JUNE 2016

ANZCA BULLETIN

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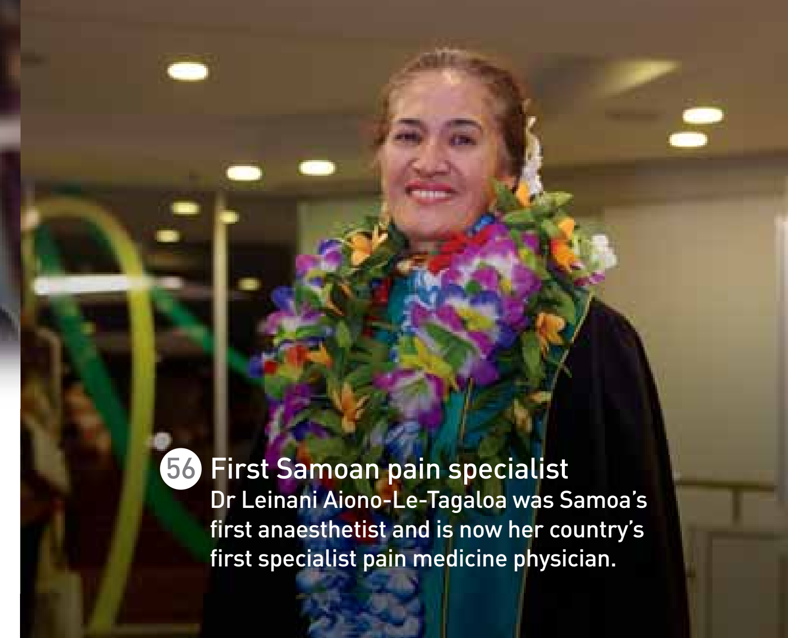

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ANZCA Bulletin
The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional medical body in Australia and New Zealand that conducts education, training and continuing professional development of anaesthetists and specialist pain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

Cover: Auckland Town Hall was the venue for the College Ceremony Reception at the 2016 ANZCA Annual Scientific Meeting.

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President's message

This is my first message as president of ANZCA, and I feel very privileged to be able to hold this position, to progress the activities of the College in advancing safety and quality in anaesthesia and pain medicine, and to represent the College on your behalf. I want to express my thanks in particular to our immediate past president, Dr Genevieve Goulding. A separate article on the opposite page outlines her contribution as a councillor and president, and we are fortunate that Genevieve will continue on the council for three more years. Genevieve has worked tirelessly as our president and set us in a very good direction for the years ahead.

The ANZCA Council is changing and on page 20 we thank Dr Lindy Roberts, Professor Alan Merry and Professor Ted Shipton for their substantial contributions to the College and welcome new councillors Dr Chris Cokis (Perth, WA), Dr Nigel Robertson (Auckland, NZ) and Dr Chris Hayes (Hunter, NSW). I also welcome Dr Rod Mitchell as the new ANZCA vice-president.

Auckland ASM

The highlight of the year so far has been the extremely successful 2016 ANZCA Annual Scientific Meeting (ASM), "Closer to the edge", held in Auckland in May and preceded by the Faculty of Pain Medicine Refresher Course Day. More than 1700 registrants enjoyed a high quality scientific program with terrific overseas and local speakers covering a breadth of relevant and interesting subjects, and a wide range of workshops and activities. A large trade contingent was present, and the social program was creative and exhaustive. The opportunity for everyone to meet, learn from each other and catch up is an important part of such meetings. What often is not realised is how many formal meetings of committees and special interest groups are taking place as well. Thanks to the organising committee, and especially to Associate Professor Michal Kluger, Dr Matt Taylor, Professor Tim Short and Dr Jim Olson for their hard work, and to the ASM Officer, Dr Nicole Phillips. Unlike many organisations, the College does not outsource event organisation and our Events team, led by the General Manager of Fellowship Affairs Jan Sharrock, did a superb job. Not only does this keep experience "in house" for the many ANZCA and special interest group meetings held each year, but it represents a significant cost saving.

As your incoming president, I take this opportunity to outline what I see as some of the key areas for the College to prioritise over the next few years. Broadly these are: professionalism, external collaboration and engagement, and perioperative medicine. Other issues of concern to Fellows, such as revalidation, workforce and role substitution, are important, ongoing, and also addressed within these areas.

Professionalism

Professionalism is the standard by which we practice and conduct ourselves and is entrusted to us by the community.

We often have little time to establish a relationship with our patients and first impressions matter. We are often busy and under stress during cases, and our behaviour and responses are observed by those around us and modelled by those learning from us – the anaesthetists of the future. We often witness or have to manage challenging interactions among our surgical or nursing colleagues; how we react to these sets the standard of behaviour.

A second aspect to professionalism is the responsibility we have to maintain our skills and knowledge to a level appropriate to our practice. The role of the College in this is life-long – training good anaesthetists, setting standards for safe practice and safe practice environments, and helping with ongoing learning and support throughout our practising lives. The College will aim for a collaborative approach to the development of a stronger and clearer support for professionalism and professional behaviours over the coming years.

Engagement

Engagement of us as individuals and the College as your representative organisation starts with the community. To strengthen our specialty we need to enlighten the community and our non-anaesthesia colleagues about what anaesthesia is.

Anaesthesia is one of the most remarkable achievements in science and medicine and will be 170 years old this year. Anaesthesia has gone from being a high-risk undertaking in healthy patients to a low-risk undertaking in critically ill patients. This been achieved by ongoing development, by active and productive research, by the ready learning and adoption of new ideas and skills into direct patient care.

Because it's safer, the community (including our medical colleagues) think it's easy. Too often we call it sleep, but general anaesthesia is not "sleep", neither is deep sedation. We safely manage patients through a complex neurophysiological transition, in addition to supporting them during the insults of surgery. The words we use with our patients and colleagues matter.

Engagement extends to our sister societies in the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists. We are building closer links and understandings while retaining our obvious core strengths.

We are increasing our collaboration with other colleges, especially the Royal Australasian College of Surgeons, but also the Royal Australasian College of Physicians; and extending overseas to the Royal College of Physicians and Surgeons in Canada, and the Irish and UK colleges as well. One aspect of this collaboration is to strengthen and maximise the benefit of overseas aid and outreach programs, which already make an impact, for example, through education programs, LifeBox, and Essential Pain Management. We also are strengthening our relationships with neighbours such as Hong Kong and Malaysia.

These collaborations will help us address the challenges I listed earlier.

Perioperative medicine

A third important area for the College is perioperative medicine. It already is part of our stated purpose. Anaesthesia and pain medicine specialists have many skills in this area. We are developing a plan for an appropriate focus in training and post-fellowship skills development for this emerging cross-disciplinary area. We will look to work with our sister organisations to achieve the best structure for the future, but our College has a lead role.

I look forward to working with you – our trainees and Fellows, our hard-working and skilled College staff led by ANZCA Chief Executive Officer John Ilott, and the talents of the ANZCA Council – to progress our specialty for the benefit of our patients over the coming years.

Associate Professor David A Scott
ANZCA President

Outgoing president Genevieve Goulding leaves a lasting legacy

It is with deep appreciation that I acknowledge and thank Dr Genevieve Goulding for her commitment and leadership over the past two years as ANZCA president.

Genevieve completed her two-year term as president following the handover ceremony at the 2016 ANZCA Annual Scientific Meeting in Auckland. Fortunately, we will not lose her experience and expertise because she continues on the ANZCA Council for the next three years and now holds the title of immediate past president.

Genevieve has been a remarkable leader for the College during her presidency, which followed seven years on ANZCA Council including two as vice-president. Genevieve travelled extensively around Australia and New Zealand during her term, which provided her with clear and direct insights into the issues affecting Fellows and trainees.

Workforce always has been a topic of great concern and Genevieve led the College's response to the Australian Government's National Medical Training Advisory Network project by providing accurate data and our profession's perspectives into its analysis.

Over the years, Genevieve has been heavily involved in training and education and was a leader in initiating the revision of our curriculum in 2013. An interest in education has led to her supporting the development of our relationship with the Royal College of Physicians and Surgeons in Canada, which has significant credentials in this area.

The welfare of anaesthetists also has always been a strong interest, and Genevieve was a founding member and former chair of the Welfare of Anaesthetists Special Interest Group. Allegations of bullying, discrimination and sexual harassment that surfaced in hospitals over the past 18 months, in particular, caused her great concern and prompted the formation of a College working group on the issue.

One of the key responsibilities of the ANZCA Council is the appointment of the College chief executive officer (CEO) so when Linda Sorrell stepped down, it fell on Genevieve to lead the search and recruitment of her successor. This was a complex and high-stakes process. We are very pleased with the appointment of John Ilott as our new CEO, which is the result of the effort she put into this undertaking. Genevieve always has been supportive of the College staff, who make an enormous contribution to our role in supporting the specialty.

Through all the major projects and events of the past two years, Genevieve has been approachable and takes the time to listen to others. She always seemed calm, even in very stressful circumstances. Her clinical practice is as an obstetric anaesthetist at the Royal Brisbane and Women's Hospital, and she tried very hard to maintain at least one or two days of clinical practice despite a very busy schedule.

Genevieve has left a legacy of a progressive and robust College for the benefit of our trainees and Fellows and, ultimately, our patients. It's not an easy task but, underpinning her hard work, Genevieve has a true passion for the speciality of anaesthesia – both in its clinical practice but also as a profession.

On behalf of the College and the ANZCA Council, I thank Genevieve profoundly for her leadership, dedication and enthusiasm.

Associate Professor David A Scott
ANZCA President

Chief executive officer's message

ICT governance

At its February 2016 meeting, the ANZCA Council approved the establishment of an Information and Communications Technology (ICT) Governance Committee. Over the past several years ANZCA has developed and implemented major IT infrastructure and education programs as well as IT-based accreditation, continuing professional development (CPD) and finance applications.

Like many organisations, ANZCA has become heavily dependent on its IT systems and this will continue to be the case. Leadership in the field of medical education will require increasing reliance on and investment in ICT infrastructure and applications. Indeed, there is still a long "pipeline" of service and technology improvements necessary to achieve the College's goals. Ongoing investment in ICT infrastructure needs to be highly strategic with clear understanding of the value to be contributed to the business in future years.

The ICT Governance Committee will assist the council and chief executive officer to effectively manage the risk and opportunity and to understand major ICT investments, ICT's impact on business continuity as well as ICT performance compared to peers.

Victorian councillor Dr Rowan Thomas will chair the committee and its membership will include two Fellows who have an interest in ICT and two external industry experts. We expect one of the Fellows appointed to the committee will be from the Faculty of Pain Medicine.

This will be a major step forward in our ICT governance and we hope to hold the first meeting of the committee in July and the second around October.

Support for professional conduct

In this issue of the *ANZCA Bulletin*, ANZCA President Associate Professor David A Scott discusses the Bullying, Discrimination and Sexual Harassment (BDSH) Working Group's progress in developing resources and recommending improvements to help us if we receive complaints about bullying and discrimination within anaesthesia and pain medicine.

The Royal Australasian College of Surgeons (RACS) has done much work in building resources and processes and they have been generous in making their resources available for use by other colleges. A fundamental approach used by RACS is the use of the Vanderbilt University model in collaborating to assist in the maintenance of high professional standards.

Vanderbilt University model adapted by RACS

Vanderbilt University model adapted by RACS

This model (see below) outlines our proposed progression for dealing with professional conduct matters, including bullying and discrimination. Working from the bottom of the pyramid, the intervention commences informally and escalates only if and when there is a requirement to do so. The following descriptors indicate how we might approach complaints about behaviour or professional practice.

1. Informal – single unprofessional incident: Advice and assistance offered.
2. Level 1 – apparent pattern: Awareness intervention. First stage of formal process. Counselling stage.
3. Level 2 – pattern persists: Guided intervention by ANZCA. Second stage of formal process. Disciplinary intervention considered.
4. Level 3 – no change evident and potential for high impact or high risk: Disciplinary intervention most likely.

Practice standards are at the core of professional practice. These will always be the guide in dealing with complaints about behaviour or professional practice.

ANZCA will also develop its philosophy in handling allegations of bullying, discrimination or professional practice.

The most likely approach will be based on a risk assessment, that is, supporting members in matters of low risk, members' health and their willingness to improve practice (for example, up to level 2), whereas the approach is likely to be more disciplinary in matters of high risk to ANZCA, its members, trainees and to patients (levels 2 and 3).

The formalised approach described above is clearly a major initiative for medical colleges. Naturally the ANZCA Council will proceed cautiously in its development but it will ultimately provide consistency and transparency when action is required in supporting the high standards of practice that are expected by the community.

Building relationships

The 2016 ANZCA Annual Scientific Meeting in Auckland was a good opportunity to get together with our partners in anaesthesia, the Australian Society of Anaesthetists and New Zealand Society of Anaesthetists.

A meeting of presidents, vice-presidents and CEOs commenced discussion on the need to address important strategic initiatives. It was universally agreed that adopting a common approach to these issues was the only way to promote the specialty's position.

The following is a brief list of the most important issues where anaesthesia needs strong and united leadership:

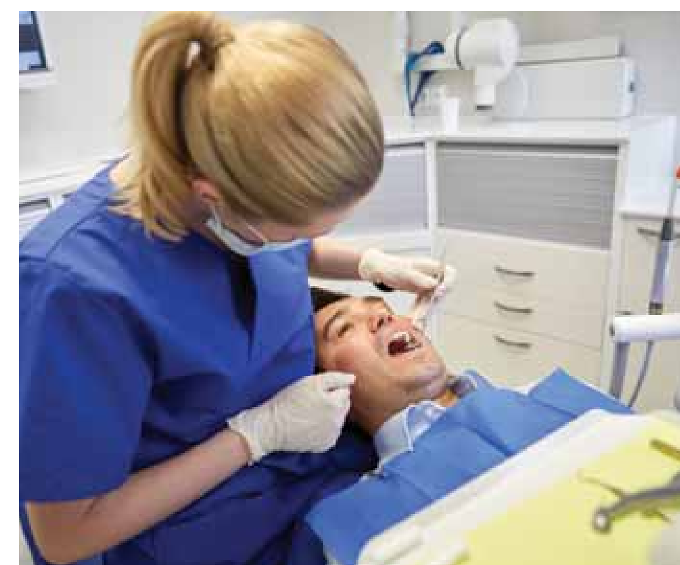
- Task substitution in anaesthesia, for example, use of non-medical practitioners, post-operative pain management, preoperative clinics.
- Revalidation or recertification for the medical profession in both Australia and New Zealand, but particularly in Australia where the models being considered by the Medical Board of Australia are still unclear.

