MARCH 2016

ANZCA BULLETIN

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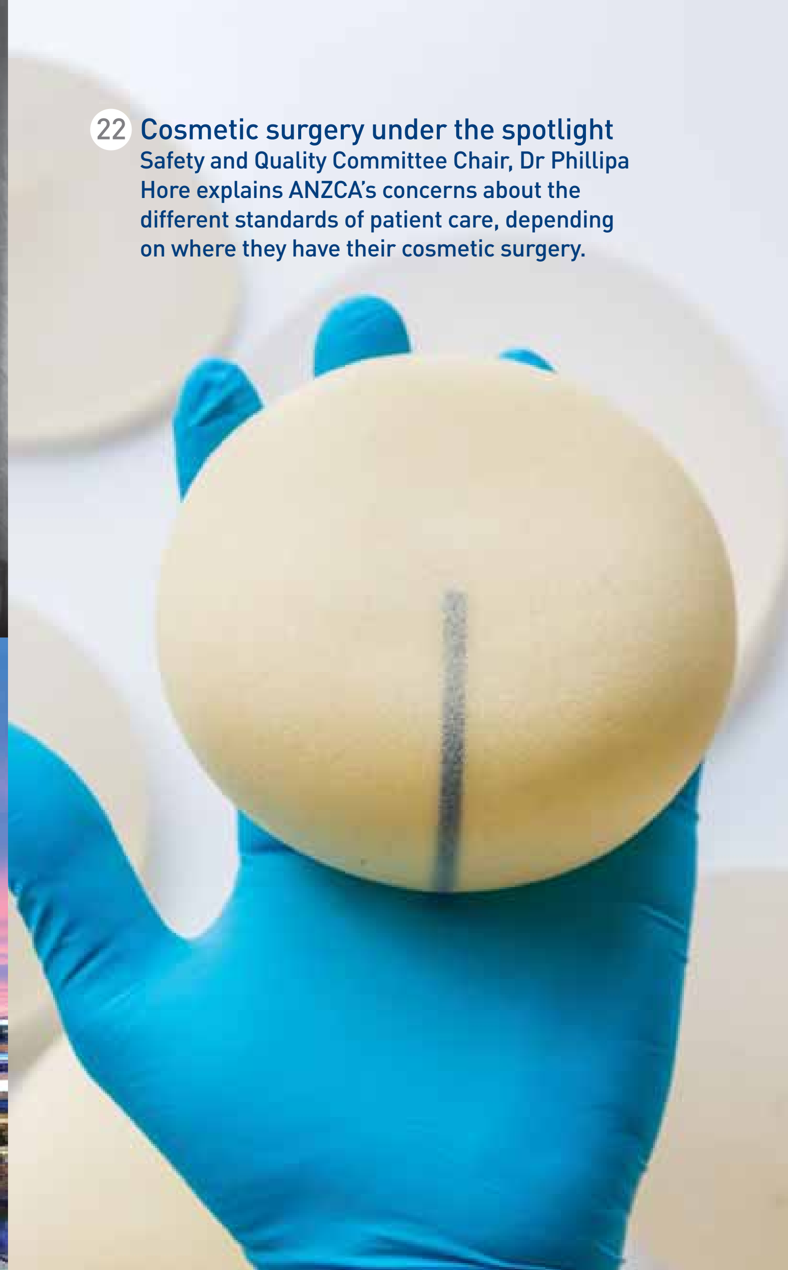

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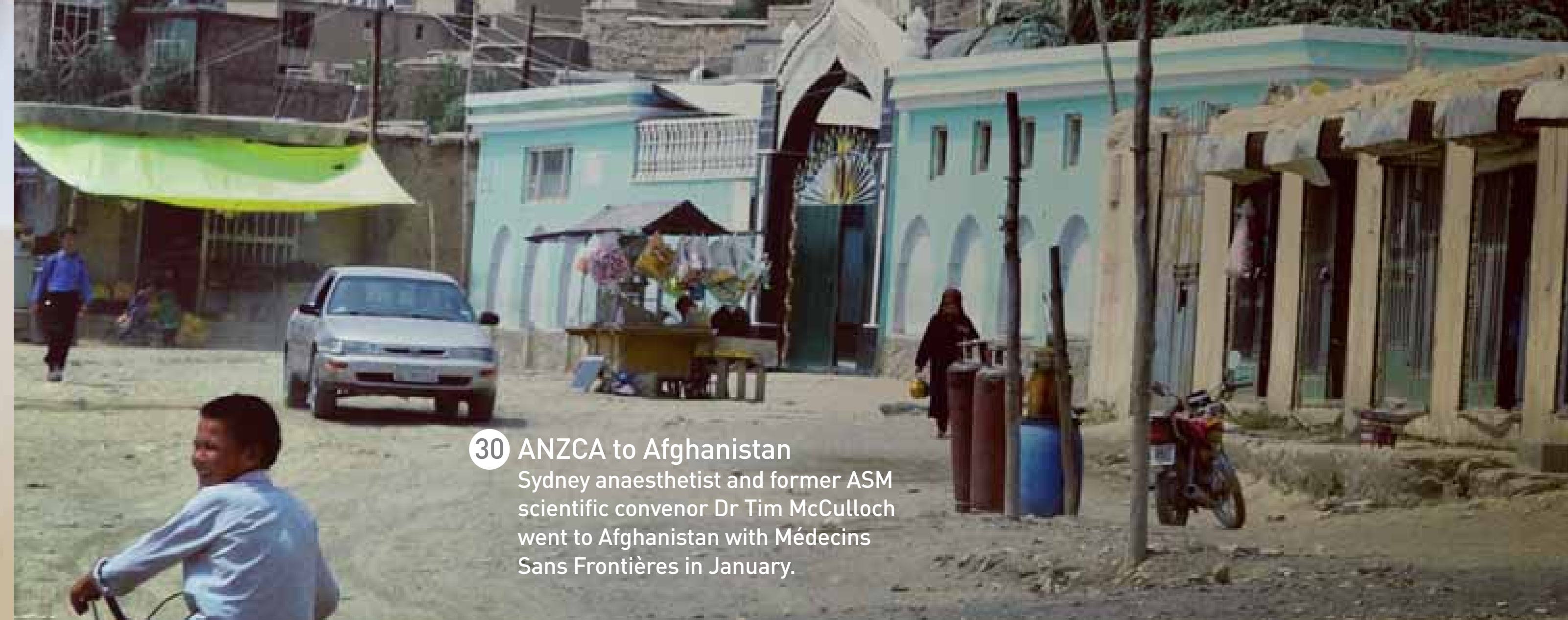

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ANZCA Bulletin

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 5000 Fellows and 2000 trainees across Australia and New Zealand and serves the community by upholding the highest standards of patient safety.

Cover: There have been a number of emergencies involving patients undergoing breast implant surgery.

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President's message

My term as ANZCA president will end at the annual scientific meeting in Auckland in May, so this will be my last opportunity to write a *Bulletin* message.

My key messages for Fellows and trainees centre on professionalism, meeting Australia and New Zealand's anaesthesia and pain medicine workforce needs, and doctors' health.

In the past few months, the Chief Executive Officer John Ilott, Vice-President Associate Professor David A Scott and I have attended several important meetings. The first was a meeting in December called by the Medical Board of Australia (MBA) and the Medical Council of New Zealand (MCNZ) with all the medical colleges to discuss revalidation, the ageing practitioner and a revised standard for supervision of international medical graduate specialists (IMGS). It is certain a form of revalidation will occur, but this is approximately three to five years away.

Revalidation

The FPM Board and ANZCA Council are keen to continue working with the colleges. More than a year ago, the Committee of Presidents of Medical Colleges issued a document outlining the principles for a revalidation process (see cpmc.edu.au/about-us/policy-statements) and this has been well received. It is probable the MBA will align itself more closely to MCNZ to ensure consistency in regulatory functions on both sides of the Tasman.

The MBA has indicated that none of the three options proposed by the Collaboration for the Advancement of Medical Education Research and Assessment (CAMERA) research (www.medicalboard.gov.au/Registration/Revalidation.aspx) best fit the board's needs. Their revalidation model is thus yet to be determined, but will build on current continuing professional development (CPD) standards and the colleges will be called on to develop and deliver it. Note that in New Zealand revalidation is called recertification.

In the interim, the MBA has convened an expert advisory group and a consultative committee and is researching community views on expectations of doctors' performance and currency. There also was acknowledgement that keeping up to date (CPD) was separate to detecting and managing underperformance ("bad apples").

Workforce

The second important meeting was with the National Medical Training Advisory Network (NMTAN), an Australian Department of Health body, which is developing modelling to assess the current workforce position of individual specialties and predicting future needs. Initial studies have focused on psychiatry, anaesthesia and general practice.

The process is enormously complex: The past does not predict the future; the population is growing and ageing, resulting in a greater burden of chronic disease; the workforce is ageing; there are generational issues in that younger doctors, sensibly, generally wish to work fewer hours than their forebears; there is tremendous fiscal pressure in both the public and private sectors; and in anaesthesia, we are approaching gender equity, which will have an impact as females have different work patterns, generally working fewer hours and having a tendency to perform a greater portion of clinical support activities than their male counterparts.

Data comes from many sources, including ANZCA, the Australian Society of Anaesthetists (ASA), the Medical Training Review Panel and the MBA's annual workforce data, supplied at the time of re-registration. There is a paucity of good data on the senior third of the profession, their work patterns, or how and when they exit the workforce. We await NMTAN's deliberations.

In 2015, heads of ANZCA departments in New Zealand were surveyed to determine the workforce position of the specialty. There was an almost 100 per cent response rate and results will appear in the *ANZCA Bulletin*.

New Zealand has a different context from Australia with only a small private sector, a significant exodus of local medical school graduates and a significant dependence on overseas-trained doctors. Initial results indicate training numbers are adequate to meet local demand, but there is maldistribution to smaller centres.

ANZCA hopes to repeat the survey in Australia, but this is challenging because there are many more training centres and approximately half of anaesthesia work is done in the private sector. Medicare billings and public hospital activity data give some measure of anaesthesia work, but do not tell the full story. Approximately 8 per cent of Medicare billings are by non-specialists, some of whom are not vocational GPs or trained GP anaesthetists, and we are starting to obtain a better picture of this part of the workforce.

Both MBA and MCNZ have data to show there is an increased rate of notifications for male practitioners and practitioners over 60. It is known there is cognitive decline associated with ageing. As a profession we must educate our members about this and ensure senior practitioners plan their pre-retirement years and are appropriately supported and monitored so they can continue to contribute and perform meaningful work.

ANZCA hopes to focus future efforts on surveying the senior third of the specialty about their work and retirement patterns to better inform what we know about the attrition end of the anaesthesia workforce and advise mid-career anaesthetists on future work scenarios.

Doctors' health and professionalism

Readers will be aware of the profound repercussions of allegations of bullying, harassment and discrimination reported in the surgical profession and the response of the Royal Australasian College of Surgeons (RACS).

ANZCA has established a Bullying, Discrimination and Sexual Harassment Working Group, chaired by ANZCA Vice-President David A Scott, to ensure the College has good processes for detecting, monitoring and managing these problems should they occur. Former anti-discrimination commissioner Ms Susan Halliday briefed members of this group, the ANZCA Council and senior staff at a workshop in preparation for rolling out ANZCA's response. All trainees were recently surveyed to determine whether this is a problem in our specialty.

Many Fellows and trainees around Australia and New Zealand have expressed their concerns to me about anaesthetists' health and wellbeing.

The 2014 Australian Medical Association/beyondblue National Survey of Mental Health in Doctors and Medical Students (see www.beyondblue.org.au) is sobering reading. Data specific to anaesthetists' health is largely anecdotal and difficult to obtain, but concurs with what we know, and that is there is an increased risk of mental health issues such as burnout and anxiety in the medical profession compared to the general population. The study showed medical students, junior doctors and females were particularly at risk and that there is an alarming incidence of stigma about mental health problems in doctors, an unexpected finding for a supposedly caring profession.

ANZCA is considered a leader among medical colleges in that doctors' welfare – through the efforts of the Welfare of Anaesthetists Special Interest Group – has had a significant profile at continuing medical education meetings, in the curriculum and in training for many years.

In Australia, the MBA is in the process of launching (arms-length) doctors' health programs in every state.

Some Fellows have recounted their difficulty in keeping their health problems confidential, a fundamental right of any patient and a cornerstone of good medical practice. They have been very distressed to find that colleagues read their charts, speak to their caring physicians about their condition or look up pathology or imaging results without their permission. Some hospitals have taken measures to ensure doctors who are patients have their privacy respected, but this is not universal. Colleagues who are patients expect and deserve the same standard of confidentiality as any of our patients.

Collaboration

CEO John Illot and I recently met with our counterparts at the ASA, President Guy Christie-Taylor and CEO Mark Carmichael, for a strategic discussion about our complementary and collaborative efforts to best serve our mutual goals of providing the highest standards of care and meeting the needs of the anaesthetic community.

In other collaborations, ANZCA is now part of a tri-nation alliance (Australia, New Zealand and Canada) involving five colleges, ANZCA, RACS, the Royal Australasian College of Physicians, the Royal Australasian College of Psychiatrists and the Royal College of Physicians and Surgeons of Canada. This group hosted a meeting in Sydney in March, the fifth such meeting, to discuss themes such as leadership and medical education.

The Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC), a tripartite (ANZCA/ASA/NZSA) committee, has recently signed an agreement for Canada to launch canAIRS, a pilot trial of the webAIRS online anaesthesia incident reporting system.

ANZCA, ASA, NZSA, Interplast and Lifebox also have signed a memorandum of understanding to allow contributions to Lifebox, a UK-registered company, to be made via Interplast, to allow tax-deductibility (see www.interplast.org.au/get-involved/donate).

Professor Tess Cramond

A private requiem mass was held at the Cathedral of St Stephen in Brisbane for the late Tess Cramond in January. The funeral was extremely well attended by friends, family and others whose life she touched, including representatives from Surf Lifesaving Australia, the Australian Resuscitation Council, and colleagues in anaesthesia and pain medicine.

A quiet achiever, many were unaware of the breadth and impact of all her achievements. See page 26 for more on her extraordinary life.

Council elections

Lastly, we will soon be conducting ANZCA Council elections for a new Fellow, as well as for vacancies or re-elections. The desirable attributes of a councillor are articulated in ANZCA regulation 39 (see table).

Please make your vote count to ensure ANZCA remains a strong college in the hands of capable Fellows in their very responsible role as its company directors.

ANZCA Regulation 39.7.2

The ideal candidate will:

- Have sufficient time to devote to the ANZCA Council and be prepared to give the College high priority.
- Be free from any conflict or other connection that may embarrass the council.
- Be respected by the members.
- Bring relevant experience, and an understanding of the business, to the council.
- Have knowledge or experience which complements that of present council members.
- Have some experience of working on boards or other relevant bodies.
- Have a reputation of a leading clinician and be seen as a role model for trainees and other clinicians.
- Be co-operative – a good team player.
- Be able to grasp new issues quickly – have an agile mind.
- Be prepared to make contributions that are succinct and to the point.
- Have an incisive mind and be able to ask penetrating questions.
- Have a strategic vision – see the big picture.
- Be an independent thinker.
- Have good written and verbal communication skills.
- Have negotiation skills.

It has been an honour to serve as your president and I thank my family and department at the Royal Brisbane & Women's Hospital for allowing me the time to do so. A huge thank you to the ANZCA Council, countless Fellows and trainees for their ongoing passion, enthusiasm, hard work, dedication and professionalism to support ANZCA's mission, and of course the CEO and ANZCA staff in all the regions and New Zealand, for their skill in making it all happen.

Dr Genevieve Goulding
ANZCA President

Chief executive officer's message

ANZCA does much to support its Fellows and trainees but we are sometimes questioned about whether we are doing enough.

Improving what we do is high on the list of College priorities and last year we engaged external consultants to look at where we can improve our relationship with Fellows.

Using surveys and various other sources of information, the consultants identified five areas where we could improve. Earlier this year we took the first steps in implementing the recommendations from a 2015 assessment of surveys and other information. The first part of this strategy is a practical tool that can be utilised by all business units of the College. Fellows indicated they wanted:

- Better value for subscription.
- The College to be more democratic and inclusive with more collaborative and transparent processes.
- The College to broaden its focus beyond Melbourne.
- A more user-friendly continuing professional development program.
- More of a focus on workforce advocacy, government relations and boosting ANZCA's media profile.

I believe the College is doing much to address these concerns but there is always more that can be done and perhaps more important, ensuring our Fellows and trainees are aware of this.

Our 2014 fellowship survey showed 56 per cent of those who responded regarded the annual subscription as fair and reasonable (10 per cent) or acceptable (46 per cent) while 40 per cent said it was too high (4 per cent unsure). This should be read in conjunction with perceptions of ANZCA across all Fellows where 79 per cent perceived ANZCA to be good (55 per cent) or very good (24 per cent). Only 2 per cent perceived ANZCA as "poor" and 4 per cent "not good" with 15 per cent perceiving ANZCA as "average".

Criticisms of the ANZCA CPD Program are decreasing as participants become more familiar with the CPD portfolio system. While criticisms have been levelled at us in relation to perceived unnecessary elements in the program, it should be remembered that it was carefully designed with the prospect of revalidation taken into consideration.

The College plays a strong role in workforce advocacy (our third Graduate Outcomes Survey later this year will shed more light and inform discussions with government authorities) and we spend a lot of time building government relations. We are regularly in the media as part of pro-active media activities.

In the *Bulletin*, we have regular sections that highlight the work we are doing with Australian and New Zealand governments as part of our advocacy role (see "ANZCA and government" on page 12) and our media activity (see "ANZCA in the media" on page 10).

These activities and their results are also regularly reported in other ANZCA communications, including our e-newsletter, social media (Twitter – @anzca) and the ANZCA and FPM websites.

We are working at being more democratic and inclusive with more collaborative and transparent processes. One of the first things Fellows can do is to elect the representatives they want to ANZCA Council. We are in the midst of an election now and members should have received their ballot papers in late February or early March. Information about the candidates will be on the ANZCA homepage until voting closes on April 8.

From next year, I am hoping the voting process will be even simpler with the introduction of electronic voting. This will require a change to the ANZCA Constitution which is being put forward at the ANZCA annual general meeting in Auckland in May.

There are many ways in which Fellows can become actively involved in the College's activities. We welcome and provide support for such contributions. Please keep an eye out for calls for expressions of interest to committees and working groups in our College publications – as an example, very soon we will be encouraging applicants to our new Information and Communications Technology (ICT) Governance Committee that will oversee and provide advice to ANZCA Council in this important area of the College's work.

Making sure that Fellows are aware of the work and activities of the College and how these provide valuable benefits is an important consideration for us.

Mr John Ilott
Chief Executive Officer, ANZCA

Letters to the editor

Days numbered for Rosewarne bougie

As a registrar at the Royal Melbourne Hospital in the early 1990s, I learned from Dr Fred Rosewarne how to manufacture Teflon intubating bougies from specially purchased lengths of industrial Teflon® (Rosewarne FA, AIC, 1993, 21(5):722-3). Dr Rosewarne was – and still is – an anaesthetic equipment guru, and this particular invention was simple yet elegant: inexpensive, reusable and as effective as the once ubiquitous but now-extinct gum elastic bougie. For 20 years, the Rosewarne bougie has been the preferred aide to difficult intubations at my hospital and, I imagine, at many others.

Now, however, the recently promulgated standard "Reprocessing of reusable medical devices in health service organisations" (AS/NZS 4187:2014) seems to have sounded its death knell. An intubating bougie is regarded as a "semi-critical medical device"; to be reusable, it must undergo high-level disinfection and also must be individually trackable. The latter is an impossible requirement for a Teflon® rod.

To my knowledge, no other jurisdiction in the world has such stringent cleaning and tracking requirements for "semi-critical RMDs". It is a pity such a useful device will be removed from our armamentarium by what appears to be infection-control zealotry. These changes add further momentum to the relentless growth of "single use" in healthcare, contrasting starkly with increasing community concern about our planet's finite and dwindling resources.

Dr Richard Barnes, FANZCA
Staff anaesthetist
Monash Medical Centre
Melbourne, Vic

Changes to TGA approved spelling of medications

Interesting development for we anesthesiologists: US phonetic (or fonetic) spelling finally wins the day.

We will miss you "th" and "ph" and will swap "y" for "i" and "s" for "zee".

Vale the Queen's English and good nite to thee!

Professor Eric Visser, FANZCA
Churack Chair in Pain Education and Research, University of Notre Dame Australia Fremantle, WA

Fellows honoured on Australia Day

Congratulations to Professor Kate Leslie, Dr Brian Spain, Associate Professor David Cherry and retired Fellow Dr John Tucker for their Australia Day awards. Professor Leslie, a former ANZCA president, was appointed an Officer of the Order of Australia (AO); Associate Professor David Cherry and Dr Brian Spain were each made Members of the Order of Australia (AM) and Dr Tucker received an Order of Australia Medal (OAM).

WFSA Distinguished Service Award

Dr Haydn Perndt has been awarded the World Federation of Societies of Anaesthesiologists Distinguished Service Award, which is given to individuals who have previously served as a WFSA Officer, Council or Committee member or who provided exceptional service in another capacity to the WFSA and the international anaesthesia community.

Dr Mark Gibbs awarded ANZCA Council Citation

The College established the ANZCA Council Citation in 2000. This award is made at the discretion of the ANZCA Council in recognition of significant contributions to particular activities of the College. Dr Mark Gibbs received his award at a dinner held by the Queensland Regional Committee in December 2015.

The curriculum vitae of ANZCA Fellow Dr Mark Kenneth Gibbs reflects a long and distinguished career in anaesthesia, focusing on rural and regional health and medicine, as well as teaching and training young anaesthetists.

It's a career path that may have moved away from anaesthesia, but for Dr Gibbs' determination and the support of a talented surgeon.

As a second-year intern on a scholarship at Charleville Hospital, almost 700 kilometres west of Brisbane, the new resident was also the hospital's only anaesthetist in 1979.

"At that time the second-year resident did anaesthetics," Dr Gibbs said.

"I had only done one rotation of anaesthetics before that placement … I can tell you that was a year of many defining moments."

His very first case was a thoracotomy, where he delivered anaesthesia to a patient having a bullet removed from their chest. The experience was a "baptism of fire", he said.

"There was another time when I finished up giving mouth-to-mouth resuscitation to a baby because I dosed their anaesthetic incorrectly."

The baby recovered with no ill effects and Dr Gibbs credits all he learnt that year to the surgeon with whom he worked, the late Dr Louis (Lou) Ariotti, who served as mentor and support.

"He was a brilliant general surgeon and he got me out of many scrapes," Dr Gibbs said.

The experience inspired him to specialise in anaesthesia.

"It frightened me so much at times I realised that if I was going to do this then I'd better learn to do it properly."

Dr Gibbs is now director of anaesthesia and intensive care at Ipswich Hospital in Queensland, a position he has held since 1998. He was awarded the ANZCA Council citation "for his life's work for the benefit of anaesthetists and GPs in Queensland" after nomination by his peers, including Queensland Regional Committee chair Dr Kerstin Wyssusek.

Among Dr Gibbs' many achievements, he also received the Australia Day Achievement Award in 2013 "for his dedication and commitment to improving the standard, quality and capacity of anaesthetic services in rural facilities across Queensland".

As chair of Queensland's Statewide Anaesthesia and Perioperative Care Network (SWAPNET) rural and remote working group, Dr Gibbs conducted a state-wide review of the anaesthetic service capacity involving 30 rural facilities in 2010-11. His review developed 18 recommendations.

He also established and led two major projects for rural facilities; the first delivered standardised anaesthetic equipment worth $3 million to 28 rural facilities and the second established a rural generalist anaesthetic introductory program. The aim of the program is to deliver high-quality general practitioner rural generalists to rural hospitals in Queensland.

Dr Gibbs also is a squadron leader for the RAAF Specialist Reserve and has served as consultant anaesthetist in Kandahar, Afghanistan.

As stated in his nomination: "Mark would always go the extra mile. He has become a mentor and role model for generations of anaesthetists in Queensland."

Foundation research features prominently in the news

Choc to ease ops for kids

Nausea kept at bay by gum

Obesity a big risk in surgery

Chocolate and chewing gum help the medicine go down

Sweet treat for surgery

Sweet treat eases pre-surgery worry

Unravelling a complex pain

Hospital horrors

Research projects funded by the Anaesthesia and Pain Medicine Foundation were the subject of a media release demonstrating simple and innovative ways anaesthetists are working to improve the comfort of their patients.

"Chocolate and chewing gum: anaesthetists lead the way in patient comfort" appeared prominently in the *Herald Sun* (circulation 344,000) and was syndicated in print and online in more than a dozen News Corp Australia publications as well as on ABC radio. This story alone reached an estimated combined cumulative audience of 1.1 million after its distribution on November 18.

Two media releases were issued from the ANZCA NZ Annual Scientific Meeting held in Wellington, November 5-7: "Medicine the only winner in warfare" and "Compassion in healthcare improved patient outcomes". These were mentioned on websites including Scoop Media (health) and worldnews.com.

The phenomenon of complex regional pain syndrome (CRPS) was the subject of a long news story in the *Sunday Age*, which further promoted ANZCA's support for research through the foundation, and appeared in print on Sunday December 7.

ANZCA Fellow Professor Andrew Davidson was interviewed for nearly four minutes on radio 2UE in Sydney after the communications team was approached to seek comment on a story about awareness during anaesthesia.

