moriarty, Ms Rosie Mahoney, and Mrs Sandy Roessler have worked tirelessly from the nursing perspective for many years.

Anaesthetists have shown leadership within the multidisciplinary team that includes specialists, GPs, nurses, and physiotherapists, as well as the ambulance services, and the first aid surf lifesaver volunteers. Specialists hail from anaesthesia, intensive care, emergency medicine, orthopaedic surgery and internal medicine. Each discipline has been encouraged to engage in their scope of practice, enhancing the relationship between practitioners from different disciplines.

Apart from the ambulance services, all other practitioners and nurses donate their time and experience pro bono. We must thank all the nurses and First Aid volunteers for their valued participation and significant contributions.

The event has utilised many ANZCA Roles in Practice:

Advocacy:

- The eight-kilometre run used to be held on the Friday evening before the Saturday swim. But, if the pre-run temperature exceeded a pre-set limit, the run had to be cancelled due to the dangers of heat exhaustion and hyperthermia. We became very good at treating hyperthermia, but the risks and morbidity were significant.
- Consequently, the leadership advocated changing the timing of the run to the Friday morning, when temperatures were much lower. This was negotiated in a collaborative manner and the change was instituted. Not only did this guarantee the event organisers that the run would be held, but there has not been one case of hyperthermia since.
- The 1.2 kilometre swim held on the following day was renowned for many swimmers developing hypothermia because wetsuits were banned. The leadership campaigned for wetsuits to be not

"Exposure to issues including orthopaedic injuries, painful stings, asthma and hypothermia has broadened the experience of those involved."

only permitted, but encouraged, and advocated lowering the time allowed in the water to complete the swim.

- As a result, the incidence and severity of hypothermia halved, and those who did experience it did not suffer as severely as previously. The treatment of hypothermia was significantly aided through the use of Bair Hugger warming blankets, which were procured by Dr Moriarty.

Medical expert:

- The management of the occasional cardiac arrest and myocardial infarction has been exemplary, with better than expected outcomes. Exposure to issues including orthopaedic injuries, painful stings, asthma and hypothermia has broadened the experience of those involved.
- Service to the community in this year's event included 90 documented and more than 40 undocumented cases of competitors and spectators requiring treatment.

Leadership and management:

- The leadership team has worked with the race committee to engineer a situation where anaesthetist expertise has become respected and valued by the race committee for more than 20 years.
- Co-ordinating and acquiring materials and equipment necessary to establish this "pop-up" facility.
- Provision of emergency services liaison and advice on competitor safety for any proposed changes, including the recently introduced 5000-metre swim three years ago.

Collaboration:

- The collaborative environment has fostered many benefits.
- The presence of orthopaedic surgeons and physiotherapists has helped anaesthetists to expand their skills and learn how to assess musculoskeletal injuries, for example.

Scholar:

- Learning – the environment where practitioners from different areas come together and discuss multiple issues is of value.
- Teaching – at medical students and nursing students attend and are often provided with learning opportunities. Unsolicited comments from a medical student and a newly graduated doctor included, "We learned more from this weekend than any other experience".

The setup of the medical area as illustrated includes the acute resuscitation bay reserved for cardiac arrest or acute life-threatening emergencies.

Anaesthetists in this environment have been recognised for their

(continued next page)

Anaesthetists play crucial Lorne Pier to Pub role (continued)

“(Anaesthetist Kevin Moriarty’s) involvement then led to the establishment of facilities and care that are now ‘gold standards’ for other similar events.”

critical roles and are respected by event organisers as well as by colleagues. The exercise has demonstrated that anaesthetists can be valued and respected for their leadership, professionalism, and medical management skills in areas outside the operating theatre.

Maybe there are some lessons here for our quest to enter the perioperative medicine arena.

Dr Peter Roessler, FANZCA
Dr Kevin Moriarty, FANZCA
Dr Mark MacLennan, FANZCA



The Lorne medical team



Doctors

Anaesthetists: Mark McLennon, Kevin Moriarty, Peter Roessler, Bob Smith, Gary Jackson, Scott Nicholson, Simon Reilly, Liz Coates, Brendon Butler, Pierre Bradley.

GPs: Peter Atkinson, Belinda Carne, Madeline Price, Stewart Gough, Dave Mullin, Brendon Kirk.

Orthopaedics: Tony Dunin, Richard de Steiger.

Emergency medicine: Mark Rugless.

Intern: Will Braidahl.

Nurses

Rosie Mahoney, Val Moriarty, Sandy Roessler, Lindy Hare, Suzie Cartledge, Tania Reilly, Gill Whitehead, Marg George, Libby Senyard, Natalie Brown, Lana Kirk.

Paramedics

Edwina Gallagher, Rich Atkinson, Clare Gardiner, Anna Lise.

Physios

Joanna Cross, Caroline Nicholson.

Medical student

Sib Braidahl.

Others

Sally Morrison.

ANZCA's finances carefully managed

Many Fellows and trainees are unaware of the work that goes on behind the scenes at ANZCA. This article, about the Finance, Audit and Risk Management (FARM) Committee, is part of a series on the activities undertaken by our College.

This article is intended to give Fellows and trainees an insight into the management of finances within ANZCA and specifically the role of the Finance, Audit and Risk Management (FARM) Committee. The first half of the article is intended to give a brief background before discussing FARM.

ANZCA is a registered company in Australia and New Zealand. As it is a company (limited by guarantee) it has a board of directors – ANZCA Council. One of the most important roles of a councillor (director) is to ensure the solvency of ANZCA (the company). ANZCA produces an annual report for the annual general meeting (see www.anzca.edu.au/communications/annual-reports) for its Fellows which includes financial reports and is vetted by external auditors (in 2016, ANZCA used the company Grant Thornton).

As well as the above, during the year, ANZCA's financial position is regularly monitored through a number of "checks and balances".

Firstly, there is the College's Finance unit which produces monthly financial reports (called "governance" reports) that detail ANZCA's financial position. These reports include monthly statements on the balance sheet, profit and loss statements, as well as a cash flow statement.

Also included are other indicators of activity including:

- Number of Fellows/new Fellows.
- Number of trainees/new trainees.
- Number of applications for examinations.
- Number of staff (against agreed establishment levels).
- Breakdowns of income/expenses on various activities (annual scientific meeting, other continuing medical education events, examinations, capital expenses, other operational projects).

These monthly statements are reviewed during the year by council as well as the ANZCA Council Executive (ANZCA's president, vice-president, executive director of professional affairs and chief executive officer).

Obviously, an individual councillor's ability to interpret such information varies.

Council has therefore undertaken a number of steps to ensure that there are informed decisions regarding the financial status of ANZCA. For example, council conducts regular sessions with the Australian Institute of Company Directors (AICD) specifically on the financial duties of a director. Many councillors undertake further training with the AICD. It should be pointed out that the CEO of ANZCA (who attends council) has a high degree of financial literacy.

The governance reports generated by the Finance unit are also reviewed by the FARM Committee (see www.anzca.edu.au/documents/finance-audit-and-risk-management-committee-terms-for-terms-of-reference). The FARM committee is constituted in accordance with regulation 2 (see section 2.24 at www.anzca.edu.au/resources/regulations/regulation-2) and meets face-to-face four times a year and also by teleconference as required.

Among its terms of reference, FARM assists council with reviewing the governance reports with the CEO and the general



manager, finance present at the meeting, reviews the annual budget prior to council approving it (again with the CEO and general manager, finance present) and reviews the annual statements for the annual general meeting prior to council "signing off". The review process of the annual statements involves a face-to-face meeting with the external auditors.

FARM will also assess the performance of the external auditors and make recommendations to council regarding the ongoing relationship with that company.

FARM also engages an internal auditor (with approval from council) to review the operations within the College. Recently, it has been reviewing IT systems within the College as well as management of finance, again within the College.

As part of its terms of reference, FARM generates and maintains a risk register/matrix for the College. It covers such issues as workforce, catastrophic IT failures, and workplace safety issues among other risks. Part of the function of such a risk register/matrix is to ensure that appropriate "controls" are in place and that they have been tested. For example, FARM will ask the head of IT if there were to be a catastrophic IT failure, "do we have the controls/backups and when were they last tested?"

Lastly, the Investment Committee has become a sub-committee of FARM, partly because of the identified risk of a loss of income and/or capital from the College's investment portfolio. FARM has now met with JB Were, the external financial advisors for the College and, with the Investment Committee, is reviewing the investment portfolio policy and strategy.

Dr Richard Waldron
Honorary Treasurer, ANZCA

What's new in the library

New journal in the library collection – PAIN Reports

PAIN Reports is an official publication of the International Association for the Study of Pain (IASP). An open access multidisciplinary journal that publishes continuously, *PAIN Reports* promotes a global, rapid, and readily accessible forum that advances clinical, applied, and basic research on pain. The online journal publishes full-length articles as well as brief reports, reviews, meta-analyses, meeting proceedings, and selected case reports. Access *PAIN Reports* through the following link: <http://journals.lww.com/painrpts/pages/default.aspx>

Check out more journals on pain through the ANZCA Library's online journal list: www.anzca.edu.au/resources/library/journals

Online book collection expanded – access anywhere, anytime

AccessMedicine has expanded coverage for 2017 with over 70 additional online textbooks!



AccessMedicine is a comprehensive online medical resource, providing a large number of the basic clinical science texts, with optimised content for any mobile device. Key features of interest include:

- Textbooks.
- Educational tools: Custom curriculum, self-assessment, interactive learning modules.
- Multimedia: Images, procedural and conceptual videos.
- Personalised access via a MyAccess account to track progress and bookmark content.
- Practice tools: Medical calculators, current practice guidelines in primary care, drug database, Diagnosaurus (DDX) differential diagnosis tool.

This resource can be accessed through the Library's E-books webpage (www.anzca.edu.au/resources/library/ebooks), or directly via this URL: www.accessmedicine.com.ezproxy.anzca.edu.au/

Want to know how to make the most of the ANZCA Library?

Think
ANZCA 2017 ASM
May 12-16, Brisbane



The library will be running two workshops "Beyond Google: An introduction to the ANZCA Library" and "Even further beyond Google: Advanced search techniques" during the 2017 ANZCA Annual Scientific Meeting (ASM) in Brisbane. Whether you haven't used the ANZCA Library before or would like to learn more advanced searching techniques and tips and tricks, these workshops will suit your information needs. Sign up to one or both workshops when you register for the ASM!

Library staff will again be available at the ANZCA booth during the 2017 ASM, ready to show you all the resources and answer your burning information questions. A number of publishers will be participating at the booth, providing promotional material and information about the ANZCA Library subscribed resources, plus your chance to provide feedback.

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 highlights the resource of the month, as well as any new books and articles of interest as soon as they hit the collection.



New apps – read ANZCA Library journals from your mobile device

BrowZine



The library is trialling a new product called *BrowZine*. *BrowZine* allows you to browse, read and follow the complete ANZCA journal collection in a beautiful visual display. The trial will run throughout 2017 and feedback is welcome via library@anzca.edu.au.

With *BrowZine*, you can:

- Browse and read journals: Browse thousands of top journals by subject, easily review tables of contents, and download full articles.
- Stay current with MyBookshelf: Create a personal bookshelf of titles to follow and receive new article notifications.
- Access on any device: Easily access *BrowZine* from your iOS and android device and on the web to stay up to date wherever you are.
- Save and export articles: Use the *BrowZine* app to save articles for off-line reading or export to services such as *DropBox*, *Mendeley*, *RefWorks*, *EndNote*, *Zotero*, *Papers* and more.

Set up your free *BrowZine* account directly through this URL: <http://browzine.com/libraries/1231/>

Read by QxMD



Following a successful trial in 2016, and thanks to all the feedback from Fellows and trainees, the library is pleased to announce that we now provide an ongoing subscription to the *Read by QxMD* app.

ANZCA and FPM Fellows and trainees have taken up *Read* app with great gusto as indicated by the usage at the end of the trial. During the trial, over 590 ANZCA/FPM Fellows and trainees registered for the app, over 46,000 abstracts were viewed, nearly 16,000 articles were read, and about 1500 articles were emailed from the program.

Registered users	590
Abstracts viewed	46,000+
Papers viewed	16,000
Articles emailed	1500

Read by QxMD aims to provide a single place to keep up with new medical and scientific research. It is user friendly and displays content in the style of a personalised digital journal. Simply select "Australian and New Zealand College of Anaesthetists" from the list of institutions to link direct to ANZCA Library full-text articles.

Download the free *Read by QxMD* app directly via www.qxmd.com/apps/read-by-qxmd-app.

Details for both apps can be found on the Apps Library Guide: <http://libguides.anzca.edu.au/apps>

Spotlight on: Indigenous Health resources



The Indigenous Health Library Guide highlights resources such as podcasts, recent articles, networks, and online learning related to Indigenous health in Australian and New Zealand.