Discussion at the meeting highlighted that the societies and the college bring different benefits to the development of solutions.

We will write more on the detail of our joint planning in future *Bulletins* but there is undoubtedly a commitment by all three organisations to work together for the benefit of the profession.

John Ilott
Chief Executive Officer, ANZCA

Dental board acts on misleading claims



The College recently was made aware of cases where dentists had portrayed themselves in a misleading fashion on their websites by advertising themselves as dental anaesthetists or anaesthesiologists. ANZCA notified the Australian Health Practitioner Regulation Agency, which referred the matter to the Dental Board of Australia for action.

The dental board considered the case of Dr F, and found that although Dr F has had two years' training in medical anaesthesia overseas, he does not practise general anaesthesia in Australia, but conscious sedation as he is endorsed to do.

In relation to Dr F's use of the title "dental anaesthesiologist" and reference to a previous job as a visiting medical officer (VMO), the board considered these terms could be misconstrued and lead people to believe that Dr F is registered as a medical practitioner when he is not. This could constitute an offence under section 117 of the national law.

As a result, Dr F has amended his website to identify himself as a "dental sedationist" and he has removed any reference to being a VMO. The board decided that no further action is required because Dr F has dealt with the issue and removed the misleading wording.

Dr Peter Roessler
Director of Professional Affairs, ANZCA

Awards

Queen's birthday honours

Medal (OAM) of the Order of Australia in the general division

Dr David Cameron Wilkinson, Royal Adelaide Hospital, SA, for service to hyperbaric medicine.

Member (AM) of the Order of Australia in the general division

Mr Kenneth James Harrison, Victoria, for significant service to the community through financial support and senior roles with horticultural, social welfare, medical and cultural groups.

Mr Harrison is on the Board of Govenors of the Anaesthesia and Pain Medicine Foundation.

Pain medicine popular in media

Hunter-based pain specialists call for a medical about-turn

Lives could be saved with access to clot-buster device: expert

Jet-lagged bees the key to better surgical recovery?

Studies confirm pre-surgery checklist routine cuts errors, saves lives

In the period since the last *ANZCA Bulletin*, media coverage has been dominated by 790 reports on the Auckland annual scientific meeting (see page 46 for full report) but there has also been other, more general, anaesthesia and pain medicine coverage.

FPM Vice-Dean Dr Meredith Craigie, was interviewed on ABC Radio's *AM* program on May 31. She welcomed a new study that confirmed long-standing concerns that morphine actually worsens chronic pain.

FPM Board member Dr Michael Vagg and Fellow Dr Malcolm Hogg appeared on a panel discussing chronic pain on Jon Faine's *Conversation Hour* on Melbourne ABC station 774 on May 26. They responded to talkback calls and discussed problems with opioids, techniques for active self-management of pain and new devices that can offer pain relief. They reached an audience of 55,000 people.

A call for an about-turn in the prescribing of opioids for chronic pain by FPM's new dean and the director of the Hunter Integrated Pain Service, Dr Chris Hayes, garnered page one of the *Newcastle Herald* on April 14. Dr Hayes said doctors had "got it wrong" and needed to do "a medical about-turn" on the over-reliance of addictive prescription opioids for chronic pain. Over time, the body adapted and became tolerant to these drugs, making their effectiveness with chronic pain doubtful.

The news report on Dr Hayes' article reached an audience of over 32,000 people in regional NSW. It was followed up by an editorial in the same paper the next day.

Former ANZCA president Professor Kate Leslie (pictured above right) talked about the latest advances in anaesthesia, bullying and women in medicine, and how we can make better specialists on the Lindy Burns radio program *Writs & Cures* on ABC 774 Melbourne on March 18. She had an audience of about 15,000 people.

Karen Kissane
Media Manager, ANZCA

Since the March 2016 edition of the *ANZCA Bulletin*, ANZCA has featured in:

- **51 print reports**
- **43 radio reports**
- **699 online reports**

Media releases since the previous *Bulletin*:

Wednesday May 4:

High cost to delirium after surgery.

Spread of cancer may be prevented by good pain relief and use of morphine.

Two new leaders for ANZCA and FPM.

Tuesday May 3:

Does ketamine prevent chronic pain after surgery?

Kind doctors make healthier patients.

Honey-bees' "waggle-dance" helps uncover the secrets of anaesthesia-induced jetlag.

Monday May 2:

Doubts about the safety of anaesthesia for infants explored.

Monday May 1:

New technique revolutionises treatment for stroke.

Exercise has more impact on health than diet.

Friday April 29:

Pain is the hidden side of the obesity epidemic.

New techniques help prevent chronic pain after surgery.

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

Specialist Training Program site engagement visits

Australia

ANZCA is the Specialist Training Program (STP) contract manager for 58 training positions in anaesthesia, pain medicine and intensive care medicine (on behalf of the College of Intensive Care Medicine) in expanded settings across the country, including rural, regional and private hospital settings. It is understood there will continue to be 900 STP trainees spread across the medical specialities in the anticipated next round of STP funding. There will be an additional 50 rural specialist training posts in 2017, increasing the total to 100 posts, under the Integrated Rural Training Pipeline. Further information is available at: www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley150.htm.

Engagement

The ANZCA Government Programs team has undertaken a number of stakeholder engagement activities in the past few months to support our Specialist Training Program sites as they await an announcement from the Department of Health regarding the outcome of the program review and an anticipated announcement of ongoing funding by the health minister. Sarah Kleinitz and Ellen Pascoe visited sites in Victoria, SA, WA, NSW and Queensland.

An extended meeting at each site included time with the head of department, supervisor of training, other STP site contacts, as well as current and former trainees. These meetings facilitated discussions about STP contracts and the advantages and challenges presented by the STP post/s.

In summary, the visits included:

- **Victoria:** Eight sites across metropolitan Melbourne and regional locations in Ballarat and Geelong with anaesthetic, pain medicine and intensive care training posts.
- **SA:** One site in metropolitan Adelaide with an anaesthetic training post. One rural site provided written feedback on their anaesthetic training post.
- **WA:** Eight sites across metropolitan Perth, Joondalup and regional locations in Bunbury and Rockingham with anaesthetic, pain medicine and intensive care training posts. One of these posts is with the Royal Flying Doctor Service. An additional meeting was held with the Western Australian Anaesthetic Rotation.
- **NSW:** Nine sites across Sydney and regional locations in Coffs Harbour, Goulburn, Maitland and Tamworth with anaesthetic, pain medicine and intensive care training posts.
- **Queensland:** Eight sites across Brisbane and regional locations in Townsville, Mackay, Rockingham, Bundaberg, Toowoomba and Redcliffe. Additional meetings were held with the Queensland Anaesthetic Rotational Training Scheme (QARTS) and the Queensland Intensive Care Pathway.

Feedback

All the feedback highly endorsed the value that Specialist Training Program funding has brought to these sites and expressed a wish for ongoing funding. Much of the feedback also mirrored the findings and recommendations from ANZCA's 2015 Specialist Training Program evaluation report: www.anzca.edu.au/Training/Specialist-training-program.

Unfortunately, due to time and financial constraints, it has not been possible to visit all STP sites, however we have provided sites with an opportunity to give feedback on the STP and the experience of the program through an email questionnaire.

ANZCA's STP training sites have implemented a variety of successful models. These vary according to the level of trainee/s, the approach of the supervisor of training and consultants, the location of the setting, the variety and complexity of cases and the easy availability of appropriate formal education sessions for the trainees. Many of the heads of department and supervisors of training spoke about the added service efficiency in these expanded settings that funding for an STP trainee brings, particularly as the number of high acuity and complex cases increase across these settings. The increasing awareness of a need to initiate succession planning within departments also was noted, especially the fostering of future supervisors of training from among current staff and within the trainee cohort, who may become future staff in that setting.

All trainees who participated in the sessions relayed the professional and the personal value of having one or more rotations in these expanded settings. The positive experience gained varied widely, depending on factors such as the number of trainees in the department, the length of rotation and the trainee's involvement in the wider community. Several former STP trainees are now employed as consultants in these private and/or rural and regional settings.

What was observed?

- Specialist Training Program posts can effectively contribute to the alleviation of training bottlenecks.
- There is greater success when heads of departments and supervisors of training play an active role in managing the type of STP trainees rotated into STP posts.
- Trainees benefit from opportunities to regularly re-join their wider cohort for formal education sessions.
- Trainees benefit from being in settings with other trainees, irrespective of whether it is another STP trainee, an ANZCA trainee or a trainee from another college.
- Supervisors and trainees benefit from regular and ongoing discussions about expectations and progress.
- Succession planning should be undertaken within the department and the hospital to ensure the ongoing success of an STP training site.

Thank you to all of the departments and individuals we visited for being so generous with your time and open in your responses about how the Specialist Training Program works in your settings.

New Zealand

This year has seen a number of changes at the Ministry of Health as it implements a new structure. Two of the major changes include disestablishing the National Health Board and the National Health Committee. Their functions will be streamlined into the Ministry of Health. Health Workforce New Zealand, the Health Quality and Safety Commission and the Health Promotion Agency remain unchanged.

The ministry also has released the updated New Zealand Health Strategy, following extensive consultation. The strategy outlines the high-level direction for New Zealand's health system over the next 10 years and is available here: www.health.govt.nz/publication/new-zealand-health-strategy-2016. The ANZCA New Zealand National Committee (NZNC) provided feedback on the strategy during the consultation phase last year.

Work continues on developing a therapeutic products regulatory regime to replace the Medicines Act 1981. In April, the ministry publicly released Cabinet papers and associated regulatory impact statements about developing the new regime. The ANZCA NZNC provided feedback to the ministry in January about draft options for the regulation of prescribing and dispensing under the new regime, and Heather Ann Moodie, General Manager NZ, will attend a briefing from the ministry in May about the recently released Cabinet papers.

The Health Quality and Safety Commission has released its final Position paper on the transparency of information related to health care interventions, available here: www.hqsc.govt.nz/publications-and-resources/publication/2463/. The ANZCA NZNC provided feedback to government agencies on this issue throughout 2015, including attending meetings and lodging submissions on the topic. An opinion from the ombudsman on public release of health outcome data is also expected in the coming months.

Virginia Lintott,
Acting General Manager, Policy, ANZCA

Submissions

Australia

- Dental Board of Australia – Consultation on entry-level competencies for conscious sedation endorsement of registration.
- Senate Standing Committees on Community Affairs – Inquiry into the Medical Complaints process in Australia.

New Zealand

- Medical Council of New Zealand – Revision of the Medical Council's Statement on Telehealth.
- Medical Council of New Zealand – Statement on advertising – testimonials.
- Health Quality and Safety Commission – The deteriorating patient: current practice and emerging themes.
- Perioperative Mortality Review Committee – 2016 report recommendations.
- Ministry of Health – Reducing harm from commercial sunbeds.

ANZCA tackles bullying, discrimination and sexual harassment in the workplace

In March 2015, media reports about neurosurgical training in Melbourne highlighted the issues surrounding bullying, discrimination and sexual harassment (BDSH) in the medical workplace.

The frank disclosures initiated further discussions and reports, revealing problems throughout hospital environments. In response, the Royal Australasian College of Surgeons (RACS) established an expert advisory group, which took submissions and surveyed surgical trainees. Its report was made public in September.

The President of RACS, Professor David Watters, publicly apologised for bullying by surgeons (www.youtube.com/watch?v=lm_YLicg9Sw) with a clear statement that such behaviours were unacceptable. RACS was not alone and many complaints of bullying, discrimination and sexual harassment have been presented in the media in Australia and New Zealand over the past year.

ANZCA Council took these issues seriously, and the ANZCA Bullying, Discrimination and Sexual Harassment Working Group was established in November 2015 to identify current resources and policies within the College; evaluate the extent of the problem as it affects trainees and Fellows; and recommend improvements the College could make to reduce such events and improve support.

The group's membership was designed to provide broad representation and expertise. ANZCA participated in the Australian Medical Association forum on bullying in November, and a workshop was held for senior staff, the ANZCA Council and the working group in January this year.

The term "bullying" is used for brevity in this article, but it is intended to mean all forms of bullying, discrimination and sexual harassment.

> "The standard you walk past is the standard you accept" – Lieutenant General David Morrison, former Chief of Army, 2013.

Bullying poses a threat to an individual's health, compromises safe patient care, can impede career progression and impacts on the wider community.

ANZCA considers bullying to be unacceptable and is working to improve all aspects of support for trainees, Fellows and College staff. The situation of specialist colleges adds complexity because – apart from College staff – bullying often occurs in a workplace governed by employers who operate under the occupational health and safety regulations of varying jurisdictions. The definitions for bullying, discrimination and sexual harassment also are jurisdictional, but have common threads (see right).

This dual-governance situation can hamper identification and management of bullying. A key role of the BDSH working group is to identify ways to work with employers and other organisations and colleges, especially RACS, to achieve the most effective outcomes and prevention strategies.

Current policies and resources within ANZCA include staff and social media policies, and the *Policy on bullying, discrimination and harassment for Fellows and trainees acting on behalf of the College or undertaking College functions*. These are underpinned by the ANZCA professionalism guide for Fellows and trainees, currently in draft form, the trainee agreement and, importantly, by a range of documents offered by the Welfare of Anaesthetists Special Interest Group.

Bullying behaviour reflects a lack of professionalism, and bad behaviours by seniors are all too often role-modelled by juniors and thus perpetuated.