The results of a survey conducted to coincide with 2015 National Anaesthesia Day in October were featured in the December edition of the *ANZCA Bulletin*. The media release "Patient weight takes its toll on anaesthetists" described the pressure placed on hospital resources and medical personnel by the increasing weight of many patients. The *Herald Sun* reported the story on December 18.

ANZCA Media Award

For the first time since its inception, the ANZCA Media Award has been won by two entries: A story that ran on the ABC *7.30* program by Victorian journalist Madeleine Morris (below left) about the risks of pholcodine, found in over-the-counter cough medications, and a feature by *New Zealand Herald's* Steve Braunias (below right), about the anaesthetic drug propofol.

Entries for the 2015 ANZCA Media Award spanned a range of pain medicine and anaethesia subjects and were published across print, radio and television media.

The award 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 ANZCA Media Award is awarded for the best news story or feature on anaesthesia or pain medicine to appear in the Australian or New Zealand media (print, television, radio or online).

The judges agreed the reports provided thoughtful and well-researched information about anaesthesia and highlighted topics that were both timely and of great interest to the general community.

Media releases since the previous *Bulletin*:

February 25: Safe before surgery: the humble aspirin. Released jointly with The Alfred.

February 18: Can blood pressure medication stop breast cancer?

December 17: Patient weight takes its toll on anaesthesia.

December 7: When noise and even a breeze can cause unbearable pain.

December 3: Are opioid prescriptions making pain worse for the elderly?

November 18: Chocolate and chewing gum: anaesthetists lead the way in patient comfort.

November 7: Medicine the only winner in warfare.

November 7: Compassion in healthcare improved patient outcomes.

Media releases can be found at www.anzca.edu.au/communications/Media.

Since the December 2015 edition of the *ANZCA Bulletin*, ANZCA has featured in:

- **More than 30 print reports.**
- **More than 10 radio reports.**
- **More than 50 online reports.**

Protection for participating in quality assurance activities – in the spotlight

The governments of Australia and New Zealand provide special legislative protections for healthcare practitioners to encourage full and frank participation in quality assurance activities. In Australia this is called "qualified privilege" and in New Zealand reference is made to "protected quality assurance activities". While similar in intent, the legislation offers different protections in each country. If granted by the relevant minister, protection is in effect for a period up to five years.

The College has applied for and received protection of information made available under three programs:

- Continuing professional development.
- Training portfolio system – cases and procedures.
- Incident recording and reporting program by the Australian and New Zealand Tripartite Anaesthetic Data Committee.

Participation in these programs automatically includes coverage under the relevant legislation. This article outlines the specifics as they apply to College programs in each country.

Australia – Commonwealth Qualified Privilege Scheme

What protection does qualified privilege provide?

The Commonwealth Qualified Privilege Scheme is legislated under Part VC of the *Health Insurance Act 1973*. The legislation was enacted in recognition that having medical practitioners participate in quality assurance activities generates significant public good for the community.

Qualified privilege is designed to protect practitioners by providing:

- Confidentiality of most information that identifies individuals and which becomes known as a result of a declared quality assurance activity.
  - It is an offence to make a record of, or disclose identifying information to another person or to a court.
  - In most cases a person cannot be required to disclose, or produce documents containing such information to a court.
- Protection from civil proceedings (apart from those relating to the rules of procedural fairness) for members of committees that assess or evaluate the quality of health services provided by others. The protection applies where:
  - The person engaged in the review process in good faith.
  - The review process adversely affects the rights or interest of a person who provides health services.
  - The relevant person participates in the review process as a member of a committee for the purpose of making an evaluation or assessment of the services provided by a healthcare practitioner.
  - All or a majority of the members of the committee are healthcare professionals belonging to the same healthcare profession as the person who provides health services[1].

How does qualified privilege fit with mandatory notifications?

Participants of a declared activity must not release identifying information that becomes known solely as a result of a quality assurance activity. For example, a practitioner is not likely to be compelled to provide identifying information revealed solely within a "protected" activity. However, this does not negate mandatory notification obligations regarding information received or actions witnessed outside of a protected activity.

The Australian Health Practitioner Regulation Agency defines notifiable conduct as:

- Practising while intoxicated by alcohol or drugs.
- Sexual misconduct in the practice of the profession.
- Placing the public at risk of substantial harm because of an impairment (health issue).
- Placing the public at risk because of a significant departure from accepted professional standards[2].

While largely consistent, there are differences between states regarding the mandatory notification process. Detailed information is available from the Australian Health Practitioner Regulation Agency at www.ahpra.gov.au/Notifications.aspx.

Where can I find further information?

Information for this article was sourced from the Department of Health fact sheets on qualified privilege. Additional information on the Commonwealth Qualified Privilege Scheme and Part VC of the *Health Insurance Act 1973* is available from: www.health.gov.au/internet/main/publishing.nsf/Content/qps-info

ANZCA's protected activities in Australia

Continuing professional development – practice evaluation and emergency responses

Existing qualified privilege covers the practice evaluation and emergency responses categories. All activities undertaken within these two categories as part of the ANZCA CPD program are covered under qualified privilege. Activities within the knowledge and skills category are outside the scope of the legislation and not covered under the declaration.

Reflective self-audit on cases and procedures within the ANZCA training portfolio system (TPS)

While the training portfolio system specifically advises users not to input identifying information, there was concern that reflections made by trainees on cases within this section could potentially be identifying or used in future litigation. The reflection section of the cases and procedures section of the TPS was declared by the Australian minister for health and provided qualified privilege.

Incident Recording and Reporting Program by the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC)

Information entered into the webAIRS is protected under the Commonwealth Qualified Privilege scheme. As an additional measure to ensure confidentiality, any identifying information inadvertently entered is manually de-identified prior to reports being provided to reviewers for consideration.

New Zealand – protected quality assurance activities (PQAA)

What protection does the PQAA mechanism provide?

In New Zealand, quality assurance activities can be protected under the *Health Practitioners Competence Assurance Act 2003 (HPCA Act)*[3] if the minister of health is satisfied that protecting the activity is in the public interest. The protected quality assurance activity (PQAA) mechanism in the HPCA Act protects the confidentiality of:

- Information that arises solely as a result of a PQAA.
- Documents brought into existence solely for the purposes of a PQAA.

Protected information is confidential and cannot be used in disciplinary and other proceedings against a person participating in the activity. It is an offence (with a fine not exceeding $NZ10,000) to make a record of PQAA information outside of the activity, or to disclose information to another person or in a judicial proceeding or investigation. This means it is essential for New Zealand Fellows and trainees of ANZCA to keep all information and documents that arise solely as a result of PQAAs confidential.

The PQAA mechanism also gives immunity from civil liability to persons who engage in PQAAs in good faith. Section 62 (1) of the HPCA Act outlines that: "No civil or disciplinary proceedings lie against any person in respect of conduct engaged in good faith in connection with a protected quality assurance activity."

What information is not protected under the PQAA mechanism?

Section 60 of the HPCA Act outlines scenarios where information is not protected under the PQAA mechanism. Information that arose solely as a result of a PQAA can be disclosed if all individuals who would be identified by the information (implicitly or explicitly) consent to the disclosure. Information or documents that do not identify any individual (either implicitly or explicitly) can also be disclosed. This means that if PQAA information is requested under the *Official Information Act 1982*[4], and the information can be de-identified, it may need to be released.

The minister of health can also authorise disclosure of PQAA information about conduct that constitutes or may constitute a serious offence, for the purposes of investigation or prosecution.

It is important to understand that only information and documents that arise solely as part of a PQAA are protected. Information that exists independently of the PQAA is not protected. For example, clinical records may be discussed or used as part of a PQAA, but because they exist independently of the PQAA, their confidentiality is not protected by the PQAA mechanism.

How does PQAA fit with open disclosure?

In New Zealand, open disclosure is a legal requirement under section 6(1) the Code of Rights[5], and under the Health and Disability Service Standards 2008[6]. When errors occur, patients are likely to be entitled to a full explanation of what happened and the error must be recorded. This means error reporting and recording must exist outside of PQAAs. Information or documents that arose solely as a result of the PQAA must still be kept confidential. However, information or documents that exist independently of the PQAA (such as information from clinical records) might need to be openly disclosed.

Where can I find further information?

Information for this article was sourced from a Ministry of Health fact sheet on PQAA, available here: www.health.govt.nz/publication/protected-quality-assurance-activities-under-health-practitioners-competence-assurance-act-2003.

Sections 52 to 63 of the *HPCA Act 2003* cover quality assurance activities. The HPCA Act 2003 is available here: www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html

Australian and NZ move to protect healthcare workers (continued)

What about local or hospital-based morbidity and mortality meetings or case reviews?
Qualified privilege in Australia or protected quality assurance activities in New Zealand are only protected when conducted under specific auspices of an activity that has been protected by ministerial approval. Practitioners should seek clarification from their own hospital as to what level of protection is or is not provided for hospital-based meetings.

Paul Cargill
ANZCA Policy Adviser, Australia

Virginia Lintott
ANZCA Senior Policy Adviser, New Zealand

References:
1. www.health.gov.au/internet/main/publishing.nsf/Content/qps-info.
2. www.ahpra.gov.au/Notifications/Who-can-make-a-notification/Mandatory-notifications.aspx.
3. www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html.
4. www.legislation.govt.nz/act/public/1982/0156/latest/DLM64785.html.
5. www.hdc.org.nz/the-act--code/the-code-of-rights.
6. www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards.

ANZCA's protected quality assurance activities in NZ

Under the HPCA Act, quality assurance activities are undertaken to improve the practice or competence of health practitioners, by assessing the services they perform, and include:

- Assessment or evaluation.
- Studying the incidence or causes of conditions or circumstances that could affect the quality of health services.
- Making recommendations about the performance of a service.
- Monitoring implementation of those recommendations.

Based on this definition, ANZCA has applied for and obtained protection for the quality assurance components of the ANZCA Continuing Professional Development Program, the training portfolio system – cases and procedures, and the ANZTADC – incident recording and reporting program. Gazette notices have been published with schedules detailing what activities are protected for each of the above three programs. The notices are available at the following links:

CPD program: www.legislation.govt.nz/regulation/public/2014/0139/latest/whole.html.

TPS – cases and procedures: http://legislation.govt.nz/regulation/public/2013/0375/5.0/whole.html#DLM5554903.

ANZTADC – incident recording and reporting system: www.legislation.govt.nz/regulation/public/2014/0113/latest/whole.html#DLM5976211.

Submissions

Australia:

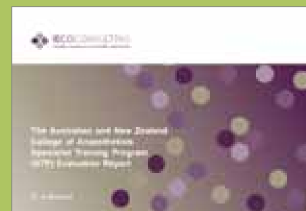
- Therapeutic Goods Administration – Proposal to enable appropriate access to medicinal cannabis products by creating new Schedule 8 entries.
- Department of Health Victoria – Medicinal Cannabis response re. Victorian Law Reform Commission findings.
- Department Education and Training – Skilled occupation list.
- RANZCR – Review of iodinated contrast guidelines.
- NSW Health – Regulation of private health facilities carrying out cosmetic surgery.

New Zealand:

- Ministry of Health – Update of the New Zealand Health Strategy.
- Ministry of Health – Draft options for the regulation of prescribing and dispensing in New Zealand.
- Ministry of Health – Draft Pharmacy Action Plan.
- Ministry of Health – Draft Mental Health and Addiction Workforce Action Plan.
- National Health Committee – Draft recommendations to improve the model of care for severe aortic stenosis.
- National Health Committee – Review of the model of care for lower back pain.
- Pharmac – Proposal to list products from Max Health Limited, including dexamethasone phosphate and neostigmine metasulphate.
- Pharmac – Proposal to award sole supply of propofol in district health board hospitals.
- Nursing Council of New Zealand – Education programme standards and competencies for the nurse practitioner scope of practice.

Many of the submissions can be found on the ANZCA website at www.anzca.edu.au/communications/advocacy.

STP evaluation report



ANZCA is pleased to announce the release of key findings and recommendations from a qualitative evaluation research project that explored the affect setting has on the quality of training in the Specialist Training Program (STP) and identified training issues for anaesthetists in expanded settings.

The Australian and New Zealand College of Anaesthetists Specialist Training Program (STP) Evaluation Report identifies a high level of support for STP posts and expanded settings and the valuable contribution they make to anaesthetic training. It suggests ways forward for the continuation and remodelling of the STP.

Access the report on the ANZCA website at www.anzca.edu.au/training/specialist-training-program.

ANZCA staff recognised

Several ANZCA staff have been recognised for achievements in 2015 in the annual Staff Recognition Awards.

Certificates were presented during the third annual Staff Recognition Awards by ANZCA's President Dr Genevieve Goulding, Vice-President Associate Professor David A Scott and Chief Executive Officer, John Ilott.

The awards align with the College's strategic priority to ensure ANZCA is a sustainable organisation through the objective of developing and retaining our best staff.

- Maurice Hennessy, Learning and Development Facilitator, Education Unit – Staff Excellence Individual Award for Customer Service.
- Monica Cronin, Curator Geoffrey Kaye Museum of Anaesthetic History – Staff Excellence Individual Award for Innovation or Process Improvement.
- Faculty of Pain Medicine Revised Curriculum Team (Helen Morris, Juliette Whittington, Penny McMorran, Deborah Sequiera, Jacqueline Rozario, Cassie Sparkes, Olly Jones, Gina Harwood, Maria Bishop, Professor Milton Cohen and Andrew Stapleton) – Staff Excellence Team Award.

ANZCA also recognised staff who achieved career milestones in 2015 – Helen Morris (20 years' service), Juliette Whittington (15 years), Sue Willmott, Renee McNamara, Gert Struve, Fraser Faithfull and Rose Chadwick (all 10 years) and Susan Collins, Katherine Hinton, Dinesh Ariyawansa, Dr Peter Roessler, Moira Besterwitch, Rebecca Dadhwal, Anthony Lam, Professor Milton Cohen, Rhian Foster, Warren O'Harae and Susan Ewart (all five years).

Clockwise from top left: Monica Cronin and Maurice Hennessy.

Jacqueline Rozario, Gina Harwood, Deborah Sequiera, Helen Morris, Olly Jones, Maria Bishop, Juliette Whittington, Cassie Sparkes, Penny McMorran and Andrew Stapleton. Absent: Professor Milton Cohen.

Joan Sheales' children Sarah and Simon with Monica Cronin, Professor Barry Baker and Dr Genevieve Goulding.

Joan Sheales award

The Joan Sheales Staff Education Award (grant amount of $A2000) was also presented at the ceremony.

This award was made thanks to a generous donation in 2014 by Professor Barry Baker in honour of the late past ANZCA CEO Ms Joan Sheales. Professor Baker is a past dean of ANZCA's precursor, the Faculty of Anaesthetists, Royal Australasian College of Surgeons and more recently ANZCA's Dean of Education and Executive Director of Professional Affairs until his retirement in 2014.

Curator Monica Cronin received this award, which will go towards her attendance at the International Symposium on the History of Anaesthesia in Boston, US, in October 2017.

The Graduate Outcomes Survey 2016 – your opinion counts

New Fellows of ANZCA and FPM are encouraged to complete a survey to help the College improve its services and address any concerns about workforce outcomes.

The Graduate Outcomes Survey is distributed every two years to Fellows within three years of attaining their fellowship. It is an online survey and generally takes no more than 15 to 20 minutes to complete. All responses are confidential and an analysis of the results will be published in the *ANZCA Bulletin* later this year. The results also guide our College in addressing issues related to its services and workforce outcomes for new Fellows.

This year the survey will be extended to Fellows of the Faculty of Pain Medicine.

In support of ANZCA's commitment to addressing bullying, discrimination and harassment, we have included a section in the 2016 survey which asks questions about your experiences with these issues. Responses will assist ANZCA in establishing and implementing robust processes and procedures to better deal with bullying, discrimination and harassment and the impact on Fellows.

A working group – led by myself and senior Fellows with support from the College – is responsible for the successful delivery of the Graduate Outcomes Survey, and preparation and approval of the questions. The working group also works with ACUITY Research for the professional delivery of the survey.

Why a graduate outcomes survey?

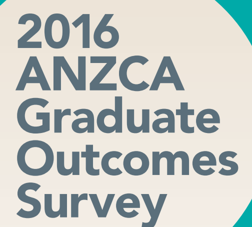
The Graduate Outcomes Survey was established and distributed in response to the Australian Medical Council's request for the College to "develop and implement a process to collect qualitative information" from new Fellows.

Its role is to gather information about the quality of services provided to new Fellows by ANZCA during their training and the employment outcomes of new Fellows.

Results from previous surveys have been used to refine and enhance these services.

Some of high-level findings from the 2014 survey showed:

- Satisfaction with all aspects of anaesthesia training was comparable to the 2013 survey results with training relevance (86 per cent excellent/very good); practical experience (82 per cent); and how well training prepared them for practice (76 per cent). Satisfaction with supervision received was 71 per cent and quality of ANZCA service 42 per cent.
- Eighty-nine per cent of graduates say they have entered the workforce and, of these, 95 per cent were providing services on a regular basis.
- The reported average hours worked per week increased slightly from 38.2 hours in 2013 to 39.5 hours in 2014 and satisfaction with hours worked slightly increased from 66 per cent in 2013 to 70 per cent in 2014.
- There is concern, yet some improvement, about future employment opportunities with 81 per cent agreeing there were more opportunities a decade ago; the number of Australian graduates who felt confident there would be enough career opportunities in Australia was up from 38 per cent in 2013 to 50 per cent in 2014; the proportion of graduates who felt confident there would will be quality options in locations they want to work increased from 43 per cent in 2013 to 48 per cent in 2014 (but 19 per cent strongly disagree with this) and 75 per cent would still recommend anaesthesia as a career.



More detailed information is available in the December 2014 *ANZCA Bulletin*, which can be accessed via www.anzca.edu.au/communications/anzca-bulletin.

What happens next?

New Fellows will receive an email from ANZCA in early June 2016 asking them to participate in the Graduate Outcomes Survey. A unique link to the survey will be embedded in this email.

The survey will be open between four to six weeks; during this time reminder emails will be sent and the survey will be promoted on social media. I will telephone a small selection of Fellows and talk through reactions to the survey, answer any questions and encourage participation.

Thank you in advance to all new Fellows for taking part in the 2016 Graduate Outcomes Survey, which is a valuable and essential tool in ensuring your College understands what is important to you.

Dr Scott Ma, FANZCA
ANZCA New Fellow Councillor

What would you do?

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

What are you worth?

With the beginning of another new year it is a good time to consider a controversial matter that explores a fundamental concept.

A young new Fellow in a large regional centre comes to you for advice. Several specialists have offered him or her an opportunity to administer anaesthesia on a regular basis in private. Your colleague's concern, however, is that each intends to siphon off a percentage of the patient fees to subsidise marketing and overheads, websites, rooms and business managers.

The real concern, however, is that they pointedly remind the anaesthetist of the current tight workforce environment.

What would you do?

Would you accept or refuse or negotiate?

Unfortunately, this is not an uncommon scenario. Individual surgeons and various facilities, such as day-surgery centres or endoscopy suites, may make demands that include determining fees anaesthetists charge, or demanding fees in exchange for access to private lists. Sometimes these proceduralists/surgeons have a financial interest in their private facilities, but occasionally they are simply price-conscious.

While the issue of financial arrangements is not the remit of the College and advice may be sought from the Australian Society of Anaesthetists, standards and professionalism are at stake involving relationships, teamwork and collaboration.

Is inducement a form of harassment? Not really, but when followed by a statement alluding to scarcity of opportunity it begins to cut close to the line.

Offers such as the one above beg the question as to the proceduralist's criteria for selection of anaesthetists. Are they based on skills and relationships developed with the anaesthetist or are they purely financial? The worry about these sorts of offers is the underlying lack of regard for colleagues and, in this instance, the intent to take advantage of perceived hardships for personal financial gain. The likelihood of such relationships lasting long-term would have to be low.

These sorts of offers question the value placed on anaesthetists and effectively relegate them to technicians. Morals and ethics are important at all times and should never be discarded. The decision to undertake a career in a vocational profession such as medicine may have financial motivations in addition to altruistic ones; however, if the financial considerations become the overriding factor then the medical profession will become indistinguishable from other businesses where all that matters is the bottom line.

In the above scenario, one has to ask whether it presents a favourable environment that encourages free communication and collaboration regarding standards, and appropriate consultation regarding quality patient care.

Unlike the public system where access to beds is the limiting factor, in private practice competition is for access to patients. Such competition in the marketplace poses a challenge for all surgeons and proceduralists, who understandably tend to resort to innovative means for attracting "market share".

Where income is the main driver or, worse still, the sole driver, there will be considerable pressure to maximise profits.

The reason for raising this topic is not to appraise the pros and cons of private practice financial arrangements, but rather the potential implications on standards and practices in circumstances where team members are undervalued.

With a focus on the "bottom line" to the extent of extracting a portion of the anaesthesia fee, anaesthetists should satisfy themselves regarding the facility's compliance with regulations, licencing and accreditation, as well as record keeping and the ability to undertake clinical audits. While many facilities are compliant, concern may arise in cases such as above where a fee is demanded from the anaesthetist.

The relevant areas of compliance with ANZCA professional documents include consideration of:

Equipment

- PS54 *Statement on the Minimum Safety Requirements for Anaesthetic Machines and Workstations for Clinical Practice*
- PS55 *Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations*
- PS56 *Guidelines on Equipment to Manage a Difficult Airway During Anaesthesia*
- PS18 *Guidelines on Monitoring During Anaesthesia*

Staffing

- PS08 *Statement on the Assistant for the Anaesthetist*
- PS31 *Guidelines on Checking Anaesthesia Delivery Systems*
- PS53 *Statement on the Handover Responsibilities of the Anaesthetist*

Standards of care

- PS07 *Guidelines for the Pre-Anaesthesia Consultation*
- PS26 *Guidelines on Infection Control in Anaesthesia*

Due to demands for high turnover, there may be limited time and facility for adequate preoperative consultation, preparation and checking of equipment, presence of appropriate staff and handover to post-anaesthesia care unit staff.

Limitations to conducting pre-anaesthesia consultation may result in claims being submitted to Medicare that clearly do not attract a rebate. Submitting a fee for this is fraudulent and carries serious consequences.

In a competitive anaesthesia market, innovative offers will be proffered by surgeons/proceduralists and will be accepted by Fellows. During negotiations it would be wise to ensure that anaesthesia is not devalued and your worth is appreciated. Hopefully this will be helpful in considering inducements and offers.

Dr Peter Roessler,
Director of Professional Affairs,
Professional Documents

Professional documents – update

The professional documents of ANZCA and FPM are an important resource for promoting the quality and safety of patient care. They provide guidance to trainees and Fellows on standards of clinical care, define policies, and serve other purposes that the College deems appropriate. Professional documents are also referred to by government and other bodies as an indicator of expected standards, including with regard to accreditation of healthcare facilities.

Professional documents are subject to regular review and are amended in accordance with changes in knowledge, practice and technology.

Recent releases:

A revised version of *PS18 Guidelines on Monitoring During Anaesthesia* was released in December 2015 for a 12-month pilot period. The title has been changed from "recommendations" to "guidelines" to align with the current professional document categories. Changes to *PS18* include clarification that "monitoring" covers clinical observation as well as measurement of applicable and relevant variables, and updated recommendations for use of the various types of monitoring equipment available today. A newly developed background paper was also released.

The revised *PS50 Guidelines on Return to Anaesthesia Practice for Anaesthetists* was also released for a pilot period in February 2016. *PS50* has undergone significant modification in light of regulatory changes and the need to ensure consistency with current continuing professional development (CPD) requirements. Both the Medical Board of Australia and Medical Council of New Zealand were consulted and separate templates for return to practice programs in Australia and New Zealand have been developed. Other changes include emphasising that completion of a return to practice program is recommended although voluntary (unless mandated by another body) and that duration and content of the program is flexible.

Feedback is encouraged on all professional documents undergoing the pilot phase (marked **PILOT** on the website). This is your opportunity to add value, be involved in the development and review process and have some input into final versions of these important college publications. Queries or feedback regarding professional documents can be directed to profdocs@anzca.edu.au.

The complete range of ANZCA professional documents is available via the ANZCA website, www.anzca.edu.au/resources/professional-documents.

FPM professional documents can be accessed via the FPM website, www.fpm.anzca.edu.au/resources/professional-documents.

Cosmetic surgery in the spotlight

Doctor saved my life: breast surgery patient

Facing up to the risks of surgery

DRASTIC SURGERY

Cosmetic clinic investigated after second heart attack

Cosmetic operations HCCC complaint filed

Stoush over horror surgery gets personal

Taking risky surgical cuts

BEAUTY AT WHATEVER THE COST

Cosmetic surgery Danger in office ops

Doctors warn of 'conscious sedation' risk to patients

Amy Corderoy

Health editor

Special report: Surgeons putting lives at risk

KNIFE AND DEATH

Cosmetic surgery Woman treated for toxicity

Local anaesthetic overdose 'likely cause of cardiac arrest'

Anna Patty

Nip-tuck surgery a heart stopper

> As there is no requirement for reporting of adverse events from unlicensed facilities, the real incidence of complications in patients having cosmetic procedures is unknown.

THERE ARE NOW TWO STANDARDS OF CARE DEPENDING ON WHETHER COSMETIC SURGERY IS PERFORMED IN A LICENSED OR UNLICENSED FACILITY.

ANZCA Safety and Quality Chair, Dr Phillipa Hore explains.