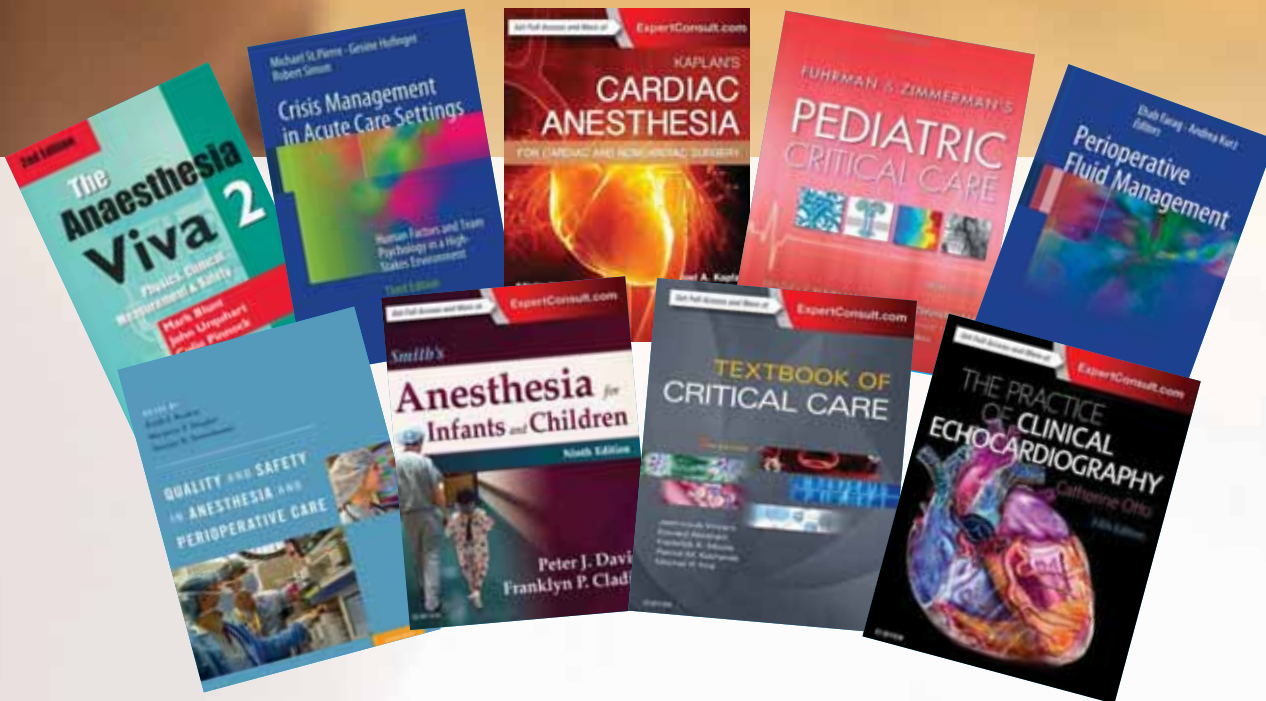
The visual display of resources is updated regularly and features:

- A series of podcasts developed by ANZCA Fellows to provide an introduction into working with Indigenous patients.
- *Perioperative Mortality in New Zealand: fifth report of the Perioperative Mortality Review Committee* (the POMRC). Report to the Health Quality & Safety Commission New Zealand (June 2016).
- Indigenous teaching and learning cases to test yourself.
- Books to support the one of the roles in practice – health advocate.

Access this Library Guide here: <http://libguides.anzca.edu.au/indigenous>



New books for loan



eBooks can be accessed via the ANZCA Library website: www.anzca.edu.au/resources/library/ebooks

The History of Anesthesiology Reprint Series online

Now available online through the Wood Library-Museum E-book collection, the Reprint Series is a collation of important and historic articles that have had a significant impact on anaesthesia. The collections vary on topics from *Endotracheal anesthesia* to *Famous patients in anesthesia* to *Ideas that failed* and were originally reprinted in the 1970s. The Wood Library-Museum have recently digitised the series as well as a number of other noteworthy anaesthesia texts.

Access directly via this URL: www.woodlibrarymuseum.org/library/ebooks or search the content through the ANZCA Library catalogue: www.anzca.edu.au/resources/library/library-catalogues

The anaesthesia viva 2: physics, clinical measurement & safety

Blunt, Mark; Urquhart, John; Pinnock, Colin. -- 2nd ed -- London: Greenwich Medical Media, 2003.

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

St. Pierre, Michael; Hofinger, Gesine; Simon, Robert. -- 3rd ed -- Switzerland: Springer, 2016.

Kaplan's cardiac anesthesia: for

cardiac and noncardiac surgery Kaplan, Joel A [ed]; Augoustides, John GT [ed]; Maneck, Gerard R, Jr [ed]; Maus, Timothy [ed]; Reich, David L [ed]. -- 7th ed -- Philadelphia, PA: Elsevier, 2017.

Fuhrman and Zimmerman's Pediatric critical care: Pediatric critical care

Fuhrman, Bradley P [ed]; Zimmerman, Jerry J [ed]; Carcillo, Joseph A [ed]; Clark, Robert SB [ed]; Relvas, Monica [ed]; Rotta, Alexandre T [ed]; Thompson, Ann E [ed]; Tobias, Joseph D [ed]. -- 5th ed -- Philadelphia, PA: Elsevier, 2017.

Perioperative fluid management

Farag, Ehab [ed]; Kurz, Andrea [ed]. -- Cham, Switzerland: Springer, 2016.

Quality and safety in anesthesia and perioperative care

Ruskin, Keith [ed]; Stielger, Marjorie P [ed]; Rosenbaum, Stanley H [ed]. -- Oxford; New York: Oxford University Press, 2016.

Smith's anesthesia for infants and children

Davis, Peter J [ed]; Cladis, Franklyn P [ed]. -- 9th ed -- St. Louis, Missouri: Elsevier, 2017.

Textbook of critical care

Vincent, Jean-Louis [ed]; Abraham, Edward [ed]; Moore, Frederick A [ed]; Fink, Mitchell P [ed]. -- 7th ed -- Philadelphia, PA: Elsevier, 2017.

The practice of clinical echocardiography

Otto, Catherine M [ed]. -- 5th ed -- Philadelphia, PA: Elsevier, 2017.



Books can be borrowed via the ANZCA Library catalogue: www.anzca.edu.au/resources/library/library-catalogues

The American Society of Anesthesiologists: a century of challenges and progress

Bacon, Douglas R [ed]; McGoldrick, Kathryn E [ed]; Lema, Mark Joseph [ed]. -- Park Ridge, Ill.: Wood Library-Museum of Anesthesiology, 2005.

Contact the ANZCA Library

www.anzca.edu.au/resources/library

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Fax: +61 3 8517 5381

Email: library@anzca.edu.au

Surgery in remote areas needs more ‘quiet achievers’



“Anaesthetists are often considered pragmatic, adaptable, patient, and gentler sorts, who quietly keep things moving.”

While surgeons get more of the pro bono limelight, surgery in the developing world relies equally on the goodwill of anaesthetists who volunteer.

Many times, I’ve seen anaesthetists give up their income, family and home comforts for a week or more, and venture on a self-paid journey to work on a surgical mission to a remote part of the Solomon Islands. Yet not much is said about these quiet achievers. Often the surgical heroics take the limelight. In fact, frequently surgical missions are described by the surgeon visiting, with the anaesthetist viewed more or less as an add-on.

This is certainly not my view. Surgeons have for many years had the reputation of being somewhat gruff or prickly, on the exterior, with a no-nonsense approach and a focus on decisiveness and efficiency.

Anaesthetists, on the other hand, whether as a result of survival or self-selection, are often considered to be more pragmatic, adaptable, patient and gentler sorts, who quietly keep things moving and are often not in the limelight. But ask any patient what scares them most before an operation, and it’s always the possibility of not waking up from their anaesthetic.

The anaesthetist holds the patient’s life literally in their hands. The importance of the anaesthetist to the team was powerfully

underlined during my last surgical visit to Gizo, in the far western remote province of the Solomon Islands, when our anaesthetist did not turn up due to an unexpected death in his family.

This was a major “spanner in the works” to our surgical mission. Working without an anaesthetist is a bit like trying to tie your shoe laces with one hand – possible, but extremely clumsy!

And for a few days we were limited to basic surgery only suitable under local anaesthetic infiltration. When our anaesthetist turned up three days later we were very grateful and respectful, with no complaints at all!

The developing world, and Solomon Islands in particular, pose unique challenges to the anaesthetist, requiring nimble adaptation and clever resourcing. This is not quite the case for the surgeon where a “knife is a knife”. In the developing world, there are far fewer investigations and drugs available, with monitoring and post-operative support far less than what is standard in Australia and New Zealand.

Performing surgery under regional anaesthesia has a particular application in the developing world, with most ANZCA anaesthetists now well-trained in the skilful use of epidurals, spinals and regional blocks. This avoids the need for general anaesthesia, and is safer in remote areas, where failure to wake promptly from general anaesthetic could be a major concern.

Over the years, the contribution that

volunteering ANZCA-trained anaesthetists have made in teaching safe anaesthetics to local doctors in the Solomon Islands, and in accompanying volunteer surgeons, has been steadily increasing. We are extremely grateful to this talented, humble and adaptable group of specialists – at the end of the day, it is they who make us surgeons look good.

Dr Sepehr Lajevardi,
Nepean Hospital, NSW

Dr Sepehr Lajevardi is an advanced plastics surgical trainee at Nepean Hospital in Western Sydney and elected Treasurer of DAISI (Doctors Assisting In Solomon Islands). Dr Lajevardi first volunteered at Gizo Hospital in December 2015, and has a particular interest in plastic reconstructive surgery. He is always looking for volunteer anaesthetists to accompany him on surgical trips, with a number scheduled for next year. Dr Lajevardi can be contacted by emailing staff@daisi.com.au.

Above from left: Anaesthetists Dr Geoffrey Tweedale and Dr Adam Hill at Gizo Hospital; Anaesthetist Jonathan Lau with surgeon Carina Chow doing hernia repair under spinal at Gizo Hospital, in the western province of the Solomon Islands.

A new plan for returning to work

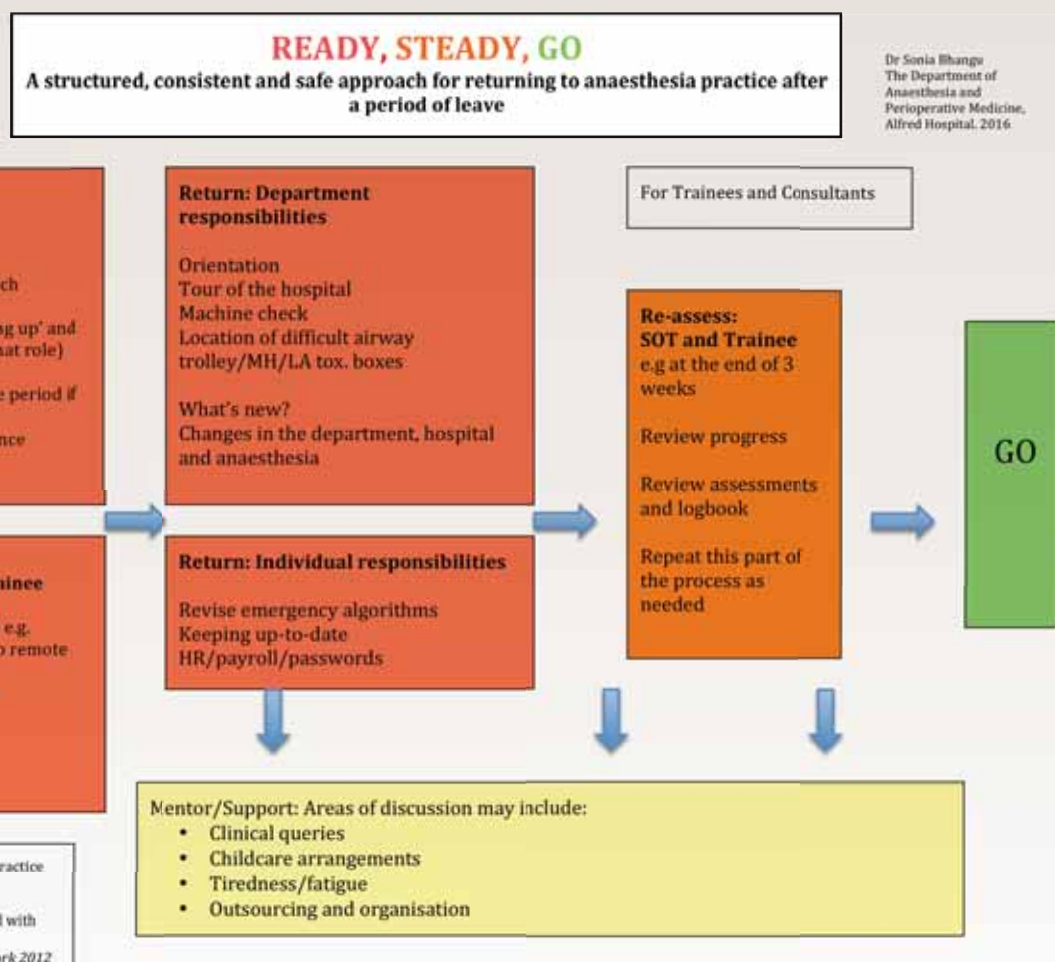


A structured process with mentors supports anaesthetists returning to work after a period of leave.

A “traffic light” pathway is being used in our anaesthetic department to help all trainees and consultants returning to work and the supervisors managing the return-to-work process. It aims to provide a consistent, structured and safe approach for all those returning to work after a period of leave.

Over recent years, there has been increasing work done about returning to anaesthesia practice after a period of leave¹, including the recent ANZCA Return to Anaesthesia Practice document². In addition, some UK hospitals have developed their own local return pathways³.

This pathway is notable for being highly visual yet simple and user-friendly. There are three main stages – “Ready, Steady and Go”, which are traffic-light coloured, making it a useful aide memoire.



Getting ready

For a planned absence, the supervisor and individual have a pre-absence meeting to discuss the proposed length of leave and the position to which the individual is expected to return. The discussion also includes arranging keeping in touch (KIT) days, continuing professional development (CPD) exercises and refresher courses during the leave period, if so desired by the individual.

Six to 10 weeks pre-return, a face-to-face meeting occurs between the individual, rota maker and supervisor, and a more specific return to work plan is devised. We use the template of three weeks of one-to-one supervision and no remote on-calls when the individual has been off work for 12-18 months. A small pool of consultants should provide this supervision in the first three weeks.

It is important that the individual and department have a clear plan in place for first day back, and that the returnee is given adequate time to re-familiarise themselves with key equipment and hospital layout.

Getting steady

A variable amount of time will be spent in this phase. The review part of the return to work period between supervisor and returnee may need to be repeated, depending on many factors such as the amount of time away and the level of practice beforehand.

Go

Again, after a variable amount of time, the returnee will feel ready to head closer towards full resumption of normal pre-leave practice.

The stages in our pathway are broadly similar to the three stage return process recently described by ANZCA².

This pathway incorporates ongoing mentoring to further help bridge the gap between going back to work and a full return to normal practice. A pool of experienced mentors, all anaesthetists,

are available to discuss both clinical and non-clinical issues.

This traffic light system provides a clear, practical, “on the shop floor” approach to the return-to-work period. It is designed to be to be paperwork light and provides a template for smooth integration to pre-leave activity levels in a structured, supportive way that can be easily varied according to individual needs.

During the early return phase, patient safety and welfare of the individual anaesthetist are priority, and our informal mentoring process is crucial in bridging the gap.