The extent of bullying within anaesthesia is being identified by surveys conducted by ANZCA: the annual trainee survey, conducted recently; and the Graduate Outcomes Survey now being conducted. Preliminary results from our trainees indicate a prevalence of bullying not dissimilar to that identified by RACS. The results will be presented in a future edition of the *ANZCA Bulletin*.

> "Bullying behaviour reflects a lack of professionalism, and such bad behaviours by seniors are all too often role-modelled by juniors and thus perpetuated."

The Faculty of Pain Medicine also is investigating how best to understand the situation in pain medicine. FPM representative Dr Lindy Roberts is working with the Faculty's Teaching and Learning Committee on data collection from trainees and recently graduated Fellows. The Faculty is seeking expressions of interest from trainees interested in being involved in an advisory group. Those who are interested should contact the Faculty's general manager, Helen Morris at hmorris@anzca.edu.au.

Training and education in the workplace forms an important role in the prevention of bullying. We are working with RACS to identify opportunities where trainees and specialists in anaesthesia and surgery can jointly participate in learning how to optimise professional behaviours. It also is important to recognise we all have responsibilities as observers of bullying behaviours, even if we are not directly affected. As the then Chief of Army, Lieutenant General David Morrison, famously said: "The standard you walk past is the standard you accept."

A future article will detail the action the College and Faculty are taking to identify and manage bullying in conjunction with employers. In the meantime, it strongly recommended that trainees and specialists first take a local, low-level approach to resolving any issues by contacting senior colleagues, supervisors of training, heads of departments or, if necessary, escalation to the hospital's human resources department. Many issues can be managed effectively in this way.

If a trainee or Fellow has concerns they can access resources on the ANZCA website (www.anzca.edu.au/Resources/Doctors-welfare) or contact the CEO directly via phone or email ceo@anzca.edu.au. RACS encourages any concerns about surgeons to be directed to their "hotline" (www.surgeons.org/about/racs-complaints-hotline/).

Associate Professor David A Scott
ANZCA President and Chair, BDSH Working Group

president@anzca.edu.au

Bullying, Discrimination and Sexual Harassment Working Group

Associate Professor David A Scott (Chair): Head of department, ANZCA President, Vic

Dr Leona Wilson: Previous head of department, Executive Director of Professional Affairs, NZ

Dr Sam Lumb: Former Trainee Committee chair, New Fellow, SA

Dr Sally Ure: Deputy education officer, NZ

Ms Jenny Lethbridge: Head of Human Resources, ANZCA

Ms Helen Maxwell-Wright: Consumer representative, Vic

Dr Lindy Roberts: ANZCA councillor, Faculty of Pain Medicine representative, WA

Dr Maggie Wong: Former supervisor of training/education officer; Director of Professional Affairs (Assessor), Vic

Advisors:

Dr Chris Hayes: Dean, Faculty of Pain Medicine, NSW

Dr Adriana Bibbo: Trainee Committee co-chair (Vic)

Dr Christine Velayuthen: Trainee Committee co-chair (SA)

Definitions

Bullying is repeated unreasonable behaviour directed towards a worker or a group of workers that creates a risk to health and safety. One-off incidents, poor communication, poor management or supervision skills, reasonable management actions such as providing performance feedback, delegation of tasks relevant to the role and disciplinary action would not be considered bullying.

Discrimination involves unwelcome behaviour resulting in unfavourable treatment relating to legally defined characteristics. These characteristics include age, disability, industrial activity, employment activity, lawful sexual activity, marital status, physical features, political belief or activity, race, pregnancy, religious belief or activity, sex, parental status or status as a carer, breast feeding, gender identity, sexual orientation, social origin, irrelevant criminal record and personal association.

Sexual harassment involves an unwelcome sexual advance, or an unwelcome request for sexual favours to the other person; or engaging in any other unwelcome conduct of a sexual nature in relation to the other person in circumstances in which a reasonable person, having regard to all the circumstances, would have anticipated that the other person would be offended, humiliated or intimidated.

Laying down the law on social media

Susan Halliday is a former sex and disability discrimination commissioner who spoke to the ANZCA Council and senior staff earlier this year about bullying, discrimination and sexual harassment. She covered risks associated with social media in her presentation.

As it approaches eight years since Virgin Atlantic sacked 13 flight attendants for inappropriate chatter on Facebook, it's clear people in both professional and personal environments have failed to take note that cyber-space is a public place, and when you *post* in the modern sense of the word, you *publish* in the traditional sense of the word.

Having called customers "chavs", commented on the six-legged variety of frequent-cockroach-flyers travelling for free and criticised the airline's flight-safety standards, the behaviour of the flight attendants in 2008 was declared "totally inappropriate" and it was found that their commentary had "brought the company into disrepute".

Fast forward to 2016 and there's a plethora of people posting online who still fail to understand they're professionally aligned with a workplace, as their fingers busily type before they think. For the record "typing before you think" is usually far more dangerous than "speaking before you think"! Be it Facebook, Instagram, Twitter, Snapchat, blogging, Wikis, Flickr, Youtube, LinkedIn or a group text message, it's important to ask oneself "would I be happy to read that comment or see that picture on the front page of the newspaper with my name, and that of my employer or medical practice, attributed?"

I routinely ask people when working with groups, about when they last updated their social media policy. I regularly receive the same pained looks in response. I hear myself repeating "it's time" and note that the 2016 WorkplaceInfo Social Media Index survey, having interviewed 371 Australian businesses, found 23 per cent of organisations experienced bullying of their employees via social media, and that 38 per cent of bullying primarily involved employees making inappropriate, derogatory and disparaging comments about their co-workers. Further, inappropriate online treatment of employees by colleagues included stalking, threats, releasing information about a co-worker, group bullying, and the posting of inflammatory material, videos and photographs.

"The 2016 WorkplaceInfo Social Media Index survey ... found 23 per cent of organisations experienced bullying of their employees via social media..."

It's fair to say the topic of social media defamation always draws a decent crowd, with some faces looking particularly worried. The recent Twitter-tale of a NSW lad formerly from Orange High School who found himself in a spot of defamatory bother and out of pocket $A105,000 in damages – at the ripe old age of 20 – tends to cement my point. Bearing a grudge against a teacher at the school, he took to Twitter and Facebook to publish his grievances. The judge was clear that the teacher in question was defamed by the public "false allegations" and that the effect on her "was devastating".

The internet has provided a platform for ordinary people and employees to *publish* 24/7 and, dare I say, they are very busy. Privacy settings are irrelevant and for every comment and every photo posted online there is likely to be a permanent record, and the odd subpoena. The key point here is that defamation is actionable irrespective of the medium. Defamation lawyers are struggling to keep up with the workload as social media fortifies their area of expertise, mindful that the traditional principles of defamation apply: if information is spread intentionally and it causes injury or damage to another person, organisation, association, practice or company's reputation, it is likely to be problematic.

To boot, in this new age, if a person who did not create the defamatory material, but chose to share or re-*publish* it, or is enough of a twit to re-tweet it, they too could have a defamation case pending. As a cautionary note I always tell the now anguished faces in the crowd to read the 38 Facebook comments before you share or re-*publish* a Facebook post accompanied by 38 comments!

It is time for those with shocked faces amidst social media site administrators (both personal and professional) to come to terms with the lay of cyberspace-land. The more astute and risk adverse know they are responsible for everything on the personal and professional social media sites they administer. But the question begs, why would you allow people to post anything on a social media site you administer before you have pre-screened and approved it for *publishing*? Does the person who administers the organisation's Facebook page and Twitter feed have the relevant duties and responsibilities detailed in their job description?

In October 2015, the Supreme Court considered whether an administrator of a Facebook page could be liable for comments posted by another user. Justice John Dixon made it clear that an administrator could be liable as a secondary *publisher* as the person had the power to remove the comments. And yes ... this case was related to a medical practitioner and Facebook posts.

Reflecting, brick walls and virtual walls are basically the same. If there is defamatory graffiti on the outside brick wall of your medical practice, and you don't remove it, the law says you are responsible for it. Now think Facebook wall, Twitter feed, false and misleading statements on LinkedIn and Instagram pictures accompanied by comments, and set some time aside to work on your "privacy" and access settings.

Susan Halliday
Former Sex Discrimination Commissioner and Disability Discrimination Commissioner

What would you do?

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

Respect and support are essential to collegiality

"Collegiality" is a term used in many contexts, however it appears to escape attention when colleagues encounter conflict with external organisations or people.

What does collegiality mean, why is it important and how do we, as individual Fellows, demonstrate collegiality?

***Collegiality** is defined as the relationship between colleagues. Colleagues are those explicitly united in a common purpose and respecting each other's abilities to work toward that purpose. A colleague is an associate in a profession or in a civil or ecclesiastical office.*

This definition highlights two important points: "united in a common purpose" and "respecting each other".

As Fellows, what is our common purpose? We have all achieved a level of excellence in our chosen area(s) of clinical practice in anaesthesia, perioperative medicine and pain medicine. A common purpose then, may be to promote the specialty and to work together to enhance the image of our specialty among our non-anaesthesia colleagues, and within the community – " a rising tide lifts all ships". This is a collective approach as each individual contributes at every patient contact, every medical practitioner contact, and every nurse contact.

With regard to respect it is easy to pay lip service to this. Some take the view that respect must be earned, while others will offer respect until an individual behaves in such a way that respect is withdrawn. Sometimes, however, we tend to be judgemental and withdraw our respect without good reason. Worse still is judging our colleagues in the absence of all relevant facts and on the basis of hearsay, and finding them guilty.

As a young consultant and deputy director at a major teaching hospital, I aspired to take over as director when the incumbent retired. My plans took a dive when a dissatisfied visiting medical officer who felt aggrieved about the allocation of a private list (which was fairly shared among all VMOs) made allegations about the director, who was of the utmost integrity and honesty. The opportunity to seize sessional funding allocations by another specialty resulted in the allegations being escalated to the hospital's administration. In the absence of any inquiry – let alone a fair one – the director was judged guilty with subsequent removal of departmental sessions. He was so shocked that he announced he would resign. Here was an opportunity for me to become director.

Knowing the allegations were completely mischievous, I encouraged the director to dispute them. He was vindicated by the subsequent inquiry, however sessions were still diverted away from the department, which he found untenable and consequently resigned. The director of medical services approached me assuming I would accept the position as director.

What would you do?

Rightly or wrongly, I felt I could not accept the offer under such circumstances and proffered a biblical quote that he should go forth and multiply. Clearly this was not the only option and it may not have been the wisest, however, it was a demonstration of my support for a colleague and mentor and I have never had any regrets.

More recently there have been incidents where colleagues have been accused of misconduct or questionable clinical management, but following investigations by the medical board no sanctions have been imposed and no negative findings made. During an inquiry, privileges are suspended by healthcare facilities. Despite strong support from their surgeons, the concerns raised by other physicians and/or peers carried greater weight. The impact of such decisions on livelihood and family is huge.

In the absence of an appropriate hospital inquiry devoid of conflicts of interest, there is a risk the findings may be prejudiced. Medical advisory committees and credentialing committees must be impartial and exclude or manage conflicts of interest. Collegiality demands that during our colleagues' suspension we assist by covering their lists until they are able to resume work. This enables us to maintain services to the community, the hospital and the surgeons while supporting our colleagues, who may be the victims of personality conflicts, poor communication or stresses to which we may all be susceptible at times.

The relevant professional documents/College documents pertinent to considerations of collegiality include:

- PS02 *Statement on Credentialling and Defining the Scope of Clinical Practice in Anaesthesia*

  Item 3 recommends the credentialling committee consist of two specialist anaesthetists of whom one does not hold an appointment at the healthcare institution. Also, that the committee must conduct itself according to the rules of natural justice without conflicts of interest or bias.

- PS16 *Statement on the Standards of Practice of a Specialist Anaesthetist*

  Item 1.2 refers to cultivating and maintaining high standards and ethical behaviour.

- PS44 *Guidelines to Fellows Acting on Appointments Committees for Senior Staff in Anaesthesia*

  Item 4 states that the College nominee on the appointments committee should not be a member of the medical staff of the hospital seeking the appointment.

  Item 6 addresses the issues of fairness of process; the need to seek College advice if the representative has any doubts about a process or decision; and that appointments committees should be free from bias.

- PS50 *Guidelines of Return to Anaesthesia Practice for Anaesthetists*

  In cases of mandated return to practice by regulatory authorities, PS50 outlines the process and complies with both the Medical Board of Australia and the Medical Council of New Zealand.

- PS57 *Statement on Duties of Specialist Anaesthetists*

  Item 3.8 refers to participation in programs to safeguard the wellbeing of colleagues, trainees and related professionals.

  Item 3.9 refers to participation in activities promoting the image of the specialty to colleagues and to the public.

- *Supporting Anaesthetists' Professionalism and Performance – A Guide for Clinicians*

  This cites numerous examples of good behaviour, including acting with integrity and fairness.

Collegiality is the regard with which we, as individuals, hold each other, and the support we provide to fellow members of our College especially during times of stress. We are most fortunate to have access to resources and we should avail ourselves of them during times of stress or conflict.

The Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists have expertise in assisting with a range of issues and their committees include very experienced and knowledgeable peers. The Welfare of Anaesthetists Special Interest Group also is an excellent support resource.

While ANZCA may be perceived as a regulatory organisation responsible for education and standards, fellowship affairs also is a major role of the College. The College cares about its Fellows and invests considerable resources into assisting and supporting its fellowship. From this perspective, there is no shortage of collegiality, so it comes back to each of us as individuals to promote our specialty and to support each other.

Dr Peter Roessler
Director of Professional Affairs,
Professional Documents
ANZCA

Professional documents – update

The professional documents of ANZCA and FPM are an important resource for promoting the quality and safety of patient care. They provide guidance to trainees and Fellows on standards of clinical care, define policies, and serve other purposes that the College deems appropriate. Government and other bodies also refer to professional documents as an indicator of expected standards, including in 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:

PS50 Guidelines on Return to Anaesthesia Practice for Anaesthetists: In February 2016, the ANZCA Council approved ANZCA professional document PS50 and a newly developed accompanying background paper for promulgation on the ANZCA website for a 12-month pilot period.