Tabloid newspapers are not part of my normal reading diet but for months last year I was fed a regular supply of them with attention-grabbing headlines: "Beauty at whatever the cost" (*The Examiner*, Launceston April 25); "Facing up to the risks of surgery" (*The Age*, April 18); "Cosmetic surgery: danger in office ops"; "Beauty's deadly gamble" (*Daily Telegraph*, July 11); and "Taking risky surgical cuts" (*Weekend Post*, Cairns, August 18).

I also was introduced to a widely read and highly regarded blog on women's issues. The largely unregulated world of cosmetic surgery exploded into the public eye with a series of adverse events involving young women having breast implants at unlicensed cosmetic surgery facilities in Sydney.

Under investigation by the NSW Health Care Complaints Commission are a number of cases including cardiac arrests, seizures and a pneumothorax. However, as there is no requirement for reporting of adverse events from unlicensed facilities, the real incidence of complications in patients having cosmetic procedures is unknown.

Cosmetic surgery is a burgeoning industry. Australian clinics are competing with an offshore market, primarily in Thailand, although the fall in the Australian dollar has seen a commensurate decrease in patients seeking procedures overseas. In Sydney and Melbourne, clinics offer breast enlargements for $5990, including a $5 per day plan. One such Sydney clinic claims to do 5000 breast enhancements a year.

Cosmetic procedures are performed outside the public health system and frequently outside a hospital or licensed day-care facility altogether. They are entirely elective and usually requested by the consumer without referral from a GP, who would have knowledge of a patient's general health. Screening and medical assessment may not form part of the management and informed consent, including provision of information regarding the risks of local anaesthesia and sedation, is not mandated.

Any registered medical practitioner can perform cosmetic surgery. Formal training varies from none to advanced training in plastic surgery. Similar variation is found in the facilities in which such procedures are performed, which range from practitioners' rooms or larger unlicensed facilities through to accredited hospitals and day-care facilities, which have to comply with the National Safety and Quality Health Service Standards.

There are jurisdictional differences in licensing requirements. The term "conscious sedation" has been used in the *NSW Private Health Facilities Act*[1] to define categories of facilities for licensing. That is, the depth of sedation is used to determine the requirement for licensing rather than the procedure itself.

General anaesthesia, epidural, spinal or major regional anaesthesia can only be undertaken in a licensed facility. This approach has pitfalls. It has led, in some unlicensed facilities, to the use of excessive doses of local anaesthetic in order to avoid deeper sedation and hence licensing. The risk of local anaesthetic systemic toxicity is real.

Of equal concern is that conscious sedation, allowable in unlicensed facilities, forms part of the sedation spectrum. ANZCA professional document *PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures* defines conscious sedation as "a drug-induced depression of consciousness during which patients are able to respond purposefully to verbal commands or light tactile stimulation. Interventions to maintain a patient airway, spontaneous ventilation or cardiovascular function may, in exceptional situations, be required."

(continued next page)

Cosmetic surgery in the spotlight

Individual patient sensitivities imply unpredictability of response to sedative drugs and the avoidance of transition from conscious sedation to deeper sedation cannot be guaranteed. In a number of cosmetic surgical practices, anaesthetists are the providers of the sedation and are clearly capable of managing a patient who loses consciousness.

The problem then lies in the potential inadequacy of the facility itself. While it is possible in a hospital environment to convert from conscious sedation to general anaesthesia (for example, in the event of patient distress) this is not an option in an unlicensed facility.

Licensing ensures that certain standards are met including:

- Provision of appropriately qualified staff.
- Adequate numbers of staff.
- Provision of appropriate equipment (including resuscitation equipment).
- Incident/adverse event management and reporting.
- Audit.
- Infection control policies.
- Drug-handling compliance.
- Emergency access (including mechanisms for transfer of patients to another healthcare facility if required) and compliance with relevant building codes.

Any patient having more than a minor procedure should have the right to care in a facility that meets these basic requirements.

Every anaesthetist should be aware of the licensing status of the facility in which they provide care. ANZCA's Code of Professional Conduct states that "Fellows should be familiar with and respect the particular legal obligations and responsibilities, codes of conduct, guidelines and other regulations applicable to medical practice in general that apply within their jurisdiction".

The presence of an anaesthetist is a significant safety advantage for patients undergoing larger cosmetic procedures whether providing sedation or general anaesthesia.

In addition to risk stratification, an anaesthetist can advise the proceduralist about the likelihood of success for a chosen anaesthetic technique (such as sedation/local anaesthesia), advise on appropriate local anaesthetic doses, appropriately monitor patients and manage complications should they arise.

Patients need to be advised that no surgical procedure is without risk. The use of poorly defined and ambiguous terms such as "twilight sedation" in cosmetic surgery patient literature is designed to give comfort. Anaesthetists need to provide valid and accurate information to enable shared decision-making and informed consent.

ANZCA provided a submission to the Medical Board of Australia's review of cosmetic procedures[2] and has provided recent input to the review of the cosmetic surgery industry in NSW by providing comment on the discussion paper *Cosmetic Surgery and the Private Health Facilities Act 2007: The Regulation of Facilities Carrying out Cosmetic Surgery.*

ANZCA recommends that the requirement for licensing should be determined by:

- The surgical procedure (as determined by expert surgical opinion)
- The use of anaesthesia or sedation.

ANZCA believes any patient having a procedure that requires intravenous sedation or local anaesthetic doses approaching maximum recommended should have their surgery in a licensed facility.

There is now the potential for two standards of care for a given procedure, depending on whether it is performed in a licensed facility or one not licensed and not subject to regulatory control.

In all of this, the media has served a useful purpose with the racy headlines, and images of ambulances and young women. In November: "Boob jobs clinic cleans up its act. Cardiac arrests spark safer surgery switch" (*Daily Telegraph*, November 28).

According to the story, the Sydney cosmetic surgery clinic where a number of women experienced severe complications "is now doing all breast enlargements under a general anesthetic" in private hospitals "where surgery is overseen by the health department and subject to audit".

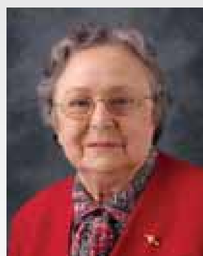
Dr Phillipa Hore
Chair, Safety and Quality Committee

References:

1. NSW Private Health Facilities Act 2007. www.health.nsw.gov.au/hospitals/privatehealth/pages/default.aspx
2. www.medicalboard.gov.au/News/Past-Consultations.aspx.

"ANZCA believes any patient having a procedure that requires intravenous sedation or local anaesthetic doses approaching maximum recommended should have their surgery in a licensed facility.

A remarkable life



Professor Tess Cramond was a pioneering anaesthetist and pain specialist who touched many lives, both directly and indirectly through her dedication to medicine.

When Professor Tess Cramond realised her own health was failing she decided to make arrangements for her own funeral as there had been some organisational difficulties following the sudden and unexpected death of her husband of 27 years, Humphry. I was stunned when she asked me to deliver a eulogy – one of three.

We had affectionately called her the Godmother as she was prone to making you an offer you could not refuse. This usually involved a task that you would consider to be beyond your level of expertise or to which you felt you were totally unsuited. To make the task easier, she gave me seven handwritten foolscap pages with what I had to say. Her writing looks neat but is almost illegible. On the next visit she produced two typed written sheets with details she had not included in the initial text.

Tess was a devout Catholic and had forged a friendship with the priest at the local church, Father Peter Gillam. Although retired, he still performed some duties at the church and visited her regularly at "Viridian" where she was in monitored care. It had been recently built in the grounds of Nudgee College and housed many members of similar faith. The funeral was to have been held at her local church but it was decided that it had insufficient capacity to cope with the estimated numbers attending. The final arrangements were completed by Elizabeth Carrigan, her niece and daughter of her only surviving sister Joan. The service was to be held at St Stephen's Cathedral.

The requiem mass commenced with a procession of six priests headed by Peter Gillam through a packed cathedral with some people in the congregation dressed to show their group membership. The Knights of Malta were particularly well represented.

After the welcome, a message of condolence from Archbishop Mark Coleridge was read prior to the placing of symbols on the coffin. There had been so many requests for items to be placed that these had to be limited to six. The first was a white robe as a reminder of baptism into the church and this was followed by a crucifix, a gown from the Order of Malta, a graduation certificate and stethoscope, an MD gown and citation, decorations and awards and Surf Life Saving memorabilia. The last of these was placed by an aged Alan Doig, one of the four lifesavers who volunteered for the demonstration of new lifesaving techniques in the early '60s.

The mass continued with prayers of the faithful being read by younger members of both families, Brophy and Cramond. Following communion, three speakers delivered reflections and remembrances. The first was Robert Ritchie, a nephew, who spoke of family heritage and the generosity and support Tess had given to nieces and nephews who were treated like her own children.

Next I spoke of her professional life, my personal experience including some of the stories she related during interviews we had prepared prior to a formal presentation for the College. The final speaker was supposed to be Jack Truelove, another of the four lifesavers, but he was hospitalised with a chest infection and his place was taken by Ron Rankin. He outlined her contribution to resuscitation in Surf Life Saving, the electricity industry and with the Resuscitation Council. She was quietly buried at the Nudgee cemetery next to her husband of 27 years.

My first contact with Tess was as an anaesthetic registrar in the neurosurgical unit – 4B – at the Brisbane General Hospital in 1966. I was told she was difficult to work with as she required you to be on time, be well dressed and do things her way.

She had developed a well-balanced and safe technique which she had acquired during her two years at the London Hospital. As a result, she recommended many trainees spend time overseas and 16 local anaesthetists have spent time at the London. We were also involved with evaluation of new drugs (fentanyl and droperidol) as well as the management of severe pain.

Tess purchased her own ventilator and had the engineers make a gas bypass which would inflate the blood pressure cuff and patients were monitored by an ECG. She battled with the nursing hierarchy to establish a training program for anaesthetic technicians and have them under the control of the department.

Even at this stage she was being recognised as a force within the anaesthesia community. Her attitude was "if you do a job, do it well". If you do a job well it is more than likely you will be asked to complete more tasks.

She became federal secretary of the Australian Society of Anaesthetists (ASA) from 1960-64 at a time when her general practitioner in Emerald as a young girl, Roger Bennet, was president. The ASA took legal advice and mounted a challenge to the Faculty of Anaesthetists, Royal Australasian College of Surgeons, who wanted to take charge of financial affairs relating to anaesthetists. Their opinion was that the Faculty would lose its tax-free status if it indulged in these matters.

The dean of the Faculty at the time was her good friend Mary Burnell and she was reluctant to talk about this incident until much later. Roger had a significant influence on her career, not only with medical politics, but he was instrumental in arousing her interest in resuscitation. When he developed intractable pain from Hodgkin sarcoma Tess determined there was a need to improve treatment in this area.

In 1964 she resigned her position with the ASA and accepted a position in Dallas, primarily to set up a neuroanaesthesia unit. She witnessed racial and sexual discrimination as well as extreme violence and described the experience as "awful". She returned home and was elected to the board of the Faculty at her second attempt in 1965. Her attitude was that even if you don't get elected it is important to keep your name where it can be recognised.

As well as developing a busy private practice, her Faculty commitment meant she was involved not only with teaching but also the setting of standards of practice and recognition of the examination process. She negotiated the rotational training program in this state and had been impressed with her Victorian colleagues who kept places at their hospitals for registrars from other states.

Tess became dean of the Faculty in 1972, having filled the positions as assessor and vice-dean. She said some people thought if you were polite, small and female that you were weak. This was not the case with Tess as she steadfastly maintained her position in negotiations with the college of surgeons, increased their representation to two and commenced the movement to achieve financial separation from the College.

At the 21st anniversary of the founding of the Faculty, the Orton Medal was conferred on Jim McCulloch and Geoffrey Kaye. Geoffrey was one of the earliest anaesthetists in Australia and had previously fallen foul of the administration but this had brought him back to the fold. The vice-dean at the time was Brian Dwyer and his pain unit was the example followed in setting up the multi-disciplinary pain unit that now bears her name at the Royal Brisbane & Women's Hospital.

Her interests were now extremely wide and recognition began to flow. She was awarded an Order of the British Empire in 1977 and became a foundation professor of anaesthetics the following year, a position she filled until 1993. Her teaching activities were widened to include the Red Cross and St John's Ambulance, Surf Life Saving and the Electricity Authority. She demonstrated in all situations and although the cherry pickers were no obstacle she detested the spiders in the electricity substation pits.

After her retirement from anaesthesia she turned her attention to pain management having already raised the funds necessary to employ pharmacologists and research scientists to investigate the use of drugs used to relieve pain.

The Australian Medical Association had also been part of her life and she was president of the local branch in 1982. The rural representative was Humphry Cramond who had been at medical school with her and had lost his wife several years previously. They were married in 1985 and enjoyed 27 years together. Her comment was "he was worth waiting for".

Asked if she intended to change her name after the wedding, she said marriage was a sacrament for life with someone you loved and she was happy to change her name.

Humphry was president of the Nudgee Old Boys Association so she broadened her interests and was seen at a rugby match.

Her professional activities associated with medicine were extensive. She was a member of the medical board, Medical Defence Society, Editorial Committee of Anaesthesia and Intensive Care, Selection Committee for the Rhodes scholarship, the National Health and Medical Research Council, the Senate and Academic Board of the University of Queensland and the Catholic University, and the National Anaesthetics Mortality Committee.

> "Even at this stage she was being recognised as a force within the anaesthesia community. Her attitude was 'if you do a job, do it well'."

The awards that followed included the Robert Orton Medal from the Faculty, the Order of Australia and an honorary fellowship from the College of Anaesthetists of Ireland. As a devoted Catholic she listed audiences with two Popes in the highlights of her career.

Following the sudden death of Humphry in April 2014, her physical condition deteriorated quite rapidly although her mental state remained sharp.

This was an extraordinary life of someone who dedicated herself to improving the health and safety of our current generation, to educate the next generation and to establish a safe and respected community in which we can all exist.

Dr John Hains, FANZCA
Brisbane

This page clockwise from left: Dr Tess Brophy (later Professor Tess Cramond) became dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons (FARACS) in 1972; The Robert Orton Medal was presented to Dr Geoffrey Kaye (centre) in 1974. To Dr Kaye's left are Dr Allan Lamphee, a South Australian foundation Fellow and Dr William Watt, FARACS Board member, and to Dr Kaye's right are Dr Brophy and Dr Gwen Wilson, Honorary Faculty Historian; Professor Cramond with her beloved husband, the late Dr Humphry Cramond.

Farewelling a pioneer in pain medicine

Professor Tess Cramond was inspired to establish Australia's second multidisciplinary pain centre at the Royal Brisbane Hospital after helping a colleague with uncontrolled cancer pain.

The passing of Professor Tess Cramond in December 2015, eight weeks prior to her 90th birthday, marked the end of a remarkable life well lived. Tess was a devoted doctor with an unparalleled sense of caring and commitment to service, a trail-blazing woman, wise teacher, nurturing mentor and tireless advocate of the patient. Tess was a leader by example and an internationally acclaimed pioneer of anaesthesia and pain medicine.

Tess's primary focus was always a determined attention to high-level patient care. This was evident early in her career as an anaesthetist and later, in 1967, when Tess was called upon to assist a colleague with uncontrolled cancer pain – it was this experience that inspired her to dedicate her career to helping ease the burden of people suffering in pain and to establish the multidisciplinary pain centre (the second in Australia) at the Royal Brisbane Hospital. In 2008, to honour Tess and her many years of service, the centre was renamed the Professor Tess Cramond Multidisciplinary Pain Centre (PTCMPC).

Tess was proud of maintaining a multidisciplinary focus from the beginning and the centre continued to grow under her strong leadership over the next 42 years. Research was an intrinsic component of PTCMPC with involvement in multicentre trials and numerous PhD and Masters degrees. Tess received strong support from the surgeons in the burns and neurosurgery units and it was these relationships that led to her involvement in major burn injury and also to one of the world's largest series of percutaneous lateral cervical cordotomy procedures for unilateral cancer pain.

Tess promoted teaching and education in pain management long before the establishment of the Faculty of Pain Medicine and was a strong supporter of the Faculty when established. Tess was granted a foundation fellowship of the Faculty in 1999 and served as an examiner for many years. The PTCMPC was one of the inaugural centres accredited for training in pain medicine from 1999 and under Tess's mentorship, has supported many local and international trainees to successfully complete their training. She encouraged the establishment of the Queensland Regional Committee of the Faculty – the first in Australia.

Tess's extensive contributions were recognised with multiple awards and honours, including an Order of the British Empire (OBE) and an Officer of the Order of Australia (AO), an Advance Australia Award, a Red Cross Long Service Award and the AMA Women in Medicine Award. She was the first recipient of the Distinguished Member Award of the Australian Pain Society and was awarded an honorary fellowship of the Australian Chapter of Palliative Medicine. The University of Queensland has awarded her the degree of Doctor of Medicine Honoris Causa and the Australian Catholic University admitted her as Doctor of the University. She has also been awarded the Gold Medal, Faculty of Anaesthetists, Royal College of Surgeons and the Robert Orton Medal, Faculty of Anaesthetists, RACS.

Tess was the first female president of the AMAQ in 1981 and served on many state and national committees.

Her high standards of patient care were underpinned by a strong faith. In 1974, Tess became a founding member of the Brisbane branch of the Order of Malta – a lay Catholic Order of Chivalry whose members were committed to helping the poor and the sick.

Tess reflected in her retirement speech, "What do I regard as my contribution to the profession – and directly or indirectly to this hospital (RBWH)?

- Foremost, the care of the individual patient be it in the ward, in theatre or in outpatients – meeting their physical, emotional and spiritual needs.
- The training of medical students, residents and registrars first in anaesthesia and subsequently in pain medicine.
- The introduction of rotational training in anaesthesia – the first in Australia in 1968 and thus ensuring a decentralised specialist anaesthetic service for this state.
- Accreditation of four training posts in pain medicine.
- The introduction of anaesthetic technicians as an integral part of the multidisciplinary anaesthetics team.
- The establishment of the multidisciplinary pain centre (MPC), and,
- Last, but no means least, persuasion of Queensland Health to develop a plan for pain services in Queensland."

Tess was an inspirational mentor who lived and encouraged dedication and contribution to the medical profession she loved. She truly considered medical practice to be a vocation. Tess regarded it a privilege to be employed in the public hospital system paid for by the community and she delivered tirelessly in return.

She inspired those who learnt under her tutelage and took immense pride in their achievements. Tess taught that there was no greater privilege than to be allowed to enter into the life of a patient as their doctor.

Outside her medical life Tess was a loyal devotee and passionate contributor to Surf Lifesaving in Queensland and Australia. Tess was instrumental in the introduction of mandatory CPR for surf lifesavers. She was an honorary life member of Surf Lifesaving Qld and Surf Lifesaving Australia.

Tess's greatest devotion was to friends and family and especially to her loving husband Humphry, who very many of her colleagues knew well. Tess continued to attend many anaesthesia and pain medicine meetings even in her frail later years. Humphry was always at her side.

It is fitting to leave the final words to Tess. These were the closing remarks from her retirement celebration in 2009:

"Initially, I will miss the patients, whose courage has so often been inspirational, and the daily contact with my colleagues, but I look forward to having more time with Humphry and our extended family, to supervising the gardener, to enjoying the matinees at QPAC (Queensland Performing Arts Centre), reading the 'must do' books that have been neglected, having morning tea or lunch with friends."

Professor Tess Cramond will be missed.

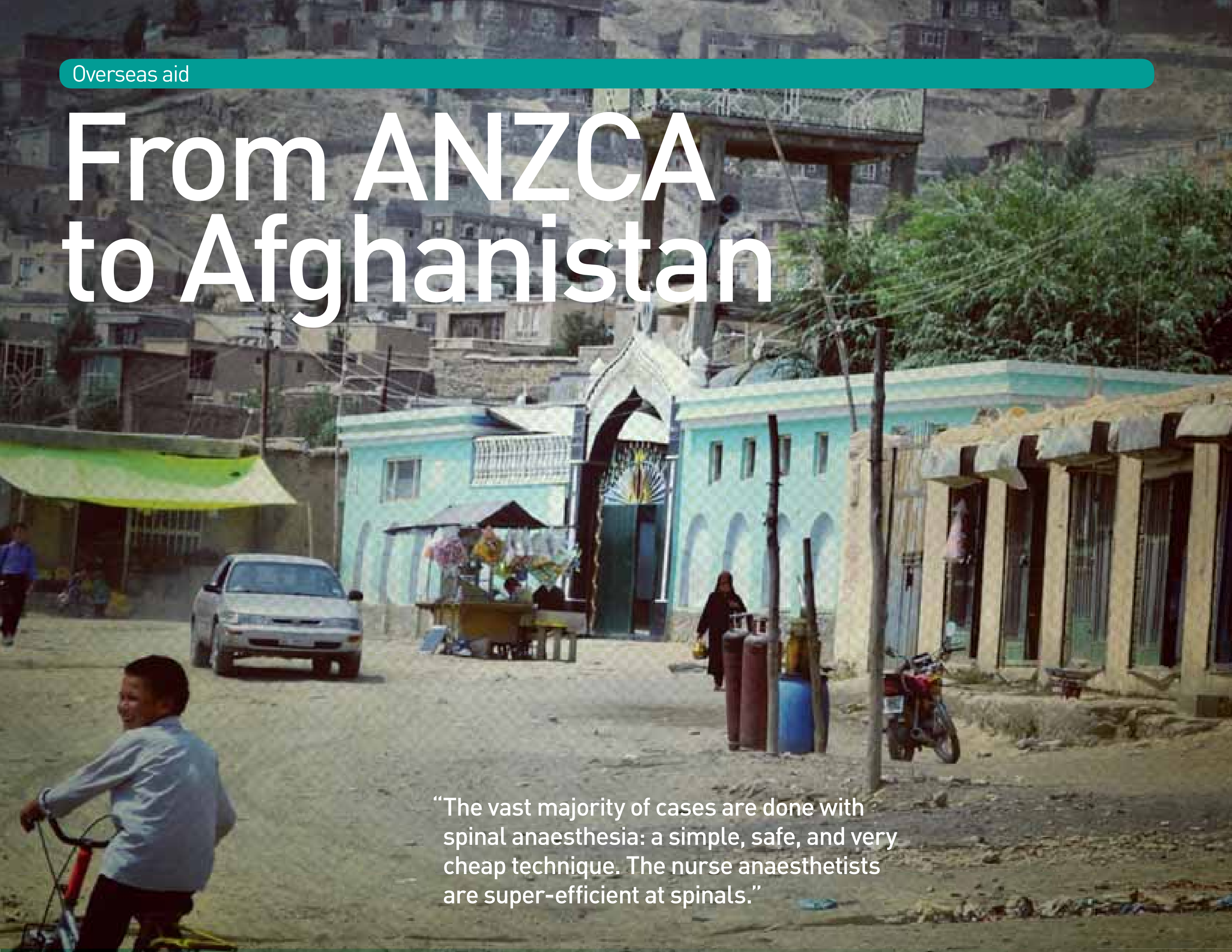
Dr Paul Gray, FANZCA, FFPMANZCA
Associate Professor Brendan Moore, FANZCA, FFPMANZCA

"Tess was a leader by example and an internationally acclaimed pioneer of anaesthesia and pain medicine."

Above from left: The Governor of Queensland, Quentin Bryce, opened the Professor Tess Cramond Multidisciplinary Pain Centre in 2008; Professor Tess Cramond.

Overseas aid

From ANZCA to Afghanistan



"The vast majority of cases are done with spinal anaesthesia: a simple, safe, and very cheap technique. The nurse anaesthetists are super-efficient at spinals."

Sydney anaesthetist and former ASM scientific convenor Dr Tim McCulloch took a break from his role at an inner-city teaching hospital in January to join Médecins Sans Frontières in Afghanistan. He describes his work in a comprehensive obstetrics and newborn care centre.

Working in Dasht-e-Barchi couldn't be more different from that at home. My main role as an anaesthetist in this project is to work with a team of Afghani nurse-anaesthetists looking after women requiring emergency caesarean sections.

In an environment like this, where there's uncertainty about the management of future pregnancies, Médecins Sans Frontières tries to avoid unnecessary caesareans, so one might expect the theatre workload to be fairly light. However, the reputation of our hospital has grown and the number of admissions is staggering for such a new and very small facility.

At over 1100 deliveries a month, even a low section rate translates to more than 50 operations in my first three weeks here. I have already rushed two eclamptic women to theatre, one for delivery of a live baby but the other for an intrauterine death. Unfortunately losing babies here is not uncommon.

Back in Sydney, I work full-time at a tertiary inner-city teaching hospital where I often find myself in high-tech environments, such as the intra-operative MRI theatre and the hybrid interventional vascular room. I'm also involved in clinical research and was recently scientific convenor of a major ANZCA conference. All of this is a far cry from providing safe, basic – but quality – care in a resource-deprived community.

The operating theatre in Dasht-e-Barchi has a draw-over anaesthetic circuit with an electronically controlled bellows for ventilation. Oxygen comes from a concentrator, with some (unlabelled) cylinders in the corner in case of electrical failure. But the vast majority of cases are done with spinal anaesthesia: a simple, safe, and very cheap technique. The nurse anaesthetists are super-efficient at spinals. There is a very good monitor that only lacks agent analysis – and, of course, no EEG monitoring.