Dr Sonia Bhangu, Anaesthetic Fellow
Department of Anaesthesia and Perioperative Medicine,
The Alfred hospital

References:

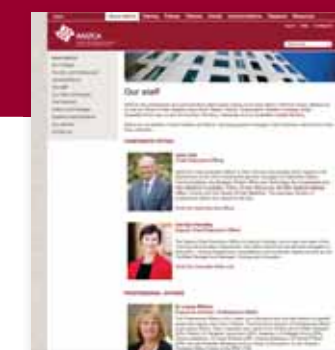
- Returning to Work after a Period of Absence
www.rcoa.ac.uk/system/files/ReturnToWork2015.pdf
(accessed November 2016)
- ANZCA Guidelines on Return to Anaesthesia Practice for Anaesthetists
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(accessed November 2016)
- Return to Training Scheme. Wessex Deanery Policy
www.wessexdeanery.nhs.uk/pdf/Final%20Return%20to%20Training%20Policy%20-%20August%202012.pdf
(accessed November 2016)

Finding ANZCA staff

ANZCA’s website has an updated page to let Fellows and trainees know whom they should contact.

The new page titled our staff introduces the executive staff in charge of the relevant business units and importantly provides information of the services provided within those units.

Some sections include hyperlinks to key departments within ANZCA and there is also a direct email link to the units at the end of each section.



Dean's message



Global Year Against Pain After Surgery

January 19, 2017 saw the launch of Global Year Against Pain After Surgery (more on page 60), backed by the International Association for the Study of Pain (IASP). There needs to be collaboration across medical specialties and beyond in addressing the pre-, intra- and postoperative phases of this common problem'. Specialist pain medicine physicians and anaesthetists are well placed to contribute to education, service planning, assessment, treatment and prevention.

Anaesthetists have particular expertise relevant to the smooth functioning preoperative clinics, the operating theatre and the acute postoperative phase. It is helpful to identify and address risk factors for postoperative pain such as the presence of preoperative pain, opioid use and psychological issues, including anxiety and unhelpful beliefs about the upcoming surgery.

Details of anaesthetic technique are important, and there may also be opportunity to talk with surgeons about the relative risk of different surgical techniques leading to intraoperative nerve injury. Severity of early postoperative pain is a critical risk factor for progression to chronicity, and the anaesthetist again can play a vital role here, via acute pain service intervention and referral, if necessary, to outpatient pain services.

Pain physicians have an important role to play in optimising (often minimising) the dose of any maintenance opioids prescribed pre- or postoperatively,

particularly for patients experiencing chronic non-cancer pain. They can also help to facilitate access, if required, to psychological and physical allied health support.

Education

Both anaesthetists and pain physicians can deliver education about pain after surgery. This year provides an excellent opportunity to run professional development meetings focusing on this topic.

The achievements of the Essential Pain Management (EPM) program are particularly noteworthy in the educational sphere and something of which FPM and ANZCA can be proud.

Between 2010 and 2017, the EPM program has been taught in 51 countries, and conducted 270 workshops with 8517 participants and 82 instructor workshops with 1193 instructors. EPM has made, and continues to make, a profound global impact.

Service design

The design of surgical programs needs to recognise the potential for futile or unnecessary surgery and guard against it. The right of the patient to choose a particular operation needs to be counterbalanced by the responsibility that we share as health professionals to offer the right treatment at the right time.

Application of therapeutic boundaries comes into play here and, in some cases, it may be reasonable to resist a patient's request for surgery and offer instead support for the "hard yards" of lifestyle change addressing thoughts, activity and nutrition. In other cases, the need for surgery may be postponed or surgical outcomes improved if adequate multidisciplinary care is provided preoperatively.

Cannabinoids and post-operative pain

The role of "medicinal" cannabinoids continues to attract attention in the media and community.

Hence it is of interest to consider the potential use of cannabinoids in acute pain. *Acute Pain Management: Scientific Evidence, Fourth Edition*² concluded

that "current evidence does not support the use of cannabinoids in acute pain management".

A new systematic review published this year gives further support to the view that cannabinoids are unhelpful in acute post-operative pain³. Seven studies were identified involving 611 patients. Studies involved dental extractions, radical prostatectomy, hysterectomy, renal surgery, mixed surgery (orthopaedics, gynaecology, urology, plastics and general) and trauma.

In five studies, cannabinoids provided equivalent analgesia to placebo, in one study the analgesia was greater than placebo (a modest but statistically significant effect) and in one study cannabinoids provided inferior analgesia to placebo. In addition when cannabinoids were combined with opioids no synergistic or additive analgesia was noted. In five of the seven studies, adverse effects were more frequent with cannabinoids than with placebo or the active comparator.

The challenge of addressing the multiple dimensions of pain after surgery is worthy of careful consideration and deliberate action by anaesthetists and specialist pain medicine physicians as 2017 unfolds.

Dr Chris Hayes
Dean, Faculty of Pain Medicine

References:

1. Shipton EA. The transition from acute to chronic post surgical pain. *Anaesthesia and Intensive Care* 2011; 39: 824-836.
2. Schug SA, Palmer GM, Scott DA, Halliwell R, Trinca J; APM:SE Working Group of the Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine (2015), *Acute Pain Management: Scientific Evidence* (4th edition), ANZCA & FPM, Melbourne.
3. Stevens AJ, Higgins MD. A systematic review of the analgesic efficacy of cannabinoid medications in the management of acute pain. *Acta Anaesthesiologica Scandinavica* 2017 doi: 10.1111/aas.12851

News

Admission to fellowship of FPM

By examination:

Dr Michael Thomas, FANZCA, Tas.

This takes the total number of Fellows admitted to 440.

Training unit accreditation

Following successful reviews, Precision Brain Spine & Pain Centre, Victoria has been accredited for pain medicine training while Concord Repatriation Hospital, NSW and Westmead Hospital, NSW have been reaccredited for pain medicine training.

FPM trainee survey

In November 2016, FPM trainees were surveyed about bullying, discrimination and sexual harassment during pain medicine training. The response rate was 37 per cent, and the ANZCA Bullying, Discrimination and Sexual Harassment Working Groups are considering the results in the development of a report to Board and Council.

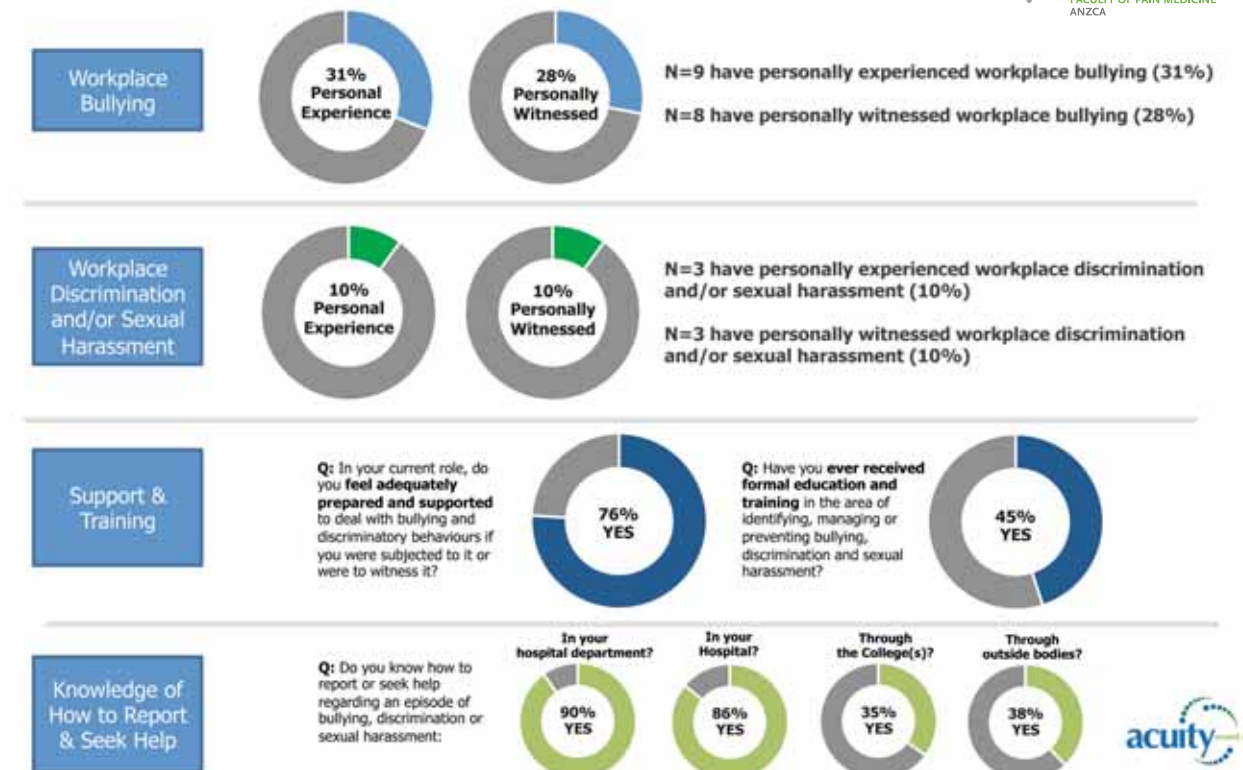
Thirty-one per cent of respondents indicated that they had personally experienced workplace bullying during their pain medicine training, while 28 per cent said they had witnessed it.

Ten per cent had personal experience of workplace discrimination and/or sexual harassment during their pain medicine training, while 10 per cent had witnessed these behaviours.

Three-quarters of respondents – 76 per cent – felt adequately prepared and supported to deal with any bullying and discriminatory behaviours they saw or experienced.

The Faculty would like to thank all those trainees who made time to provide feedback to the Faculty about this important issue. See page 62 for a report on the ANZCA Trainee Committee Survey.

Summary of Key Results



Faculty of Pain Medicine (continued)

Global Year Against Pain After Surgery begins



The Faculty of Pain Medicine united with the Australian Pain Society and PainAustralia to launch 2017 as the Global Year Against Pain (GYAP) After Surgery, which promotes better pain management through professional and community education and increased awareness.

The three organisations issued a joint Australia-New Zealand media release on January 24 to draw attention to the millions of people affected by persistent or chronic pain after surgery, many of whom fail to get appropriate treatment.

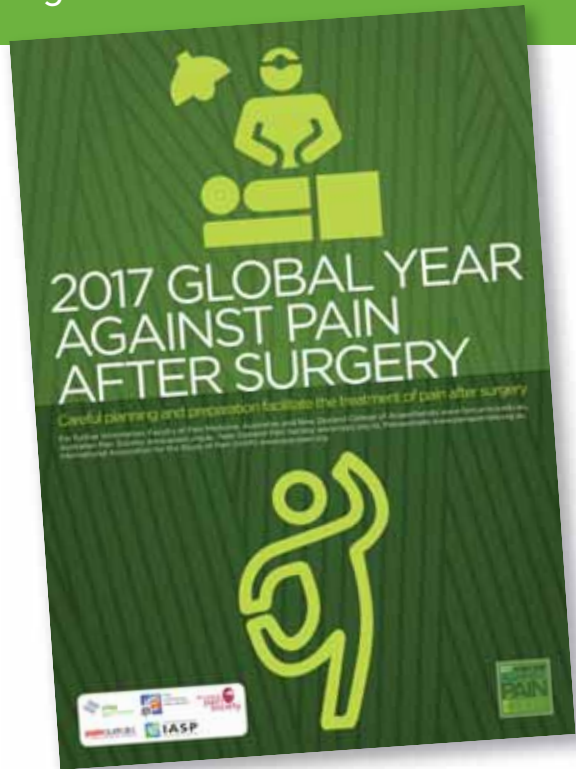
The International Association for the Study of Pain (IASP) reports persistent post-surgical pain can affect as many as one in two patients undergoing major surgery such as amputations, and one in four for all kinds of surgery combined. This is largely the result of nerve damage, and can be due to the original medical problem or the surgery itself. It is identified by symptoms of neuropathic pain such as burning pain, shooting pain, numbness and changes to physical sensation or sensitivity to temperature or touch.

FPM Fellow Professor Stephan Schug, Australasian member of the GYAP taskforce, did several media interviews and told the community that many health professionals are still unaware of the problem.

“In the past, we under-estimated how many people developed chronic pain after surgery and it is still poorly understood,” he said.

“It is critical that doctors are well versed on the matter, because there are ways to reduce the risk.”

There is a strong link between the severity of pain in the 10 days or so after surgery and the development of long-term pain. This means adequate pain relief immediately after surgery



is critical to preventing ongoing pain. Other risk factors for onset of post-surgical pain are pre-existing pain, dependence on opioid medication, anxiety, infection and bleeding, and chemotherapy.

The GYAP aims to encourage government leaders, healthcare organisations and others to support policies that result in improved management of pain after surgery.

The IASP webpage on the Global Year Against Pain After Surgery can be found at www.iasp-pain.org/globalyear.

The page has resources including fact sheets for healthcare professionals and patients; top articles on the subject; FAQs on the GYAP; and suggestions about how to participate and how to follow activities on Facebook and Twitter. There is also a Global Year logo that can be used on websites, event flyers, announcements and other materials, and an auto-signature for email messages.

Karen Kissane
Media Manager, ANZCA

Supervision and feedback a positive experience for trainees

Results of the 2016 ANZCA Trainee Committee Survey indicate a high level of satisfaction among trainees of the ANZCA anaesthesia training program.

Trainee satisfaction with supervision and feedback received during training, the hospital training environment, and the training program, were focuses of the ANZCA Trainee Committee survey which also explored variations in regional areas.

The survey, which was conducted under the direction of the ANZCA Trainee Committee and the Education Training Assessment Development Committee, also included an optional section that focused on bullying, discrimination and sexual harassment.

The survey was distributed to 1484 trainees of the 2013 ANZCA Training Program in late August 2016 and was open for three weeks. The survey response was significantly higher than the previous year, with an overall response rate of 39 per cent.

Acknowledging trainee support

The support of ANZCA trainees and willingness to share information has greatly contributed to the success of the ANZCA Trainee Committee Survey. We are always pleased to receive feedback from trainees and answer any questions related to the survey and results. Please do not hesitate to contact the Education unit via our dedicated email address education@anzca.edu.au.

Dr Adriana Bibbo and Dr Christine Velayuthen
Co-Chairs, ANZCA Trainee Committee (2016)

Michelle McKenzie
Quality Manager, Education, ANZCA

Supervision and feedback received during training

A high proportion of ANZCA trainees agreed or strongly agreed with the following statements about their supervision and feedback:

- The ANZCA Training Program allows my supervisors and me to identify deficiencies in my experience and opportunities for further learning (82 per cent strongly agree or agree).
- The supervision I receive is appropriate for my level of training (95 per cent).
- I am able to use the feedback I receive in the workplace to improve my performance (92 per cent).