PS07 Guidelines on Pre-Anaesthesia Consultation and Patient Preparation: In April 2016, the ANZCA Council approved the release of the revised ANZCA professional document PS07, with updated fasting guidelines and an accompanying background paper for promulgation on the ANZCA website for a 12-month pilot period.

There are presently inconsistencies in fasting recommendations between PS07 and *PS15 Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery*, which is undergoing review to rectify this problem. In the meantime, fasting guidelines in PS07 take precedence over those in PS15.

PS61 Guidelines for the point-of-care management of evolving airway obstruction transition to the can't intubate can't oxygenate airway emergency: In April 2016, the ANZCA Council approved the new ANZCA professional document PS61, with cognitive aid and an accompanying background paper for promulgation on the ANZCA website for a 12-month pilot period.

PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures: The New Zealand Society of Gastroenterology has recently endorsed *PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures*. This important document provides guidance for non-anaesthetists administering sedation across a range of procedural settings.

Feedback is encouraged on all professional documents during the pilot phase. 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.

Faculty of Pain Medicine professional documents can be accessed via the FPM website.

Changes to the ANZCA Council

Your new ANZCA Council

The ANZCA Council changed in May with Professor Alan Merry stepping down after 11 years and Dr Lindy Roberts retiring after 12 years, including two years as president.

Alan and Lindy have made substantial contributions to the College; Alan with a particular focus on safety and quality and research, and Lindy in education and training. Hopefully they will continue to be able to contribute.

Professor Ted Shipton is also leaving the ANZCA Council, having served brilliantly as dean of the Faculty of Pain Medicine for the past two years. Dr Chris Hayes (Newcastle, NSW) has been elected as dean and is an able successor.

Also to be congratulated are re-elected councillors Dr Pat Farrell (Newcastle, NSW), Dr Rod Mitchell (Adelaide, SA) and Dr Richard Waldron (Hobart, Tasmania). I am very pleased to welcome Dr Chris Cokis (Perth, WA) and Dr Nigel Robertson (Auckland, NZ) as new councillors.

I am very grateful to our outgoing councillors and look forward to working with our new "team" as we deal with the opportunities and challenges faced by our College and specialty. With great pleasure I also welcome Dr Rod Mitchell to the position of vice-president. Rod was elected at the New Council Meeting in Auckland.

Associate Professor David A Scott
ANZCA President

David A Scott and Rod Mitchell take the reins

Associate Professor David A Scott, of the University of Melbourne and St Vincent's Hospital, took up the role of president of ANZCA during the 2016 ANZCA Annual Scientific Meeting in Auckland in May.

Associate Professor Scott is the director of the Department of Anaesthesia and Acute Pain Medicine at St Vincent's Hospital in Melbourne. He also is an associate professor in the Faculty of Medicine, Dentistry and Health Sciences at the University of Melbourne.

His key research interests include cognitive change following anaesthesia, patient blood management in cardiac surgery, and the safe and effective management of acute pain.

Associate Professor Scott, who replaces Dr Genevieve Goulding, said, "It is a privilege and responsibility to lead the Australian and New Zealand College of Anaesthetists.

"Our College has an outstanding international reputation in both the clinical excellence of our Fellows and the quality of our research.

"There are many challenges in healthcare at the moment, and the College will continue to engage with healthcare and other professional organisations, government and regulators to achieve the best outcomes for our patients."

The new vice-president of ANZCA is Dr Rod Mitchell of South Australia, whose practice includes anaesthesia and intensive care medicine, in both the public and private sectors.

Dr Mitchell worked for many years in Alice Springs, both as a specialist anaesthetist and a GP anaesthetist, and with the Royal Flying Doctor Service. He continues to have a professional interest in indigenous health.

During his time on the ANZCA Council he has chaired several committees including the Professional Affairs Executive Committee, Continuing Professional Development, Indigenous Health, the Joint Consultative Committee on Anaesthesia, and Fellowship Affairs.

Both appointments run for two years.

Karen Kissane
Media Manager, ANZCA

ANZCA Council officer bearers

President – Associate Professor David A Scott (Vic)
Vice-President – Dr Rod Mitchell (SA)
Immediate Past-President – Dr Genevieve Goulding (Qld)
Honorary Treasurer – Dr Richard Waldron (Tas)
Chair of Examinations – Dr Michael Jones (NSW)
Honorary Curator – Dr Christine Ball (Vic)
Honorary Historian – Professor Barry Baker (NSW)

A full list of committee members and their chairs can be found on the ANZCA website under "Council, committees and representatives".

All College correspondence to the president should be directed to either the president's email address (president@anzca.edu.au) or the CEO's email address (ceo@anzca.edu.au).

Introducing our new councillors

Dr Chris Cokis

Dr Chris Cokis is an anaesthetist working in the area of cardiothoracic anaesthesia at Fiona Stanley Hospital in Perth, Western Australia. His interests include the examination process for trainees and he has been actively involved with the Cardiac Thoracic Vascular and Perfusion (CTVP) Special Interest Group for many years.

Dr Nigel Robertson

Dr Nigel Robertson emigrated to New Zealand from Scotland nearly 30 years ago. He is a specialist anaesthetist and former clinical director of the adult anaesthesia division at Auckland City Hospital with an interest in neuro-anaesthesia and orthopaedics. He was chair of the New Zealand National Committee of ANZCA and is an expert advisor to the Health and Disability Commissioner in NZ. He is the new chair of the Continuing Professional Development Committee and is a hospital accreditation visitor for ANZCA.

Dr Chris Hayes

Dr Chris Hayes is dean of the Faculty of Pain Medicine. Having trained initially in anaesthesia, Chris now works entirely in pain medicine and is the director of the Hunter Integrated Pain Service based at John Hunter Hospital in Newcastle, NSW. Chris's interests include the multidimensional treatment of chronic pain, health-system redesign and a personal focus on pain associated with endurance trail running.

Our College's evolution: 2004-16

Former president Dr Lindy Roberts reflects on her 12 years on council.

Over the past 12 years, I have witnessed many changes.

Highlights include the election of our first female president (and first residing in New Zealand, Dr Leona Wilson); the election of the first female dean of the Faculty of Pain Medicine (Dr Penny Briscoe); more effective trainee and new Fellow voices (ANZCA Trainee Committee established 2007, represented on ANZCA Council from 2010; new Fellow councillor from 2008); formation of the Indigenous Health Committee; community representatives on committees; Australian and New Zealand recognition of pain medicine as a specialty; establishment of the Anaesthesia and Pain Medicine Foundation and the ANZCA Clinical Trials Network (supporting internationally recognised as well as novice researchers); creation of the ANZCA Overseas Aid Committee (and Essential Pain Management); increasing focus on welfare (for example, the Ray Hader Award for Pastoral Care, improved assistance for trainees experiencing difficulty); and more support for clinical teachers and supervisors (for example, the ANZCA Educators Program). The list goes on.

There are many things that strengthen our College and Faculty. Foremost is the large pool of Fellows, trainees and international medical graduate specialists (most of whom become Fellows) who give their time and energy to advance our professions. They work in many capacities – teachers, researchers, supervisors of training, examiners, committee members and chairs, ANZCA Council and FPM Board members, and so on. While the central contribution of these volunteers has not changed, the College is now better able to support their efforts.

College and Faculty activities would not be possible without our highly capable staff – not just in visible areas, such as, education, communications, fundraising, fellowship affairs, continuing professional development, professional affairs and conference management, but also in critical supporting portfolios, such as finance and project management.

Staff capability in all areas has improved enormously over the past 10 years. The New Zealand office, with its media and health policy resources, is a good example. Staff expertise allows us not only to respond to government inquiries, but increasingly we are the "go to" body for other organisations.

There is now a College Communications team, which produces hundreds of anaesthesia and pain medicine media stories each year and high quality publications (for example, National Anaesthesia Day posters).

Other examples are curriculum development, professional documents, conference organisation, research fundraising, the ANZCA Library, the Geoffrey Kaye Museum of Anaesthetic History (recently accredited by Museums Australia), WebAIRS and other safety and quality initiatives. When I first joined the ANZCA Council, councillors managed many College activities (or not at all); now Fellows provide their expertise, ably supported by professional College staff.

(continued next page)

Changes to the ANZCA Council (continued)

The ANZCA Council also has evolved over those years under the leadership of past presidents, councils and chief executive officers, each building on the achievements of predecessors.

Increasingly there is an expectation that councillors are trained for their roles as company directors, through an induction process, an annual council education program and company director courses. Decisions now formally consider strategy, risk and budget. Council takes advice from external advisors and has a Finance, Audit and Risk Management Committee. These formal business processes ensure that College resources are used wisely and to best effect.

A healthy organisation is one that adapts to meet the challenges, opportunities and changes of the time. Fellows and trainees can be reassured that ANZCA and its Faculty of Pain Medicine are not only well regarded, but also work effectively to advance the specialties of anaesthesia and pain medicine in the interests of our patients.

Dr Lindy Roberts
Past ANZCA president

ANZCA farewells…

Dr Lindy Roberts

Elected to the ANZCA Council in 2004, Dr Lindy Roberts served as assessor, treasurer, chair of Education and Training, and FPM Board representative. As president (2012-14), she had a leadership role in the ANZCA Strategic Plan 2013-2017, the introduction of the revised curriculum in 2013, the ANZCA/FPM Continuing Professional Development Program revision and represented the College in many external forums on issues such as workforce and revalidation. Most recently, she was chair of the Anaesthesia and Pain Medicine Foundation Committee, ANZCA representative to the Australian Society of Anaesthetists Professional Issues Advisory Committee, councillor to the Education Training and Assessments Executive Committee, and FPM representative to the Bullying, Discrimination and Sexual Harassment Working Group. She is passionate about education and training, complex acute pain management, ENT anaesthesia and film noir.

Professor Alan Merry

Professor Alan Merry is chair of ANZCA's Research Committee and has served on the ANZCA Council since 2004. He is an anaesthetist and specialist in pain medicine at Auckland City Hospital, NZ. He chairs the board of the Health Quality and Safety Commission in NZ. Working with others, he contributed to the establishment of ANZCA's Quality and Safety Committee, which is going from strength to strength under the leadership of Dr Phillipa Hore, and the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC), now under the chairmanship of Dr Neville Gibbs and the direction of Dr Martin Culwick. Professor Merry believes the ANZCA Council is in great heart and that councillors appointed in recent years have strengthened the sense of collegiality, purpose and commitment to the good of our speciality and the patients we serve. He believes the opportunity to serve on council, and on the NZ National Committee before this, has been one of the great privileges of his career.

Professor Edward (Ted) Shipton

Professor Ted Shipton is the immediate past dean of the Faculty of Pain Medicine. Ted is an anaesthetist and specialist pain medicine physician in Christchurch and Burwood hospitals in Canterbury, NZ. He is head of the Department of Anaesthesia at the University of Otago in Christchurch, and medical director of the Pain Management Centre for the Canterbury District Health Board. He is director of Pain@Otago Research Theme, and serves on the MBCHB Curriculum committee, and on the Professional Conduct Committee of the Medical Council of New Zealand. He considers anaesthesia to be in good hands due to the tireless commitment and collegiality shown by the members of the ANZCA Council in enhancing the quality of training, research and patient safety. He says it has been a great honour to be a member of the ANZCA Council.

Anaesthetists tackle a weighty problem

The 2015 National Anaesthesia Day survey found obesity is a growing medical concern.

ANZCA conducted a survey on anaesthetists' attitudes to obesity as part of the National Anaesthesia Day activities in October 2015. The survey revealed a problem: anaesthetists often find it difficult to communicate with obese patients about their weight.

About two thirds of respondents indicated that obesity was the most common co-morbid condition they encountered and the same proportion had anaesthetised at least one obese patient on their most recent clinical day. The survey respondents almost universally agreed that obesity increases both perioperative and lifetime risks for patients. However, respondents suggested uncertainty in knowing how best to approach the problem, with comments such as "obesity is the new norm", and "I feel politically incorrect if I have to discuss with patients their extreme weight and the problems it can cause".

A collaborative group was formed to explore options for resolving this problem. The group consists of two anaesthetists (Associate Professor Natalie Smith, University of Wollongong; and Professor David Story, University of Melbourne), a specialist obesity physician (Dr Nic Kormas, Camden and Concord Repatriation General Hospitals, Sydney) and a specialist in medical communication (Associate Professor Robyn Woodward-Kron, University of Melbourne).

The group reviewed the literature to try to answer this question: "How can anaesthetists best communicate with obese patients regarding perioperative risk and weight loss?"

The answer was very short: we found no literature to address the specific question of how anaesthetists should communicate with their patients, perioperatively, about the risks and management of obesity. One letter to the editor noted that anaesthetists should directly address obesity-related risks with patients in the pre-assessment setting rather than simply noting and managing such risks. However, no guidance on the best methods of doing so was found.

Addressing major perioperative risks during the pre-assessment process is essential to good perioperative care. Weight-loss conversations could be considered similar to the smoking cessation conversations that physicians learned how to initiate with patients in the past.

Patients expect their health risks will be assessed and addressed when they interact with health professionals; This has been called the "teachable moment". The preoperative assessment provides a window of opportunity in which to do so. With sufficient time, it allows the patient to start to modify their risks.

The question of how to initiate risk discussions with obese patients remains important.

In the next stage of this work, we are using the literature closest to our original search topic to construct recommendations that could be used as guidance for anaesthetists. This literature includes evidence-based suggestions about initiating weight-loss conversations with obese patients in other settings and by a number of healthcare professionals. It includes particular groups of patients, such as those in paediatric and maternity care. These suggestions will be reviewed and confirmed in consultation with the team. We aim to produce guidelines that will be of practical use for anaesthetists, which can be implemented and investigated in the future.

Dr Natalie Smith, FANZCA
Wollongong Hospital

Professor David Story, FANZCA
University of Melbourne

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Hinck C. Fellows call for action on obesity. ANZCA Bulletin, Dec 2015, pp32-33.