Médecins Sans Frontières' huge experience in delivering anaesthesia in difficult circumstances has been distilled into a collection of sensible protocols, which helped me prepare. Also, I was lucky to get a place on the excellent Real World Anaesthesia Course held in Darwin last year where I gained some familiarity with draw-over systems and met wonderful anaesthetists with a wealth of overseas experience.

Some techniques considered bread-and-butter in obstetric anaesthesia in Australia are pretty much forbidden by Médecins Sans Frontières, and for good reasons. There is no epidural service – in fact no epidural kits – and neuraxial opioids are not used. The risks of these more complex techniques are too great when the level of training and the reliability of clinical monitoring is variable and the number of patients is sometimes overwhelming.

Sometimes the anaesthetist is the best-qualified person to look after problems that would be considered outside my usual scope of practice at home. Without an ICU, there was no "park-and-run" option for the post-op eclamptic woman with florid pulmonary oedema and shutdown peripheries, so I had to manage as best I could (she recovered).

My other roles include some teaching for the nurse anaesthetists, solving equipment issues, managing the sicker post-operative patients, and working with the team to generally improve the quality of care. We are currently working on implementing a safe-surgery checklist in the operating theatre.

One of the many learning experiences on a first field placement is spending all day, every day, living, eating and working with a small group of strong-minded people from many parts of the world. There is obvious potential for misunderstandings and disagreements to boil over, but fortunately my experience has been fun and easy. In this project, the anaesthetist is permanently on call so I can't ever be far from the hospital.

I suppose the most important quality to cultivate when working on a project like this is flexibility and an appreciation of the fundamental aims of what we – as an organisation – are trying to achieve.

Modern medicine has become very complex as we grapple with chronic conditions and embark on surgery in ever-sicker patients.

Anaesthetic trainees are acquiring new skills, such as echocardiography on the operating table, to help massage frail patients through major interventions. These advances are terrific and professionally rewarding, but it's worth keeping in mind that the greatest good to the greatest number of people comes from simple operations under basic, safe anaesthesia.

Another consideration for those considering this line of work is financial. If you want to help out with humanitarian work then be careful not to accumulate debts and cultivate a lifestyle that makes you reliant on never missing a month of your – by world standards – very high income. Having said that, anaesthetists are fortunate in that we can be usefully employed on short missions, so it's possible to do field work with relatively minor disruption to our careers.

I've known of Médecins Sans Frontières since I was a medical student; I always thought one day I would like to work for them, but it never seemed the right time. In the end, I waited until both my kids finished high school before joining the team in Afghanistan this year.

Of the professions for which there is a great need in the developing world, anaesthesia is certainly one.

Dr Tim McCullouch, FANZCA
Royal Prince Alfred Hospital, NSW

One hospital in Dasht-e-Barchi

The area of Dasht-e-Barchi has more than one million inhabitants, but only one public hospital and three public health centres. The population is predominately Hazara, a people from the central Afghan mountains who are said to be descendants of Genghis Khan's invading forces. The Hazara people are struggling economically and have very little access to antenatal or perinatal health, which partly contributes to a very high fertility rate. About a year ago, in a bid to reduce maternal and neonatal mortality, Médecins Sans Frontières opened a new obstetric department within the hospital, providing free, around-the-clock care for women presenting with complications in pregnancy or labour, and for sick and at-risk newborns.

MSF recruiting

Médecins Sans Frontières Australia is looking for anaesthetists to work in the field. You must be able to commit to a minimum of six weeks. To learn more, visit www.msf.org.au/recruitment/.

MSF yes
msf.org.au/yes
MEDECINS SANS FRONTIERES DOCTORS WITHOUT BORDERS

Opposite page: The hospital in Dasht-e-Barchi, with three small clinics, is the only public health facility in this district of Kabul and serves a population of more than a million people.

This page above from left: Dr Tim McCulloch working in Afghanistan; In November 2014, Médecins Sans Frontières opened a comprehensive obstetrics and newborn-care centre in the hospital to focus on the management of complicated deliveries.

Photographs by Mathilde Vu/MSF.

ATACAS-aspirin published in New England Journal of Medicine

The Aspirin and Tranexamic Acid for Coronary Artery Surgery (ATACAS) trial is the world's largest randomised trial ever to evaluate the safety and effectiveness of aspirin in cardiac surgery.

The trial received more than $A4.5 million dollars from the National Health and Medical Research Council, and also was funded by ANZCA. ATACAS has been running for more than 10 years and with 4662 patients recruited at more than 30 cardiac sites in six countries.

Professor Paul Myles, the principal investigator of the ATACAS trial, showcased the results of the ATACAS aspirin arm at the 2015 ANZCA Annual Scientific Meeting in Adelaide in front of a large audience of anaesthetists and trial co-ordinators. Now the results of the ATACAS-aspirin arm have been published in the *New England Journal of Medicine*.

The results of ATACAS-aspirin provide the definitive evidence that patients undergoing cardiac surgery can safely receive aspirin until the day of surgery without an extra bleeding risk. Furthermore, although aspirin can reduce the risk of myocardial infarction, stroke and death in patients with known coronary artery disease, there was no protective effect in those undergoing coronary artery surgery. This shows, once again, that studies done in medical (non-surgical) patients do not necessarily translate to the perioperative setting.

The ATACAS trial builds on the success of other Clinical Trials Network-endorsed trials in improving the evidence-base in the perioperative setting. These trials reflect the hard work of study investigators, research co-ordinators and patients around the world to ultimately improve patient safety.

Professor Myles will present the results of the ATACAS tranexamic arm at the upcoming annual scientific meeting in New Zealand.

About the trial

Most patients with coronary artery disease receive aspirin for primary or secondary prevention of myocardial infarction, stroke and death. Aspirin poses a bleeding risk for patients undergoing surgery, but it is unclear whether aspirin should be stopped before coronary artery surgery.

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The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Stopping vs. Continuing Aspirin before Coronary Artery Surgery

Paul S. Myles, M.P.H., M.D., Julian A. Smith, F.R.A.C.S., Andrew Forbes, Ph.D., Brendan Silbert, M.B., B.S., Mohandas Jayarajah, M.B., B.S., Thomas Painter, M.B., Ch.B., D. James Cooper, M.D., Silvana Marasco, Ph.D., John McNeil, Ph.D., Jean S. Bussières, M.D., and Sophie Wallace, M.P.H., for the ATACAS Investigators of the ANZCA Clinical Trials Network*

ABSTRACT

BACKGROUND
Most patients with coronary artery disease receive aspirin for primary or secondary prevention of myocardial infarction, stroke, and death. Aspirin poses a risk of bleeding in patients undergoing surgery, but it is unclear whether aspirin should be stopped before coronary artery surgery.

METHODS
We used a 2-by-2 factorial trial design to randomly assign patients who were scheduled to undergo coronary artery surgery and were at risk for perioperative complications to receive aspirin or placebo and tranexamic acid or placebo. The results of the aspirin trial are reported here. Patients were randomly assigned to receive 100 mg of aspirin or matched placebo preoperatively. The primary outcome was a composite of death and thrombotic complications (nonfatal myocardial infarction, stroke, pulmonary embolism, renal failure, or bowel infarction) within 30 days after surgery.

RESULTS
Among 5784 eligible patients, 2100 were enrolled; 1047 were randomly assigned to receive aspirin and 1053 to receive placebo. A primary outcome event occurred in 202 patients in the aspirin group (19.3%) and in 215 patients in the placebo group (20.4%) (relative risk, 0.94; 95% confidence interval, 0.80 to 1.12; P=0.55). Major hemorrhage leading to reoperation occurred in 1.8% of patients in the aspirin group and in 2.1% of patients in the placebo group (P=0.75), and cardiac tamponade occurred at rates of 1.1% and 0.4%, respectively (P=0.08).

CONCLUSIONS
Among patients undergoing coronary artery surgery, the administration of preoperative aspirin resulted in neither a lower risk of death or thrombotic complications nor a higher risk of bleeding than that with placebo. (Funded by the Australian National Health and Medical Research Council and others; Australia New Zealand Clinical Trials Registry number, ACTRN12605000557639.)

From the Alfred Hospital (P.S.M., D.J.C., S.M., S.W.) and Monash University (P.S.M., J.A.S., A.F., D.J.C., S.M., J.M.), Melbourne, VIC, St. Vincent's Hospital, Fitzroy, VIC (B.S.), and the Royal Adelaide Hospital, Adelaide, SA (T.P.) — all in Australia; Plymouth Medical School, Devon, United Kingdom (M.J.); and Institut Universitaire de Cardiologie et de Pneumologie de Québec, Quebec, QC, Canada (J.S.B). Address reprint requests to Dr. Myles at the Department of Anaesthesia and Perioperative Medicine, Alfred Hospital, Commercial Rd., Melbourne, VIC 3004, Australia, or at p.myles@alfred.org.au.

*A list of participating centers and investigators in the Aspirin and Tranexamic Acid for Coronary Artery Surgery (ATACAS) trial of the Australian and New Zealand College of Anaesthetists (ANZCA) Clinical Trials Network is provided in the Supplementary Appendix, available at NEJM.org.

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ATACAS was designed as a multi-centre, double-blind, randomised, two-by-two factorial trial design in which 2100 patients planning to undergo coronary artery surgery and were at risk for perioperative complications were randomly assigned to receive aspirin or placebo and tranexamic acid or placebo.

Patients were randomly assigned to receive aspirin (100mg) or matched placebo preoperatively. The primary outcome measure was a composite of death and thrombotic complications (non-fatal myocardial infarction, stroke, pulmonary embolism, renal failure or bowel infarction) within 30 days of surgery. Secondary endpoints included blood transfusion, re-operation, respiratory failure renal failure, serious wound infection and hospital length of stay.

Among 5784 eligible patients, 2100 consenting patients were enrolled; 1047 were assigned to the aspirin group and 1053 were assigned to the placebo group. The primary outcome occurred in 202 (19.3 per cent) patients in the aspirin group and 215 (20.4 per cent) patients in the placebo group (relative risk, 0.94; 95 per cent confidence interval, 0.80 to 1.12; P=0.55). Major haemorrhage requiring re-operation occurred in 1.8 per cent and 2.1 per cent of patients (P=0.75), and cardiac tamponade occurred in 1.1 per cent and 0.4 per cent of patients (P=0.08), in the aspirin and placebo groups respectively.

In patients having coronary artery surgery, pre-operative aspirin did not decrease the risk of death and thrombotic complications or increase bleeding risks. Aspirin can be safely continued up to the day of coronary artery surgery.

Professor Paul Myles
Principal investigator, ATACAS trial

CTN news

CTN revises survey research policy

One of the primary mandates of the ANZCA Clinical Trials Network (CTN) is to facilitate survey research for Fellows and trainees.

The CTN developed and recently revised the ANZCA Survey Research Policy. The policy applies to all ANZCA Fellows and trainees wishing to conduct survey research, including trainees who wish to conduct survey research in order to fulfill ANZCA's training program requirements. The policy also applies to survey research conducted by special interest groups (SIGs) or regional/national committees that are exempted from CTN review by the SIG or regional/national committee chair.

The CTN serves as a "gatekeeper" for all survey research conducted by Fellows and trainees of ANZCA where the survey is being distributed to members of ANZCA.

The role of the CTN (or the SIG or regional/national committee chair where exemption from CTN review has been granted) involves reviewing survey research applications, assessing the scientific validity of surveys, providing advice to researchers, seeking evidence of ethics approval, protecting the privacy of ANZCA Fellows and trainees, and ensuring they are not overburdened with surveys. The CTN also may assess whether it is feasible to proceed with the survey research, given the survey response rate anticipated, the resources required, the risks to the College and its members and the costs involved.

Survey research is an important medical research tool, particularly to assess variation in practice among specialties such as anaesthesia and pain medicine. Survey research also is advantageous in supporting research grant applications. Many thanks to all Fellows and trainees who participate in ANZCA-facilitated survey research. For advice regarding survey research and the application process, contact the CTN manager at ctn@anzca.edu.au.

Visit www.anzca.edu.au/ctn to download the ANZCA survey research policy and application form.

Some useful CTN references for conducting survey research are:

- Jones D, Story D, Clavisi O, Jones R, Peyton P. Surveys: An introductory guide to survey research in anaesthesia. *Anaesthesia and Intensive Care* 2006: 34: 245-253.
- Story D, Gin V, Na Ranong V, Poustie S, Jones D. Inconsistent survey reporting in anaesthesia journals. *Anesthesia and Analagesia* 2011: 113: 591-5.

Pilot grant awards

The ANZCA Clinical Trials Network congratulates the following investigators on receiving pilot grants in the 2015 round:

C-Café pilot study: "Colorectal cancer, anaemia and iron management: a large multi-centre, stepped wedge, cluster randomised controlled trial" (Dr Megan Allen).

PADDI Genomics Pilot Study: "Preliminary analysis of changes in peripheral white blood cell inflammatory gene expression and function over 24 hours following intravenous (8 mg) dexamethasone" (Dr Chris Bain).

The CLUES Trial: "Cognitive and Lifestyle interventions to Understand the impact on the Elderly of anaesthesia and Surgery: A multi-centre cluster randomised controlled trial" (Associate Professor David Scott and Associate Professor Lis Evered).

8th Annual Strategic Research Workshop 2016 – save the date

The ANZCA Clinical Trials Network is please to host its eighth annual strategic research workshop at Coogee Bay, Sydney from August 12-14, 2016.

The meeting will feature discussions on new research ideas and keynote presentations from the Federal Member for Fraser, Andrew Leigh, a former professor of economics.

The meeting also will feature two concurrent half-day workshops for research co-ordinators and emerging researchers on Friday morning August 12. Lock in the dates for what will be another fabulous meeting, filled with thought-provoking ideas for clinical research. For up-to-date information, visit www.anzca.edu.au/ctn.

Books and eBooks

New books for loan

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

Safety of anaesthesia
A review of anaesthesia-related mortality in Australia and New Zealand 2009-2011 / McNicol, Larry [ed]. / Australian and New Zealand College of Anaesthetists, Mortality Sub-Committee. --Melbourne: Australian and New Zealand College of Anaesthetists, 2014.

Manual of Simulation in Healthcare
Riley, Richard H [ed]. -- 2nd ed -- Oxford: Oxford University Press, 2016. *Kindly donated by the author, Dr Richard Riley.*

Governor William Hobson
His health problems and final illness / Trubuhovich, Ronald V. --Auckland, NZ: Ronald V. Trubuhovich; Auckland Medical History Society, 2015. *Kindly donated by the author, Dr Ron Trubuhovich.*

A history of the intensive care unit within the family of Royal Perth Hospital
Clarke, Geoff. -- Perth: Geoff Clarke, 2015. *Kindly donated by the author, Dr Geoff Clarke.*

Library Guides – a new way to access the library's resources

The ANZCA Library has implemented new software, LibGuides, to enhance and integrate access to library resources. LibGuides is a content management system used by libraries worldwide to organise information on different topics through an online platform.

Library Guides collates recommended resources, such as library databases, journals, books, web pages and other useful links, to assist you to find information most relevant to your area of study. It also provides access to learning tools, such as interactive tutorials.

Library Guides naturally suits specialist areas, such as special interest groups, because the library can curate resources to help you stay up to date in your area of interest. Resources related to training and exams, continuing professional development, apps, special interest groups, and safety and quality are some of the areas covered by Library Guides.

Keep an eye out for the new Library Guides across the College website. Feedback and comments are welcome at library@anzca.edu.au.

New eBooks

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

Essentials of Mechanical Ventilation
Hess, Dean R; Kacmarek, Robert M. --3rd ed --New York: McGraw-Hill Education, 2014.

Acute Pain Management: Scientific Evidence
Australian and New Zealand College of Anaesthetists; Australian and New Zealand College of Anaesthetists, Faculty of Pain Medicine. -- 4th ed --Melbourne: Australian and New Zealand College of Anaesthetists, 2015.

Examination medicine
A guide to physician training / Talley, Nicholas J;O'Connor, Simon. -- 7: Church Livingstone Elsevier, 2014.

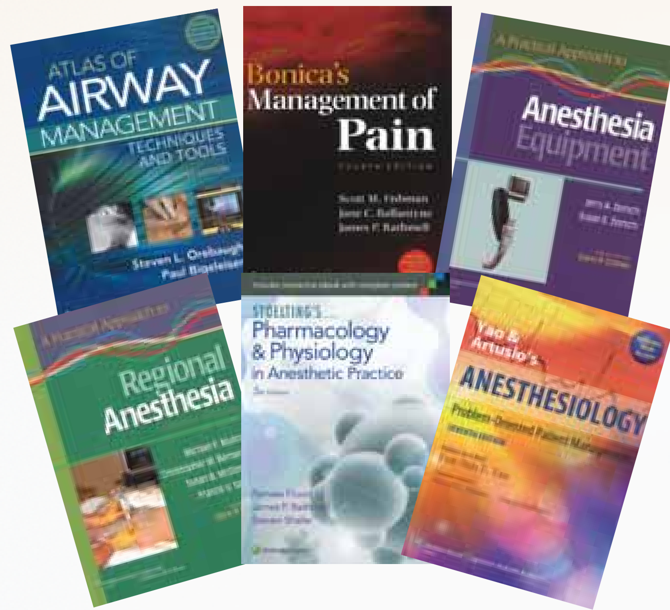
The Australian and New Zealand College of Anaesthetists Specialist Training Program (STP) Evaluation Report
Burnard Jo. / IECO Consulting. --Hawker, ACT: IECO Consulting, 2015.

Ethical Issues in Anesthesiology and Surgery
Jericho, Barbara G. [ed]. -- Switzerland: Springer International Publishing, 2015.

Pre-Hospital Anaesthesia Handbook
Lowes, Tim; Gospel, Amy; Griffiths, Andrew; Henning, Jeremy. -- 2nd ed --Switzerland: Springer International Publishing, 2016.

Ciottone's Disaster Medicine
Ciottone, Gregory R. [ed]; Biddinger, Paul D. [ed];Darling, Robert G. [ed]; Fares, Saleh [ed]; Keim, Mark E. [ed]; Molloy, Michael S. [ed]; Suner, Selim [ed]. -- 2nd ed --Philadelphia, PA: Elsevier, 2016.

New in the library



New online textbook collections

The ANZCA Library has added the **LWW Health Library Anesthesiology**, an online platform for the delivery of high quality educational and clinical content. It covers authoritative texts, multimedia resources and teaching and learning tools specific to anaesthesia. Titles include:

- Stoelting's Pharmacology and Physiology in Anesthetic Practice.
- Yao & Artusio's Anesthesiology: Problem-Oriented Patient Management.
- "A Practical Approach" series.

The ANZCA Library also recently added more than 25 new online textbooks from the **Taylor & Francis CRCnetBASE** collection on anaesthesia and pain medicine.

Titles include:

- Acute Pain Management: a Practical Guide.
- Principles of Physiology for the Anaesthetist.
- "Clinical Pain Management" series.

Access these collections through the online textbook list: www.anzca.edu.au/resources/library/online-textbooks.

Easy linking to ANZCA Library resources

The library provides 24/7, remote single sign-on access to online journals, books and databases through the ANZCA website. ANZCA and FPM Fellows and trainees can now link directly to subscribed resources with their College log in and no longer need to navigate through the library webpages. Examples of how this enhancement can improve your workflow include:

- Using apps such as **Papers** and **metajournal**.
- Emailing article/book chapter direct links to yourself or an ANZCA or FPM colleague.

More information about the Papers app: www.papersapp.com/ios/

More information about the metajournal app: www.metajournal.com/

Please send any questions or feedback to the library email: library@anzca.edu.au

Library at the ANZCA ASM 2016 in Auckland

Attending the ANZCA annual scientific meeting in Auckland? Be sure to visit the library at the ANZCA stand to learn more about the library services and resources.

Want to know more about how to make the most of the ANZCA Library? Sign up to the "Using the library" workshop on Saturday April 30 as part of the ASM program: https://asm.anzca.edu.au/

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- Available on iPhone/iPad.

More information about the Papers app: www.papersapp.com/ios/

New open-access journal dedicated to simulation in health and social care

Advances in Simulation, the official journal of the Society in Europe for Simulation Applied to Medicine (SESAM), is an open-access, peer-reviewed, online journal providing a forum to share scholarly practice to advance the use of simulation and learning technologies in the context of health and social care. It includes articles relevant to simulation that include the study of healthcare practice, human factors, education, biomedical engineering, pharmacology, etc.

Access this journal through the ANZCA Library journal list: www.anzca.edu.au/resources/library/journals

Clinical queries limits in Medline

"Clinical queries" is a feature in the OVID Medline database that allows users to limit searches using specific search strategies to aid in retrieving scientifically sound and clinically relevant study reports indexed in Medline databases. With "clinical queries" limits, you can cast a wide net of results by filtering the highest quality content, eliminate the noise by eliminating low quality studies or get a balance of both when trying to find clinically relevant material. You will get consistent, accurate results no matter who is performing the search.

To limit your Medline search to the best evidence-producing studies, click on "additional limits" and then limit by "clinical queries".

Searches can be refined using specific search strategies designed to produce results in nine research areas: Therapy, diagnosis, prognosis, reviews, clinical prediction guides, qualitative, causation (etiology), costs and economics.

As research may require different emphasis, three strategies are provided for each area:

- High sensitivity – the broadest search to include all relevant material. It may include less relevant materials.
- High specificity – the most targeted search to include only the most relevant result set, may miss some relevant materials.
- Best balance – retrieves the best balance between sensitivity and specificity.

Access clinical queries in OVID Medline through the ANZCA Library databases webpage: www.anzca.edu.au/resources/library/databases

Contact the ANZCA Library
www.anzca.edu.au/resources/library
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Email: library@anzca.edu.au

Hospital staff welcome recycling scheme

Polyvinyl materials are being collected and recycled as part of an innovative initiative led by an anaesthetist.

The oxygen mask you fitted to a patient today could soon become the springy, coloured playground surface your child plays on – at least if you work in Hutt Hospital, near Wellington.

Within a few months, ANZCA Fellow and trainee intensivist Dr Sabine Pecher has managed to establish a recycling scheme at Hutt Hospital, which has won enthusiastic support from colleagues across the staffing spectrum.

The scheme involves collecting polyvinyl chloride (PVC) intravenous bags, oxygen tubes and oxygen masks from theatre and supplying them to a manufacturer about 70km away to recycle into the material for playground tiles.

Dr Pecher drew inspiration from hearing about recycling initiatives at a small-group discussion on sustainability, held at the ANZCA annual scientific meeting in Adelaide in May last year. She subsequently discovered Dunedin Hospital was doing something similar and by October had a scheme up and running at her own hospital, despite having been told it would take at least two years to get everyone on board.

"The scheme is really simple," Dr Pecher said.

"The bags, tubes and masks go out of theatre with the patient and are put in a bin in recovery. There is a small amount of extra work involved – removing metal clips, elastic straps and other bits of hard plastic – so I thought staff might object, but everyone was really enthusiastic.

"They said 'this is amazing' and that it was what they had been waiting for, for a long time. They were so happy they could do something."

About the same time Dr Pecher introduced the idea, a group of employees keen to look at recycling waste established a committee; it includes orderlies and infectious control staff among others.

"We had them on board from the start so we knew it was ok and could work," she said.

Staff are already finding ways to expand the initiative, for example by selling the metal clips to a scrap-metal dealer and using the elastic straps in craft work at home. There also is motivation to recycle materials such as glass and cardboard.

"Although it was my initiative, it would not have been possible without the enthusiasm and work of the entire team," Dr Pecher said.

Initially the scheme involved the theatres and recovery rooms, but within three months it had expanded to the intensive care unit and will soon roll out in the medical assessment unit and emergency department. The rest of the hospital is expected to follow suit, with ward staff who collect patients from recovery keen to introduce it to the wards.

The scheme also saves money for the hospital, which pays $NZ300 to $400 a tonne for waste sent to landfill, Dr Pecher said. The manufacturer removes the recycled material for free.

About 400 kilograms of material was recycled in the first three months.

Hutt Hospital and nearby Wellington Hospital are joining forces to undertake a waste audit across both hospitals, supported by a $20,000 grant from the Wellington City Council and Hutt City Council expertise.

"This should give us a much better idea of what else can be recycled and where. For instance, unlike domestic packaging, our plastic isn't marked to show what can and cannot be recycled so hopefully the audit will assist with that."

Dr Pecher, a member of ANZCA's New Zealand National Committee, has a strong commitment to sustainability. She has been selected as one of this year's NZ Anaesthesia Visiting Lecturers, under a program that sees top quality lectures from New Zealand's bigger hospital departments presented at regional departments around the country. Her topic will be "Sustainable anaesthesia – how green is my anaesthetic?" in which she examines a wide range of ways in which medical staff and hospitals can work more sustainably. She will present at Gisborne and Wanganui hospitals.

"Recycling is only one part of sustainability. We need to look at reducing waste generally," she said. "My talk will cover topics around waste in theatre (recycling, reducing, reusing), the global warming potential of anaesthetic gases, and areas where everyone can have a personal influence (how you travel to work, divestment, etc)."

Susan Ewart
ANZCA Communications Manager, NZ

Safe systems reduce risk of air emboli

Applying human factors to the design of systems can reduce the risk of preventable deaths caused by central line-related air emboli, writes Dr Rob Hackett.

You are at a cardiac arrest on the ward. The nurse informs you the patient rapidly deteriorated when their fluids were disconnected from their central line. That is when you notice the central line lumens have been left open to air. You are suspicious of an air embolus, which is confirmed on admission to ICU and, despite resuscitative attempts, the patient dies two days later. The unfortunate nurse involved subsequently quits nursing.