Hospital training environment

Survey participants were asked to nominate up to three hospitals worked in during the last 12 months. An overwhelming 96 per cent of ANZCA trainees provided at least one hospital name – with 65 per cent providing two hospital names, and 28 per cent providing three hospital names. Therefore, while a total of 582 trainees completed the survey – the survey has achieved feedback on 1126 hospital placements.

The highest levels of agreement (more than 90 per cent) have been achieved on the following statements:

- There were allowances made to attend Part 1 and 2 courses (94 per cent strongly agree or agree).
- I have had appropriate access to leave (93 per cent).
- My supervisor of training was helpful and actively engaged in my training (92 per cent).
- I felt well supported at my workplace (92 per cent).

While results were positive, there were however, areas where improvement could be made. A notable minority (more than one in six) disagree or strongly disagree with the following statements:

- I have had adequate formal teaching (tutorials) (20 per cent disagree or strongly disagree).
- I have had a balanced roster (for example, hours, overtime, weekends) (17 per cent).
- I have had opportunities to complete specialised study units (17 per cent).

To note, however, strong agreement with each of these statements was also reported (respectively, 30 per cent, 29 per cent – and to a lesser extent 26 per cent for specialised study units). These results suggest there may be significant variation of experiences across hospitals with these particular attributes.

ANZCA Training Program

Moderate majorities agreed with the following statements regarding the training program:

- I am satisfied with the overall usability of the training portfolio system (62 per cent strongly agree or agree).
- I feel the volume of practice targets describe appropriate minimum experience to prepare me for consultant practice (63 per cent).
- Completing the workplace-based assessments provides feedback I can use to improve (64 per cent).
- I find the learning resources on ANZCA Networks helpful for my learning (72 per cent).

Improvements to the ANZCA Training Program

A review of the 2013 ANZCA Training Program was initiated in March 2015 to revise training program documentation to be better aligned, more manageable in size and less complex.

A range of recommendations were approved by the Education, Training and Assessment Executive Committee in June 2015 and April 2016 that include improvements to the training portfolio system (TPS), volume of practice requirements, and workplace-based assessments.

Improving functionality of the training portfolio system

Recommendations have been approved to include additional functionality to the TPS to improve accessibility and usability while recording training progress. Technology enhancements will be released for the 2018 hospital employment year.

Reducing volume of practice targets

The first release of 2013 training program improvements were launched for the 2017 hospital employment year and included a reduction in volume of practice targets that came into effect for Australian and New Zealand trainees on December 5, 2016.

Volume of practice requirements for specific skills in clinical fundamentals and specialised study units were reduced to focus trainees on achievement of the required learning outcomes rather

than meeting the minimum assessment targets. Further volume of practice target reductions will be released for the 2018 hospital employment year. A summary of the current and future volume of practice targets is located on the 2013 training program webpage.

Addressing workplace-based assessments

As part of the second release of improvements to the training program for the 2018 hospital employment year, recommendations have been approved to:

- Improve the delivery of workplace-based assessments to provide more meaningful and regular feedback.
- Update the workplace-based assessments forms to better reflect the emphasis on formative assessment.

Furthermore, development of workplace-based assessment support resources are under way to provide supervisors of training, assessors and trainees with knowledge and practical advice to use workplace-based assessments to support the learning and development of individual trainees.

Improving search and presentation of Networks

A project is under way to improve the search function of content within Networks to improve the platform's usability. The enhanced user interface will be released early this year.

Trainee survey – key findings (continued)

ANZCA trainees surveyed on BDSH

The optional bullying, discrimination and sexual harassment (BDSH) section of the ANZCA Trainee Committee survey was completed by 95 per cent of respondents.

Trainees were asked whether they had directly experienced or witnessed BDSH in the last 12 months.

Information was sought about the perpetrators, what action was taken and how effectively the issue was resolved. Finally, respondents had the option to indicate whether they wanted further contact with the College regarding any concerns.

The survey included a clear definition of BDSH in each relevant question, and also provided information on where to report events or seek assistance, including contacting the College.

Workplace bullying

In the past 12 months, close to one in three (30 per cent) ANZCA trainees indicated they have personally experienced workplace bullying and a greater proportion (54 per cent) have witnessed it.

Incident analysis showed that registrar anaesthetists were more likely to be the recipients of bullying by consultant anaesthetists, and more likely to witness bullying of registrar anaesthetists and surgeons by consultant anaesthetists and surgeons. The majority of these incidents were reported as ongoing and no action had yet been taken to resolve them.

Similar results were reported in the BDSH section of the 2016 Graduate Outcomes Survey of new ANZCA and FPM Fellows; 34 per cent of respondents indicated they had personally experienced workplace bullying and 59 per cent personally witnessed it in the last three years.

Furthermore, both of these survey results were not very different from figures published by the Royal Australasian College of Surgeons and indicates that despite the different clinical supervision structures in the ANZCA Training Program, an unacceptably high level of workplace bullying is occurring.

Workplace discrimination and/or

sexual harassment

A notably lower proportion of ANZCA trainees reported having experienced or witnessed discrimination and/or sexual harassment in the workplace in the past 12 months, relative to those who reported workplace bullying.

One in eight (13 per cent) trainees recalled being personally subjected to discrimination and/or sexual harassment in the workplace, while 18 per cent indicated that they have witnessed it.

Support and training

Close to six in 10 (58 per cent) ANZCA trainees feel that they are adequately prepared and supported to deal with bullying and discriminatory behaviours if they were subjected to it or were to witness it in their current role.

Knowledge of how to report and seek help

Overall, the majority (84 per cent) of ANZCA trainees indicated that they would know how to report or seek help regarding an episode of BDSH in their hospital department, however, proportions decrease to 53 per cent regarding reporting through college(s) and 37 per cent through outside bodies.

RACS and ANZCA join forces against BDSH



The presidents of ANZCA and the Royal Australasian College of Surgeons (RACS) have signed a letter of agreement that confirms a collaborative approach toward building respect in the medical workplace and eliminating bullying, discrimination and sexual harassment (BDSH).

RACS President Mr Philip Truskett said research has shown that bad behaviour has a negative impact on the whole team and not just the people at which it's directed. The agreement is an important step towards improving patient safety and work environments.

"It is a shared commitment to providing high quality training and a safe shared working environment to our respective trainees, Fellows and international medical graduates," Mr Truskett said.

ANZCA President Professor David A Scott said that RACS was

to be commended for the leadership they had shown in taking significant steps to address this important issue.

"Anaesthetists and surgeons work closely together on a daily basis. A collaborative approach is the most effective way to improve workplace behaviours and make workplaces appropriately respectful.

"This commitment is underpinned by our collective objectives of advancing training, education, research and professional standards in our respective specialties, and our sharing of resources and educational opportunities is a major step forward in making our workplaces safer for all."

Workplace bullying



N = 165 have personally experienced workplace bullying (30%)

N = 298 have personally witnessed workplace bullying (54%)

Workplace discrimination and/or sexual harassment

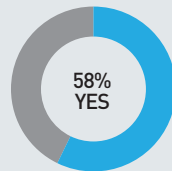


N = 298 have personally witnessed workplace discrimination and/or sexual harassment (13%)

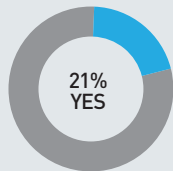
N = 99 have personally witnessed workplace discrimination and/or sexual harassment (18%)

Support and training

Q: In your current role, do you feel adequately prepared and supported to deal with bullying and discriminatory behaviours if you were subjected to it or were witness it?



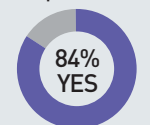
Q: Have you ever received formal education and training in the area of identifying, managing or preventing bullying, discrimination and sexual harassment?



Knowledge of how to report and seek help

Q: Do you know how to report or seek help regarding an episode of bullying, discrimination or sexual harassment:

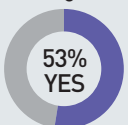
In your hospital department?



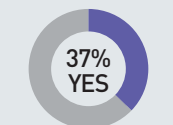
In your hospital?



Through the College(s)?



Through outside bodies?



Commitment from the College

The College has followed up survey respondents that requested contact regarding concerns, advising on support and/or improving information. Should assistance be required, please access the following resources:

- ANZCA supervisors of training, department heads and welfare officers.
- Doctors welfare pages on the ANZCA website (including Welfare of Anaesthetists Special Interest Group information – www.anzca.edu.au/resources/doctors-welfare).
- ANZCA's chief executive officer – ceo@anzca.edu.au.

Western Health study explores finding the right trainees

Selecting suitable trainees into the highly competitive, rigorous field of anaesthesia will become easier thanks to an innovative Western Health study.

To choose the right registrars, recruiters are moving away from traditional, standard methods to focus on candidate performance in a high-pressure simulated medical crisis, leadership and communication skills, and personality testing.

Led by Dr Elizabeth Hessian, Deputy Director of the Department of Anaesthesia and Pain Medicine at Western Health, this new approach looks at alternative ways to recruit to the training program.

Trainee selection has traditionally relied on the standard methods of curriculum vitae, letters of recommendation and interview, but these can be poor predictors of future performance.

“Entry into anaesthesia training is highly competitive, and we want to ensure that our patients are cared for by anaesthetists who have been optimally selected for their suitability to train and work in this area,” Dr Hessian said.

“Evaluation of CV, references and interview provides a lot of information about candidate suitability, but sometimes we have situations where candidates we know are good in the theatre setting fail to obtain entry because they do not interview well.”

The 30 candidates shortlisted for interview with the North Western Anaesthesia Training Scheme were put through their paces during the selection day, held last September at the Western Centre for Health Research and Education at Sunshine Hospital.

The process included an interview; high-pressure simulated medical crisis; computer-based personality test; and feedback survey.

Department of Anaesthesia investigators closely looked at non-technical skills including leadership, teamwork, resource

Above: Anaesthesia investigators from left: Dr Adriano Cocciantie; Dr Martin Nguyen; Dr Candida Marane; Dr Elizabeth Hessian and Dr John Ozcan.



management and situational awareness.

Simulation is increasingly being used as an important component of clinical education at Western Health and this study follows on from the recent research into the use of simulation for selection of critical care trainees.

Candidate Dr Jane Doan said the process gave her the opportunity to show the leadership and communication skills she would bring to the role.

“An interview doesn’t show what kind of trainee you will be and how you will react to a stressful situation but this process, especially sim training, does,” she said.

Correction

The list of candidates in the successful candidates listing for the final fellowship examination (August/October 2016) in the 2016 December *Bulletin* contained a spelling error. The name of New South Wales candidate William Lindsay Dey was incorrectly spelt. Our apologies to Dr Dey.

Course for non-technical skills



A pilot study found educators enthusiastic about a new way to assess trainees’ cognitive and interpersonal abilities.

Introduction

Anaesthetists as educators are often familiar with the assessment of trainees’ technical proficiencies, as this is part of our training. However, in modern anaesthesia practice the assessment of technical skills alone is not enough. To train high-calibre anaesthetists, we need to consider the assessment of non-technical skills, in an objective, standardised and reproducible manner.

These non-technical skills can be divided into two sub-groups:

- Cognitive or mental skills.
- Social or interpersonal skills.

These skills are implicit in good anaesthetic practice; however, up until recently, they have not featured explicitly in the formal assessment of trainees.

In 2003 a collaborative team from Scotland developed the Anaesthesia Non-Technical Skills (ANTS) behavioural marker system for the assessment of Non-Technical Skills (NTS). These behavioural markers may be defined as “observable, non-technical behaviours that contribute to superior or sub-standard performance within a work environment”.

A one-day course – ANTS – has since been developed and endorsed by the Royal College of Anaesthetists. It is designed for those in an educational supervisor role wishing to become more familiar with using the ANTS framework for observation and feedback.

ANTS in Australia and New Zealand

To date, there has been no course that teaches the ANTS framework in Australia or

New Zealand, so the faculty lead was keen to develop an Australian ANTS course. A pilot ran on July 26, 2016 at Fiona Stanley Hospital in Western Australia. It was attended by nine candidates from seven different WA hospitals.

This required three steps:

- Close collaboration with the ANTS development group in the UK.
- Recruiting an enthusiastic and motivated anaesthetic faculty with knowledge of behavioural marker systems.
- Logistical and organisational arrangements.

The course was for supervisors of training, aiming to assess their perceptions of the course and its applicability to the ANZCA training scheme. It consisted of short presentations on the four categories of the ANTS framework (situation awareness, decision making, task management and team working), followed by videos of simulated clinical scenarios showing behaviours relating to each category.

These were then discussed in small groups to help participants link and rate behaviours to categories within the framework using the ANTS tool. The day ended with a discussion about using ANTS in clinical practice, with tips and suggestions for empowering assessors to use ANTS in the workplace.

Future direction

The faculty’s vision for the future is to further establish the course and integrate the framework into the ANZCA curriculum of training.

Dr Anthony Eidan (Faculty Lead), **Dr Trevelyan Edwards**, **Dr Matthew Harper**
Fiona Stanley Hospital, Perth

Dr Angela Palumbo, **Dr Edward Mellanby**
Sir Charles Gardner Hospital, Perth

Comments from candidates

“Excellent course overall, institutional/ College level uptake will be important.”

“Course should be introduced early in training.”

“Given me more structure to assess the ANTS with my trainees.”

“Really good, should be compulsory for wider multi-disciplinary team.”

“Excellent, appropriate level. Applicable to clinical practice.”

“Great faculty, clear goals, well run day.”

“Excellent collegiate atmosphere with interesting discussions.”

Acknowledgement:

We thank the Royal College of Anaesthetists and Dr N Maran, Dr P Milligan and Dr R Glavin from the Scottish Centre for Simulation and Clinical Human Factors for their support with supplying the materials for the course. We are indebted to our faculty, who often attended in their free time.

References:

1. RCoA, Anaesthetists as Educators, ANTS course.
2. Fletcher G, Flin R, McGeorge P, Galvin R, Maran N, Patey R. Anaesthetists’ Non-Technical Skills (ANTS): evaluation of a behavioural marker system. *British Journal of Anaesthesia* 2003; 90: 580-8.
3. Fletcher G, McGeorge P, Flin R, Galvin R, Maran N. The role of non-technical skills in anaesthesia: a review of current literature. *British Journal of Anaesthesia* 2002; 88: 418-29.