Astin J, Hardy R. Peri-operative risk reduction in obese patients. Anaesthesia, 2015, 70, 1462.

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"About two thirds of respondents indicated that obesity was the most common co-morbid condition they encounter and the same proportion had anaesthetised at least one obese patient on their most recent clinical day."

Librarians from two institutions performed formal searches with search terms including the following, individually and in combination:

Communication	Interpersonal/physician-patient relations	Weight/weight loss
Perioperative care/period	Obesity/body mass index	Diet
Health education/promotion	Narration	Directive counselling
Referral and consultation	English language	2006 to current

New Perioperative Anaphylaxis Management Guidelines

The Australian and New Zealand Anaesthetic Allergy Group (ANZAAG) and ANZCA have released the second version of the Perioperative Anaphylaxis Management Guidelines.

The new guidelines have been modified as a result of simulation research[1], feedback from anaesthetists who have managed episodes of intraoperative anaphylaxis and from the many anaphylaxis workshops conducted since the initial guidelines.

The new resources include six management cards and more extensive guideline and background documents designed for planning and protocol development prior to an emergency. The background document outlines how to use the cards, including team structure, incorporating human factors research, as well as electronic reference links and the level of evidence for the recommendations.

The key changes in the 2016 co-badged guidelines are:

- Two paediatric cards for the immediate and refractory management of anaphylaxis in children. This allows for age-specific recommendations and simplifies information on the adult cards.
- Introduction of cardiac arrest recommendations at the top of the immediate management cards.
- Increased emphasis on rapid, large volume fluid resuscitation. Observations during simulation sessions indicate that fluid administration is frequently insufficient.
- Changes to the diagnostic card to make it a differential checklist rather than a textbook differential diagnosis list.
- Changing the drug name "adrenaline" to "adrenaline (epinephrine)" to be consistent with the Australian Therapeutic Goods Administration approach to international harmonisation of drug and ingredient names. The dual nomenclature is restricted to headings in most instances.

It is strongly recommended that institutions update to the new management guidelines and consider how to implement them locally. The process can be facilitated by preparing an anaphylaxis box, which can be used to conduct anaphylaxis management education and then provide ready access to the necessary resources during an anaphylaxis crisis. Instructions describing how to prepare an anaphylaxis box and supporting documents are available from the ANZAAG website.

All management cards, guidelines and background papers, and anaphylaxis box documents can be found on the ANZAAG website at www.anzaag.com and the ANZCA website www.anzca.edu.au/Resources/Endorsed-guidelines. ANZAAG has a policy of continuous resource monitoring and quality improvement. Feedback from ANZCA Fellows is welcome to admin@anzaag.com.

Dr Helen Kolawole, FANZCA
Chair ANZAAG Anaphylaxis Management Group, member ANZCA Anaesthetic Allergy Sub-Committee

Dr Helen Crilly, FANZCA
Chair ANZAAG Web/Data Group, Co-opted member ANZCA Anaesthetic Allergy Sub-Committee

Reference:
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Anaphylaxis during Anaesthesia

Immediate Management

Adults 12+

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IF Adult CARDIAC ARREST Pulseless Electrical Activity, PEA	• ALS GUIDELINES for non-shockable rhythms • **1 mg I.V. Adrenaline**, Repeat 1 - 2 minutely prn • Immediately start **CPR**. Elevate legs. **2 L Crystalloid**
DR Danger and Diagnosis Response to stimulus	• Unresponsive hypotension or bronchospasm • Remove triggers e.g. chlorhexidine, synthetic colloid • Stop procedure. Use minimal volatile if GA
S Send for help and organise team	• Call for Help and Anaphylaxis box • Assign a designated Leader and Scribe • Assign a Reader of the cards
AB Check/Secure Airway Breathing - 100% oxygen	• Consider early intubation: airway oedema • Confirm FiO_2 100%
C Rapid fluid bolus Plan for large volume resuscitation	• If hypotensive: Elevate legs • Bolus **2L Crystalloid**, Repeat as needed • Large bore I.V. access. Warm I.V. fluids if possible
D Adrenaline Bolus Repeat as needed Prepare Infusion	Initial I.V. Adrenaline Bolus (Adult) Dilution 1 mg in 10 mL = 100 mcg/mL • Give dose below every 1-2 minutes prn • Increase dose if unresponsive
I.M. Adrenaline (Adult) No I.V. access or haemodynamic monitoring OR awaiting Adrenaline Infusion 1:1000 1mg/mL 500 mcg lateral thigh Every 5 minutes prn	Moderate (Grade 2): 20 mcg = 0.2 mL Life Threatening (Grade 3): 100-200 mcg = 1-2 mL
Adrenaline INFUSION (Adult) >3 boluses of Adrenaline start infusion Can be administered peripherally	**3 mg Adrenaline in 50 mL saline** Commence at 3 mL/hr = 3 mcg/min Titrate to max. 40 mL/hr = 40 mcg/min (Infusion rate 0.05 - 0.5 mcg/kg/min)

If NOT RESPONDING see 'Refractory Management'

Appendix 1 ANZAAG-ANZCA Perioperative Anaphylaxis Management Guidelines version 2 May 2016. The scientific rationale and evidence base for the recommendations on this card is explained in more detail at www.anzca.edu.au and www.anzaag.com © Copyright 2016 – Australian and New Zealand College of Anaesthetists, Australian and New Zealand Anaesthetic Allergy Group. All rights reserved.

Anaphylaxis during Anaesthesia

Refractory Management

Adults 12+

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Request more help	• Consider calling arrest code • May require assistance with fluid resuscitation
Triggers removed?	• **Chlorhexidine** including impregnated CVCs • **Synthetic Colloid** disconnect and remove • **Latex** remove from OR
Monitoring	• Consider **Arterial line** • Consider TOE/TTE
Resistant Hypotension • Continue Adrenaline Infusion • Additional I.V. fluid bolus 50 mL/kg • Add second vasopressor • Consider CVC • Cardiac bypass/ECMO if available	Adult Recommendations **Noradrenaline Infusion** 3 – 40 mcg/min (0.05 - 0.5 mcg/kg/min) and/or **Vasopressin** bolus 1- 2 units then 2 units per hour If neither available use either **Metaraminol** or **Phenylephrine Infusion** **Glucagon** 1- 2 mg I.V. every 5 min until response Draw up and administer I.V. (Counteract β blockers)
Resistant Bronchospasm • Continue Adrenaline Infusion • Consider: - Airway device malfunction - Circuit malfunction - Tension pneumothorax (decompress) • Add alternative bronchodilators	Adult Recommendations **Salbutamol** • Metered Dose Inhaler 12 puffs (1200 mcg) • I.V. bolus 100-200mcg +/- infusion 5-25mcg/min **Magnesium** 2 g (8 mmol) over 20 minutes **Consider** Inhalational Anaesthetics and Ketamine
Pregnancy	• Manual Left Uterine Displacement • Caesarean within 4 minutes if arrest or peri-arrest
Consider other diagnoses	See **'Differential Diagnosis Card'** in Anaphylaxis Box

Once stable refer to 'Post Crisis Management'

Appendix 3 ANZAAG-ANZCA Perioperative Anaphylaxis Management Guidelines version 2 May 2016. The scientific rationale and evidence base for the recommendations on this card is explained in more detail at www.anzca.edu.au and www.anzaag.com © Copyright 2016 – Australian and New Zealand College of Anaesthetists, Australian and New Zealand Anaesthetic Allergy Group. All rights reserved.

Anaphylaxis during Anaesthesia

Immediate Management

Paediatric 0-12

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IF Paediatric CARDIAC ARREST Pulseless Electrical Activity, PEA	• ALS GUIDELINES for non-shockable rhythms • **0.1 mL/kg of 1:10,000 (10 mcg/kg) I.V. Adrenaline** • Repeat 1-4 minutely prn • Immediately start **CPR. 20 mL/kg Crystalloid**
DR Danger and Diagnosis Response to stimulus	• Unresponsive hypotension or bronchospasm • Remove triggers e.g. chlorhexidine, synthetic colloid • Stop procedure. Use minimal volatile if GA
S Send for help and organise team	• Call for Help and Anaphylaxis box • Assign a designated Leader and Scribe • Assign a Reader of this card
AB Check/Secure Airway Breathing - 100% oxygen	• Intubate early: airway oedema CVS/Respiratory compromise • Confirm FiO_2 100%
C Rapid fluid bolus Plan for large volume resuscitation	• If hypotensive: Elevate legs • Bolus **20 mL/kg Crystalloid**, Repeat as needed • Large bore I.V. Access. Warm I.V. fluids if possible
D Adrenaline Bolus Repeat as needed Prepare Infusion	Initial I.V. Adrenaline Bolus (Paediatric) Dilution 1 mg in 50 mL = 20 mcg/mL • Give dose below every 1-2 minutes prn • Increase dose if unresponsive
I.M. Adrenaline (Paediatric) No I.V. access or haemodynamic monitoring OR awaiting Adrenaline Infusion 1:1000 1mg/mL lateral thigh < 6 years = 0.15 mL (150 mcg) 6-12 years = 0.3 mL (300 mcg) Every 5 minutes prn	Moderate (Grade 2): 0.1 mL/kg, 2 mcg/kg Life Threatening (Grade 3): 0.2-0.5 mL/kg, 4-10 mcg/kg
Paediatric Adrenaline Infusion Commence infusion as soon as possible Can be administered peripherally	**1 mg Adrenaline in 50 mL (20 mcg/mL)** Commence at 0.3 mL/kg/hr (0.1 mcg/kg/min) Titrate to max. 6 mL/kg/hr (2 mcg/kg/min)

IF NOT RESPONDING see 'Paediatric Refractory Management'

Appendix 2 ANZAAG-ANZCA Perioperative Anaphylaxis Management Guidelines version 2 May 2016. The scientific rationale and evidence base for the recommendations on this card is explained in more detail at www.anzca.edu.au and www.anzaag.com © Copyright 2016 – Australian and New Zealand College of Anaesthetists, Australian and New Zealand Anaesthetic Allergy Group. All rights reserved.

Anaphylaxis during Anaesthesia

Refractory Management

Paediatric 0-12

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Request advice/help	• Contact local/regional paediatric service • Consider calling arrest code
Triggers removed?	• **Chlorhexidine** including impregnated CVCs • **Synthetic Colloid** disconnect and remove • Latex remove from OR
Monitoring	• Consider **Arterial line** • Consider TOE/TTE
Resistant Hypotension • Continue Adrenaline Infusion • Additional I.V. fluid bolus 20 - 40 mL/kg • Add second vasopressor • Consider CVC	Paediatric Recommendations **Noradrenaline infusion 0.1 - 2 mcg/kg/min** 0.15 mg/kg in 50 mL run at 2 - 40 mL/hr and/or **Vasopressin infusion 0.02 - 0.06 units/kg/hr** 1 unit/kg in 50 mL 2 mL bolus then 1 - 3 mL/hr **Glucagon 40 mcg/kg I.V. to max 1mg**
Resistant Bronchospasm • Continue Adrenaline Infusion • Consider: - Airway device malfunction - Circuit malfunction - Tension pneumothorax (decompress) • Add alternative bronchodilators	Paediatric Recommendations **Salbutamol** • **Metered Dose Inhaler (100 mcg/puff)** 6 puffs < 6 years, 12 puffs > 6 years • **I.V. Infusion** as per local paediatric protocol **Magnesium sulfate 50% (500 mg/mL)** 50 mg/kg to max 2 g over 20 minutes (0.1 mL/kg 50% solution= 50 mg/kg) **Aminophylline** 10 mg/kg over 1 hour (max 500 mg) **Hydrocortisone** 2 - 4 mg/kg (max 200 mg)
Consider other diagnoses	See **'Differential Diagnosis Card'** in Anaphylaxis Box

Once stable refer to 'Post Crisis Management'

Appendix 4 ANZAAG-ANZCA Perioperative Anaphylaxis Management Guidelines version 2 May 2016. The scientific rationale and evidence base for the recommendations on this card is explained in more detail at www.anzca.edu.au and www.anzaag.com © Copyright 2016 – Australian and New Zealand College of Anaesthetists, Australian and New Zealand Anaesthetic Allergy Group. All rights reserved.

Anaphylaxis during Anaesthesia

Differential Diagnosis Card

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Possible Causes & Actions

Cardiac Arrest	• Hypoxia • Hypovolaemia • Hypo/hyperkalaemia/metabolic disorders • Hypo/hyperthermia • Tension pneumothorax (Decompress) • Tamponade • Toxins • Thrombosis: pulmonary or coronary
High Airway Pressure/ Airway Compromise	Dyspnoea, wheeze, stridor, difficulty inflating lungs • Circuit malfunction → Check using Self Inflating Bag • Misplaced/kinked Airway device → Check with suction catheter/Consider changing device • Tension pneumothorax → Decompress • Exacerbation of Asthma → Treat as per Refractory Management • Foreign Body → Consider bronchoscopy • Acid aspiration → Consider bronchoscopy
Hypotension	• Hypovolaemia • Sepsis • Drug overdose • Vasodilation by drugs • Neuraxial blockade • Embolism: Thrombotic, Air or Amniotic • Vasovagal
Skin and Mucosa Hives, flushing, erythema, urticaria, swelling head and neck or peripheries	• Direct Histamine Release • Venous obstruction • Head down position • C1-esterase deficiency (Angioedema only) • Mastocytosis • Cold induced anaphylaxis

Absence of tachycardia or cutaneous signs does not exclude anaphylaxis
Anaphylaxis is usually rapid in onset but is occasionally delayed

Mild (Grade 1)	Generalised mucocutaneous signs: Erythema, Urticaria +/- Angioedema
Moderate (Grade 2)	Moderate – Multi-organ manifestation may include: • Hypotension, tachycardia • Evidence of bronchospasm, cough, difficult ventilation • Mucocutaneous signs
Life Threatening (Grade 3)	Life Threatening and requiring immediate and specific treatment: • Severe hypotension • Bradycardia or tachycardia, arrhythmias • Severe bronchospasm, and/or airway oedema • Cutaneous signs may be absent, or present only after correction of hypotension
Arrest (Grade 4)	Cardiopulmonary Arrest

Appendix 5 ANZAAG-ANZCA Perioperative Anaphylaxis Management Guidelines version 2 May 2016. The scientific rationale and evidence base for the recommendations on this card is explained in more detail at www.anzca.edu.au and www.anzaag.com © Copyright 2016 – Australian and New Zealand College of Anaesthetists, Australian and New Zealand Anaesthetic Allergy Group. All rights reserved.