Central line-related air emboli have caused numerous preventable deaths. Awareness about this issue is limited and solutions so far implemented have had limited effect. There is a need to appreciate the complexity of our work environments and apply human factors engineering to prevent these iatrogenic avoidable complications.

There were 14 reported incidents with six preventable patient deaths between January 2012 and April 2015 in NSW public health facilities from actual or suspected air embolism related to central line management[1].

How are they happening?

Two conditions must be present for an air embolism to occur:

1. Direct communication between the atmosphere and the circulatory system.
2. The presence of a pressure gradient that favours air entry into the circulation.

It is estimated that a volume of air as small as 70ml in an adult can be fatal. The literature references a range of 70 to 500ml of air. A volume of 100ml of air per second may enter the circulation through a 14-gauge catheter with a pressure gradient of only 3.7mmHg (5cm of H_2O). Unfortunately the cardiac arrest that often results is frequently intractable.

Of the six deaths reported in NSW, four deaths were related to central line removal, one death was related to insertion and one during routine care processes[1].

Removal:
Air emboli events on central line removal were often related to patients being in an upright position. Patient co-morbidities may make it difficult for them to tolerate the trendelenburg position or even lying flat.

Routine care:
Several events occurred when lines were disconnected from their attachments and accidentally left open to air. Procurement of specific equipment could completely remove this risk.

Insertion:
Air emboli during insertion were more likely in spontaneously breathing patients having large bore catheters (for example vas caths) inserted. Positive pressure ventilation may reduce the risk in patients having these procedures under general anaesthesia.

Patient types:
Patients with respiratory pathology or intravascular depletion (generate greater negative intrathoracic pressures), and patients with a low body mass index (smaller venous tract between the atmosphere and vessel) feature prominently.

The hierarchy of intervention effectiveness

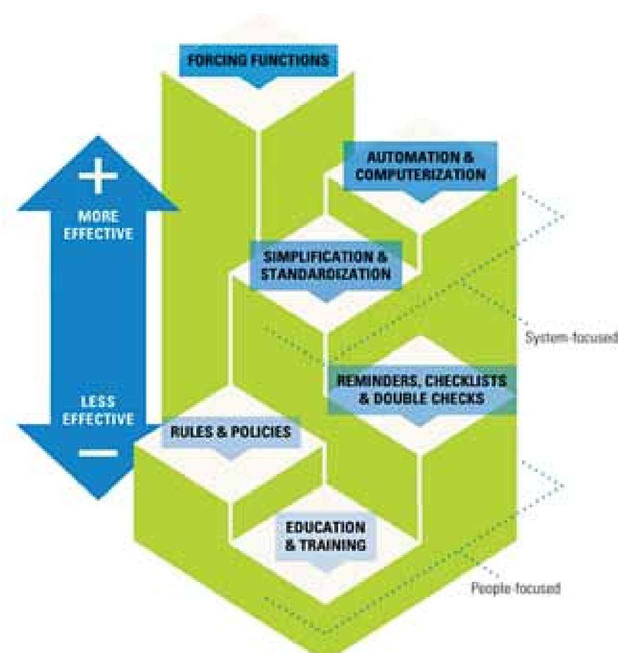

Figure 1. Joseph A. Cafazzo and Olivier St-Cyr. From Discovery to Design: The Evolution of Human Factors in Healthcare. Healthcare Quarterly Vol.15 Special Issue 2012.

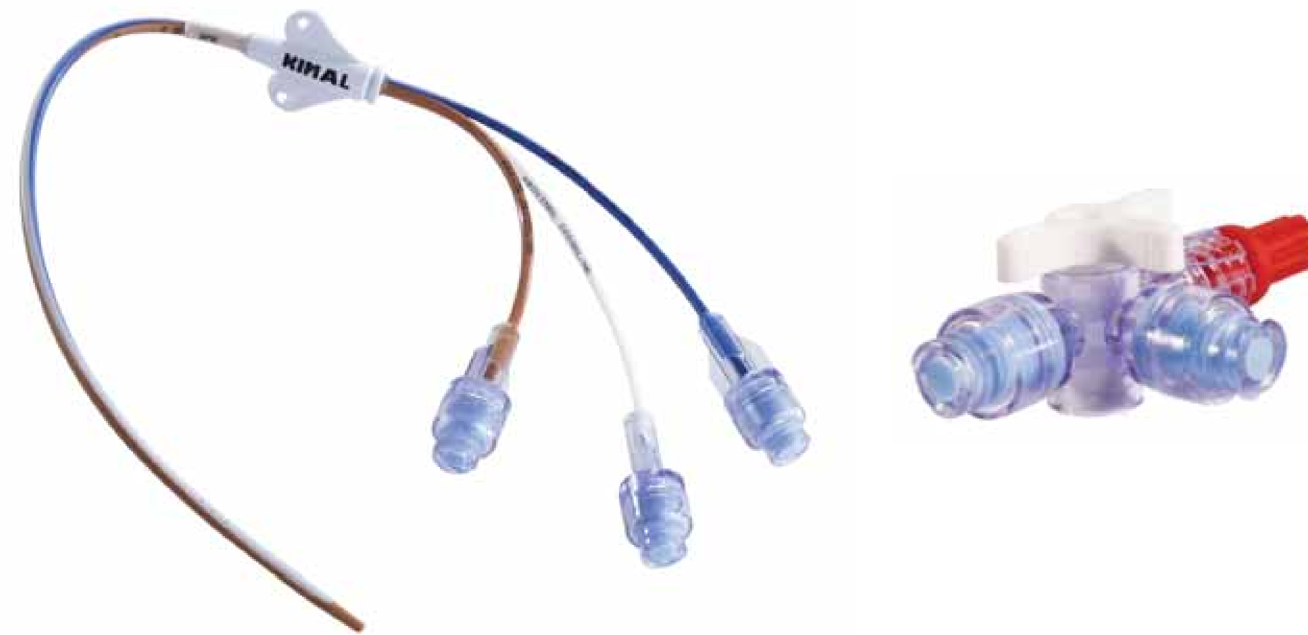

Figure 2. Central line with moulded valves.

Figure 3. Stopcock (three-way tap) with moulded valves.

Why has this issue remained relatively undetected?

Air emboli may occur more frequently than we are aware. Cardiovascular collapse may often be attributed to other causes given the premorbid state of patients requiring central lines. For an air embolus to be suspected, staff need to be present at the time who consider this as a differential diagnosis.

An echocardiogram demonstrating air in the cardiac chambers often is unlikely to be performed given the acute nature and location of most events.

If air embolism is suspected as a cause of death, the pathologist should be notified so the organs can be opened under water to detect escaping gas.

Are these events widespread?

In the international literature, incidence rates for central line-related air emboli range from one in 47 central line insertions to one in 3000, with some sources implying incidence rates as high as 0.1 to 2 per cent of all central lines used[1].

Clusters of central line-related air emboli have been reported in Pennsylvania, US[2] and now in NSW. It is likely they occur at similar frequencies across all hospitals. As staff become more aware of the issue we may observe an initial increase in reported incidents.

What has been done to prevent these events?

Given that air embolism events continue to occur, solutions are required in addition to those already implemented.

Root cause analysis:
Reported cases will often lead to a root cause analysis (RCA). RCA is a time-consuming process, which has a mandated turnaround of 70 days in NSW. As a consequence, limited local patient-safety resources spend a lot of time investigating incidents and then have to quickly generate recommendations. The RCA process is hindered by hindsight bias, risk of premature conclusion, failure to follow up and focus on the wrong contributing factors, and may lead to ineffective and non-sustainable solutions[3].

Medical alerts:
Several medical alerts have been disseminated in the past[4,5]. Medical alerts can provide education about adverse events and how they may be avoided. They also may prepare staff to be more understanding of subsequent procedural changes. On their own they tend to have limited effect in preventing adverse events. Medical alerts may fail to reach frontline staff due to breaks in communication chains. Feedback mechanisms to assess for this are seldom in place.

Medical alerts have a temporal constraint, being viewed upon their initial dissemination then become lost among other alerts and policies.

Protocols

Healthcare staff often work in complex environments and at several different institutions. Each institution may have a similar protocol addressing the same issue. Many staff will be unaware of the existence of particular protocols or how to access them.

Protocols may not pay due respect to their workability. There may be a large gap between "work as perceived" by the protocol developers and "work as performed" by frontline staff. For example, protocols that correctly indicate patients should have their central line removed in the supine or slight trendelenburg position do not provide an option when this position cannot be tolerated. It is then left to the staff member to breach the protocol, often without realising the potential severe implications.

Perhaps it would be prudent to prompt a procedural escalation when patients cannot lie supine or when their observations are outside preset variables (for example, contact senior medical staff, consider delaying removal, use increased levels of monitoring with ready access to resuscitative equipment).

Protocols, if used at all, need to be succinct, simple, workable, readily accessible, centralised and recognisable across numerous healthcare facilities.

(continued next page)

Safe systems reduce risk of air emboli (continued)

What should be done to prevent these events?

The complexity of our work environments needs to be appreciated and human factors engineering used in creating effective sustainable safety solutions. It is essential to understand there is a hierarchy of intervention effectiveness from the most effective – system-focused "forcing functions" through to the least effective people-focused "education, training and policies" (Figure 1).

Procurement:

The risk of air embolus from accidental central line detachment during routine care can be eliminated by abolishing all central lines and attachments that have the ability to be left open to air and replace them with those that cannot. Unless vascular access devices are being used for pressure manometry they do not need to open to air. In human factors engineering, this intervention is considered as a system-focused "forcing function" as it prevents the user from making the mistake – it is a highly effective safety intervention.

Central lines and attachments with moulded valves that can be swabbed also offer an advantage in decreasing central line-associated blood stream infections (Figures 2 and 3).

Centralised central line management form and audit:

In 2011, the NSW Department of Health published an excellent policy directive entitled Central Venous Access Device and Post Insertion Care[6]. It outlines the salient features of central line management with respect to their risks. It also refers to the Central Venous Line Insertion Record[7], a valuable form for documentation. The use of this form should be encouraged in all NSW hospitals.

Implementation of forms or e-health places time stress on staff. In that context, the Central Venous Line Insertion Record could be streamlined to focus on the important aspects of central line management from request through to removal with documentation of the most useful data. A more powerful tool can be developed for reviewing the processes and equipment used.

Centralised decision tree:

Several decision trees exist[8] indicating if a central line is indicated and which vascular access device should be requested for a particular situation. The morbidity and mortality attributed to central lines appears underestimated, and consequently patients may die from central line complications when a central line is not required. Existing decision trees overlook "stepping down" with the invasiveness of requested line, for example if a PICC line cannot be inserted, serial peripheral cannulation may be more appropriate than a central line.

Ideally, there should be one centralised decision tree with which all staff are familiar across hospitals. It should be adaptable for use at particular institutions depending on the skills and facilities present.

Centralised central line management education and accreditation:

The Clinical Excellence Commission, NSW Agency for Clinical Innovation and Health Education Training Institute have almost completed a series of learning modules and assessment tools focused on central line management. This centralisation of training and accreditation will be greatly beneficial to patient safety.

Effective awareness campaign

The majority of central line-related air emboli reported in NSW occurred during line removal. Of these nine cases, seven of the patients were sat up while the central line was removed. In the remaining two cases, the patient was sat up very quickly after removal.

An effective awareness campaign could be extremely useful in focusing staff on this point. Maybe "central lines are removed supine", with an interactive animated screensaver (away from the eyes of concerned relatives and patients), which succinctly explains how air emboli occur and the essential steps for prevention[9]. This could link to related educational material.

In summary, a great deal can be done to improve safety with regards to central line management and decreasing patient exposure to the risk of air embolism. The implementation of effective and sustainable safety solutions requires an understanding of human factors engineering. We should focus on procurement of safer central lines and attachments and the importance of significant steps during central line removal, particularly ensuring the patient is supine or slightly head down.

Dr Rob Hackett
Royal Prince Alfred Hospital, NSW

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Updating medicine ingredient names

From April 2016, a number of medicine ingredient names in Australia will change in a move towards international harmonisation. Of more than 300 proposed changes, a number will be directly relevant to anaesthetists and pain medicine specialists. Some are minor spelling adjustments to active and excipient ingredient names or updates to chemical or hydration states. Others represent major changes that will require extended use of dual labelling. Key examples include li-g-nocaine to li-d-ocaine and adrenaline to epinephrine.

What's in a name?

The Therapeutic Goods Administration (TGA) is responsible for maintaining a list of current approved ingredient names in Australia. In most circumstances, the International Non-proprietary Name (INN) is preferred. This list was developed by the World Health Organization (WHO) and is maintained by a committee of member states. These are used in medication labelling and product information publications and create a common language for doctors, nurses, pharmacists and patients. This is of particular importance, with the proliferation of trade names and generic medicines creating confusion for end-users[1].

The problem

Despite positive moves in recent years, there remains a lack of consistency and global harmonisation in ingredient names. This creates a risk of confusion and a potential for medication error. There is an additional burden for suppliers of medications and associated industries with increased administrative and compliance costs for those serving international markets.

Difficulties also have been observed for communication and searchability of medical literature. For example, an article appearing in an American journal about a problem with "lidocaine" is about "lignocaine", using the current Australian terminology.

Managing the change

In May 2013 the TGA began consultation with key stakeholders, including industry, healthcare professional and consumer groups. ANZCA was invited to participate in consultation workshops in October 2015.

Feedback was sought on the perceived value of the move toward harmonisation and strategies for implementation. Previous international harmonisation efforts in the UK (2003) and NZ (2008) were studied. A regulation impact statement assessed a number of options and recommended the adoption of a reduced list of ingredient name changes with a four-year transition period.

Significant changes will require dual labelling with the old and new ingredient names for three years beyond the four-year transition period to a total of seven years. The change from adrenaline to epinephrine has previously been associated with confusion[2] so products will require both names to be displayed indefinitely. The TGA has indicated it will work with industry and consumer groups to support the changes. Anaesthetists and pain specialists are invited to provide feedback through the ANZCA Safety and Quality Committee at sq@anzca.edu.au.

Changes relevant to anaesthesia and pain medicine

A list of name changes of particular interest to our specialities is provided in the table. Please note the list is not exhaustive. Refer to the TGA website for full information: www.tga.gov.au/updating-medicine-ingredient-names-list-affected-ingredients.

Old name	New name
Adrenaline	Adrenaline (epinephrine)
Amethocaine hydrochloride hydrochloride	Tetracaine (amethocaine)
Atracurium besylate	Atracurium besilate
Atropine sulfate	Atropine sulfate monohydrate
Benztropine mesylate	Benzatropine mesilate
Bupivacaine hydrochloride monohydrate	Bupivacaine hydrochloride
Bupivacaine hydrochloride anhydrous	Bupivacaine hydrochloride
Calcium chloride	Calcium chloride dihydrate
Calcium gluconate	Calcium gluconate monohydrate
Cephazolin	Cefazolin
Cisatracurium besylate	Cisatracurium besilate
Codeine phosphate	Codeine phosphate hemihydrate
Dantrolene sodium hemiheptahydrate	Dantrolene sodium
Glycopyrrolate (glycopyrrolate)	Glycopyrronium bromide
Lignocaine	Lidocaine (lignocaine)
Magnesium sulfate	Magnesium sulfate heptahydrate
Morphine hydrochloride trihydrate	Morphine hydrochloride
Morphine sulfate	Morphine sulfate pentahydrate
Naloxone hydrochloride	Naloxone hydrochloride dihydrate
Naloxone hydrochloride anhydrous	Naloxone hydrochloride
Noradrenaline acid tartrate acid tartrate Monohydrate	Noradrenaline (norepinephrine)
Salcatonin	Calcitonin salmon (salcatonin)

Dr David Bramley, MBBS MPH FANZCA
Deputy Director, Department of Anaesthesia and Pain Medicine
Western Health, Victoria

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Near misses equally good for learning

Learning from near misses can be as powerful as learning from serious adverse events, says New Zealand's Health Quality & Safety Commission (HQSC). This is why it has renamed its work around adverse events to signal a greater emphasis on learning from all events.

Commission Chair Professor Alan Merry says learning from things that go wrong in healthcare is a focus of the HQSC's 2015 report on adverse events (previously known as serious adverse events, or serious and sentinel events). The HQSC works with New Zealand's district health boards and other healthcare providers to encourage an open culture of reporting, to learn from what went wrong and to put in place systems to stop incidents recurring.

In 2014-15:

- 525 adverse events were reported by district health boards and 67 events by other providers. While this is an increase on previous years, the report attributes this to an improvement in the processes used to identify and review events, rather than an increase in event frequency.
- Serious harm from falls was the most frequently reported event, with 277 cases.
- Clinical management incidents were the next most reported, with 205 cases, including those relating to delays in treatment, assessment, diagnosis, observation and monitoring (including patient deterioration).
- Incidents involving prescribing, dispensing or administration of medication were the next most frequently reported events, with 23 cases.

The 2014-15 adverse events report (available at www.hqsc.govt.nz) includes a special focus on learning from cases where there was a delay in recognition or a lack of recognition of a patient's deteriorating condition.

The HQSC has done a thematic analysis of unrecognised or delayed recognition of clinical deterioration using 27 case review reports from eight district health boards. It shows that while the New Zealand health and disability system has established processes for recognising patient deterioration, communication failure was a common theme across events. The findings are in line with international evidence and indicate focus areas for quality improvement.

The HQSC says that analysis of the review methodology used by district health boards indicates there should be an increased focus on systemic factors that contribute to events and recommendations could be strengthened. The HQSC is supporting these findings with a pilot training program to help improve the quality of reviews.

Health professionals also have been able to share knowledge of adverse events through Open Book learning reports.

Areas identified for further development in the 2016 review of the national reportable events policy include that greater attention be directed to recommendations made in adverse event reviews and that health providers share at least one case for learning with other health providers annually via Open Book reports.

Susan Ewart
ANZCA Communications Manager, NZ

Safety alerts

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

Recent alerts:

- HeartWare Ventricular Assist Device – potential loss of power.

Teamwork sharpens focus on safety

Team training improves patient safety

Between 2003 and 2013, Rona Flin developed systems to identify behavioural markers affecting patient safety in operating theatres. A tiered taxonomy of categories was designed to group the observed behavioural markers. Separate programs were developed for surgeons, anaesthetists and nurses – that is non-technical skills for surgeons (NOTSS), anaesthetists' non-technical skills (ANTS) and the Scrub Practitioners' List of Intraoperative Non-Technical Skills (SPLINTS).

The Royal Australasian College of Surgeons brought the NOTSS course to Australia in 2011. The Australian NOTSS faculty encouraged interest from the "top end of the surgical table" and invited anaesthetists to become facilitators in 2012. The anaesthesia perspective was found helpful by both faculty and attendees. Consequently, RACS opened the program to anaesthetists in 2014 with seven anaesthetists completing the course to date.

The NOTSS faculty recognised the difficulty of teaching a behavioural rating scheme to practitioners unfamiliar with human factors or rating schemes. As a consequence, the course has redefined its purpose. The aim is to develop a personal practice of reflecting on communication and teamwork in the operating theatre. This is promoted through a discussion of the importance of human factors, built around the taxonomy provided by the NOTSS system. The conversation is facilitated by a number of illustrative video vignettes where the various behavioural markers are noted and rated.

In 2014, the NOTSS faculty decided to develop a multidisciplinary course engaging operating teams in their own hospitals rather than separate disciplines meeting in external venues. The faculty was expanded to include educational representatives from ANZCA, the Australian College of Nursing and the Australian College of Operating Room Nurses.

Together they developed a combined course under the title Safer Australian Surgical Teams (SAST). This group has gained funding from Rural Health Continuing Education. Following successful pilots in four centres in 2014, the course was extended to a further four regional centres in 2015.

There is now a significant need for anaesthetists to facilitate the SAST courses. It is recommended that potential facilitators participate in a NOTSS or SAST course and then act as support persons in a course.

If you would like to help shape this program or would like more information, please contact Dave Sainsbury (david.sainsbury@adelaide.edu.au) or Peter Roessler (peter.roessler1@bigpond.com).

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Anaesthetist-led training to help reduce NZ's treatment injury rate

The New Zealand Government is providing funding so that multidisciplinary simulation training developed by anaesthetists in Auckland can be rolled out nationally to help reduce an alarming increase in treatment injury claims.

The government announced late last year that it would invest $NZ15-20 million over five years on initiatives to reduce treatment injury rates because treatment injury claims had increased by 63 per cent since 2009 – a higher rate of increase than for other types of injury.

New Zealand's Accident Compensation Commission (ACC) will work with the Ministry of Health, the Health Quality & Safety Commission (HQSC) and the Health & Disability Commissioner on the issue.

Health Minister Dr Jonathan Coleman said it was important from a clinical and financial point of view to understand why claims were increasing.

Since 2009, ACC treatment injury claims have increased by 63 per cent, from 1.8 claims per 1000 in 2008/09 to 2.9 claims per 1000 in 2014/15. Costs have increased by 43 per cent, from $264 million in 2008/09 to $379 million in 2014/15. Infections and adverse reactions are the most common types of treatment injury claim.

As part of the $NZ15-20 million investment, ACC is working with the health sector to progress initiatives, including:

- Funding surgical simulation training for operating theatre staff throughout NZ by rolling out multidisciplinary training developed at Auckland University by a team led by Associate Professor Jennifer Weller, a member of ANZCA's Research Committee (see *ANZCA Bulletin*, March 2015, p26).
- Developing a program to reduce the number and severity of preventable birth injuries.
- Establishing a program to help reduce the prevalence of pressure injuries.
- Extending HQSC's surgical site infection program.

Speaking about the multidisciplinary operating room simulation (MORSim) training, Accident Compensation Commission Minister Nikki Kaye said: "It's important that there's good communication and teamwork between staff in the operating room, and this program is aimed at improving teamwork and communication skills. An evaluation of the pilot program showed this could translate to a 14 per cent reduction in treatment injuries."

Susan Ewart
ANZCA Communications Manager, NZ

Improving compliance and engagement in use of the WHO Surgical Safety Checklist

There is overwhelming evidence that use of a surgical safety checklist can reduce perioperative morbidity and mortality. Perhaps not surprisingly, there also is evidence that the success of checklists substantially depends on the engagement and compliance of operating room teams with their use. It follows that there has been a recent focus on optimising checklist administration.

Surgical safety checklists are typically administered in three "domains" during an operation: "sign in" when the patient first enters the room; "time out" just prior to the first surgical incision; and "sign out" at the end of the procedure. In the most prevalent administration paradigm, the circulating nurse is responsible for initiating each domain and administering the relevant checklist items from a paper copy of the checklist. There is often a requirement to complete tick boxes to record that checklist items were administered.

There are several problems with this approach. First, investing administrative responsibility solely in the nurses encourages a belief that the checklist is a nursing initiative rather than a process owned by the operating room team.

Second, the clinicians most central to activities occurring at the time of administration (especially anaesthetists during "sign in" and surgeons during "time out") are prone to disengaging by continuing with other tasks while the checklist is administered.

Third, the nurses frequently do not look at the paper checklist and no one else can see it, often resulting in omission of items, and sometimes administration of confabulated items not on the checklist.

Finally, the requirement to tick checkboxes encourages a sense that the checklist is a "paperwork exercise", and boxes are often ticked even when items are not administered.

BMJ Quality and Safety has published a study by the Patient Safety Group at the University of Auckland who described an approach to checklist administration designed to circumvent these problems[1]. In the new administration paradigm, each checklist domain appears as a large poster on the wall of the operating room, there are no paper copies or checkboxes, and leadership of the three domains is distributed among the three operating room teams (an anaesthetist leads "sign in", a surgeon leads "time out" and a nurse leads "sign out").

This approach has resulted in a much more consistent administration of checklist items, seemingly because the checklist was visible to all present and the administrator was consequently less likely to deviate from the prescribed items. There were marked improvements in the proportion of cases where all professional sub-teams in the operating room were properly engaged in the process. This was particularly true of the "time out" domain where the proportion of cases with engagement of all three sub-teams improved from 15 per cent to 92 per cent.

This inexpensive change in checklist administration paradigm is simple, team-building and goes some way towards addressing a key issue in relation to checklists: "Checklists do not work by themselves: they must be used, and used in an engaged fashion with the mind focused on the issues at hand"[2].

Associate Professor Simon Mitchell, FANZCA
ANZCA Research Committee
and
Professor Alan Merry, FANZCA
Chair, ANZCA Research Committee

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2. Merry AF, Mitchell SJ. "Advancing patient safety through the use of cognitive aids." BMJ Qual Saf. Online First, published on January 4, 2016 as 10.1136/bmjqs-2015-004984.

Compiled by Dr Peter Roessler
Communication and Liaison Portfolio
ANZCA Safety and Quality Committee

Faculty of Pain Medicine

Dean's message

The Faculty of Pain Medicine was established in 1998. By December 2015, the number of Fellows admitted had reached 423. Being Dean of the Faculty of Pain Medicine (FPM) and heading up a talented board and staff has been a great honour. Last year I said I would like to concentrate the efforts of the board and our Fellows to serve the Faculty in five areas. How have we progressed?

Help sustain the progress and implementation of the Faculty's Curriculum Redesign Project.
Training and education of specialist pain medicine physicians remains at the heart of the Faculty's role. The revised curriculum training program started in December 2014 in New Zealand and in January 2015 in Australia. It is competency-based and is based on particular CanMEDS roles. It focuses on the patient's perspective and is delivered centrally (with a knowledge focus) and in the training units (with a skill's focus). It incorporates ongoing work-based formative assessment and progressive summative assessment completed in two stages, the core training stage and the practice development stage. In November 2015, 21 candidates successfully completed the core training stage and its formal summative assessment. Thirty-eight trainees were admitted to fellowship during 2015.