Above from left: Dr Angela Palumbo, Dr Matthew Harper, Dr Anthony Eidan, Dr Stephen Lamb and Dr Edward Mellanby; small group discussions at the course.

Trekking for charity

Dr Gareth Andrews is an advanced trainee from St Vincent's Hospital in Sydney. Not your average gym junkie, Gareth's idea of an extreme physical challenge is spending a month trekking across the Greenland ice sheet.

He embarks on these incredible journeys not just for the sake of adventure, but in the name of charity. His last expedition to Greenland raised money for the Puffin Magic Foundation, which supports patients with spinal cord injury. Gareth also works with MedWorld, a support network for junior doctors that promotes the importance of physical and mental wellbeing in medical training.

Q: Tell us a bit about your expeditions.

My fascination with the North Pole is deep-seated. Since I was young, the incredible polar explorations of Robert F. Scott and Ernest Shackleton captured me. Five years ago, I did some expedition training courses. I went on treks across the Atacama Desert in Chile and then the Annapurna range in the Himalayas to build experience. Finally, in 2013, I trekked to the Magnetic North Pole across the Arctic sea ice for 600 kilometres unsupported, which means we had no outside help and we carried all our own kit for a month. Our sleds weighed about 80-90 kilograms each. Then I repeated my efforts by crossing the Greenland ice sheet for 580 kilometres from the east to the west coast in 2016.

Q: What motivates you to go on these highly dangerous treks?

It has always been my dream to explore the polar regions. These expeditions really capture the essence of adventure – the wild and the dangerous. However, what I really appreciate is the serenity, the solitude and the unique mental space these tremendous journeys allow me to experience on those rigorous 14-hour days, trekking in subzero temperatures across an endless expanse of ice. I often compose letters to my family in my mind.

It is a combination of uncompromising drive, yearning for extreme physical challenge and the support of my family that keeps me going on these trying journeys.

Q: Your family must play a huge role in supporting you in all of these epic expeditions. Tell us about your family.

My family is my rock. Currently it consists of my wife, Andrea, who is a dietitian, and our naughty cat, Toby. Andrea is very supportive of me going on these trips. Of course, she worries about me, but she is very adventurous herself, so she understands that it is part of who I am.

We are also expecting a baby in November. While this next step as a family won't stop us from taking on new challenges, it will definitely change our perspective.



Above from left: Dr Gareth Andrews; Gareth with "Dave" at the North Pole; Gareth on his skis with a 80-kilogram sled on the Greenland ice sheet.

Q: Have you had any close brushes with death?

One that immediately comes to mind is the time when I was in the Arctic. One night, we woke to a polar bear rummaging through our camp. Polar bears are dangerous creatures that can kill a human with one swipe of its paw. Luckily for us, it just left after investigating the contents of our sleds. In the morning, we found all these dinner-plate-sized paw prints outside the tent. It was quite a confronting experience.

There is another incident that comes close. Just to give you a bit of background, the Greenland ice sheet is like a dome that covers a range of mountains. Towards the edges of the ice sheet, it concertinas off the edge into these big glaciers and forms these huge crevasses. Crevasses are like huge bottomless black holes that can be hidden by a cover of snow. Crevasse rescuing is a crucial skill that every polar explorer is trained in. There was a time when we were quite high in the ice sheet, so we were not expecting any crevasses. Suddenly, I put my foot down, and it felt like my ski had broken. I looked down, and there was a huge crevasse beneath me. I tried my best to scramble out of it and pull myself up.

The sled behind me fell and quickly opened up the crevasse even more. I was very fortunate, as I came very close to falling into a crevasse.

Q: What is something that expeditioners do well in that doctors can learn from?

Polar explorers are very strong communicators. They are polite, kind and unassuming in most of their interactions with others. In extreme environments you rely completely on your team-mates, there is no room for negativity or arguments. It is not a competition between one member and another; everyone is a part of the team. This is an important quality that members of a theatre team would be wise to adopt to avoid unnecessary conflicts.

Q: What are the three things that you will always take

on your expeditions?

A sense of humour, a compass and "Dave" – a yellow duck that my mother gave me for an expedition to Borneo when I was 18.

Q: Do you have role models in either extreme adventures or medicine?

Sir Chris Bonington is my hero in extreme adventures. He is an extraordinary British mountaineer who climbed Mount Everest several times. As an example of how inspiring he is – Bonington completed the arduous climb of The Old Man of Hoy to celebrate his 80th birthday. He just never gives up!

In medicine, my parents are my role models. My mother is an obstetrician and my father is a general practitioner. They are both adored by their patients. I aim to one day offer as high quality care to my patients as they have given to theirs.

Q: What are your plans for the future?

Eventually, I would like to have a balance between retrieval medicine and clinical anaesthetics based in Sydney. I look forward to doing a fellowship in the UK in the next couple of years. In the meantime, I plan to continue exploring the world's wild places working with MedWorld and fundraising for charities such as the Puffin Magic Foundation.

Dr Faith Wang
ANZCA trainee

Tracheostomy training saves lives



An innovative safety simulation course is reaping rewards in Western Australia.

It's 6pm, you're the duty anaesthetist and you're called urgently to a ward. When you arrive you find the patient is blue; they have a tracheostomy. Do you know what to do? Are you able to assess the tracheostomy? What are the people around you able to do? There are no ENT surgeons on site. How do you resuscitate the patient?

Fiona Stanley Hospital (FSH) is a new tertiary hospital in Perth, WA. Patients with tracheostomies are managed on all wards, so all staff may care for these patients and, hospital-wide, the workforce must be knowledgeable, skilled and experienced in tracheostomy management.

Tracheostomy complications and emergencies can result in significant morbidity and mortality; up to 1 per cent die from complications and, in NSW, a catastrophic event involving a patient with a tracheostomy occurs approximately every six weeks¹. There is increasing evidence demonstrating the relationship between staff training and the reduction in and prevention of significant adverse events. A growing number of tracheostomies are performed in hospitals due to increased demands for intensive care unit (ICU) services. Pressure for ICU beds means more patients are transferred to wards with tracheostomies.

The FSH Tracheostomy Safety Simulation Course started in 2015, devised by expert clinicians dedicated to the safer management of patients with tracheostomies. Senior staff from anaesthesia, speech pathology, nursing,

physiotherapy, ear nose and throat surgery and allied health education created a novel program comprising interactive lectures and workshops, followed by high-fidelity emergency simulation training with structured debriefing. This course, the first of its kind in Australia, aims to:

1. Improve patient safety.
2. Improve participant understanding of tracheostomy care and management.
3. Increase awareness of a standardised emergency management algorithm.
4. Improve emergency patient care through better crisis resource management and understanding of human factors by improving teamwork, communication and confronting traditional medical hierarchies.
5. Include participants from allied health, medicine and nursing and mandate a team-based approach to training.

In a tracheostomy emergency, every second counts. Staff confronted with such crises may find themselves in unfamiliar territory. Simple interventions can improve a patient's airway and may be lifesaving. We instruct people on an emergency management algorithm created by the internationally endorsed UK National Tracheostomy Safety Project². Our team took on board the project's recommendations in the design, development and implementation of the training program. The course aims to improve the knowledge of staff working with patients with an altered airway, so the right skills are available should tracheostomy crises occur. Standardising

crisis management algorithms, equipment and communication can make overwhelming situations more manageable. We want to empower staff to make safe, sensible, life-saving interventions.

Simulation Fellows from the Department of Anaesthesia, trained in debriefing, were incorporated into the faculty and we developed simulated scenarios to immerse candidates in worsening tracheostomy and post-laryngectomy emergencies. Airway crises are some of the most acute emergencies in hospitals and have the potential to require complex interventions, which can overwhelm response teams. Emergency management is provided by multidisciplinary teams of varying experience, often working together for the first time, in a variety of clinical environments. These factors all have the potential to result in less effective teamwork and crisis management.

In keeping with the FSH model of tracheostomy care, all candidates, regardless of profession, are part of the simulated emergency response team. The scenarios stress candidates in a graded fashion, allowing each of the professional groups an opportunity to lead within a safe learning environment, thus allowing an examination of the human factors that can affect team performance. We employ a highly structured approach to debriefing and use the 'advocacy inquiry' model of questioning 'with good judgment', where debriefers offer clear, perhaps critical, but respectful judgment together with a genuine curiosity to understand why things happen the way they do³. This open, honest and confronting approach has allowed us to identify consistent themes:

- Resistance to the use of and following algorithms.
- Not calling for help early enough.
- Poor communication.
- Poor allocation of team leaders and a resistance of non-medical professionals to lead.
- The disadvantages of traditional healthcare hierarchies and deferring to late-arriving medical staff.
- Non-medical staff resistant to stepping beyond their 'scope of practice' in crises.
- Poor or repeated handovers.
- Unwillingness to remove blocked tracheostomies despite the algorithm.

Safely confronting these themes while debriefing candidates from a wide variety of clinical backgrounds requires skill and is hard work. However, the process is immensely rewarding especially in those "light bulb" moments when colleagues understand what drives each other's behaviours and work together to improve their collective performance. We believe all participants in this learning activity are intelligent, well trained, care about doing their best and want to improve patient care⁴, and agreeing to this way of thinking facilitates the safe learning environment within which we can directly question our actions.

Developing any new project takes considerable time and effort but, despite being in a brand new hospital with new colleagues, we implemented a high-quality training program within six months of opening. We have created an enthusiastic, expert faculty and concentrated on developing our clinical, teaching, simulation and debriefing skills to develop an innovative teaching program, which has to-date trained more than 150 allied health, medical and nursing staff working across acute, rehabilitation and outpatient settings.

The course aims to improve tracheostomy care throughout the hospital and WA, encouraging a culture of clinical best practice; we have seen a marked increase in the presence of patient-specific and emergency algorithm tracheostomy bedhead posters, and the presence of emergency equipment. Feedback continues to be overwhelmingly positive, with all candidates reporting that their knowledge and skills have improved as a result of the course, allowing improved patient management; clinical audit data shows the course is assisting patients to receive best-practice care throughout the hospital. We are now in the exciting position of training clinicians from other hospitals in the metropolitan region, have widened internal candidates to include anaesthetic technicians, and hope to take our training to remote and rural areas of WA. We have recently learned the benefits of our training first-hand. One of our faculty is currently working as an anaesthetist in the UK and when faced with a tracheostomy emergency on a night shift, relied heavily on his simulation training, leading to the survival of the patient.



We believe multidisciplinary team simulation training followed by high-quality debriefing is essential to delivering safer clinical care and we encourage our colleagues to develop their own programs.

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LESSONS FROM AFRICA



There was much to be taught – and learnt – during a six-month anaesthesia fellowship in Zambia.

“Africa will get under your skin”, a friend advised as I was preparing to leave for a six-month Global Anaesthesia Fellowship in Zambia. With little more thought as to what that really meant, my wife and I packed our bags and with two young children, we juggled our way from Melbourne to Zambia.

After arriving in the capital, Lusaka, I wondered at one stage if this friend had been speaking literally. I had heard about the Putzi fly (*Cordilobia anthropophagia*), but now can say I know the sensation of cutaneous myiasis – maggots under your skin! For me, a total of 11, and a memorable experience for my wife who removed them! A real introduction to Africa.

Hospital

Starting work at the hospital delivered another dose of reality. University Teaching Hospital (UTH) is the largest teaching hospital in Zambia and, with a bed capacity of over 1800, provides medical and surgical care for all specialties to the 2.5 million residents of Lusaka and beyond. It is a busy hospital, and places such as the labour

ward are particularly crazy, with 60 to 90 deliveries per day.

The anaesthetic department is staffed by several expat consultants, mostly from Uzbekistan, and non-physician clinical officer anaesthetists. The 24 anaesthetic trainees provide most of the day-to-day anaesthesia service for the 16 operating theatres. The anaesthetic department also is responsible for running the main intensive care unit.

My role at the hospital was as a visiting lecturer with the Zambia Anaesthesia Development Project – a UK Aid-funded project that supports anaesthesia specialist training through a local masters of medicine in anaesthesia (MMed). Anaesthesia specialty training for doctors is new to Zambia, having started in 2011. My time with the project was divided between classroom teaching, clinical supervision and teaching, and quality improvement activities.

The clinical teaching and supervision was, as expected, interesting. The caseload in the operating theatres included many of the routine procedures familiar to an Australian hospital. For example, in the adult elective operating theatres procedures such as TURPs, thyroidectomies, and hysterectomies were common. There were regular operating lists for more

specialised surgery, including paediatric neurosurgery and cardiac surgery.

Emergency surgery included everything from abscess incision and drainage through to major trauma. The emergency obstetric theatres daily had patients with severe pre-eclampsia or eclampsia, uterine rupture, APH, and severe PPH. The lowest Hb from a patient with a PPH I saw there was 18 g/L. Fortunately, she survived. There was no neonatal service for the obstetric theatres, and the anaesthetic team was responsible for neonatal resuscitation.

I worked alongside MMed trainees in the main intensive care unit one day each week. The ICU had 10 beds, with varying levels of working equipment to support each patient. The ICU was especially challenging with a broad range of pathology represented, usually late in the disease process. There were many interesting cases. Examples include a four year old with intermittent seizures – it was discovered that a family member was poisoning her with low-dose organophosphates. And, a patient with severe postpartum pre-eclampsia with pulmonary oedema, initially saturating at 65 per cent who was extubated two days later – a win! It was especially satisfying to have these patients, who did well, among the many patients who presented too late for effective

treatment.

Challenges

Limited resources presented many challenges. Some of these challenges included unreliable anaesthetic machines, no gas monitoring, frequent power outages, limited drug availability, and limited disposables. Suxamethonium and Pancuronium were the only muscle relaxants available. Sometimes the sux did not work at all, as was the case for my first general anaesthetic caesarean for uterine rupture. Opioids were often in short supply, and ampoules of fentanyl would often be divided between multiple patients. Laryngoscopes were hot property, and were sometimes shared by up to three operating theatres. Pathology results were slow and at one stage we went for more than a month without being able to measure electrolytes.

The real challenge in each of these clinical areas was to facilitate optimal learning for the anaesthetic MMed – safe practice with the resources available – while encouraging them to take leadership in improving the systems supporting safe patient care.