Anaphylaxis during Anaesthesia

Post Crisis Management

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Once Situation is Stabilised

Consider Steroids	**Dexamethasone** 0.1 - 0.4 mg/kg (Paediatric maximum 12 mg) **Hydrocortisone** 2 - 4 mg/kg (Paediatric maximum 200 mg)
Consider ORAL Antihistamines	Consider Oral non-sedating Antihistamines when patient able to take oral medications
I.V./I.M. Antihistamines	NOT RECOMMENDED

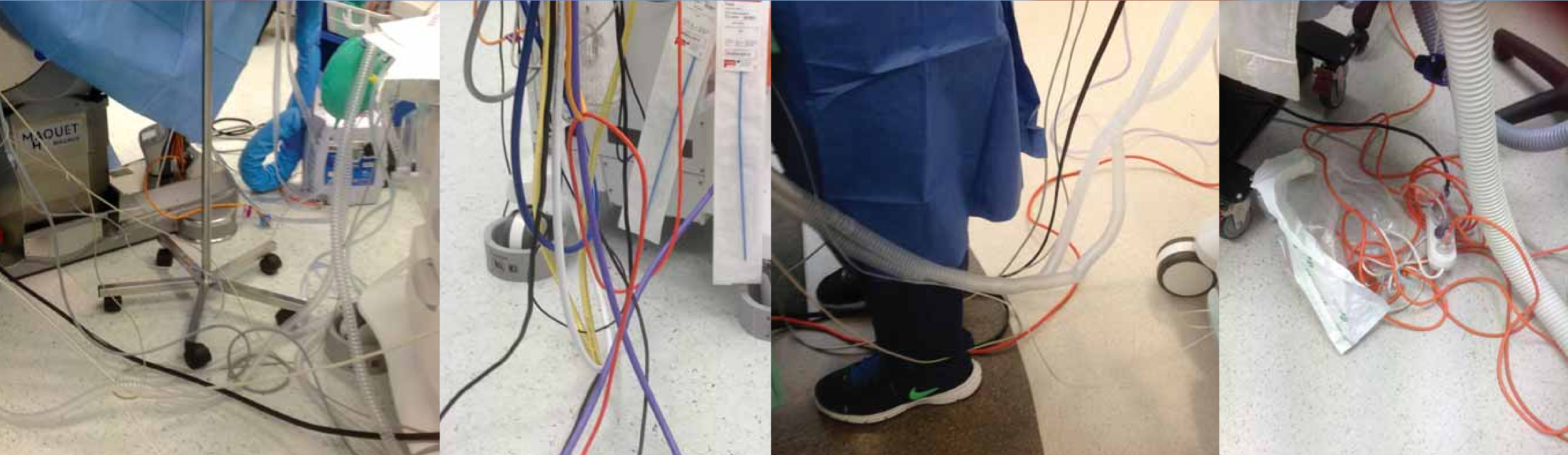
Consider: Proceed/Cancel/Postpone Surgery
Postoperative ICU/HDU monitoring

Investigations	• Tryptase at 1 hour, 4 hours and > 24 hours Send to laboratory for processing ASAP If >1 hour to laboratory then refrigerate Use serum (SST) or plain tube • Other investigations as clinically indicated • Coagulation screen if proceeding with surgery
Observations	• Monitor closely for 6 hours • Consider 24 hours ICU/HDU if moderate to severe • Anaphylaxis may persist for >24 hours despite aggressive treatment

Letter with Patient: Reaction Description + Agents Used
Refer Patient for Testing and Allergy Assessment
For referral form & to locate nearest testing centre go to www.anzaag.com

Appendix 6 ANZAAG-ANZCA Perioperative Anaphylaxis Management Guidelines version 2 May 2016. The scientific rationale and evidence base for the recommendations on this card is explained in more detail at www.anzca.edu.au and www.anzaag.com © Copyright 2016 – Australian and New Zealand College of Anaesthetists, Australian and New Zealand Anaesthetic Allergy Group. All rights reserved.

Our operating rooms: A safe place for patients but not always for staff



A series of common scenes from a representative sample of operating rooms, in both public and private facilities, in Melbourne.

Opposite page from left: An untidy collection of necessary anaesthetic equipment. No fixture available to secure the breathing circuit off the floor. Not the cleanest place to have equipment; Equipment on the floor needing to be negotiated by staff. A potential trip and fall hazard; Anaesthetic equipment potentially creating a trip and fall hazard; An electrical junction box sited under an operating table at risk of liquid spill and operating four appliances. A potential for circuit overload and the loss of function of the four appliances attached.

It has become apparent we have overlooked some safety aspects of the equipment we use daily in many of our operating rooms.

The size and amount of equipment required to administer modern anaesthesia and complete surgical procedures is staggering when compared with 30 years ago.

Moving around the operating theatre and our patients in the presence of all this equipment, cluttered tubing and electrical cabling can present hazards to staff. Even our patients may be at risk if circuits are inadvertently disconnected or staff need to be replaced due to injury.

Colleagues and staff comment on hazards within the operating theatre. Such statements as, "when will telemetry be introduced?" are often repeated. This is not unreasonable; telemetry was available in coronary care units decades ago.

Manufacturers of anaesthesia machines seem to ignore the need to provide a means to appropriately manage equipment emanating from them.

It is a moral and legal requirement for employers to provide as safe a working environment as possible for staff in any workplace. Our operating rooms are no exception. In Victoria, this requirement is enshrined in the *Victorian Occupational Health and Safety Act 2004*.

The manner in which trip and fall hazards and electrical safety are managed in many of our operating theatres would no longer be regarded as best practice by experts in work safety (personal communication).

The problem

Staff might presume the operating room environment will be a safe work environment, but unfortunately best practice is not always adopted. Operating staff also might expect that occupational health and safety (OH&S) issues in the operating room are resolved as part of regular hospital accreditation processes. This is unlikely to be the case. While accreditation standards do include reference to OH&S aspects of operating rooms, electrical hazards or trip and fall hazards are rarely – if ever – assessed in public or private hospitals using National Safety and Quality Health Service (NSQHS) Standards[1] or International Organisation for Standardisation (ISO) Standards[2], respectively.

Common OH&S problems generally fall into two categories: electrical hazard, and trip and fall hazards. How often do we see electrical cables traversing our paths or junction boxes with an inadequate international protection (IP)[3] rating for the task or with an inappropriate number of electrical devices attached creating a potential short-circuit hazard?

What about all the equipment emanating from the anaesthesia machine, much of which crosses to the patient across the floor? Many owners and operators of operating theatres seem unaware of safety codes applicable to these facilities and are unlikely to act unless found in breach of the law.

Must we wait until a serious injury occurs before implementing change?

The solution

So what can be done to improve safety in our operating rooms?

The first step is for the owners and operators of our operating rooms to facilitate regular risk and safety audits and reviews of functioning operating rooms. This will enable the problems to be defined. Only then can solutions be developed. Currently these reviews do not appear to be happening.

In addition to the inclusion of anaesthetist advice in future operating theatre design, the following measures may be helpful:

- The addition of up to two pendants per operating room.
- The number of power outlets to be commensurate with the number of anticipated devices to avoid junction boxes.
- Simple fixtures attached to the anaesthesia machine (as already exist) should be used where available to tidy up the anaesthesia end!
- A proactive attitude by anaesthetists. Just lifting cables and tubes off the floor can be helpful.

Long-term improvements will require a multidisciplinary approach with all interested parties involved, once the issues have been defined.

Summary

It is time to rethink the way equipment essential for the care of the surgical patient is managed in the modern operating room.

The problems are not insurmountable. Improvements can be made after implementing regular reviews of current practices, the application of good industrial design and a focus on workplace best practice.

Did we not put a man on the moon in 1969? Hopefully interested parties will take the problems seriously and initiate the process for achieving better operating room safety for all participants.

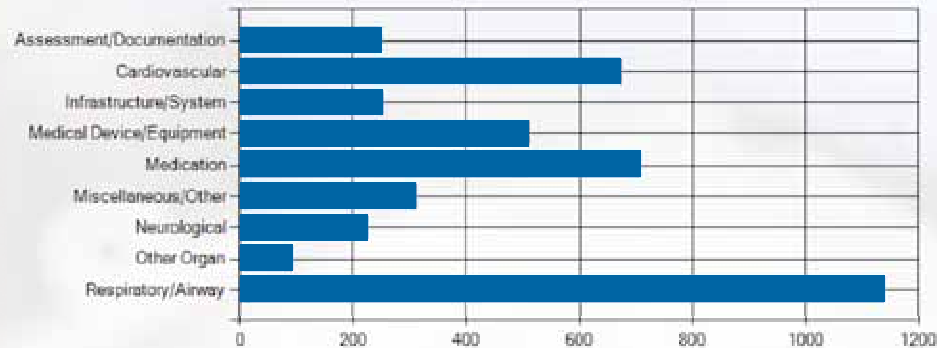
Dr Grant Brace, FANZCA
Albert Street Anaesthetic Group, Victoria
ANZCA Perioperative Medicine Working Group

References:

1. NSQHS Standard 10, Preventing Falls and Harm from Falls.
2. ISO 9001: 2008 (E), 6.3 Infrastructure and 6.4 Work Environment.
3. International Protection Code (IEC – International Electrotechnical Commission standard 60529). A code that classifies and rates the degree of protection against intrusion of body parts, dust, accidental contact and liquids.

webAIRS news

Analyse Incidents (from 2009 onwards)



Since its inception, webAIRS has collected 4179 critical events and registered 123 sites across Australia and New Zealand. A recent enhancement to webAIRS is the "Analyse incidents" page. Currently undergoing Beta testing, this feature allows local administrators and webAIRS analysers to review local incidents, create charts for morbidity and mortality meetings (similar to the diagram above) and compare local results with bi-national data. The page is undergoing continuous improvement and feedback from users is encouraged. As is the case with all webAIRS reports, all data on the "Analyse incidents" page remains de-identified.

The webAIRS homepage has been updated and now features dynamic registered sites and incident report statistics. The news section details upcoming presentations and workshops, the next of which is at the 2016 Australian Society of Anaesthetists National Scientific Congress, Melbourne. As well as two workshops, a webAIRS session entitled "Error reduction strategies" will feature on Tuesday, September 20. Continuing professional development program credits (in the practice evaluation category) are awarded for participation in workshops just as they are for each report made in webAIRS.

Presentations of webAIRS data will feature at the annual scientific meetings of ANZCA, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists. Most recently, a presentation at the 2016 ANZCA ASM included interim analysis relating to malignant hyperthermia and to hypertension. The recently formed webAIRS publication group will undertake further analysis of these themes. The March 2016 edition of *Anaesthesia and Intensive Care* features the first publication of a peer-reviewed article using webAIRS data.

Did you know that webAIRS allows you to submit incident reports as an individual? It is optional to link to a registered site – or register a new site – and at the conclusion of data input, the system will ask if you wish to forward the reported incident to an organisation or simply submit it anonymously. Each and every report in webAIRS earns you continuing professional development points and is making a valuable contribution to this important service improvement initiative.

For more information, please contact: Dr Martin Culwick or administration support via **anztadc@anzca.edu.au**. To register visit **www.anztadc.net** and click on the registration link at the top right hand side of the page. A demonstartion can be viewed at **www.anztadc.net/Demo/IncidentTabbed.aspx**

Safety alerts

Changes to adrenaline autoinjector labels

During 2016, adrenaline medicine labels will start to show "adrenaline (epinephrine)" as the ingredient name. It is important to remember it is only the label of the autoinjector that will change to include this new information. The ingredients, including dose amounts, will stay the same. In different countries, different names are used to describe the same ingredient. In Australia, adrenaline is the approved name of the ingredient in autoinjector devices used for the emergency treatment of anaphylaxis. Currently, the only available autoinjector to treat anaphyla xis in Australia is supplied under the brand name EpiPen®.

Using different names for the same ingredient can be confusing for Australians travelling overseas, visitors to Australia, and health professionals trained internationally. Including both adrenaline and epinephrine on Australian medicines should help make it clear that these are the same ingredient. Both names also will be used in the accompanying consumer medicine leaflet inside the packaging. More information about changes to adrenaline labels is also available on the Therapeutic Goods Administration (TGA) website www.tga.gov.au/changes-adrenaline-and-noradrenaline-labels.

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:

- Urgent product recall – Ondansetron 4mg (10) and 8mg (10) Dr Reddys®.
- Epipen 300 Microgram Adrenaline Injection Syringe Auto Injectors.
- Reduced vacuum for optional suction on certain Aisys of Anaesthetic Devices.
- Draeger Primus machines.
- Particles in propofol.
- Recall: Children's Panadol 5-12 years suspension 200 mL bottle.
- Medtronic RestoreSensor implantable neurostimulators.
- Urgent Recall: Dräger D-Vapor and D-Vapor 3000 with Baxter Desflurane Agent and Bottles.
- Phenylephrine - lack of haemodynamic effect.
- Marcain Spinal 0.5% Heavy and reports of failed or incomplete spinal anaesthesia.

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

Dr Mary Burnell: A remarkable life

It is 50 years since Dr Mary Burnell became the first dean of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons.

Mary Taylor Angel was born in Norwood, South Australia, on February 21, 1907. She was educated at St Peter's Collegiate Girls School for both primary and secondary schooling. Having completed school at age 16, she found herself, in her own words, "quite without ambition"[1] and in 1924 enrolled in an arts degree at the University of Adelaide. The following year she transferred to science, which she studied for two years, and in 1927 transferred to medicine, from which she graduated, MBBS, in 1931. Her younger sister, Laura Angel, had also enrolled in a science degree and they graduated together.