This year sees the start of the practice development stage. This is a mandatory 44-week period of approved activity chosen by trainees, and directly relevant to pain medicine.

Help design and implement an online modular educational program for primary healthcare and an online education program in pain medicine for medical school undergraduates.
Better Pain Management – Pain Education for Professionals is an interactive online education program that examines best practice pain management for all healthcare professionals. It fosters consistency and excellence through a multi-disciplinary approach to the management of pain. The second six modules to supplement the first six (available on Networks) have now been developed. An external review of the project's needs and the market is being undertaken before any technological access solutions are progressed.

An Opioid Calculator smart phone app for Apple and Android smart phones has been developed to facilitate the use of conversion factors in the Opioid Dose Equivalence table. The app helps to compare different opioid regimens in individual patients or in patient cohorts.

Help build the capacity and capability of the Australian and New Zealand fellowship, including promoting pain medicine as a career and attracting trainees.
In the past year our Fellows continued to promote pain medicine topics on radio, television, and in print, reaching a cumulative audience of more than 4.1 million readers, listeners and viewers. Seven medical schools took up the opportunity of awarding the Faculty's prize to the student who excelled in undergraduate pain medicine.

Help further develop the multidisciplinary approach of our new specialty and grow our Faculty.
As a Faculty we maintained our advocacy efforts with both independent and collaborative representations to government and other bodies, thereby indirectly advocating for patients suffering in pain. Fifteen pain medicine media releases were published. Independent and collaborative submissions with ANZCA and Painaustralia were undertaken with regard to key issues, including caution on the use of "medicinal cannabis", the re-scheduling of codeine and *National Safety and Quality Health Service Standards Version 2*. A new memorandum of understanding was signed between the Faculty and the Medical Council of New Zealand to update requirements related to the assessments of international medical graduates and recertification of pain medicine specialists.

The first benchmarking reports of the Electronic Persistent Pain Outcomes Collaboration (ePPOC) became available in 2015. This describes adult patient treatment outcomes by specialist pain services in Australia and New Zealand using a standard set of data items and assessment. By December 2015 there were 50 participating sites. The Faculty continued to be represented on both its Management Advisory Group and Scientific and Clinical Advisory Committee.

Help establish the Faculty as a leading trainer of specialist pain physicians in the world.
The fourth edition of *Acute Pain Management: Scientific Evidence* was published online in December. The publication covers a wide range of clinical topics, combining a review of the best available evidence for acute pain management with expert current clinical practice. It was the result of many months of hard work headed up by Professor Stephan Schug and his hard-working and enthusiastic editorial team. It will be launched in print form in May at the 2016 ANZCA Annual Scientific Meeting in Auckland. The third edition was endorsed by the International Association for the Study of Pain, and by colleges, societies and associations from the UK, Ireland, Hong Kong, Singapore and Malaysia, and recommended to its members by the American Academy of Pain Medicine.

Last year the European Pain Federation (EFIC) decided develop a diploma in pain medicine. EFIC is a multi-disciplinary professional organisation in the field of pain research and medicine, consisting of the 37 chapters of the International Association for the Study of Pain (IASP). The President of EFIC, Chris Wells, requested permission to use and modify the Faculty's curriculum for this purpose. The Faculty granted EFIC approval to use the parts of the FPM curriculum that were in the public domain for modification with appropriate acknowledgement, including the Faculty's logo.

Highlights in 2015 have been many and varied in a very busy and successful year as we continue to strive towards our strategic vision "to reduce the burden of pain in society through education, advocacy, training and research". These achievements remain a testimony of the efforts of those Fellows who have willingly donated their valuable time, and to our Faculty's staff.

Professor Ted Shipton
Dean, Faculty of Pain Medicine

News

Admission to fellowship

The following have been admitted to fellowship of FPM by examination:

Dr Catherine Abi-Fares, FANZCA, Queensland
Dr Michelle Harris, FANZCA, South Australia
Dr Jacquelyn Nash, FANZCA, Victoria
Dr Christopher Rumball, FAFOM (RACP), New Zealand
Dr Fiona Tsui Pui Yee, FANZCA, Hong Kong
Dr Nina Loughman, FANZCA, Tasmania
Dr Stiofan O'Conghaile, FCARCSI, Victoria
Dr Wei Chung Tong, FANZCA, New Zealand

We are pleased to report that this takes the total number of Fellows admitted to 424.

Exam dates

The written exam will be held across FPM regional and national offices on Friday November 4.

The clinical examination will be held in Melbourne on Saturday November 26.

The closing date for exam registrations (both written and clinical) is Wednesday September 30.

Faculty of Pain Medicine (continued)

Genders experience pain differently, and women feel it more

"While results have at times been conflicting, what we are learning is that females consistently show lower pain thresholds and increased pain following a painful stimulus than males."

There is a lot to learn about gender and pain, with some researchers now thinking pain in men and women may even occur through different mechanisms and pain pathways.

More women than men suffer from chronic pain, described as pain that persists for more than six months. In addition, much of this pain remains undiagnosed or untreated.

As well as the pain associated with menstruation or the bearing of children, waiting rooms of pain physicians, rheumatologists and gastroenterologists show clear majorities of women.

Research has found the only pain conditions more common in men are the relatively infrequent cluster headaches (where strong pain occurs on one side of the head), nerve pain after shingles, ankylosing spondylitis (a form of spinal arthritis) and migraine without perceptual disturbances of light and smell (called "aura").

Everything else – from pelvic pain, irritable bowel syndrome, all other headaches, multiple sclerosis, rheumatoid arthritis, jaw pain, bladder pain syndrome, fibromyalgia, chronic regional pain syndrome to odontalgia (painful teeth) – is more common in women.

Men and women also describe pain differently. Research found women tended to use more descriptive, graphic language with a focus on sensory symptoms. Men were more likely to express anger or swear, but recalled the event more objectively.

Male subjects' written responses were shorter and less detailed, with potential influences being gender role expectations of pain response, a male reticence to report painful sensations and feelings of embarrassment when reporting a pain experience.

History of thinking about pain

We understand pain in others best when we have real or imagined shared experience. Pain in women is frequently both unable to be visualised (unlike lacerations or other visible injuries) and outside the experience of their health professional.

How to view a female patient with pain that can't be seen is a problem the ancient Greeks pondered as early as 400BC. Faced with a complex range of suffering and complaints in women, ancient Greek physicians came up with a novel explanation: the "wandering womb". The womb was believed to move upward in a woman's body whenever it became hot and dry, searching for cool moist places, and causing stress and damage to her physical and mental wellbeing.

Hippocrates (460-370BC) used the term "hysteria", which derives from the Greek word "hysteros" for "womb", to describe a wide variety of female emotional and physical conditions. By inference this labelled women in pain as weak, inferior or irrational. Parallel to their inferior social position in ancient Greece, Aristotle (384-322) used the concept of hysteria in his book, The Nicomachean Ethics, as proof that women were unsuitable for public office.

There's a common belief that women have a higher pain threshold so they can give birth, but actually men's pain threshold is higher.

While such beliefs seem far-fetched today, the diagnosis of "hysteria" continued to be commonly used in European medical practice to describe a wide variety of symptoms in women for the next 2000 years. Only in 1980 was it removed from the *DSM III Manual of Psychiatric Disorders*.

Unlike women, historical accounts of men's pain have been influenced by their ability to withstand injuries incurred in warfare. As English poet William Cowper (1792) noted, incitements including "renown and glory" helped men disregard pain on the battlefield.

Research in pain

In 1977, with concern about the risk that new drugs might have on an undiagnosed pregnancy, the US Food and Drug Administration recommended that all women who were capable of becoming pregnant be excluded from drug trials. The presumption was that pain research in men would be applicable to both genders. While well intentioned, the consequence of this decision has been that the majority of pain research has been undertaken in male humans or male rodents.

"The presumption was that pain research in men would be applicable to both genders. While well intentioned, the consequence of this decision has been that the majority of pain research has been undertaken in male humans or male rodents."

This decision has since been reversed and research into pain differences between the sexes has dramatically increased. While results have at times been conflicting, what we are learning is that females consistently show lower pain thresholds and increased pain following a painful stimulus than males. This doesn't mean women are weaker than men or their pain isn't real, but they feel pain more intensely than men.

Pains specifically associated with women, such as menstrual pain, may predispose women to feeling pain more acutely in other areas. Women's brains produce less endorphin (which inhibits pain) following a pain stimulus than men. Yet when morphine is given to treat pain, it generally works equally well in either gender.

Clearly there is still a lot to learn about gender and pain. Newer thinking suggests that pain in men and women may even occur through entirely different mechanisms and pain pathways.

For example, microglia are cells from the immune system involved in chronic pain. Research in mice has shown that drugs that prevent activation of microglia are effective in reducing pain in male, but not female, mice.

So, the observed differences in ability to withstand acute pain on a battlefield (traditionally associated with males) and ability to withstand the pain of chronic disease (more commonly associated with females) may prove to have a physiological basis.

Every one of our cells knows whether we are male or female and responds accordingly. That there are differences between male and female pain should not be surprising.

Dr Susan Evans, FRANZCOG, FFPMANZCA
University of Adelaide

This article appeared in The Conversation in December as part of a series focusing on pain. Access the full article at: https://theconversation.com/genders-experience-pain-differently-and-women-have-it-more-49428. Read other articles in the series at: https://theconversation.com/au/topics/pain-series

THE CONVERSATION

Anaesthetists support White Ribbon Day

Unless you were trapped in theatre, you must have noticed it was national White Ribbon Day on Wednesday November 25, such was the high profile media coverage in Australia.

White Ribbon Day is Australia's campaign to prevent men's violence against women (www.whiteribbon.org.au). It is the largest global male-led movement to stop violence against women which has been operating for the past 12 years, educating and raising awareness about men's violence against women, focusing on the positive role that men can play to influence the actions of those few who use violence, whilst attempting to break the cycle of violence in society.

In Brisbane, a group of anaesthetists demonstrated their support by attending a White Ribbon Day breakfast in aid of the not-for-profit charity DVconnect (www.dvconnect.org), a Queensland-wide, organisation offering help, including a crisis hotline, emergency accommodation and counselling, to anyone affected by domestic or family violence.

The breakfast was hosted by the Queensland Premier, Ms Annastacia Palaszczuk, who spoke about a special taskforce on domestic and family violence in Queensland chaired by Dame Quentin Bryce AD CVO, in response to the fact that in 2013 -2014 there were 66,000 (180 a day) reports of domestic violence to police. The Premier's Implementation Council on Domestic Violence has been established, chaired by Dame Quentin.

So, what does this have to do with anaesthetists? Contrary to the popular portrayal of domestic violence as isolated to low socioeconomic groups, it is present everywhere and effects people from all walks of life, including doctors, including anaesthetists.

So, on White Ribbon Day our group of anaesthetists stood with the 600 other breakfast goers in Brisbane and vowed "Not now, not ever".

Dr Anna Hallett, FANZCA
Brisbane

Above from left: Dr Anna Hallett, Dr Martina Meyer-Whiting, Dame Quentin Bryce, Dr Bridget Effeney; Dr Anna Hallett with Mr Darren Lockyer.

If you or anyone that you know is a victim of domestic violence please go to www.whiteribbon.org.au/finding-help or http://areyouok.org.nz/ in New Zealand.

Foundation update

Below from left: Dr Hugh Taylor, Dr Nicole Tan, Professor Stephan Schug.

ANZCA Melbourne Emerging Anaesthesia Researcher Award

The Anaesthesia and Pain Medicine Foundation is proud to announce the ANZCA Melbourne Emerging Anaesthesia Researcher Award (AMEARA) for 2016 has been awarded to Dr Hugh Taylor, an anaesthetist at Western Health in Melbourne, for the project "A pilot study to investigate post-operative oxygen consumption (POpOC) after colorectal surgery requiring bowel resection".

The award, a collaboration between the foundation, Melbourne Medical School's Anaesthesia, Perioperative and Pain Medicine Unit (APPMU), and foundation supporter Dr Peter Lowe, provides a $A10,000 grant to a Fellow within five years of fellowship and working at a University of Melbourne-affiliated hospital.

Congratulating Dr Taylor on his success, University of Melbourne Chair of Anaesthesia and head of the APPMU, Professor David Story, said the project "continues the Western Hospital tradition of measuring oxygen consumption".

Major sponsors

The foundation thanks its partner and major sponsor Perpetual for the new Perpetual ANZCA Emerging Researcher Award. The first award has been given to Dr Nicole Tan for her 2016 project "Does the addition of LIA to a multimodal systemic analgesia regimen improve recovery after anterior THR?".

The foundation is very grateful to Pfizer for its support of the ANZCA pain medicine research program through its major sponsorship and the Pfizer ANZCA Research Award, which in 2016 will go to Professor Stephan Schug for his project "Obesity and chronic pain management: piloting a new model of care".

Supporting emerging researchers

The future delivery of high-quality research to support clinical practice and patient outcomes is closely related to the early encouragement and development of talented new researchers.

Establishing the AMEARA Award and the Perpetual ANZCA Emerging Researcher Award help increase funding for, and recognition of, high-potential investigators starting their research careers.

The foundation has been invited to submit a proposal to Australian Executor Trustees for a new funding grant to support an emerging researcher in South Australia.

The foundation will work to secure other funding opportunities for emerging researchers this year. Anyone interested in supporting new grants for emerging researchers should contact the foundation for a confidential discussion.

Board of Governors

The Board of Governors met on December 17 and heard a short presentation from Leo Orland, a senior partner at one of Australia's leading fundraising consultancies, Robejohn and Associates. Mr Orland discussed the need to invest in fundraising and relationships and the importance of telling compelling stories about the impact of research on patients' lives.

The board has invited Mr Orland to conduct a half-day workshop on the subject to assist board members as they speak with prospective foundation supporters.

The foundation and the board are now scheduling meetings with potential supporters who were introduced to the foundation last year. If you have a short story that powerfully demonstrates the personal impact of research on patient outcomes, please contact the foundation.

Thank you to subscription donors

The foundation thanks the generous supporters who made donations with their 2016 subscriptions. Your support is vital in increasing the breadth and depth of the research being conducted by Fellows, which contributes to national and international standards of safety and quality, and health and life outcomes for patients.

Leaving a legacy

A bequest is the most lasting way to support excellence in anaesthesia and pain medicine research. For information on how to make a bequest please contact the foundation.

Donations can be made via the foundation section of the ANZCA website (www.anzca.edu.au/fellows/foundation) by mail or by calling Rob Packer at the foundation on +61 3 8517 5306.

Rob Packer,
General Manager, Anaesthesia and Pain Medicine Foundation

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

We continue our series of articles on some of the projects ANZCA has helped fund.

Study looks at regional anaesthesia in fistula surgery

About half of all patients with end-stage kidney disease require an operation that connects a renal artery and a vein, known as an arteriovenous fistula (AVF), a procedure offered before dialysis, according to ANZCA Fellow Dr Raymond Hu.

Dr Hu, from Austin Health in Melbourne, received the ANZCA Research Committee's Novice Investigator Grant for 2016 for a project that will look into whether the use of a regional or general anaesthetic has any bearing on the patient's outcomes after the creation of such a fistula.

"These patients with end-stage kidney disease are very sick – there are many associated medical conditions with their illness," Dr Hu said.

"There can be a concern about the use of general anaesthesia in these procedures – but there are also worries about the use of regional anaesthesia. For example, "having a general anaesthetic can extend a patient's recovery time in this procedure, while regional anesthesia may be associated with more peripheral nerve dysfunction.

"Evaluating the impact of anaesthesia technique on arteriovenous fistula patient outcomes has the potential to alter renal anaesthetic practice significantly."

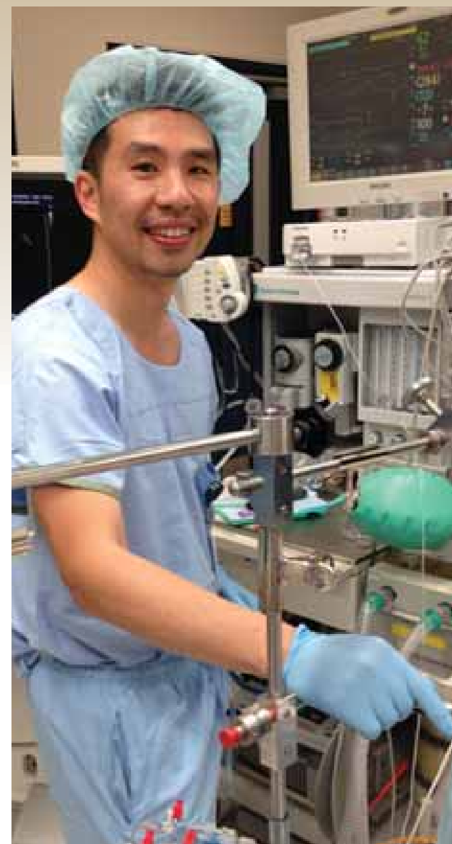
One of the chief concerns after the creation of an arteriovenous fistula is the ability to optimise blood flow through it, he said.

There was some evidence that regional anaesthesia could optimise blood flow through an AVF, but the strength of the data was modest, he said.

Dr Hu and his team will be gathering data from multiple hospitals across Victoria to investigate the six-week outcomes of patients having their AVF created in relation to the anaesthesia they received, general versus regional. Successful blood flow through the AVF will be a critical component that will be investigated.

"Six-week outcomes are clinically important as a decision to reintervene or abandon the AVF is typically made within this timeframe," he said.

"We hope this pilot can lay the foundations for the development of a multi-centre randomised controlled trial investigating whether the choice of anaesthesia influences the success of the procedure and especially to establish whether regional anaesthetic might improve blood flow."



If you are concerned about yourself or a colleague, contact

The Doctors' Health Advisory Service

Hotline

nearest to you

Australia:
New South Wales/Northern Territory +61 2 9437 6552
Australian Capital Territory +61 407 265 414
Queensland +61 7 3833 4352
Victoria 1300 853 338
Western Australia +61 8 9321 3098
Tasmania 1300 853 338
South Australia +61 8 8366 0250
New Zealand: 0800 471 2654

Trading with the enemy: The story of Ludwig Brück

> "I have taken poison and to make quite sure, I have poured a quarter pound of chloroform on my handkerchief to lay my face on. When you read this letter I shall be dead about 42 hours."

SCHEDULE B.
FORM OF PASSENGER LIST.
NAMES AND DESCRIPTIONS OF PASSENGERS.

AGENTS FOR THE TRANSFER OF MEDICAL PRACTICES.
Intercolonial Medical Transfer and Agency Office,
L. BRUCK, Manager,
35 CASTLEREAGH STREET, SYDNEY.
ASSISTANTS, legally qualified or sine diploma, provided.
LOCUM TENENS, suitable and fully qualified, who are thoroughly accustomed to General Practice, and possess good testimonials as to ability, sobriety, and steadiness, can be engaged at a short notice.
PARTNERSHIPS ARRANGED. PRACTICES FOR SALE IN ALL COLONIES.

Ludwig Hermann Brück arrived in Australia aboard the *Van Diemen* in September 1873. He had taken a rather circuitous route from his home in Silesia (modern day Poland), although it was probably a standard route in the 19th Century. Travelling from Hamburg aboard the *Hansa*, he first went to New York then arrived in Liverpool, England on May 24. He departed for Melbourne exactly a month later.

He travelled at the same time as a Peter Bruch, whose name appears directly above his on the *Van Diemen's* passenger list. As a result, Brück's family name has been recorded as nothing more than a flourish of the pen, indicating he bears the same name as the man listed above him. The same flourish has been used to indicate the profession of Bruch, labourer, to be the profession of Brück. Emigration documents from Hamburg reveal Brück's profession to be "Buchhändler" or bookseller.

A rates book from 1881 records Brück as the owner and occupier of a brick property in Washington Street, Toorak, probably a flat. Towards the end of 1881, Brück relocated to Sydney, and was employed as a manager at the Intercolonial Transfer and Medical Agency Office. He was also well known to the NSW and Victorian chapters of the British Medical Association, and volunteered to publish the first edition of the *Australian Medical Gazette*, considered the "...official organ of the combined Australasian branches of the British Medical Association"[1].

In 1883, he added a new publication to his stable, the *Australasian Medical Directory and Handbook*. The aim of the medical directory, as stated by Brück, was to fulfil the need for a "book of reference" that contained a list of registered and unregistered medical practitioners based in Australia, New Zealand and Fiji[2]. This publication was to become a valuable tool in the professionalisation of medical practice in the colonies. Five editions of the directory were published until 1900. The 1886 edition attracted some notoriety with the inclusion of a *List of Unregistered Practitioners*. Some 257 practitioners within the colonies had been identified and named as unregistered.

By 1890, Brück had set up his own business as a medical instrument importer and bookseller. During this time, he commissioned the creation of the Brück inhaler, which came onto the market in about 1908. The Brück inhaler is a modification of the Clover inhaler. Brück added a clear glass dome that enabled the level of ether to be monitored during administration. This was a revolutionary change, although Brück's modification was not the first to include it. This inhaler is larger than other Clover modifications but the airways remain similar, thereby classifying this as a small-bore inhaler. The inhaler also has a stopcock for admission of oxygen or nitrous oxide opposite the bag attachment[3].

Business appears to have not only continued, but to have flourished. In March 1914, Richard Thomson joined Brück as a business partner, and later, as Brück faced public shame and disgrace, he would take over the business entirely.

On August 4, 1914 Britain declared war on Germany which immediately brought Australia, as a Dominion, into the war. A royal proclamation was issued on August 5, and within days was widely circulated throughout the Dominions. Any individual entering "...into dealings whatsoever, with the Emperor or his government"[4] would be considered to have undertaken treasonous actions.

Once war broke, Brück found himself in the midst of anti-German sentiment. The *War Precautions Act 1914* stipulated any citizen of enemy countries could be interned for the period of the war. Despite any professional reputation he built since arriving in Australia over 40 years earlier, Brück, like other Germans at the time, was destined to live out the war years in a state of suspicion.

In August 1915, Ludwig Hermann Brück was accused of having traded with the enemy, under the *Trading with the Enemy Act 1914*. Mr Mitchell, an inspector appointed under the act, had called at the business and demanded to see all the company's foreign correspondence since the outbreak of war. These were then seized as primary evidence. Was it Brück's German name that brought this unwanted attention? Was it his public and outspoken persona or was it merely an inspector completing his job with diligence?

The case revolved around two letters written in September of that year. The first was from Brück to Rusch and Co, based in Germany and the second was to Steinmetz and Knetsch, based in Sweden. Both companies were involved in the import/export of medical equipment.

A year later, on August 14, 1915, Brück's business partner Richard Thomson became worried. He had been expecting to meet with Brück to discuss the legal problems the business was now facing. Brück never appeared. Thomson returned to their offices with a detective and found Brück collapsed on a chair in the basement. There were two letters with him.

In each, Brück expressed his sorrow at the events that had transpired. "I trust you will believe me when I state I had no intention of transgressing against the law and if I had only studied the proclamation all would have been well"[5], he wrote to his business partner.

He explained to his wife, that in order "...to save an inquest you can tell the coroner I have taken poison and to make quite sure I have poured a quarter pound of chloroform on my handkerchief to lay my face on. When you read this letter I shall be dead about 42 hours".

His suicide didn't go quite as planned. He was still alive when Thomson and the detective found him. He was to die a few hours later in Sydney Hospital.

Thomson was left alone to face the charge of trading with the enemy. The Central Police Court found the firm of Brück & Thomson guilty of the charge, fining the company £50, court costs and witnesses' expenses.

Just as Brück had hoped, Thomson was able to keep the business running from the same address by changing its name to Richard Thomson and Company, thereby removing any association with the ill-fated German.

The Geoffrey Kaye Museum of Anaesthetic History holds a Brück inhaler, lavishly engraved with Brück's name. The inhaler was donated by Prince Henry's Hospital in 1939.

Monica Cronin, Curator, Geoffrey Kaye Museum of Anaesthetic History

and

Ari Hunter, Deakin University

Ari Hunter is a student with Deakin University's Master of Cultural Heritage & Museum Studies program. Ari has been undertaking a collection management internship at the Geoffrey Kaye Museum of Anaesthetic History since September 2015.

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1. The Australasian Medical Gazette, Vol 1, 1881, L. Bruck, Sydney, p1
2. 'Preface', The Australasian Medical Directory and Handbook, Vol. 1, 1883, Sydney
3. Christine Ball, 'The Bruck Inhaler', Anaesthesia & Intensive Care, Vol 18, No 2, May 1990, p168
4. The Sydney Morning Herald, 'Trade with the enemy: Royal Proclamation' Saturday August 8, 1914, p14
5. The Advertiser, 'A Letter from the Dead: Germ who Committed Suicide "Victim of the War"', Adelaide, August 17, 1915, p7

Above from left: Passenger list from the Van Diemen which sailed from Liverpool to Melbourne, 1873, with Brück aboard; Brück inhaler from the Geoffrey Kaye Museum of Anaesthetic History, c. 1908; Business advertisement for the Intercolonial Transfer and Medical Agency Office where Brück was a manager when he first moved to Sydney.

Representatives give ANZCA a community voice

The presence and purpose of community representatives within health and medical organisations has grown powerfully over the last 10 years.