Quality improvement

Lack of blood availability was the most common systems cause of perioperative

mortality at the hospital and led to a major quality improvement project for Zambia Anaesthesia Development Project and the University Teaching Hospital’s anaesthesia department.

Lack of blood did not just affect the operating theatres, it was a major issue throughout the hospital. For example, half of the obstetric patients who had a major haemorrhage at the hospital did not have blood available for them; a third of patients with major haemorrhage died. Our project identified sources of significant blood wastage – up to 44 per cent of blood products could not be accounted for after leaving the blood bank. This and many other findings led to us developing a program to address each of the identified problems in close collaboration with a team from the hospital and the Zambia National Blood Transfusion Service.

Alongside our Zambian colleagues, we conducted numerous workshops on blood transfusion and major haemorrhage with nearly 500 health staff from 27

Above from left: Elephants in Zambezi; Dr Nathan Oates teaching one of the many workshops in Kabwe; Senior MMed trainees enrolled in the masters of medicine in anaesthesia; Simulating major haemorrhage in the elective operating theatres.

(continued next page)

LESSONS FROM AFRICA (CONTINUED)



hospitals across Zambia. It was a privilege to be involved with this process, to work alongside a fantastic group of motivated Zambian clinicians and blood bank staff toward a common goal.

Countryside

The Zambian countryside is beautiful. There are spectacular national parks with abundant wildlife to visit, several within a few hours' drive of the capital. The magnificent Victoria Falls – Mosi-oa-Tunya (“*The smoke that thunders*”) is within a day's drive. The easy access to these amazing places was a welcome respite from the busy schedule at the hospital. It was a little surreal to drive for a couple of hours to be immersed in African wildlife.

After one sleepless night listening to hippos wandering around our tent munching grass, I came to accept one thing – camping in the African national

parks is different to Australia! Sometimes the cheap option is just not worth it. As my friend had suggested, there are any number of reasons that Africa gets under your skin. The beautiful countryside and climate, and the majestic and crazy animals certainly contribute. The tragedies and successes in the hospital provide constant source for reflection, and the clinical work with limited resources makes even the straightforward cases more interesting. For me, however, it was the people who really got to me – the great team of anaesthetic trainees, of National Blood Transfusion Service staff, who work in this challenging environment with energy and optimism. Their friendliness and sense of humour belied the difficult tasks they faced every day. Although I was there as a visiting lecturer, I spent as much time learning from my Zambian colleagues as teaching. These people left

me with a real sense of hope for the future of anaesthesia in Zambia. There is much work to be done, but the future looks bright.

Dr Nathan Oates, FANZCA
ZADP International Liaison

Applications for fellowship positions with ZADP in 2018 are now open. For further information or to apply please contact Nathan Oates via nathoates@gmail.com or visit zadp.org.

Above from left: Sundown at Victoria Falls; Tonsillectomy by torchlight – power outages were a frequent occurrence.

Books smoothing children's surgical path



The gift of books for children about to undergo surgery – an initiative by anaesthetist Dr Celine Baber – is reaping benefits.

Books are helping take the minds of South Auckland children off impending surgery, thanks to a Books for Kids initiative by anaesthetist Dr Celine Baber.

Dr Baber, a specialist at Middlemore Hospital in South Auckland until late last year, recognised that hospital and the prospect of surgery can be very frightening for children, and sought a way to alleviate some of that anxiety.

She came up with the idea of providing all children aged between five and 11 who visit the Manukau Surgery Centre for elective surgery with books to take home.

Dr Baber thinks the idea was probably linked to having three young children of her own (now aged five, four and 15 months) and seeing the desperate circumstances of some of those who came to the hospital, which is located in one of New Zealand's most deprived socio-economic areas.

Advice from the Middlemore Foundation (the hospital's charity arm) led to enthusiastic support from Scholastic, a book publisher that also supports charitable giving of books. As well as providing books, Scholastic offer good deals on books for donors who prefer to provide a book rather than give money.

“Anaesthetists love them as the children get them pre-op and take the books with them. It really helps take their minds off what is about to happen.”

The direct work with the children has been handled by the pre-operative nurses at the Manukau Surgery Centre, which provides surgery to 1000 or more children each year. The nurses often also provide post-op care.

“They have been awesome,” Dr Baber says. “They sort and store the books, along with gifting them to the children. They have been fantastic ambassadors for the scheme, and they seem to really enjoy it as well.”

Publicity after the initial sourcing and distribution of books saw the scheme really take off, boosted by an email drive to doctor colleagues. Dr Baber estimates that more than 3000 books have been given out since 2015, the scheme's first year of operation.

Each child is offered a new book to keep, with nurses helping them to choose according to their expressed interests. Siblings who accompany the child to the hospital may also be offered a book, and those in greatest need may be offered a set of books. Some of the children have never owned a book before.

“The kids love them. Their carers love them. Anaesthetists love them as the children get them pre-op and take the books with them. It really helps take their minds off what is about to happen.”

“Probably the ones who love the scheme the most, apart from the kids, are the nurses. They see the hardship suffered by some of the children and there is only a limited amount they can do. Gifting a new book to these children helps them make a positive difference to these children's lives and they get huge pleasure themselves out of the joy it gives the children.”

Dr Baber and her family have moved to Perth this year so her radiologist husband can take up a fellowship.

She has handed over the running of the scheme to anaesthetist colleagues at Middlemore, Dr Helen Firth and Dr Cath Purdy, though she remains involved in a fund-raising capacity.

People who want to support the “Books for Kids” initiative can follow the relevant links on www.middlemorefoundation.co.nz or email booksforkidsnz@gmail.com.

Susan Ewart
ANZCA Communications Manager, NZ

Above: Dr Celine Baker with one of the books she has helped provide to comfort South Auckland children undergoing surgery.

Eminent professors to speak at foundation ASM function



Chat and think big with the investigators!

The ANZCA Research Foundation will once again host its regular cocktail function for friends of ANZCA's research, overseas aid and Indigenous health programs, during the College's annual scientific meeting (ASM) in Brisbane during May.

The function will be held amidst the city views of the Skyroom at the Brisbane Convention Centre from 6.30-7.30pm on Sunday May 14, during the ASM. Our guest speaker, Professor Paul Myles, Director of Anaesthesia and Perioperative Medicine at Alfred Hospital and Monash University, will address the theme of "Thinking Big in Research – from local studies to global impact on clinical practice".

Professor Myles will reflect on the remarkable contribution of ANZCA Fellow-led research on global knowledge and practice in recent years; a trend very worthy of recognition during the College's 25th anniversary year.

Another significant part of the evening will be Professor Barry Baker's inaugural presentation of our exciting new research award targeting provisional and new Fellows, funded by his generous endowment to the foundation.

We are expecting to have many of the foundation's research grant recipients present, from the rising stars to the established investigators with their combined wealth of experience, so it will be a great chance to chat with them personally and learn about their work.

All are welcome, so please consider joining us for what is always a relaxed and enjoyable yet inspiring evening. Tickets are available with conference registration or by contacting the foundation. Please note that attendance is complimentary for all foundation donors.

Australian Executor Trustees

After securing a \$35,000 grant in 2016 from Australian Executor Trustees (AET; a part of IOOF) for the project "Do Bolus intravenous fluids cause Lung Injury: Role of TRPV4 channels" led by Dr Thomas Painter (Royal Adelaide Hospital), Dr Painter and the foundation were interviewed in February by the Australian Centre for Social Innovation, to assist in developing a framework for reporting on outcomes of AET-funded projects.

The foundation was also invited to attend the launch of the 2017/18 AET Discretionary Grants Program at the South Australian Health and Medical Research Institute in Adelaide, on Monday February 27, and will be applying for further funding in this program.

Foundation bequests

Following the significant bequest left to the foundation by the late Dr Elaine Kluver from Southport, Queensland in May 2016, a further two Fellows who have been long-time supporters of the foundation's mission have recently advised their intentions to include bequest gifts in their wills.

The foundation's resources are limited, and we attempt to maximise the allocation of funds to research and education. Bequests and endowment gifts, whether for general research grants or special purposes such as emerging researcher scholarships and post-doctoral fellowships, are therefore crucial for the survival of the foundation's ability to support further development of research and education in the long term beyond the College's formal training curriculum.

The foundation and the College's Finance unit have the capacity to invest these gifts through leading investment managers, allowing donors to generate a legacy of income that supports scientific inquiry for the benefit of anaesthetists, specialist pain medicine physicians and patients.

Subscriptions appeal

The response to the foundation's appeal in the 2017 subscription notices has been very encouraging. Foundation Committee Chair Dr Genevieve Goulding and everyone at the foundation would like to thank those who donated.

At the time of writing, more than \$A50,000 has been raised through this appeal, the most of any subscription appeal to date.

Automatic deductions make giving easier

A reminder that the foundation now offers patrons and other regular donors the facility of automatic donation from Visa and Mastercard, making it even easier to support our important cause. These may be cancelled by the donor at any time. To establish automatic donations, please contact the foundation.

Making a bequest

Any Fellow interested in creating a special endowment, or including a foundation bequest in their wills should contact Rob Packer at the foundation on +61 3 8517 5306 or rpacker@anzca.edu.au.

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

Training site research capability profiled through survey

In June 2015, a working party of the ANZCA CTN Executive conducted a cross sectional survey to capture information on research capacity across ANZCA accredited training sites.

The survey aimed to collect important baseline data from sites in Australia, New Zealand, Hong Kong, Malaysia and Singapore to:

1. Document research capability at sites.
2. Identify research leaders and emerging research leaders to engage and further support.
3. Identify research co-ordinators, their full-time equivalent (FTE) workplace commitment and how they are funded.

The survey was distributed to heads of departments and included sections on research areas, publications, specialist anaesthetists active in research, research heads, leaders and emerging leaders, and research co-ordinators. Department heads were given the opportunity to provide names of research heads, research leaders, emerging research leaders and research coordinators to enable engagement in CTN initiatives.

This survey provides the first research profile of accredited sites and has identified a strong base upon which to build research capability among sites in Australia and New Zealand. In particular opportunities for expansion of research activity in a variety of regions and settings, in the private hospital sector and in regional/rural Australia. We have included some of the key survey findings here that was to be published in *Anaesthesia and Intensive Care* in early March. Thank you to everyone who was involved in the survey and to all our hard working sites participating in our trials, and to the sites that are about to come on board our trials.

Inspiration and motivation

In 2016, the CTN Executive moved the CTN strategic workshop from Queensland to Coogee Beach in Sydney to focus efforts on engaging more sites in NSW in CTN trials (Figure 1). The relocation of the workshop resulted in a 150 per cent increase in attendance from NSW delegates (n=38) compared to the two years prior.

In addition, members of the CTN visited NSW hospitals to meet leaders and emerging leaders to discuss CTN trials. We are pleased that many new NSW sites are about to come on board soon. At the time of the survey, New Zealand had 46 per cent of sites participating in CTN. With many thanks to the efforts of Balanced Anaesthesia Study team based in New Zealand, this has now increased to 50 per cent with Dunedin recently joining our trials.

Research at sites and publications

The survey identified 28 non CTN participating sites (39 per cent) undertaking multicentre research. Furthermore, 33 non CTN participating sites (46 per cent) had published between 2011 and 2015. Therefore, there is untapped resources and skills at these sites that we could draw on to get sites engaged in CTN research.

Workforce capability

Head of research

In the 128 sites or groups of sites that completed the survey, 59 per cent of CTN participating sites had a head of research compared with 17 per cent of sites not participating in research, highlighting the importance of strong research leadership.

Specialist anaesthetists involved in research

In the 128 sites or groups of sites that completed the survey, 93

per cent of CTN participating sites had at least one specialist anaesthetist involved in research compared with 63 per cent of sites not participating in research, indicating that there is potential at non CTN participating sites to upskill to participate in CTN research.

Research leaders and emerging leaders

We identified at least one "research leader" (a person with a research qualification, university affiliation, site chief investigator status for an ANZCA-CTN endorsed study and chief investigator status on a national grant) at 23 (18 per cent) of sites and at least one "emerging leader" (a person with at least two of the research leader attributes) in 46 per cent of sites.

These dozens of emerging leaders need encouragement and support to complete research degrees, gain university affiliations and step up to chief investigator status on ANZCA CTN trials.

Research co-ordinators

The survey identified that a third of sites participating in CTN trials do not have a research co-ordinator. More than half of the research coordinator FTE in these sites was funded by research grants, with further funding coming from hospitals, foundations and industry. The CTN Executive is pleased to have formalised the Anaesthesia Research Co-ordinators Network Sub-Committee chaired by Lauren Bulfin.

This committee will represent over 100 research co-ordinators around the Australia and New Zealand, most of whom are facilitating ANZCA CTN trials. Research coordinators are vital to the success of research departments as they provide the knowledge and expertise to perform critical roles in research and clinical trials, for example, screening patients suitable for studies, consent, recruitment and high quality data follow up.

ANZCA Research Foundation

The survey found that among the sites that reported having a research co-ordinator, 80 per cent of research co-ordinators rely partially or completely on competitive peer-review funding for their employment. We are very grateful to the ANZCA Research Foundation and its donors, whose funding support makes possible the many exploratory studies (including CTN pilot studies) undertaken by Fellows that are critical to gaining competitive funding for major clinical trials.

These studies help develop the investigators and provide the pilot data required for success in securing the large competitive grants needed to run international multicentre trials (for example, RELIEF, ATACAS, Balanced Anaesthesia Study, ROCKeT) that helps sites build a sustainable workforce to answer important clinical questions.

For more information on how to get involved in CTN trials and register for the CTN Strategic Research workshop, August 11-13, 2017 NSW, visit www.anzca.edu.au/ctn.

Karen Goulding
CTN Manager

Professor Kate Leslie AO
Chair, CTN Executive

"The ANZCA Clinical Trials Network (CTN) aims to deliver high quality trial evidence that translates into safe and effective practice in anaesthesia, perioperative and pain medicine."



Key demographics

We identified 207 accredited training sites in mid-2015. Of these sites, 58 (28 per cent) were identified as a site that had participated in recent CTN trials (ATACAS, ENIGMA-II, POISE-II, METS, Balanced Anaesthesia Study and RELIEF).

Figure 1 shows the proportion (%) of ANZCA accredited sites participating in CTN trials in New Zealand (NZ), Hong Kong (HK), Singapore (SIN) and Malaysia (MAL), and by state or territory in Australia.