In 1932, Dr Mary Angel was a resident medical officer at Adelaide Children's Hospital and by 1934 had been appointed honorary anaesthetist[2]. Her relationship with the hospital continued in this capacity until 1965, when she took up the position of honorary consulting anaesthetist, later renamed emeritus anaesthetist.

It also was in 1934 Burnell became involved with the Australian Society of Anaesthetists (ASA), becoming a founding member of the society, as well as the first female member. A year later, in 1935, she worked as secretary for the South Australian section of the society. Burnell also joined the British Medical Association in 1932 and was awarded honorary life membership in 1982 after 50 years of membership.

Also in 1934, Mary married a surgeon, Glen Howard Burnell. Together they had three children and Mary Burnell stepped aside from her public anaesthesia practice in 1937 to devote time to their growing family. However, she was able to continue private practice working with her husband as they scheduled operations around domestic commitments.

She returned to public practice in 1942 when hospital staff and resources had been drained by the demands of World War II, causing many women to be called back into public service. At this time Burnell was honorary anaesthetist at both the Royal Adelaide Hospital and Adelaide Children's Hospital. In a brief, unpublished memoir, she recounted having to "learn the specialist pediatric (sic) techniques the hard way, as there was no one who knew any more to teach me"[3]. She became aware of the great differences between administering anaesthesia to children and to adults and, as the only visiting anaesthetist there for a number of years, performed "all the difficult anaesthetics"[4]. As a result, Burnell went on to make significant contributions to paediatric anaesthesia.

Burnell continued to contribute to the ASA throughout the 1940s and, in 1953, was elected president[5]. She was the first female to hold this position. A year earlier, the Faculty of Anaesthetists at the Royal Australasian College of Surgeons was established, with Burnell as a foundation Fellow. Burnell reflected on her involvement with the foundation of the Faculty, downplaying any direct contribution: "Another source of pride to me is the fact that I was able to arrange in my own drawing room the meeting between Dr Harry Daly and Mr (later Sir) Ivan Jose (president of the College of Surgeons) which led very quickly and smoothly to the foundation of the Faculty of Anaesthetists in the Royal Australasian College of Surgeons[6]."

Burnell believed strongly in collaborative practice and knowledge sharing. In 1953 she invited Dr Bernard Johnson from England to speak at the annual meeting of the society in Adelaide[7]. This began a tradition of inviting overseas speakers which continues today.

Burnell was elected to the board of the Faculty of Anaesthetists in 1955, and the board minutes of June 18, 1966 record her official appointment as dean. She was the first woman in Australia to hold such an appointment and one of the first in the world.

Appointments and accolades continued throughout her career, testament to her dedication and expertise.

In 1968, her determination to create and foster international collaborative relationships saw her recognised with election to the fellowship of the Faculty of Anaesthetists, Royal College of Surgeons[8]. In 1973, she was further recognised with honorary life membership of the Australian faculty[9].

In 1977, she was awarded a Silver Jubilee Medal, presented by Queen Elizabeth in a ceremony held at Buckingham Palace[10], and in 1995, the inaugural Mary Burnell Lecture was given at the annual scientific meeting in Townsville, Queensland, by Dr John Sear from the UK[11].

Outside of anaesthetics, Burnell was a member of the committee of Mothers' and Babies' Health Association of South Australia and the South Australian Medical Women's Society[12]. She was an avid reader and highly knowledgeable about wines. Her love of good wine gained her the distinction of being a *Chevalier du Tastevins*, a rare honour for a woman of her time[13]. She had a passion for history and sponsored the appointment of a female historian, Gwen Wilson, to the staff of the faculty.

Dr Mary Taylor Burnell is remembered as a forthright and generous woman in both her personal and professional life.

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.

References:

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2. Robert E. Steele, 'Australian Society of Anaesthetists', Letter, 6th August 1982, ANZCA Archives, Series 11
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4. ibid.
5. Australian Society of Anaesthetists, 'ASA Presidents', 2015, Online: https://www.asa.org.au/ASA/About_us/History_of_the_Society/Past_Presidents/Past_Presidents.aspx.
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9. John Loewenthal, 'Royal Australasian College of Surgeons', Letter, 24th May 1973, ANZCA Archives, Series 11
10. Buckingham Palace, 'By Command of Her Majesty the Queen the Accompanying Medal is Forwarded to Dr. Mary Taylor Burnell', Certificate and Invitation, 7th June 1977, ANZCA Archives, Series 11
11. ANZCA, 'Mary Burnell Lectures', 2011, ANZCA Archives, Series 11
12. Anne Prior, 'Mary Taylor Burnell', Funeral Speech, Enfield: South Australia, 28 August 1996, ANZCA Archives, Series 11
13. ibid.

Above from left: Official portrait of Dr Mary Burnell, Dean Faculty of Anaesthetists, Royal Australasian College of Surgeons, 1966; Dr Burnell being presented with Honorary Fellowship, Faculty of Anaesthetists, Royal College of Surgeons, 1973; University of Adelaide graduation program, 1931; Invitation to Silver Jubilee celebration, 1977.

Women leaders in anaesthesia: Past presidents and deans

Mary Burnell

Dean of the Faculty of Anaesthetists
1966 – 1967

MBBS, FFARACS

Mary Burnell was a key figure in the establishment of the Faculty of Anaesthetists, Royal Australasian College of Surgeons. Her dedication to the practice was recognised through an array of awards and leadership positions. Burnell served as President of the Australian Society of Anaesthetists and Dean of the Faculty of Anaesthetists. Through her commitment to fostering overseas connections, Burnell was awarded a fellowship of the Faculty of Anaesthetists, Royal College of Surgeons, honorary fellowship to the Faculty of Anaesthetists at RACS, honorary fellowship to RACS, life membership of the ASA and member of the Court of Honour, RACS.

Teresa (Tess) Cramond

Dean of the Faculty of Anaesthetists
1972 – 1974

MBBS, DA RCP

Tess Cramond was the first woman president of the Queensland branch of the Australian Medical Association, dean of the Faculty of Anaesthetists at the Royal Australasian College of Surgeons (RACS), and was also the first woman councillor there. She was the first Queenslander to be enrolled in the Court of Honour of RACS, and the first woman appointed a colonel in the Defence Health Service. In 1978, Cramond was appointed professor of anaesthetics at the University of Queensland, and went on to specialise in pain control and palliative care. She was awarded an Order of the British Empire, Dame of Magistral Grace in the Sovereign Military Order of St John, Fellow of the Australian Medical Association, Officer of the Order of Australia and the Women in Medicine Award, among other national and local awards.

Leona Wilson

President, 2008 – 2010

BMedSci, MB ChB, FFARCS, FFARCS, FFANZCA, MPH, FAICD

Leona Wilson was the first woman and the first New Zealander to hold the ANZCA presidency. She was involved with the formation of the Perioperative Mortality Review Commission in 2010, and was a member of earlier committees that changed the NZ Crimes Amendment Act of 1997. During her time as president, Wilson skilfully negotiated the College through the departure of the Joint Faculty of Intensive Care Medicine. Wilson was key in the development of the Emergency Management of Anaesthetic Crises course, alongside other important curriculum redevelopments. Wilson was appointed an Officer of the New Zealand Order of Merit in 2010, and received the Robert Orton Medal in 2013.

Kate Leslie

President, 2010 – 2012

MBBS, FANZCA, MD, M EPI, FAICD, FAHMS

Kate Leslie began her presidency with a vison of engagement. She endeavoured to create networks to ensure the continuity of a healthcare system that would serve effectively in the future. Leslie received the Robert Orton Medal and the Women in Medicine Award from the Australian Medical Association in 2014. More recently she was appointed an Officer of the Order of Australia. She has published extensively and is known for her involvement in research around patient awareness during anaesthesia. Leslie is currently pursing research into large multi-centre trials in anaesthesia and perioperative medicine as head of research at the Royal Melbourne Hospital's Department of Anaesthesia and Pain Management.

Lindy Roberts

President, 2012 – 2014

BMedSci (Hons), MBBS (Hons), FANZCA, FFPMANZCA, FAICD, GradCertClinEd

Lindy Roberts is a dual qualified specialist anaesthetist and specialist pain medication physician. During her term as president she encouraged the understanding of concerns voiced by both Fellows and trainees, and attempted to provide answers to their questions. This quality saw her strengthen and clarify the relationship between ANZCA and the Board of the Faculty of Pain Medication. Roberts also was involved with curriculum and policy development as an ANZCA assessor and as chair of the ANZCA Education and Training Committee. Outside of her medical practice, Roberts has a particular interest in classic Hollywood and film noir. She plays the clarinet for a number of concert bands and orchestras.

Genevieve Goulding

President, 2014 – 2016

MBBS, FFARACS, FANZCA, FAICD, FCAI

Genevieve Goulding is a foundation member and former chair of the Welfare of Anaesthetists Special Interest Group (ANZCA). Her interest in this field is ongoing, with a particular emphasis on the areas of impairment, competency assessment and substance misuse. This interest carried through to her presidency, during which time Goulding initiated a Royal Australian and New Zealand College of Psychiatrists/ANZCA working group to develop evidence-based clinical guidelines for management of propofol misuse in anaesthetists and, in 2015, participated in the National Australian Medical Association/Beyond Blue Roundtable Advisory Group.

Burnell fountain restoration

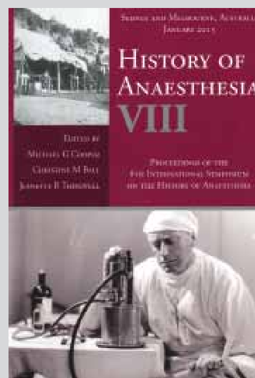
In 1993, Dr Mary Burnell presented the newly formed Australia and New Zealand College of Anaesthetists with the working maquette of a large fountain she presented to RACS in 1971. The large fountain came to be dubbed "Forest Landscape" and was commissioned in memory of her late husband Dr Glen Howard Burnell.

A maquette is a model produced by a sculptor to help them visualise their ideas and determine both scale and form. In this case the sculptor was Stephen Walker, one of Australia's premier large-scale bronze artists of the time.

While bronze is a sturdy material, it also requires some attention to keep it looking its best. Over the years the piping had broken down, along with the fountain mechanism and the plinth had mysteriously disappeared. In early 2016 the maquette was sent to Millennium Art Services for a buff and polish, and to have its various parts serviced and restored.

In March it was returned to ANZCA in full working order. Now cleaned and polished, it has retained its patina and will continue to develop the rich, warm colourings of bronze patination for years to come. The working fountain augments the stunning gardens at ANZCA House and provides a touchstone to the values of improvement and innovation Dr Burnell held during her life and which were instrumental in the formation of both the Faculty and the College.

History of Anaesthesia VIII



In 2013, the 8th International Symposium on the History of Anaesthesia was held in Sydney, with a satellite meeting in Melbourne. More than 100 people from around the world presented on areas of historical interest within the practice of anaesthesia and pain medicine.

The proceedings from the meeting were published in April 2016 and are now available for purchase.

It is a weighty tome, covering a range of interest areas, including: "Biological and chemical warfare: An historical perspective" by DR Bacon; "How Joseph Banks was the impetus to materia medica, including drugs of anaesthetic importance" by AG McKenzie; "Anaesthesiologists and the development of pain medicine" by MJ Cousin and DB Carr; and "No experience required: a historical look at the teaching of anaesthesia in Victorian Britain" by the honorary curator of the Geoffrey Kaye Museum of Anaesthetic History, Christine Ball.

With 106 papers to choose from, there is sure to be a topic of interest to everyone.

The book can be purchased online via the Australian Society of Anaesthetists' website.

The 9th International Symposium on the History of Anaesthesia will be held in Boston, Massachusetts from October 24-28, 2017. For more information check the website of the American Society of Anesthesiologists.

Training anaesthesia assistants

The Australian College of Peri-Anaesthesia Nurses will offer a clinical fellowship program for anaesthesia and recovery when it launches in July.

Help, I need somebody
Help, not just anybody
Help, you know I need someone
Help!
– The Beatles

It is well recognised that specialists require help to administer safe anaesthesia[1] and that anaesthesia is safer when two trained practitioners are present at induction and emergence of anaesthesia[2]. Recently, the ANZCA professional document *PS8 Statement on the Assistant for the Anaesthetist* (pilot)[3] has been revised and recommends core competencies that should be covered in curricula used to train anaesthetic assistants.

Across Australia and New Zealand there is considerable variation in the training undertaken by health professionals who fulfil the assistant's role. Three groups of professionals, registered nurses (RNs), enrolled nurses (ENs) and anaesthetic technicians, usually assist the anaesthetist. In New Zealand, technicians are more commonly the assistant, while in Australia registered nurses are more commonly in this role.

Currently, education for assistants depends on anaesthetic departments providing their own training and, in many cases this has been of very high standard, backed up by courses in anaesthetics and recovery (nursing), or diploma of paramedical science (anaesthesia) and some specific TAFE courses. In many cases, current courses do not satisfy the requirements of the revised *PS8*.

The Australian College of Peri-Anaesthesia Nurses (ACPAN, formerly ASPAAN) is launching nationally in Australia in July and will offer a clinical fellowship program for anaesthesia and recovery in collaboration with the University of Tasmania.

This program will satisfy the requirements of *PS8* and will involve basic life support, advanced life support and anaesthesia crisis training. The university will provide online material and anaesthetic departments will provide local supervision of clinical experience and training.

Assessments will be done by ACPAN in the form of written and viva examinations. The University of Tasmania will assess recognition of prior learning to give registered nurses who are currently in the role an opportunity to gain a postgraduate certificate.

The Australian Anaesthesia Allied Health Practitioners (AAAHP, formerly ASAPO) represents anaesthetic technicians nationally in Australia and are ensuring their education for technicians satisfies the standard of *PS8*. The diploma of paramedical sciences (anaesthesia) is not offered in NSW. Another issue is that whereas registered nurses and enrolled nurses are registered with the Australian Health Practitioners Regulatory Authority (AHPRA), technicians are not.