Community representative Ms Helen Maxwell-Wright, who sits on ANZCA's International Medical Graduate Specialist (IMGS) Committee, the IMGS interview panel and the College's Safety and Quality Committee, says community representatives are key to bringing a fresh perspective and voice to decisions that will ultimately affect consumers, people who use health and medical services.

"It's a way of supporting transparency and consistency in decision-making, another step in making sure that ultimately the needs of the community are well served," she said.

Each community representative has a link to the health and/or community services sector and experience in the role of advocate.

Ms Diana Aspinall, who sits on ANZCA's Education, Training and Assessment Management Committee, sums up her role: "My aim is for the voice of consumers who interact with the health system to be heard and listened to and support consumers in a positive role for the delivery of health services," Ms Aspinall said.

ANZCA's community representation policy lists the following responsibilities of representatives:

- To contribute to a robust, transparent decision-making process that aligns with the College mission.
- To provide a societal perspective on issues.
- To ensure the committee recognises community concerns.

"The College strives to serve the community by fostering safety and high-quality patient care in anaesthesia, perioperative medicine and pain medicine," the policy states.

"As a result, Australia and New Zealand have one of the best patient safety records in the world – a factor that contributes to the high level of health outcomes enjoyed by most.

"The engagement of community representatives is a valued means of supporting transparency and consistency in decision-making. The College seeks to continually improve its operations, in line with community expectations."

Meet our community representatives

Ms Diana Aspinall

Ms Aspinall is a consumer advocate who also manages, with her health team, her own multiple chronic health conditions. She is a director of Wentworth Healthcare Ltd operating as the Nepean-Blue Mountains PHN (NBMPHN) supporting primary healthcare in the region. She has been a senior consumer representative for the Consumer Health Forum of Australia since 2006. Ms Aspinall has been a consumer representative on ANZCA education and training committees since 2009. She is on the Education, Training and Assessment Management Committee and the Trainee Scholarship Evaluation Sub-Committee. A retired health professional and registered nurse, she has a tertiary qualification in health promotion strategic planning.

Ms Dorothy McLaren

Ms McLaren is a PhD candidate at RMIT University in Melbourne and her research interest is "problem identification and resolution in rural communities". This interest stems from six years working in disability advocacy and 15 years of community development practice in the Wimmera area of Victoria. she has served on the community advisory committees for two rural base hospitals in western Victoria. Her current research focuses on the experience of rural citizens travelling for healthcare and "finding a common language and understanding for patients and health service organisations and health providers as they strive to improve the flexibility and accessibility of services". She sits on the Professional Affairs Executive Committee.

Ms Helen Maxwell-Wright

Ms Maxwell-Wright has worked in health sector management for most of her career and sits on the ANZCA Safety and Quality Committee, the International Medical Graduate Specialist (IMGS) Committee, the IMGS interview panels, the Document Development Group for Cultural Awareness, the Bullying, Discrimination and Sexual Harassment Working Party and as a reviewer for the Pain Management Guidelines for the FPM. She has been a community representative for ANZCA since 2002. She is director of Maxwell-Wright Associates, a member of the panel of chairs for the monitoring committee of Medicines Australia, chair of the state leadership group of the Juvenile Diabetes Research Foundation and president of OzChild Children Australia, a welfare agency that cares for vulnerable children.

Ms Susan Sherson

Ms Sherson retired in 2012 from the position of nurse educator and chair of the Clinical Ethics Committee at the Royal Melbourne Hospital and has worked in a variety of nursing roles and clinical specialities in Australia and overseas. Her early interest in ethical issues related to clinical practice was deepened by her experience as a member of the first civilian surgical team sent from Australia to South Vietnam during the war in that country. She wrote of these experiences in *House of Love – Life in a Vietnamese Hospital* published in Australia at the end of 1966. It also was published overseas and translated in 25 countries. She sits on the ANZCA Training Accreditation Committee.

Dr Angela Watt

Dr Watt is the director of Research Governance and Ethics at Melbourne Health and holds a bachelor of science with honours in microbiology and a PhD in immunology from the University of Melbourne, and a graduate diploma in health services management from RMIT University. In 1994 she was appointed head of the Office for Research at the Royal Melbourne Hospital. She also served as manager and secretary of the hospital's Human Research Ethics Committee from 1994 until 2008 and continues as a member of that committee. she has a strong interest in research ethics and governance and is involved in various Victorian and national initiatives surrounding human research management. She is the community representative for ANZCA's Research Committee.

Ms Sue Driver

Ms Driver is an experienced board member, senior manager, project manager and advisor/contractor in the public, private and not-for-profit sectors. She is a member of the New Zealand Parole Board and works with not-for-profit organisations as an advisor on capacity building, management and governance. She is a former Wellington city and Wellington regional councillor, and has worked in the health, social and community services sectors in managerial and consultancy roles with an emphasis on decision-making, consultative and deliberative processes. She is the community representative on ANZCA's New Zealand Panel for Vocational Registration.

The team behind our training program

Many Fellows and trainees are unaware of the work that goes on behind the scenes at ANZCA. This article, about the Education, Training and Assessment Executive Committee, is part of a series on the activities undertaken by our College.

The Education, Training and Assessment Executive Committee (ETAEC) is the peak educational committee responsible for all aspects of the ANZCA training program. Reporting directly to the ANZCA Council, ETAEC oversees, guides and reports on the activities of the following Education, Training and Assessment (ETA) committees:

- Education, Training and Assessment Management Committee (ETAMC).
- Education, Training and Assessment Development Committee (ETADC).
- Training Accreditation Committee (TAC).
- International Medical Graduate Specialist Committee (IMGSC).
- Education, Training and Assessment Strategy Committee (ETASC).

ETAEC usually meets six times each year, two face-to-face meetings and four by teleconference. These meetings are carefully scheduled to allow ETAEC to receive reports and recommendations from the above committees, consider their implications across the breadth of the ETA and accreditation activities of the College and enact decisions within ETAEC's delegated authority from the council. Recommendations regarding changes to regulations, the strategic direction of the College, removal of trainees from the training program or removal of accreditation from an approved training site must be considered and decided by the council.

Some of the key matters under consideration by ETAEC include:

- The development and advancement of the primary and final examinations, which was the subject of an Examinations Strategic Planning Workshop in November 2015. A particular area of interest is the potential to move written examinations, including multiple-choice and short-answer questions, to an electronic platform to enhance the writing, delivery, marking and analysis of candidate responses.
- Responding to changes in the Australian Medical Council (AMC) standards and requirements for the assessment of international medical graduate specialist (IMGS) anaesthetists. The IMGS Committee is reviewing regulation 23, which governs the College's IMGS assessment processes.
- The implementation of the AMC's recommendation that the interval between hospital accreditation visits should be reduced from seven to five years. This will be facilitated by the introduction of the new online system to support the accreditation process.
- A review of the College's educational governance structure, which resulted in a recommendation that face-to-face meetings of the ETAEC and the ETASC should be aligned so a broader group of Fellows can contribute to the determination of the College's ETA strategies.
- A detailed evaluation and review of the 2013 curriculum, which is being undertaken in 2015 and 2016. There are three phases to this review. The first phase, the training program documents review, examined the curriculum, regulations and *Training and Accreditation Handbook*, and made recommendations regarding the size, complexity and presentation of the documentation. The second phase of the curriculum review, now nearing completion, has involved a review of regulations, rules, processes and curriculum content by three expert implementation groups. These groups have examined how we manage time, volume of practice and assessment throughout the ANZCA training program. The third and final phase of the review will consider the College business processes and technologies, including the training portfolio system, which support the implementation and operation of the revised training program.

Contact the ETAEC through Administrative/Committee Support Officer Diana Acosta (dacosta@anzca.edu.au) or the Dean of Education, Dr Ian Graham (igraham@anzca.edu.au).

Dr Ian Graham
Chair, Education, Training and Assessment Executive Committee

Above from left: The February 2016 meeting of the Assessments and Reviews Expert Implementation Group, clockwise from left: Maria Bishop, Paula Stephenson, Rebecca Campbell, Dr Frances Page, Dr Maggie Wong, Dr Jennifer Taylor, Dr Damian Castanelli, Jodie Atkin, Frederick Rhoads, Dr Louise Munro, Dr Jenny Weller, Oliver Jones, Dr Ian Graham; Dr Graham, Chair, Education, Training and Assessment Executive Committee.

Supporting anaesthesia and pain medicine in our region

"Five billion people lack access to safe, affordable surgical and anaesthesia care when needed."

This article on supporting anaesthesia and pain medicine in low and middle-income countries addresses issues frequently raised by ANZCA Fellows and trainees engaging in international projects, education, clinical work, equipment donation, and supporting opportunities for in-country training in Australia and New Zealand.

Last year was momentous for global anaesthesia. Traditionally surgery and anaesthesia have been a low health priority in many low and middle-income countries due to the misconception of it being a high cost, complex intervention applicable to a limited population.

However, recent literature consistently identifies many essential surgical services as among the most cost-effective health interventions. Chao et al[1] extracted cost-effective ratios for seven categories of surgical intervention, concluding "essential surgical interventions are cost effective or very cost effective in resource poor countries".

For example, the median cost-effective ratios for cleft palate repair ($47.74 per disability-adjusted life years, DALY), general surgery ($82.32 per DALY) and ophthalmic surgery ($136 per DALY) were similar to BCG vaccination ($51.86-220.39 per DALY). Similarly, obstetric and orthopaedic surgery was more favourable than antiretroviral therapy for HIV and medical management of ischaemic heart disease.

On May 22, 2015, the 68th World Health Assembly (WHA) unanimously approved resolution A68/31[2] "Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage". Universal healthcare had typically been considered to be "vertical issues", such as sanitation, vaccination, malaria control and HIV management. However, conditions that could be surgically treated account for about 30 per cent of the total global burden of illness. Each year 270,000 women die from complications of pregnancy and five million die from injuries. Now, for the first time, governments worldwide were recognising that surgery cuts across almost all health issues, including trauma, childbirth, cancer and disease.

Also last year, the landmark Lancet Commission on Global Surgery 2030[3] was released, a must-read for Fellows and trainees seeking to support international anaesthesia and pain medicine. The commission emphasised that surgery was an "indivisible indispensible part of basic healthcare".

Among the report's first key messages were the challenging facts that:

- Five billion people lack access to safe, affordable surgical and anaesthesia care when needed.
- 143 million additional surgical procedures are needed each year in low and middle-income countries.
- Growing the anaesthetic and surgical workforce is essential to satisfy this demand and the Global Surgery 2030 target has been set at "100 per cent of countries with at least 20 surgical, anaesthetic, and obstetric physicians per 100,000 population by 2030".

In 2015, the World Bank published the *Disease Control Priorities, 3rd edition. Volume 1, essential surgery*[4], reinforcing the conclusions of the Lancet Commission and the World Health Assembly. They identified 44 surgical procedures that are cost effective, address a substantial need and are feasible, concluding that essential surgery would prevent 6 per cent or 1.5 million of all avertable deaths in low and middle-income countries.

The Lancet Commission identified three "bellwether" procedures: caesarean section, laparotomy, and treatment of open fracture, however to achieve 80 per cent worldwide provision of timely access to this essential surgery and anaesthesia by 2030 we will need to double the surgical workforce. In 2014, across 23 low and middle-income countries in 2014, the frequency of anaesthetists ranged from only 0 to 4.9 per 100,000[5].

Australian and New Zealand anaesthetists have been influential in supporting anaesthesia training in many low and middle-income countries, including Fiji, Micronesia, Timor Leste, Myanmar, Cambodia, Laos, Mongolia, Nepal, Bhutan and Papua New Guinea (PNG).

In PNG, ANZCA has been providing support since 1994. This long-term commitment has focused on supporting anaesthesia within the School of Medicine and Health Sciences as well as the PNG Society of Anaesthetists.

The College's focus is on providing training opportunities at all levels, as well as continuing professional development. This includes annual week-long programs for anaesthetic scientific officers (non-physician providers), diploma of anaesthesia candidates and MMED anaesthesia candidates, as well as support at the annual PNG medical symposium and co-ordinating short courses such as Essential Pain Management (EPM) and Safer Anaesthesia from Education program.

To raise the profile of anaesthesia within the PNG medical community, the College supports three annual anaesthesia prizes for the top undergraduate medical student in anaesthesia, the top diploma of anaesthesia candidate, and the Garry David Phillips Prize (PNG), which is awarded annually in the form of a medal for outstanding achievement in the MMED anaesthesia program. After a number of years of graduating one or no new specialists, interest in anaesthesia training in PNG is expanding. This year it is anticipated four candidates will sit the MMED examination.

If PNG and other low and middle-income countries are to reach the aspirational goals of the Lancet Commission, a further 2.2 million surgical, obstetric and anaesthetic providers will need to be trained, however given the diversity of the anaesthetic landscape between nations it is unlikely that one educational strategy will be ideal for all.

The enthusiasm of national governments and anaesthetic societies, the current duration of anaesthetic training, the current anaesthetic practice, the acceptability of task shifting, the eventual volume and scope of practice and potential educational and infrastructure resources will all influence the development of training for future anaesthetic providers.

In a few areas, some of the bellwether procedures may only be achievable through educating non-medical providers to deliver open-drop ether, while in other countries, all bellwether procedures may be anaesthetised for by doctors trained to a similar program as the Joint Consultative Committee on Anaesthesia rural GP anaesthetists.

Australian and New Zealand anaesthetists are actively engaging with several national anaesthetic societies, including in Mongolia, Myanmar, Cambodia and India, to develop programs. By working in concert with local societies, sharing and employing prior low and middle-income countries educational experiences and using the expertise of ANZCA, including the Education Training and Assessment committees, Australian and New Zealand anaesthetists can be pivotal in low and middle-income countries achieving the goals of Lancet 2030.

Associate Professor David Pescod,
FANZCA
ANZCA Overseas Aid Committee

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1. Cost-effectiveness of surgery and its policy implications for global health: a systematic review and analysis. www.ncbi.nlm.nih.gov/pubmed/25103302.
2. WHA reaches agreement on polio, International Health Regulations and strengthening surgical care www.who.int/mediacentre/news/releases/2015/wha-22-may-2015/en/.
3. Lancet Commission on Global Surgery 2030: Evidence and solutions for achieving health, welfare and economic development. www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(15)60160-X.pdf).
4. Essential Surgery: Key messages from disease control priorities, 3rd edition. http://dcp-3.org/node/1802.
5. Shortage of doctors, shortage of data: a review of the global surgery, obstetrics, and anesthesia workforce literature. www.ncbi.nlm.nih.gov/pubmed/24218153.

Above from left: Essential Pain Management Lite is established at the School of Medicine and Health Sciences, University of Papua New Guinea; Group discussion at the Pacific's first SAFE Anaesthesia Obstetrics Workshop in August 2015; PNG anaesthesia community celebrates World Anaesthesia Day 2015; Inaugural Garry David Phillips prize winner Dr Jack Puti (centre) practicing intubation in 2010.

New Zealand news

Enhanced maternal recovery and sustainability on menu for 2016 lectureship program

NZ Anaesthesia Visiting Lectureships for 2016 have been awarded to Dr Matthew Drake (above), National Women's Health, Auckland, for his presentation on "Adapting Enhanced Recovery for Caesarean Section: The National Women's Experience"; and to Dr Sabine Pecher (above), Hutt, for "Sustainable Anaesthesia – how green is my anaesthetic?".

Clinical director Dr Marty Minehan nominated Dr Drake for his excellent presentation about National Women's enhanced recovery initiative, which is improving outcomes for women having a caesarean. Dr Drake is looking forward to sharing National Women's experience of enhanced recovery, which, he says, is a new concept in obstetric surgery with anaesthetists well placed to influence the perioperative care of their patients.

Nominating Dr Pecher, Hutt Clinical Director Dr James Cameron said her talk on sustainability in anaesthesia was an excellent and very topical description of the various ways anaesthetists and routine anaesthetics can affect the environment. The presentation highlights areas that could be improved and how this could be done. Dr Cameron noted that while sustainability is a worldwide issue, the impact anaesthetists can have is not something taught or frequently discussed, and he felt that a talk of this quality would be beneficial to other departments in New Zealand. Dr Pecher has also led a recycling progam at Hutt Hospital (see page 38).

The visiting lectureship program is offered by the NZ Anaesthesia Education Committee to enable smaller regional hospitals to benefit from excellent presentations developed at major departments.

Each lecturer visits two regional centres. In 2016, Dr Pecher will present at Gisborne Hospital and at a regional meeting being held at Wanganui Hospital. Dr Drake will present at Masterton/Hutt Hospitals, and another regional centre, still to be confirmed.

Nominations for the lectureship and expressions of interest in hosting a lecturer close on September 30 each year. See www.anaesthesiaeducation.org.nz for more information.

Encouraging growth of Māori in medical workforce

In 2014, New Zealand's medical workforce was 15,366 or approximately 340 doctors for every 100,000 people, according to the Medical Council of New Zealand's (MCNZ) 2013-2014 medical workforce survey.

Released in January, the survey also showed continuing increases in the number of international medical graduates (42 per cent of the medical workforce), women doctors (42.4 per cent of the workforce) and the age of doctors (45.7 years).

Registration data show that the number of practising doctors increased by 2.7 per cent in 2014, compared with increases of 1.8 per cent in 2013 and 2.6 per cent in 2012.

There was also an increase in the number of doctors identifying themselves as Māori – up to 3.2 per cent from 2.7 per cent in 2013 – while the proportion of Pasifika doctors increased to 2.0 per cent, though these proportions are still well below their proportion in the population overall.

However, the proportion identifying as Māori was higher in the junior ranks – house officers (5.4 per cent) and registrars (4 per cent) – suggesting that although Māori are currently under-represented among specialists (2 per cent), this should change as those younger doctors advance into more senior positions.

MCNZ Chair Mr Andrew Connolly says this bodes well for Māori and is in line with the MCNZ's position of addressing issues of inequity Māori face in the health system.

"Māori doctors play a key role in breaking down the barriers experienced by Māori patients in accessing the health system. This continues with today's Māori medical students and doctors, and extends far beyond any one clinical consultation. Their leadership, knowledge and commitment are critically important in building cultural competence throughout the profession and to addressing Māori health inequity.

"We need to make this a priority in order to overcome historical and current disparities in this regard.

"It is encouraging to see that in 2015, for the first time, demographic proportionality has been achieved, with the number of Māori students entering medical school proportionate to the Māori population," Mr Connolly said.

The report is available at www.mcnz.org.nz/news-and-publications/.

Registrars appreciate wide range of topics at annual meeting

A wide variety of topics were presented in the morning session of the 11th Annual Registrar Meeting held at Auckland City Hospital on December 4 and convened by Dr Nicola Broadbent. The ARM is supported by the ANZCA NZ National Committee.

The topics included:

- The ANZCA CPD Program and what senior trainees need to do to comply during their provisional fellow time, presented by Dr Vanessa Beavis who led the recent redevelopment of the CPD Program.
- A 40-year perspective of anaesthesia delivered by Dr Chris Nixon, who outlined experiences and the changes he has observed in the course of his 40 years of anesthetic practice.
- Anaesthesia: beyond dollars and sense, in which Dr Maurice Lee discussed volunteering, aid and humanitarian work in anaesthesia.
- Introducing SATURN – an introduction to the new proposed trainee research network, delivered by recent FANZCAs Dr Helen Lindsay and Dr Alison Jackson who have helped set up the network.
- A fellowship forum in which recent FANZCAs discussed organising overseas fellowships, including logistics and their experience. Presenters included Dr Kathryn Hagen who has recently returned from Cork, Ireland, and Dr Tin Chiu who went to New York. Dr Lindsay also outlined the organisation of her planned Canadian fellowship.

With 18 abstracts submitted for the afternoon scientific session, the judges (Associate Professor Jenny Weller, Associate Professor Tim Short and Dr Ted Hughes) had to rank them to allocate 10 for oral presentation and the others for a moderated poster session. Everyone prepared a poster for attendees to read during the breaks.

The 2015 prizewinners (all from Auckland City Hospital) were:

- ANZCA Prize for the Best Scientific Presentation: Dr Helen Lindsay for "The breath alcohol of anaesthetists using the five moments of hand hygiene during routine anaesthetic practice: an observational study".
- NZSA Prize for the Best Quality Assurance Presentation: Dr Jeeyoung Kim for "Audit of Postpartum Haemorrhage in Level 9 Auckland City Hospital".
- Caduceus Award for Excellence in Anesthesiology Research: Dr David Harvey for "Comparison of two CO2 absorbents in a closed circuit rebreather system".

Above from left: Dr Jeeyoung Kim and Dr Helen Lindsay.

June dates for mortality review workshops

Two of the Health Quality & Safety Commission's (HQSC) mortality review committees that have direct relevance for anaesthetists will hold their annual day-long workshops in June.

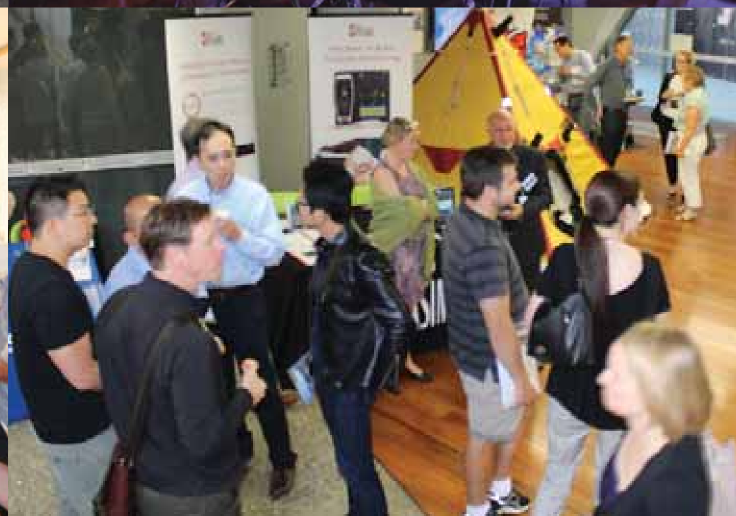
The Perioperative Mortality Review Committee (POMRC), chaired by FANZCA Dr Leona Wilson, will hold its 2016 workshop on Monday, June 13, 2016 at Te Papa in Wellington. The workshop is an opportunity to learn about the latest perioperative mortality data for New Zealand and its implications for improving the quality and safety of perioperative care. POMRC advises the HQSC on how to reduce the number of perioperative deaths in New Zealand.

The Perinatal and Maternal Mortality Review Committee (PMMRC) will hold its annual workshop on Tuesday, June 28, 2016, also at Te Papa in Wellington. PMMRC reviews the deaths of babies and mothers in New Zealand. It will present its latest findings and discuss their implications for maternity care at the workshop.

See www.hqsc.govt.nz for more information.

Australian news

Tasmania



"Anaesthesia in the extreme" highlights the "extreme" links in Tasmania between the environment and the scientific community

Another Tasmanian combined Annual Scientific Meeting has come and gone, and while the weather wasn't extreme, the numbers attending certainly were. A new record of 190 delegates (including trainees) attended on the Saturday, representing a 400 per cent increase in numbers over the past four years.

As in previous years, the proceedings were kicked off with the Trainee Day. Thirty-eight trainees from around Australia attended; again a new record for Tasmania. The day started with an informal breakfast for the trainees who were joined by both the international keynote speaker, Professor Peter Slinger of Toronto General Hospital Canada, and Associate Professor Reny Segal of the Royal Melbourne Hospital. This was followed by a variety of interesting and challenging presentations and trainee feedback was extremely positive.

The Trainee Day culminated in a balmy evening on the Hobart waterfront. Trainees and delegates mingled over drinks and canapés in a relaxed and friendly environment while being serenaded with music from the classical guitar repertoire.

On the following day the delegates enjoyed presentations from Professor Slinger on topics such as general anaesthesia for patients with severe lung disease, anaesthetising patients with mediastinal masses and an update on lung protective ventilation. Associate Professor Segal also provided an update on the new UK Difficult Airway Society's algorithm, and Associate Professor David Scott of St Vincent's Hospital Melbourne revised the current state of knowledge regarding the effects of anaesthesia on the elderly brain.

The committee was also fortunate in securing Associate Professor Larry McNicol from Austin Health in Melbourne, who provided an update on current practices and advances in massive transfusion. He also led a major haemorrhage workshop which was well received by all attending delegates. Another highlight of the meeting was the over-subscribed Difficult Airway workshop, which received positive feedback from participants.

Tasmania is known for its vast wilderness, extreme landscape and growing art and cultural scene. This was reflected in the "winter wonderland" themed conference dinner that provided a highlight for conference delegates on the Saturday night.

An Antarctic display, facilitated by the Australian Antarctic Division, provided delegates with an interactive display including an Antarctic tent, an anaesthesia machine used in Antarctica and a visual display of the medical work which occurs there.

Dr Clare McArthur, convenor of the meeting, was very pleased with the level of attendance. She explained that the combination of a well known, respected international speaker, admired Australian speakers, interesting and relevant topics, and a growing reputation for provision of high quality conferences once again drew delegates to Tasmania. She pointed out that extensive, detailed planning was required by her cohesive organising committee to bring the meeting to a successful conclusion.

Dr Peter Wright, both CPD Officer on the Tasmanian Regional Committee and member of the organising committee for 2016, was thrilled with the high standards set in 2016 and confirmed that plans for the 2017 conference are well underway. The key dates for next year are March 18-19 and Dr Wright is excited to announce that, Professor of Anaesthesiology Steven Shafer at Stanford University and editor-in-chief of *Anesthesia and Analgesia*, has agreed to the role of keynote speaker. On behalf of The Tasmanian Regional Committee, we look forward to seeing you next year.