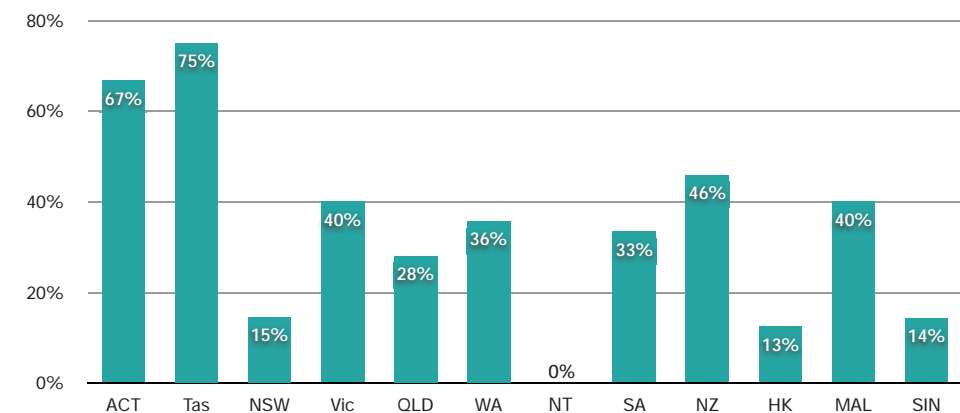
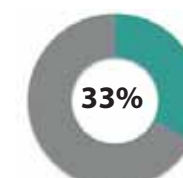
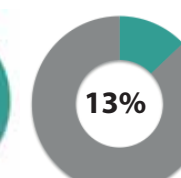


Figure 1

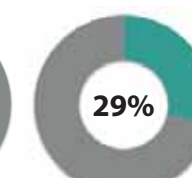
Region (Australia only)



Major cities



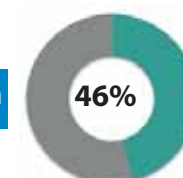
Inner regional



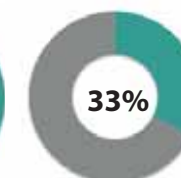
Outer regional

n=35 sites in major cities participated in CTN trials (33%)
n=4 sites in inner regional areas participated in CTN trials (13%)
n=2 sites in outer regional areas participated in CTN trials (29%)
No sites in remote or very remote areas (n=3) participated in CTN trials

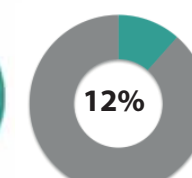
Accreditation



3 years



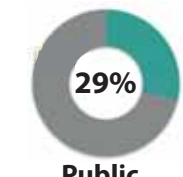
2 years



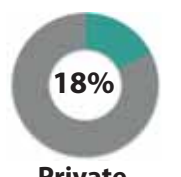
1 year

n=35 sites accredited for 3 years of training participated in CTN trials (46%)
n=14 sites accredited for 2 years of training participated in CTN trials (33%)
n=9 sites accredited for 1 year of training participated in CTN trials (12%)
No sites accredited for 6 months of training (n=11) participated in CTN trials

Sector



Public



Private

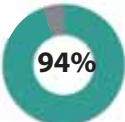


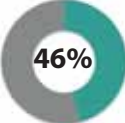






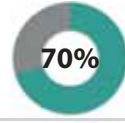
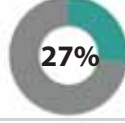


n=55 public sites participated in CTN trials (29%)
n=3 private sites participated in CTN trials (18%)

“This survey provides the first research profile of accredited sites and has identified a strong base upon which to build research capability among sites in Australia and New Zealand.”

Key survey findings

Of the 207 accredited training sites, 167 eligible sites were identified to participate in the survey. The survey was disseminated to the heads of departments in June 2015. A further 24 sites were excluded since the head of department responded together with a partner site. Of the 143 sites eligible to respond, 128 sites responded resulting in an overall response rate of 90 per cent, however, there was a 100 per cent response rate yielded in Australia and New Zealand.

We analysed the responses to compare research capability and workforce between sites participating in CTN trials (n=54) and non participating sites (n=74). Key findings are presented here.

	CTN participating site	Non participating site	
Multicentre research	 94%	 39%	n=51 participating sites undertaking multicentre research (94%) n=28 non participating sites undertaking multicentre research (39%)
Publications	 94%	 46%	n=51 participating sites published at least paper between 2011 and 2015 (94%) n=33 non participating sites had published between 2011 and 2015 (46%)
Workforce capability			
Head of research	 59%	 17%	n=32 participating sites had a head of research (59%) n=12 non participating sites had a head of research (17%)
Research active anaesthetists	 93%	 63%	n=50 participating sites had at least one anaesthetist actively involved in research (93%) n=45 non participating sites had at least one anaesthetist actively involved in research (63%)
Research leaders	 35%	 6%	n=19 participating sites had at least one research leader (35%) n=4 non participating sites had at least one research leader (6%)
Emerging leaders	 70%	 27%	n=38 participating sites had at least one emerging research leader (70%) n=19 non participating sites had at least one emerging research leader (27%)
Research coordinators	 67%	 13%	n=36 participating sites had at least one research coordinator (67%) n=9 non participating sites had at least one research coordinator (13%)

Museum activities for 2017

One of the big activities for 2017 is putting together a new section of the Lives of the Fellows online exhibition project, outlining the first ANZCA Council. This is part of the ANZCA-wide 25th anniversary celebrations. There are a lot of other activities and events being offered by the museum throughout the year, and you are encouraged to get involved.

At the ANZCA Annual Scientific Meeting in Brisbane, Honorary Curator, Dr Christine Ball and Curator, Monica Cronin, will be running a history workshop aimed at refining online research skills and helping Fellows and trainees to contribute to the Lives of the Fellows project.

Three more oral histories will be filmed. This project will also focus on the 25-year anniversary. Former ANZCA president, and first dean of FPM, Professor Michael Cousins, first ANZCA president, Dr Peter Livingstone, and former Joint Faculty of Intensive Care Medicine dean, Dr Felicity Hawker will be interviewed. Existing oral histories can be found at www.anzca.edu.au/about-anzca/anaesthesia-stories.

A new exhibition will be launched at the ASM, called "Restoring the Apparently

Dead: The search for effective resuscitation techniques". The name and visuals have been inspired by a poster from the Royal Humane Society of Australasia, showing interesting methods of resuscitation.

The museum also had a hand in organising the Art & Mindfulness workshop to be held at Brisbane's Gallery of Modern Art (GOMA) during the ASM. During 2014 and 2015 the museum began looking at the way art is increasingly being used in medicine and the sciences. In recent times, observing and making art is being seen as a useful tool for reducing or managing stress, and for developing ambiguity tolerance. A similar program has been running at the Boston Museum of Fine Art for nearly a decade, and continues to be seen as a relevant part of medical education.

Then in October, the Honorary Curator, Dr Christine Ball, and Curator Ms Monica Cronin, will be going to the US to present at the 9th International Symposium on the History of Anesthesia in Boston.

The museum is also looking for guest bloggers. Anaesthesia, pain medicine and other related disciplines, have incredibly interesting histories. If there is a topic you



would like to write about, please contact the museum.

Monica Cronin
Curator, Geoffrey Kaye Museum
of Anaesthetic History



Strong interest in new Quality Assurance Network

Facilitated by ANZCA's NZ National Committee (NZNC), the Quality Assurance Coordinators Network held its inaugural meeting at the ANZCA office in Wellington on February 17. The network is being led by NZNC members Dr Rob Fry (chair of quality assurance for the five Auckland City Hospital anaesthesia divisions) and the NZNC's Safety & Quality Officer, Dr Geoff Laney.

Quality assurance co-ordinators from most of New Zealand's public hospital anaesthesia departments were joined by Dr Jennifer Reilly from Australia. Dr Reilly is a member of the Quality Improvement Committee at John Hunter Hospital in Newcastle, New South Wales, and is spending this year in Melbourne undertaking research training with Professor Paul Myles at The Alfred hospital, looking particularly at patient-centred perioperative outcomes. Especially relevant

at the Wellington meeting were discussions about research and long-term outcome studies, plus those on how information technology can be used for quality assurance solutions, one of her interests.

As well as hearing what each attendee wanted out of the network, the meeting discussed measures of anaesthesia quality, including current initiatives and IT support/requirements; and looked at the need for a national framework of anaesthesia quality, including data sharing, benchmarking and incident reporting, such as through WebAIRS.

Post-meeting evaluation showed that participants particularly appreciated getting to know what their counterparts around the country were doing and "realising that we struggle with similar problems". They also commented on the value of "getting a broader view of quality improvement work" and "creating linkages between quality assurance processes across New Zealand".

BWT Ritchie scholarship – award criteria highlighted

Dr BWT Ritchie undertook his anaesthetic training in the UK at a time when there was very little financial support for registrars, and they were required to travel to complete training from New Zealand. He set up the BWT Ritchie Scholarship to assist registrars in financial hardship to travel overseas to extend their training from New Zealand and return to practise here.

Every year, the NZ Anaesthesia Education Committee (NZAEC) invites applications for the scholarship. It reports that in 2016 it received a number showing that many registrars were embarking on exciting and challenging fellowships abroad. While encouraging those initiatives, the NZAEC decided not to award a scholarship.

"This is not owing to the quality of applicants but because all are moving to salaried positions in international departments, and this does not meet Dr Ritchie's requirement that the scholarship support applicants in financial hardship," the committee reports. It encourages 2017 applicants to look at opportunities that may not have an associated salary but offer professional extension, such as research or higher professional degrees.

Applications for the 2017 award close on October 31 but should be investigated well in advance as they need to include a detailed proposal of how it will be used. For more information about the scholarship and reports on how it has been used previously, see the NZAEC website, www.anaesthesiaeducation.org.nz.

Appreciation for Part



Zero

A total of 34 new trainees took advantage of ANZCA's new Part Zero Course, offered in each of New Zealand's four training rotations in December – Midland in Hamilton on December 5, Northern in Auckland and Southern in Christchurch on December 9, and Central in Wellington on December 21.

Presenters included supervisors of training, NZ Trainee Committee members, new Fellows and more advanced trainees, as well as a representative from the NZ Society of Anaesthetists (NZSA). The key focus was on the requirements of the ANZCA Training Program but also covered were trainee welfare, College resources, tips for exams and training, involvement with ANZCA, professionalism and performance, opportunities in anaesthesia and the role of the NZSA. Feedback showed that participants found the day very valuable, providing an excellent "overview of expectations of the training scheme and the basis of assessments" with "wonderful facilitators" who "all obviously put in a lot of work and were very open to questions".

Above from top: Participants in the Central Rotation Part Zero Course held in Wellington; Trainees at the Northern Rotation Part Zero Course with presenters Dr David Tan (left) and Dr John Panckhurst (right).



Paediatric presentation wins ANZCA ARM prize

Dr Jesse Chisholm from Auckland City Hospital won the ANZCA NZ National Committee prize for the best scientific presentation at the 2016 Annual Registrar Meeting, held on December 2. His research, undertaken with others at Auckland's Starship Children's Hospital, was titled "Quality of Chest Compressions in Operating Room Staff before and after Visual Feedback from Paediatric QCPR Simulation Mannequin".

This year's judges were Dr Sara Allen (Auckland District Health Board (ADHB)), Associate Professor Jenny Weller (ADHB and University of Auckland) and Associate Professor Guy Warman (University of Auckland).

The other prizewinners (also from Auckland City Hospital divisions) were:

- NZSA Prize for the Best Quality Assurance Presentation: Dr Ee Mei Soo for "Venous thromboembolism prophylaxis after elective and emergency Caesarean section: are we doing any better?"
- The University of Auckland Caduceus Award for Excellence in Anesthesiology Research: Dr Liz Maxwell for "Emergency Laparotomy Quality Improvement Intervention Study".

As well as funding the prize for the best scientific presentation, the ANZCA NZ National Committee provides funding to help run the ARM, which is convened by Dr Nicola Broadbent, Auckland.

Above from left: ANZCA prizewinner Dr Jesse Chisholm; NZSA prizewinner Dr Ee Mei Soo with Dr Matthew Drake and Dr Justine Wright from National Women's; University of Auckland prizewinner Dr Liz Maxwell.

Above from left: Quality assurance co-ordinators from around New Zealand at their new network's inaugural meeting, with convenor Dr Rob Fry at right; A busy discussion over morning tea at the meeting for New Zealand's quality assurance co-ordinators, from left: Dr Elsa Taylor (Starship Children's), Dr Kerry English (Auckland City), Dr Rob Fry (Auckland City and Convenor), Dr Jennifer Reilly (John Hunter, NSW, observer), Dr Niall Wilton (Auckland City), Dr Alan McKenzie (Wellington) and Dr Duncan Watts (Dunedin).

Australian news

New South Wales



Part II Refresher Course

The Part II Refresher Course in Anaesthesia (pictured left) was recently held at Royal Prince Alfred Hospital Sydney from February 6-17. The course was convened by Dr Chris Wong with more than 50 doctors assisting with lectures, tutorials, panel sessions, trial vivas and culminating on the final day with a hands on anatomy workshop. Thank you to all those who presented to assist those candidates intending to sit for their final examinations.

New South Wales Primary Refresher Courses in Anaesthesia

The course is a full-time revision course, run on a lecture/tutorial basis and is suitable for candidates presenting for their primary examination in the second part of 2017 or the first part of 2018.

Date: Monday May 1 – Friday May 12, 2017 or
Monday October 16 – Friday October 27, 2017

Venue: Large Conference Room, Kerry Packer Education Centre
Royal Prince Alfred Hospital, Missenden Road, Camperdown, NSW

Fee: \$A1078 (including GST)

A comprehensive set of supplementary notes, lectures notes and USB will be given to each participant at the commencement of the course.

Applications close on Monday April 10 for the May course and Friday September 29 for the October course.

The number of participants for the course will be limited. Late applications will be considered only if vacancies exist.

For information contact: Annette Strauss
nswcourses@anzca.edu.au
+61 2 9966 9085

Queensland



Evening CME lecture

On February 15, 51 Queensland Fellows, trainees and retired anaesthetists attended our evening CME lecture “Mechanical ventilation in the Operating Theatre: The least harmful way to ventilate the patient during a surgical procedure”. We were very fortunate to welcome Professor Rolf Rossaint as our presenter.

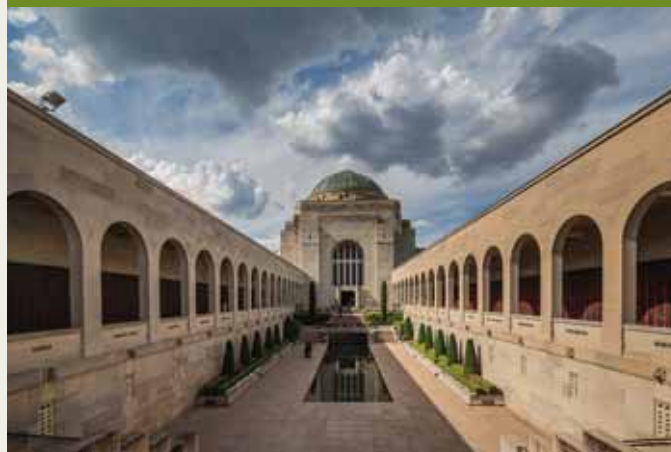
Since 1997 Professor Rossaint has been Head of the Department of Anaesthesiology and Professor for Anaesthesiology at the University Hospital Aachen in Germany. Prior to his present appointment, he was Associate Professor in the Clinics for Anaesthesiology and Surgical Intensive Care at the Humboldt University of Berlin. He is member of the National Academy of Science Leopoldina.

Professor Rossaint has (co)authored more than 540 articles in peer-reviewed journals. His clinical and research interests include pulmonary pathophysiology, ALI, ARDS, sepsis treatment, extracorporeal lung assist, xenon anaesthesia, coagulation management and telemedicine in emergency medicine. His presentation was centred around clinically appropriate ventilator management for patients undergoing different types of surgery. The presented evidence based strategies were very well received by the audience and sparked an enthusiastic discussion. We would like to thank Professor Rossaint for his contribution to our profession and for a most interesting evening.

Celebrating our 25 year anniversary in the ANZCA Rooms in Brisbane are Associate Professor Kerstin Wyssusek, Director of Anaesthesia and Perioperative Medicine at Royal Brisbane and Women's Hospital, visiting Professor Dr Rolf Rossaint, Director Department of Anaesthesiology University Hospital Aachen, Germany, Dr Helmut Schoengen also of Royal Brisbane and Women's Hospital and from Adelaide, Associate Professor Dr Bernd Froessler; Professor Rossaint and captivated listeners.

Australian news (continued)

Australian Capital Territory



This year will be another great one

2016 was a terrific year for the ACT in which we ran more CME events than any year previously, including several key registrar events. We kicked off with Associate Professor Dennis' engaging presentations on obstetric emergencies in April, brought you an airway workshop and paediatric and neonatal ALS course mid-year, and rounded out 2016 with our flagship CME event, the Art of Anaesthesia, including CICO, anaphylaxis and fibre-optic intubation workshops. We also hosted the inaugural Scan and Ski Workshop in Thredbo in July that received such wonderful feedback that we will be repeating the event in August 2018.

In 2017 we will again bring our local Fellows and trainees a range of educational events including a special presentation by Professor Ian Kerridge of the University of Sydney on the philosophy of medicine and particularly the ethics of futility. The presentation will take place on Thursday June 1 from 5.30pm at CaféEQ. A registration link will be conveyed via email and available on our website soon.

The 2017 Art of Anaesthesia CME will be held over the weekend of September 23-24 at the Australian War Memorial in Canberra and further details will be posted on our website as they become available. Our CME convenors for this year's event are Dr Carmel McInerney and Dr Girish Palnitkar. If you have anything you would like to see at this year's event we encourage you to please get in contact to discuss ideas.

2017 will also bring a change to the position of Chair of the ACT Regional Committee and the ACT Trainee Committee with both Dr Andrew Hehir and Dr Jennifer Hartley stepping down from their current positions on the committees. Once confirmed, details of the new chairs will be published in both the *Bulletin* and through local sources. We take this opportunity to thank Dr Hehir and Dr Hartley on their tremendous efforts as Chair of the respective ACT committees.

Western Australia



Part Zero Course starts the year

In 2017 the WA CME Committee will be holding a Cable Beach Country Conference from June 16-18 at Cable Beach Club Resort. It is titled "Comfortably numb: Updates in regional anaesthesia" and is convened by the CME committee. This conference will follow a similar structure to the country conference that is usually held in Bunker Bay.

The Part Zero Course is aimed at basic trainees in their first year of training or doctors about to take up training positions in 2017. The course covers many topics ranging from how to deal with clinical errors, to what to expect in anaesthetic training and how to look after your own welfare, all delivered in a short and informal format. ANZCA WA provided the Part Zero Course for new trainees commencing in 2017. Dr Jennifer Bruce and Dr Kevin Hartley provided the new recruits with information and insight on how to manage their schedules and work life balance as an anaesthetic registrar. Invited guest speakers included current trainees presented on welfare, other trainees' experience and the Training Portfolio System. We thank Dr Bruce and Dr Hartley for their valuable time in coordinating another successful program.

The Part Two Course is also well underway, so if you are a trainee studying for your exam and would like some further tutoring please visit the ANZCA Calendar for the Part Two Tutorial registration page.

All committee meeting dates and members are on the ANZCA WA website for future reference.

Prize winners

The ANZCA/ASA WA office would like to congratulate Christiana Mustac as the recipient of the Dr Wally Thompson Prize for Anaesthetics from the University of Notre Dame. We also congratulate Declan Scott as the recipient of the Gilbert Troup Prize in Anaesthetics from the University of Western Australia.



Above: Dr Wally Thompson awarding the prize to Christiana Mustac.

Victoria



Part Zero Course

The Victorian Part Zero Course was run at ANZCA House on Friday February 24. A healthy balance of new Victorian introductory trainees and resident medical officers aspiring to be future trainees and anaesthetists, attended the whole day course.

Again this year, a large part of the course was run by trainees for trainees. The focus of this course is to lend support to new Victorian introductory trainees as they embark on their specialist training. The stresses of being a new trainee, how to manage when plans do not come to fruition and preparing for exams are all covered during this course. The welfare of doctors and harassment and bullying on the job also form a very important part of this program. An interactive question and answer session with supervisors of training completed the first half of the course. The day finished with group airway sessions aimed at teamwork and team learning.

The highlight of the day was the opportunity for trainees to network and forge friendships.

I would like to thank all the organisers, session chairs, ANZCA administrative staff, presenters, SOTs and workshop facilitators for their generosity of time and participation in college events.

Dr Shiva Malekzadeh, Convenor – VRC
Co-Convenor Dr Nicholas Lanyon, trainee

Above from top: Attendees at the Victorian Part Zero Course; Presenters at the course from left: Dr Tabara Dione, Chair Victorian Trainee Committee 2016, Dr Nicholas Lanyon, Co-Convenor and Dr Phuong Pham, Trainee Presenter.

Tasmania



A busy start to the year

It has been a hectic start to the year in Tasmania with trainees enjoying a feast of training and educational opportunities.

January saw the Part 3 Course occur for the more advanced trainees with February providing two days of workshops and educational programs for new trainees.

On February 17 Anaesthetic Foundation Day was run at Launceston General Hospital. Eighteen doctors commencing anaesthesia training this year attended including first year trainees, senior RMOs, and registrars rotating from Emergency and ICU. The day focused on practical skills for those new to anaesthetics with workshops in ALS, obstetric epidurals, airway emergencies, pre-op assessment and an introduction to ultrasound. This popular event appears to be unique to Tasmania.

Tasmania's inaugural Part Zero Course was held the following day at The Charles Hotel in Launceston. The convenor, Dr Luke Murtagh, organised a friendly and interesting day. Ten trainees who attended valued the information provided as well as the opportunity to network with their colleagues from around the state. The chair of the Tasmanian Regional Committee, Dr Colin Chilvers, congratulated Dr Luke Murtagh on convening a great meeting and believes that combining the Foundation Day with the Part Zero Course provides an excellent orientation to anaesthesia training in Tasmania.

March continues the hectic pace with the traditional trainee day at the Hobart Conference and Function Centre which is held the day before the Tasmanian Annual Scientific Meeting (ASM). The trainee day provides trainees from around Australia the opportunity to meet with other trainees and hear from some of the keynote speakers at the ASM in a smaller and more intimate setting.

There will be a full report on the Tasmanian trainee day and ASM in the next edition of the *Bulletin*.

You are invited to mark August 26 into your calendar for the Tasmanian mid-winter workshop. This year the meeting moves to the north-east of Tasmania to one of Australia's top golfing destinations, Barnbougle. The theme of the one day workshop, InnOzvate, brings together a complete breathing experience for delegates. Here you will not only be able to attend a hands-on breathing emergency workshop, you can also hear and discuss innovative airway research as you breathe the fresh clean air that abounds at Barnbougle. Spaces are limited to 40 and online registrations are anticipated to open in May.

Above from top: Luke Murtagh (convenor, on left) and anaesthetic trainees, Part Zero Course, Tasmania; Abby Chapman practicing epidurals on the unrealistically low BMI model; Aung Htay rescues the situation with a percutaneous cricothyroidotomy; Jana Vitesnikova unable to ventilate via LMA discusses Plan B with the team.

South Australia and Northern Territory



For trainees, by trainees

The 2017 SA and NT Primary Part One long course for introductory and basic trainees commenced in February. The course is run for the trainees, by the trainees and covers a broad range of topics in the primary curriculum. This course would not be able to run without the outstanding contribution of the convenor, Dr Agnieszka Szremska, above left, or the invaluable input of several South Australian Fellows facilitating each session.



ANZCA 25th anniversary celebrations

Committee members from the SA/NT Regional Committee and SA/NT Continuing Medical Education Committee celebrated ANZCA's 25 years of leadership on Tuesday, February 7.

Teresa Camerelli, SA/NT Regional Coordinator said "Our two committee meetings were scheduled to meet on the actual date of ANZCA's 25th anniversary, so we thought it was too good an opportunity to miss and organised cake and bubbles to mark the occasion."

Above: Dr Smrithi George, Dr Marni Calvert, Dr Sarah Flint, Teresa Camerelli, Dr Christine Hildyard, Dr Jason Koerber, Dr Richard Church, Dr Tim Benny, Dr Sam Willis and Dr Waleed Alkhazraj.

Remembering Dr Maurice Sando

Mrs Margaret Sando recently visited ANZCA's SA/NT Regional Office in Adelaide, which is named Sando House after Mrs Sando's late husband, Dr Maurice Sando. Mrs Sando (pictured) was pleased to be able to visit and see the named building and the commemorative plaque honoring Dr Sando's achievements.

Dr Sando (1930-1984) was appointed Director of Anaesthesia at the Royal Adelaide Hospital in 1962 and continued to serve the public of South Australia until 1982 when ill-health curtailed his career. He contributed to the development of anaesthesia and the new specialty of intensive care, both of which are an indispensable part of the modern public hospital system. As a member, secretary and chairman of the SA Committee of the Faculty of Anaesthetists between 1961-1980, he played a key role in developing educational programs and examination systems for the specialty. Ever mindful of his responsibilities to the broader medical community, he was also SA President of the AMA (1973-1974), Member of the Medical Board of SA (1974-1982) and was Chairman of the Red Cross Blood Transfusion Service (1978-1984).

Teresa Camerelli, SA Regional Coordinator was delighted to meet Mrs Sando, "Margaret popped in to drop off a large folder of Dr Sando's reports and presentations that we will be able to send onto ANZCA's Geoffrey Kaye Museum of Anaesthetic History. We were delighted to have the opportunity to meet Mrs Sando and thanked her for entrusting her husband's precious documents to the care of the museum where they can be accessed by future generations of anaesthetists."

Dr Alistair Huw Davies, FANZCA

1974 – 2016



Dr Alistair “Alboy” Davies arrived in Perth from the UK in 1999 as a young junior doctor and completed his FANZCA in 2006 via the Western Australian anaesthetic training program. He died on September 28, 2016 at home.

In January 2007 Alistair started as a consultant at Fremantle Hospital and quickly embedded himself into the very fabric of the department with interests in paediatric anaesthesia, MRI and radiology and quality improvement. He also started down the path that would define his clinical career, the development and teaching of regional anaesthesia.

His love of regional techniques manifested itself in Al’s unique approach to teaching, with many a consultant and trainee assisting him in blocking a nerve on himself in order to demonstrate a block, thus recapturing the pioneering spirit of the early anaesthetists! His ultimate goal was opioid free anaesthesia and he relentlessly pursued the development of novel regional techniques for a multitude of different specialities and operative procedures.

Alistair was also passionate about the patient experience and an early adopter

and enthusiast for enhanced recovery programs. At Fiona Stanley Hospital (FSH) he was fundamental in developing the NOF pathway and ERAS program resulting in superb results and outcomes for this cohort of patients.

He was an extremely enthusiastic and skilled teacher being recognised with several clinical awards for teaching at Fremantle Hospital. He ignited the flames for a love of regional anaesthesia in all those that he taught.

Not only was Alistair a highly skilled and extremely capable anaesthetist, but nothing ever seemed to faze him and he was a doctor who always put the patient first, at the centre of everything he was doing.

Alistair moved with many from Fremantle Hospital to the new Fiona Stanley Hospital in November 2014. He was one of the very first who volunteered to work and anaesthetise at the institution and was also involved in the successful commissioning of the hospital. The first couple of years saw huge change for many, but throughout all of the challenges Alistair was there to help, advise and support his colleagues and the department in general. He continued to work at both sites and supported both institutions.

To all of us who knew and worked with him, he was not only an invaluable colleague and part of the very core of the departments, but he was a trusted colleague and a great friend. He was greatly respected for his wonderful manner, humour, patient focus, knowledge and skills, dedication and integrity.

For me personally, he was a great barometer. A confidant and adviser, never afraid to tell me if he thought I was on the

wrong track with a decision, never taking sides, and always providing a balanced opinion with the patient at the centre of his focus. I will miss our great talks and his sage advice.

Outside work, Alistair was a loyal and incredibly generous friend. He was a gifted sportsman, with a love and huge appetite for football. He was an amazingly talented guitarist and songwriter and many of us will fondly remember his gigs, the playing of his band on Triple J radio or his legendary karaoke performances. Alboy was gregarious, funny, cheeky and usually the life and soul of the party.

Alistair, you were a wonderful, unique and extraordinary man. It was a pleasure and a privilege to have known you.

RIP.

Dr Alex Swann, FANZCA
Head of Department, Anaesthesia
& Pain Medicine, Fiona Stanley Hospital