Opposite page, clockwise from top left: Open microphone session "Anaesthesia on the front line" with (from left) Dr Guy Christie-Taylor, Associate Professor David Scott, ANZCA President Dr Genevieve Goulding, Professor Peter Slinger and facilitator Clinical Associate Professor Marcus Skinner; The conference dinner theme was "winter wonderland" and was held at the Hobart Town Hall; The trade area and the Antarctic display; Friday night drinks at the Waterside Pavillion.

South Australia and Northern Territory

Part Zero Course

The South Australia and Northern Territory Part Zero Course was held on January 16 and attended by the new trainees joining the SA and NT Rotational Anaesthetic Training Scheme (SANTRATS). We welcome them to the program and wish them all the best in their training.

Above from left: Ben McDonald, Alicia Paterson, Craig Morrison, Carmel Toms and Brian Chui.

Australian news (continued)

Queensland

Primary Exam Preparation Course

The bi-annual Primary Exam Preparation Course (PEPC) was held from January 18-22 at the Brisbane ANZCA Queensland Regional Office. Thank you to all of our wonderful presenters who continue to give up their time and energy to test and teach candidates and to the staff at the regional office for helping to make it a great success. Best of luck to the 29 candidates who signed up for this course. Future PEPC candidates should keep in mind that maximum benefit will be derived from this course if you attend just before you sit the next scheduled primary exam.

Western Australia

Part Zero Course and key dates for the year

The Part Zero Course is run for new trainees who have been selected to start on the WA Rotational Training Program. The course aims to provide trainees with an introduction to the anaesthetic program as a whole – where to start, what to expect and a few hints on finding their feet. It was held on February 5 at the ANZCA WA office. The course was facilitated by Dr Jay Bruce and included topics on the Training Portfolio System, welfare, workplace-based assessments and tips for training. The speakers delivered well prepared and punchy speeches offering a balance of perspectives. Feedback on the day from new trainees was very positive.

The first WA office committee meetings have been held for the year. The ASA committee met on February 10 and the WA Regional Committee met on February 16. The EO/SOT Committee held their annual dinner and first meeting at Chez Pierre on January 27.

The Primary Exam was held on February 22 at the WA office and the Final Exam will be held from March 18-19 and we wish the trainees well in their studies leading to the exam.

The WA Conference dates for the year are as follows: Autumn Scientific Meeting March 12, 2016 at the University of Western Australia and the Country Meeting October 21-23, at the Pullman Resort Bunker Bay. See the event calendar on the ANZCA website for further information.

Australian Capital Territory

Scan and Ski Workshop in July

The ACT Regional Committee will host a new workshop in 2016 entitled "Scan and Ski: Regional ultrasound scanning workshop for peripheral nerve blocks". The workshop will be convened by Dr Ross Peake, and feature world-renowned ultrasound specialists, Dr Alwin Chuan, Dr Peter Hebbard, Dr Brad Lawther, Dr Andrew Lansdown and Dr David Scott. The workshop will be held at the Thredbo Alpine Hotel and run over two days, using the morning and evening sessions for hands-on ultrasound scanning and instruction, and leaving the middle of each day free for skiing or sightseeing in the beautiful NSW Snowy Mountains. The workshop will cover upper limb blocks, lower limb blocks, trunk and spinal blocks, among other topics.

The workshop will be limited to a small group only (to ensure maximum time with the instructors and equipment), and presently only a few places remain available so register now to avoid missing out on this exciting new workshop. Event details can be found on the ANZCA ACT web page.

Preeclampsia and obstetric emergencies – an evening with Associate Professor Alicia Dennis

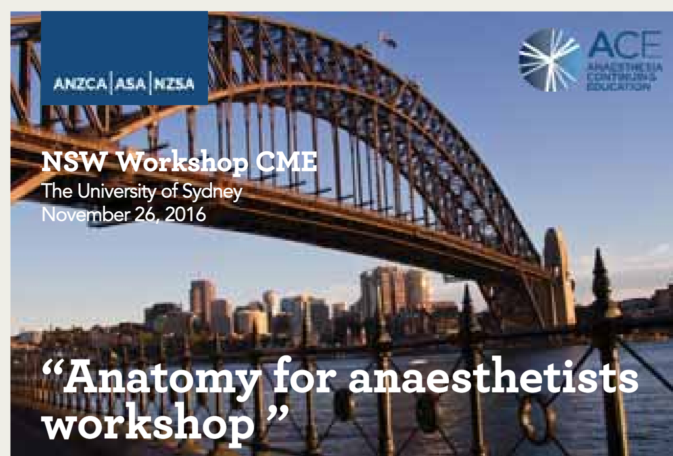
The ACT regions of ANZCA and the ASA are pleased to announce an evening presentation on preeclampsia and obstetric emergencies by Associate Professor Alicia Dennis. The evening will be held on Thursday April 14 at Café EQ and we invite all local trainees and Fellows to attend. Associate Professor Dennis is a staff specialist anaesthetist and Director of Anaesthesia Research at the Royal Women's Hospital in Melbourne. She is an NHMRC fellow and her research program, which leads on from her PhD work, examines heart function in women with preeclampsia, a common high blood pressure condition in pregnant women. On the evening, Associate Professor Dennis will give two presentations "Haemodynamics in women with preeclampsia – the unified theory of preeclampsia" and "Key issues for anaesthetists when managing obstetric emergencies – obstetric haemorrhage, severe preeclampsia, immediate operative birth and maternal collapse". Online registration and further event details can be found on the ANZCA ACT web page.

Art of Anaesthesia – save the date!

In 2016, the annual Art of Anaesthesia scientific meeting will be held over the October 15-16 weekend. This coincides with the renowned Floriade festival on the shores of Lake Burley Griffin and is a beautiful time to visit the Nation's Capital. The theme of this year's meeting is "Back to the future" and co-convenors, Dr Carmel McInerney and Dr Girish Palnitkar, have many wonderful ideas to make the meeting bigger and better than ever.

Australian news (continued)

New South Wales



New South Wales

Primary Refresher Course 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 2016.

Date: Monday May 16 – Friday May 27, 2016, or
Monday October 17 – Friday October 28, 2016
Venue: Large Conference Room, Kerry Packer Education Centre
Royal Prince Alfred Hospital Missenden Road Camperdown
NSW 2050
Fee: $ A1078 (including GST)

In addition, 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 Friday April 29, 2016 for the May course and Friday September 3 for the October course (if not filled prior).

The number of participants for the course will be limited.
Late applications will be considered only if vacancies exist.

For further information contact:
Tina Lyroid
Email: nswcourses@anzca.edu.au
Telephone: +61 2 9966 9085

Part Zero Course

The Part Zero Course was held on Saturday March 5. This was the first year with a more standardised ANZCA format. We welcomed presenters from around the state who kindly shared their knowledge and experience as well as detailing training and it's surrounding issues. The course was attended by both new and prospective trainees and we tailored the afternoon session to meet their differing needs and interests by separating into two streams. It was very well attended and received positive feedback. The committee would like to thank all the speakers and support staff for their contributions and hard work.

Victoria

Above from left: Workshop facilitators Dr Belinda Phillips, Dr Louise Ellard, Dr Candida Marane and Dr Stuart Marshall.

Part Zero Course at ANZCA House

The Victorian Part Zero Course, in its new reformatted structure, was held at ANZCA House on Friday March 4.

The whole day course was attended by a healthy balance of new Victorian introductory trainees and resident medical officers aspiring to be trainees and anaesthetists.

A significant part of the course was run by trainees for trainees. The attendees learnt how to deal with being a new trainee, preparing for exams and what to do if plans fail. They also learnt how to deal with stresses of the job, harassment and bullying, and about the organisations and committees available as recourse. There was an interesting session with the supervisors of training (SOTs). The day finished with group airway sessions, aimed at teamwork and team learning.

A highlight of the day, however, was the opportunity for trainees to network and hopefully forge longtime friendships.

I would like to thank all the organisers, session chairs, ANZCA administrative staff, presenters, SOTs and workshop facilitators for their hard work which contributed to a very successful event.

We wish longevity for the course, and hope it will continue to inform and bring together the new anaesthesia trainees in Victoria.

Dr Shiva Malekzadeh
Convenor, Victorian Regional Committee

Victoria

Quality assurance workshop

This is a combined ANZCA and Australian Society of Anaesthetists workshop. It includes lectures, QA activities and small group discussions. The program will conclude with drinks in the foyer.

Date: Saturday May 14, 1.30-6pm
Venue: Auditorium,
ANZCA House,
630 St Kilda Road,
Melbourne Vic 3004.

Registration: $110 (including GST)

For further information contact:
Daphne Erler
vic@anzca.edu.au
+61 3 8517 5313

Victoria

37th Annual Victorian ANZCA/ASA combined CME meeting

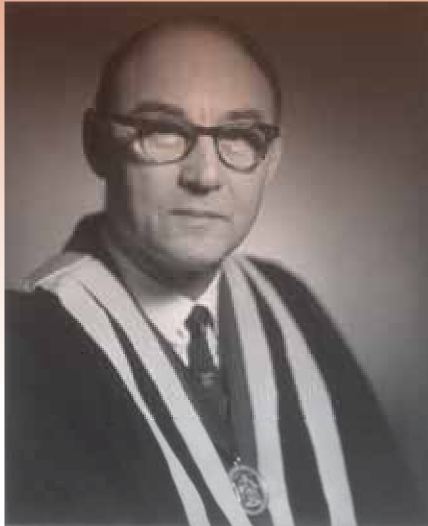
"Trade secrets – seek, master and excel" with guest speaker Professor Stephan A. Schug MD FANZCA FFPMANZCA

Saturday July 30, 2016 from 8am to 5.30pm
Sofitel Melbourne On Collins
25 Collins Street, Melbourne

Registration	Fees
Fellows	$352 (including GST)
Trainees	$242 (including GST)
Retirees	$110 (including GST)

For further information contact:
Daphne Erler
vic@anzca.edu.au
+61 3 8517 5313

Recognising Victoria's foundation Fellows



In past editions of the *Bulletin*, we have profiled the foundation Fellows of the Faculty of Anaesthetists, Royal Australasian College of Surgeons, when it was formed in 1952. This final article in the series profiles 12 foundation Fellows from Victoria.

Victoria is home to the largest cohort of foundation Fellows of the Faculty of Anaesthetists, Royal Australasian College of Surgeons (FARACS). The following brief biographical vignettes focus on the curious minds of those who not only practised anaesthesia, but also published widely and experimented with their craft. ANZCA continues to celebrate the contributions of several early Victorian Fellows.

Eric Gandevia Bachelor of Medicine, Bachelor of Surgery, (MBBS) Melbourne, 1917, Diploma in Anaesthetics, Royal College of Physicians London, Royal College of Surgeons England DA (RCP&S) 1938 was honorary assistant anaesthetist at the Royal Melbourne, Women's and Austin Hospitals (1927-37). Dr Gandevia was secretary to the Section of Anaesthetists, British Medical Association (Australia) in Melbourne (1929) and served as chairman of the Australian Society of Anaesthetists (ASA) Victorian Branch and then president of the national body (1952-53). He died on duty at Bethesda Hospital in 1958.

J Ellis Gillespie MBBS (Melb) 1918, DA 1949 (Melb) studied at Melbourne University (1912-18), deferring his studies to serve in World War I. Dr Gillespie worked at The Alfred and during World War II at the Heidelberg Military Hospital in Melbourne. He completed his DA at the University of Melbourne (1949). Dr Gillespie was the first president of the newly formed ASA Victorian Branch (1949-50) and joined the interim board of the Faculty of Anaesthetists RACS (1951). He died in 1970. In memoriam, ANZCA has the annual Ellis Gillespie Lecture.

Florence Marjory Hughes MBBS 1922 (Melb) DA (RCP&S) 1938 worked as an honorary anaesthetist at The Alfred from 1923 and contributed to their volume *Practical Anaesthesia*. She also worked at the Eye and Ear Hospital (1937-46), Royal Melbourne Hospital (1938-59) and Prince Henry's Hospital (until 1930). Dr Hughes continued to practise until the 1960s. She died in 1995. An ANZCA research award was established (1997-2002) with funding from her estate.

Ian Clinton James MBBS Melbourne 1931, Member of the Royal College of Physicians (MRCP) Edinburgh 1936, DA (RCP&S) 1936 joined the ASA (1934) and served as the organisation's librarian from 1939. Dr James worked as consultant anaesthetist at the Royal Melbourne Hospital (1933-35) and studied in London and Edinburgh (1935-36). He worked as honorary anaesthetist at the Royal Melbourne Hospital from 1938 and as senior honorary anaesthetist from 1946, following war service. Dr James died in 1955.

Norman James Licentiate of the Royal Colleges of Physicians and Surgeons (LRCP&S), Edinburgh, 1936, DA (RCP&S), was the first director of anaesthesia at the Royal Melbourne Hospital (1948) and established the first recovery room in Australia (1953). He contributed greatly to resuscitation through his positive pressure resuscitator (RMH Resuscitator). Dr James moved to Dallas (1960) to teach anaesthesiology at the University of Texas (retiring 1974). He died in 1987 and is buried in Winnsboro, Texas.

Geoffrey Kaye MBBS 1926, MD (Melb) 1929, DA (RCP&S) 1939, Fellow of the Faculty of Anaesthetists, Royal College of Surgeons (FFARCS) 1949 was a resident, later honorary anaesthetist, at The Alfred (1927). He edited the first Australian textbook on anaesthesia, *Practical Anaesthesia* (1932) and lobbied for the creation of the ASA (1934). Dr Kaye was the ASA secretary (1934-46), a lecturer at the University of Melbourne (1937) and served in World War II. Dr Kaye was elected an honorary life member of the ASA (1944), foundation Fellow of the Faculty of Anaesthetists RACS (1952) and founded the Geoffrey Kaye Museum of Anaesthetic History. Dr Kaye resigned his Faculty of Anaesthetists RACS Fellowship (1957), later accepting the Faculty's Orton Medal (1974) and honorary fellowship of the Faculty (1977). He died in 1986.

Margaret McLelland MBBS (Melb) 1931, DA (London) 1942 studied at the University of Melbourne and then pursued postgraduate studies in London. Dr McLelland worked at the Royal Melbourne Hospital and at St Vincent's Hospital, becoming an honorary anaesthetist, later anaesthetist-in-charge, at the Royal Children's Hospital (1948). She was elected president of ASA (1964), awarded the Faculty of Anaesthetists RACS Robert Orton Medal (1968) and was elected to honorary fellowship of the Faculty (1971). Dr McLelland died in 1990.

Robert Hamilton Orton MBBS (Melb) 1930 graduated from the University of Melbourne (1930) and worked at The Alfred (1931-33). Dr Orton became a full-time anaesthetist in the thoracic unit at The Alfred (1946) and served as director of anaesthetics (1950-66). He was president of the ASA (1947-48) and Faculty of Anaesthetists RACS dean (1955-59) and assessor (1959-64). Dr Orton resigned from the Faculty Board in 1964, and died in 1966. The board initiated the Robert Orton Medal the following year.

William Arthur Pryor MBBS (Adelaide) 1919 served as honorary anaesthetist at the Royal Adelaide Hospital (1930-35), honorary assistant physician at Mareeba Babies' Hospital and lecturer at the University of Adelaide. Dr Pryor served in both world wars. In 1951 he worked in Ballarat as the honorary anaesthetist at Ballarat Hospital. Dr Pryor joined the ASA in 1945 and served as the Executive Committee state representative for Victoria (1957-59). He died in 1981.

Douglas Renton MBBS (Melb) 1922, DA (RCP&S) Eng 1939, FFARCS 1950 completed his MBBS at the University of Melbourne (1922) and residency at The Alfred and Women's Hospitals (1922-29). Dr Renton created the first Australian carbon dioxide absorption unit (1931). He joined the ASA in 1934, serving as president from 1949-50. Dr Renton was appointed to the Interim Board of the Faculty of Anaesthetists RACS (1951), later elected acting dean (1952-53) and dean (1953-55) of the Faculty. He died in 1955. The Renton Prize was established in memorium and was first awarded in 1958.

Lennard Travers MBBS (Melb) 1930, Fellow of the Royal College of Surgeons of Edinburgh (FRCS) 1935 completed his MBBS at the University of Melbourne (1930) and initially practised surgery, before commencing practice in anaesthetics during World War II. Dr Travers became a senior honorary anaesthetist and chairman of staff at the Royal Melbourne Hospital, and also assisted the ASA Victorian Branch. He served the Faculty of Anaesthetists RACS Board (1951-65) in various roles including dean (1959-61). He died in 1968. In memoriam, the Lennard Travers Professorship has been awarded since 1972.

Arthur Lionel Bridges-Webb (also recorded as AL Bridges Webb) MBBS (Melb) 1924 graduated from the University of Melbourne (1924) and practised in country Victoria. He served in World War II as a major at the Heidelberg Military Hospital (1939-45) and also at the thoracic unit at Austin Hospital. Dr Bridges-Webb became the ASA Executive Committee state representative for Victoria (1948) and later joined the Melbourne Anaesthetic Group (1956). He died in 1971.

Fraser Faithfull, ANZCA Archives (with assistance from Rebecca Lush, University of Sydney, intern with the Geoffrey Kaye Museum of Anaesthetic History).

Above from left: Dr Douglas Renton; Dr Robert Hamilton Orton; Dr Lennard Travers; Dr Geoffrey Kaye.

Further reading:

Brydon, AG (et al). *Practical Anaesthesia*, by the anaesthetic staff of The Alfred hospital, Melbourne, Monographs of The Baker Institute of Medical Research No. 1, 1932, Australasian Medical Publishing Company, Glebe NSW (organising editor: Dr Geoffrey Kaye).

Kaye, Geoffrey; Orton, Robert; Renton, Douglas, *Anaesthetic Methods*, 1946, Ramsay, Melbourne.

James, Norman R, *Regional Analgesia for Intra Abdominal Surgery*, 1943, J & A Churchill, London.

Doctors Gandevia, Hughes, Norman James, Kaye, Orton, Renton, Travers and Bridges-Webb published articles in the *Medical Journal of Australia*. These articles have been indexed by Dr Gwen Wilson, *A Bibliography of References to Anaesthesia in Australian Medical Journals 1846-1962*, published Faculty of Anaesthetists, Royal Australasian College of Surgeons, Melbourne.

Dr Terry Loughnan has published biographical articles in the *ANZCA Bulletin* on Dr Renton, Dr Orton and Dr Travers as part of his extensive series on former deans and presidents: March 2004, pp7-8 (Renton), June 2004, p9 (Orton), August 2004, p21 (Travers).

Dr Vivian Vy Nguyen 1982 – 2016

Nelson Mandela said: "There is no passion to be found playing small – in settling for a life that is less than the one you are capable of living."

Vivian Nguyen was born in Melbourne and raised by a loving family who came to Australia from Vietnam. As a child her personality was distinguished by an insatiable curiosity and a vibrant engagement with people around her. She had wisdom beyond her years and was strikingly mature and focused. She won a scholarship to Melbourne Girls Grammar where she thrived. She relished debating and cornered the role of second speaker, as she loved rebuttal. She graduated in 2000 and was dux of her year.

To her family, Vivian was dedicated, loving and giving as a sister and as a daughter. To her extended family and friends she was fun, vivacious and generous to a fault. She was very forthright and honest in her opinions, but also fiercely loyal and supportive. She made enduring friends across Australia and the globe.

She studied medicine at the University of Melbourne in 2001. She graduated with first-class honours, made it to the Dean's Honours list in 2001 and 2006, and took out the Austin top student prize in 2006. She undertook a surgical elective in Tonga in 2005.

Vivian entered anaesthetic training in her third year after graduating. Her anaesthetic training took place in the Royal Melbourne training scheme with rotations to many hospitals including the Royal Melbourne Hospital, Royal Children's Hospital, Royal Women's Hospital, Western Hospital and Ballarat Base Hospital. In 2010, she was awarded the Renton Prize for being the best candidate in ANZCA's primary exam. She completed her provisional fellowship year in 2014 at St Vincent's Hospital in Melbourne and was appointed as a consultant the following year. She also had an appointment at the Royal Victorian Eye and Ear hospital and was establishing a private practice.

She had an amazing work ethic and was ambitious in her many activities as a provisional fellow and consultant. She took a keen interest in research, revelling in its challenges and rewards. She was part of a team that secured an ANZCA competitive grant for research into advanced cardiac output monitoring in 2015 and made a promising start as an early career researcher. She conducted a number of audits (post-operative residual curarisation, surgical site marking, safety in endoscopy) fuelling her desire to improve patient outcomes and safety during surgery.

She had a zeal for engaging and mentoring registrars and an enormous energy devoted to exam preparation. She would put aside time to mentor registrars with their formal projects. She was very active in airway teaching, including being a "can't intubate, can't oxygenate" and Emergency Management of Anaesthetic Crisis (EMAC) course instructor, developing a departmental fibreoptic intubation manual and giving numerous airway tutorials. She completed the ANZCA Foundation Teacher Course and was undertaking a post-graduate certificate in health professional education.

Vivian's endeavours on behalf of the department and the specialty were characterised by real energy, devotion and care for those around her. This was recognised and much appreciated by many who worked closely with her. The Vivian Nguyen Memorial Young Researcher Award will be established in the Department of Anaesthesia and Acute Pain Medicine at St Vincent's Hospital to capture that spirit of endeavour for future generations of developing researchers.

Away from the operating theatre, Vivian had a wide range of interests. Her love of travel took her across seven continents, including to Everest base camp and Antarctica. There was a spirit of adventure in many of her pursuits, including flying helicopters to the standard of a pilot. She also studied Italian while undertaking her medical degree and French during her anaesthetic training.

At the age of 33, Vivian had achieved more than what many others could in a lifetime. She was remembered in a moving funeral at St Dominic's Parish in Camberwell and will be sadly missed by her parents, Rang and Nhung, her bothers, Kha and Minh, as well as numerous family members and friends. Her close work colleagues and the wider medical community share in this loss.

Recounting the range of Vivian's accomplishments and understanding her passion, loving nature and daring ambition brings us closer to her memory. We remain inspired by a life lived to its fullest.

Mr Peter Lake,
Family friend

Dr Tuong Phan, FANZCA
St Vincent's Hospital, Melbourne, Vic

Dr Crispin Wan, FANZCA
St Vincent's Hospital, Melbourne, Vic

Dr John Sandilands Ogilvie 1928 – 2015

John Sandilands Ogilvie was born in Christchurch on February 25, 1928 at the start of the Great Depression. He was the sixth child of Charles and the first child of Dorris Jane Ogilvie (known as Wendy). Charles was an elder in the Presbyterian Church and the manager of Beath & Co, a department store in Christchurch. Dorris later had another child, Gavin, to whom John was particularly close.

John went to Cashmere Primary School and later to St Andrews College. His father was very much in the mould of the Presbyterian Church of the time, emphasising education and encouraging his children to attend university.

Although John wanted to be a farmer, his father urged him to pursue medicine. He arranged for a place at Middlesex Hospital in London where John started studying through the University of London in 1947. His first year at university wasn't a success, no doubt far from home and away from the usual support, but he persevered and graduated with a bachelor of medicine and a bachelor of surgery in April 1953. Shortly after, he became a member of the Royal College of Surgeons.

John was a house surgeon for a couple of years, first at the Mount Vernon Hospital, Northwood, and later at Royal Northern Hospital, Holloway. He toyed with the idea of surgery for a time but developed an interest in the emerging field of anaesthesia. He became a registrar in 1956 at St Thomas' Hospital, Lambeth, achieving FFA (Fellowship of the Faculty of Anaesthetists). He was later awarded FANZCA on the strength of this.

John met Veronica Kelly, a Scottish nurse, in 1954 at St James' Hospital in Balham. John and Veronica married the same year and lived in Hampstead for about two years.

John wanted to return to New Zealand to be closer to his mother and in January 1958 he and Veronica moved back to Christchurch briefly, with John taking a position at Timaru Hospital. His first son, Iain, arrived that March and the family moved to Auckland later in 1958 where John had secured a position as a registrar at Auckland Hospital. Fiona was born in 1960, Michael in 1961 and Angus in 1968.

In 1964, the family moved to Vietnam after a surgeon with whom John worked, Cam McLaurin, invited him to join a civilian medical team working at Qui Nhon. This experience led to John enlisting as a territorial in the army on his return to New Zealand in 1965. He was given a commission as a major in the Royal New Zealand Medical Corps and served for two years.

On the civilian side, John became the fourth member of the then recently established Epsom Anaesthetic Group (EAG), which had set up shop at 110 Remuera Road in the heart of the "medical mile". John provided a wide range of anaesthetics during his time with EAG.

The practice grew rapidly and is still providing anaesthetics in private hospitals and dental practices across the Auckland region.

A family beach house was built at Hahei on the Coromandel Peninsula in the early 1970s.

John and Veronica separated in 1980. John moved to Parnell in 1985 and married Rene in 1991.

John retired from practice in 1995 at the age of 67. He then spent time working at a horticultural venture growing orchids in Mangere, took up golf, travelled extensively and enjoyed spending time with friends and family.

He spent the last two years of his life at the Elizabeth Knox home in Epsom, having suffered a stroke and become increasingly frail. John died on May 28, 2015 aged 87.

Angus Ogilvie, Auckland
with assistance from
Dr Evan Watts, FANZCA, Auckland