"The standard of education of assistants is very varied across Australia and is largely delivered locally."

The Anaesthetics Assistants Working Group at the Agency for Clinical Innovation (ACI) has been working on the issues surrounding the provision of a suitably trained assistant to the anaesthetist for the past six years. It has collaborated with the equivalent organisation in Queensland, StateWide Anaesthesia and Peri-operative NETwork (SWAPNET) and contributed to the revision of *PS8* in 2014.

The role of ACI's clinical networks is to work with clinicians, consumers and managers to design evidence-based models of care and assist with their implementation in NSW health services. On this issue there has been considerable collaboration with other health groups including the NSW Ministry of Health, the NSW Health Education and Training Institute (HETI), ACORN, ASAPO and ASPAAN.

With so many interested groups, it has been difficult to gain acceptance of a single approach, but the ANZCA guideline has been useful in summarising the educational issues. The recent leadership from ACSPAN and ACORN, in collaboration with University of Tasmania, to put a national focus on nursing education for the assistant to the anaesthetist is a promising development and similar national organisation from AAAHP will hopefully do the same for educational standards for anaesthetic technicians.

Once the educational standards of both groups have satisfied PS8, it is envisaged there should be no barrier to blended departments of registered nurses, enrolled nurses and technicians. At this stage, technicians are not allowed to handle or check S8 drugs in every state and they do not work in recovery units. The plan at present is to educate assistants to the anaesthetist in two separate educational streams, one for registered nurses and one for technicians. Enrolled nurses will probably convert to registered nurses or train via the technician pathway.

The standard of education of assistants is very varied across Australia and is largely delivered locally. In many cases, the standard is quite high, especially in larger anaesthesia departments, however smaller institutions and rural locations may not be as well resourced to provide onsite training. Standardised courses and training should deliver higher standards of education and a better trained workforce. This in turn should result in greater safety for patients having anaesthesia in Australia.

The ACI has a role in implementing new models of care in order to support standardisation of practice across the system.

Proper educational pathways must be established for all assistants to the anaesthetist. Organisation of training for our assistants – whether registered nurses, enrolled nurses or technicians – on a national level should be an achievable goal.

Dr Michael Amos
Chair of Anaesthesia and Perioperative Network,
Agency of Clinical Innovation

References:
1. Kluger, M T; Bukofzer, M; Bullock, M. Anaesthetic assistants: Their role in the development and resolution of anaesthetic incidents. Anaesthesia and Intensive Care 27.3 (Jun 1999): 269-74.
2. Weller J, Merry A, Robinson B, Warman G, Janssen A. The impact of trained assistance on error rates in anaesthesia: a simulation-based randomized controlled trial. Anaesthesia 2008; 64: 126-130.
3. www.anzca.edu.au/resources/professional-documents/pdfs/ps08-2015-statement-on-the-assistant-for-the-anaesthetist.pdf

"Proper educational pathways must be established for all assistants to the anaesthetist. Organisation of training for our assistants – whether registered nurses, enrolled nurses or technicians – on a national level should be an achievable goal."

What is the Agency for Clinical Innovation?

The Agency for Clinical Innovation (ACI) works with clinicians, consumers and managers to design and promote better healthcare for NSW. This includes:

- Service redesign and evaluation.
- Specialist advice on healthcare innovation.
- Initiatives including guidelines and models of care.
- Implementation support.
- Knowledge sharing.
- Continuous capability building.

The ACI's Anaesthesia Perioperative Care Network was established to improve patient care by addressing and promoting practice improvement across a multidisciplinary network. Since its establishment, the network has worked with clinicians, consumers and managers to identify priority areas for NSW anaesthetic services.

Current priorities include:

- Implementation of the Minimum Standards for Safe Procedural Sedation.
- Supporting education strategies for assistants to the anaesthetist.
- Development of the Perioperative Toolkit.

The network also is working with the ACI's Surgical Services Taskforce to support the implementation of the Operating Theatre Efficiency Guidelines.

More information on the ACI and the Anaesthesia Perioperative Care Network can be found at www.aci.health.nsw.gov.au/networks/anaesthesia-perioperative-care.

New in the library

Read QxMD app on trial to keep up-to-date on your specialist topic

The ANZCA Library is trialling the Read by QxMD app until the end of 2016. ANZCA and FPM Fellows and trainees can keep up-to-date on their specialist topic and favourite journals through access to the ANZCA Library resources. Simply select ANZCA from the list of institutions under the Settings section of the app.

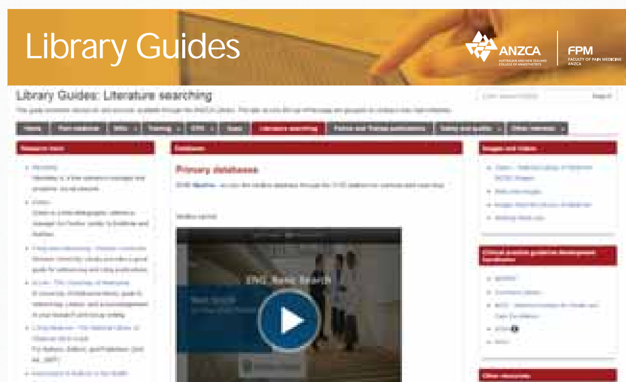
Read by QxMD provides a single place to discover new research, read outstanding topic reviews and search PubMed. It provides a simple interface that drives discovery and seamless access to the medical literature by reformatting it into a personalised digital medical journal.

Read by QXMD is available on Google Play and the app store: www.qxmd.com/apps/read-by-qxmd-app.

The library encourages your feedback during this trial via library@anzca.edu.au.

For more information about Read by QxMD and other apps available through the ANZCA Library, visit the Apps library guide: http://libguides.anzca.edu.au/library/apps.

Spotlight on: Library guide for literature searching



The Literature Search Library Guide provides information and video tutorials to assist you in searching databases for materials in an efficient and effective manner. Useful links to research tools, books and articles on searching will enable you to retrieve only the most relevant materials. Resources available to help you get started include:

- Learn how to use the primary databases, such as Medline, PubMed, TRIP, AusDI and ERIC.
- Research tools, such as Mendeley, Zotero and Citing Medicine.
- Clinical practice guideline development handbooks.
- Recommended books on evidence-based medicine.
- Articles on literature searching.
- Information on clinical queries limits in Medline.

Access the library guide here: http://libguides.anzca.edu.au/library/litsearch

ANZCA Library comes to New Zealand

In the lead-up to the annual scientific meeting (ASM) in Auckland, Fellows from around Australia and New Zealand took advantage of a hands-on workshop about using the ANZCA Library for research. Participants had a range of experience from “new to the library” to “PhD researcher”, as well as varying specialty interests, so it was a great opportunity to learn library tips and tricks. Library staff also were on hand at the ANZCA stand during the ASM to provide information about services and resources for the Fellows and trainees. Oxford University Press joined in on Sunday to promote the *British Journal of Anaesthesia and BJA Education*, with syringe-shaped highlighters proving very popular with attendees. If you missed visiting the library during the ASM, don’t forget library services are available online anywhere 24/7!

New books for loan

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

History of anaesthesia VIII
Proceedings of the 8th International Symposium on the History of Anaesthesia / Cooper M.G. [ed]; Ball, C.M. [ed]; Thirlwell, J.R. [ed]. 2016.
Kindly donated by the editors.

Stereopharmacological research in anaesthesiology
A thesis based on selected published works submitted in the fulfilment of the requirements for the degree of Doctor of Medical Science of Sydney Medical School, The University of Sydney /Mather, Laurence E. -- Sydney, Australia: University of Sydney; Sydney Medical School, 2015.
Kindly donated by the author.

Understanding ultrasound physics
Edelman, Sidney K. -- 4th ed -- Woodlands, Texas: ESP, 2012.

Contact the ANZCA Library
www.anzca.edu.au/resources/library
Phone: +61 3 9093 4967
Fax: +61 3 8517 5381
Email: library@anzca.edu.au

New eBooks

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

Anesthesiology core review
Part 2, advanced exam / Freeman, Brian S [ed]; Berger, Jeffrey S [ed]. -- New York: McGraw-Hill Medical, 2016.

Anesthesia secrets
Duke, James [ed]; Keech, Brian M [ed]. -- 5th ed -- Philadelphia, PA: Elsevier, 2016.

Anesthesia student survival guide: a case-based approach
Ehrenfeld, Jesse M [ed]; Urman, Richard D [ed]; Segal, Scott [ed]. -- New York: Springer, 2016.

Guyton and Hall textbook of medical physiology
Hall, John E. -- Philadelphia, PA: Elsevier, 2016.

Oxford handbook of anaesthesia
Allman, Keith [ed]; Wilson, Iain [ed]; O'Donnell, Aidan [ed]. -- 4th ed -- Oxford, UK: Oxford University Press, 2016.

Oxford textbook of paediatric pain
McGrath, Patrick J [ed]; Stevens, Bonnie J [ed]; Walker, Suellen M [ed]; Zempsky, William T [ed]. -- Oxford, UK: Oxford University Press, 2013.

Pain management secrets
Argoff, Charles E [ed]; McCleane, Gary [ed]. -- 3rd ed -- Philadelphia, PA: Mosby/Elsevier, 2009.

Pain procedures in clinical practice
Lennard, Ted A. -- 3rd ed -- Philadelphia, PA: Elsevier, 2011.

Perioperative diagnostic and interventional ultrasound
Harmon, Dominic. -- Philadelphia, PA: Elsevier, 2008.

Perioperative medicine - current controversies
Stuart-Smith, Karen [ed]: Springer International Publishing, 2016.

Peripheral nerve blocks and peri-operative pain relief
Harmon, Dominic [ed]; Barrett, Jack [ed]; Loughnane, Frank [ed]; Finucane, Brendan [ed]; Shorten, George [ed]. -- 2nd ed -- Philadelphia, PA: Elsevier, 2011.

Pharmacological management of headaches
Mitsikostas, Dimos D [ed]; Paemeleire, Koen [ed]. –New York: Springer, 2016.

Practical issues updates in anesthesia and intensive care
Chiumello, Davide [ed]. -- New York: Springer, 2015.

Preoperative evaluation
Pulley, Debra D [ed]; Richman, Deborah C [ed]. -- Philadelphia, PA: Elsevier, 2016.

Safer healthcare: strategies for the real world
Vincent, Charles; Amalberti, René. -- New York: Springer International Publishing, 2016.

Spinal injections and peripheral nerve blocks
Huntoon, Marc [ed]; Benzon, Honorio [ed]; Nauroze, Samer [ed]; Deer, Timothy [ed]. -- Philadelphia, PA: Elsevier, 2012.

Wall and Melzack's textbook of pain
McMahon, Stephen B [ed]; Koltzenburg, Martin [ed]; Tracey, Irene [ed]; Turk, Dennis C [ed]. -- 6th ed -- Philadelphia, PA: Elsevier, 2013.

EXPLORING CLOSER TO THE EDGE

Delegates from every state and territory of Australia, and across New Zealand converged on Auckland for the 2016 ANZCA Annual Scientific Meeting held from Saturday April 30 to Wednesday May 4. They were joined by delegates from as far away as Austria, Canada, China, Germany, India, Ireland, Italy, Japan, South Korea, Malaysia, the Netherlands, Norway, Pakistan, Qatar, Saudi Arabia, Singapore, South Africa, Spain, the UK and the US.

AUCKLAND ASM 2016 – A PLEASURE HOSTING YOU!

Closer to the edge sounds like a great theme! How about making a video about walking around the Skytower and then jumping off?!

The speed of agreement and willingness to walk 300 metres above the streets of downtown Auckland attached by a scarily thin rope convinced me that our Regional Organising Committee (ROC) was going to make the 2016 ANZCA Annual Scientific Meeting (ASM) something special. A year later, after several hundreds of hours of preparation, thousands of emails and numerous trans-Tasman phone calls, the meeting became a reality.

Our team wanted to showcase not only the work of ANZCA and the Faculty of Pain Medicine and its Fellows, but also the beauty, friendliness and thrill of Auckland. True to the Kiwi spirit, we wanted to push boundaries, expose delegates to new and innovative speakers and, at times, make them feel uncomfortable. Importantly, we were aware of the significance of using new and emerging technology and encouraged presentations from various platforms, including Twitter, Facebook, FOAMed (free open access medical education), Skype and "virtual" presentations.

Our meetings had many high points. The New Fellows Conference at Waiheke Island was highly successful due to excellent invited speakers and a location that encouraged free thought and sharing of how the future of our speciality will progress. The FPM Refresher Course Day attracted not only FPM delegates but also anaesthetists who enjoyed the varied and exciting program delivered by leaders in the areas of acute and persistent pain. The launch of the fourth edition of *Acute Pain Management: Scientific Evidence* created considerable interest nationally and internationally and was widely covered in the media.

A new innovation this year was the introduction of video cameras for the College Ceremony and monitors for the stage party. It was fantastic to see those Fellows presented for their FANZCA and FPM fellowships up close and projected in the fabulous Aotea Centre main auditorium screen. The College orator, Rob Hamill, was an engaging, entertaining and thought-provoking speaker, who moved our emotions from laughter to tearfulness when discussing his personal sporting challenges, as well as the battle to get justice for his brother, who was killed by the Khmer Rouge. His journey from sportsman to politician was truly inspiring, and this was appreciated by new and older Fellows alike.

Our plenary speakers created an interesting blend of basic science, state-of-the-art clinical quality research, clinical updates and even a fascinating discourse into the rationale and validity of ethnicity as a construct. None of our speakers sat on the fence and all took the concept of presenting their thoughts to reflect the "Closer to the edge" theme.

As always at ANZCA ASMs we had fantastic support from our healthcare industry colleagues. Their involvement with breakfast sessions, industry-supported talks, as well as a hugely popular trade display, complemented our scientific program extremely well.

Our gala dinner promised so much – the decadence of the 1920s and *The Great Gatsby*. What an evening! There were dancers, a great lighting show, fantastic master of ceremonies and flowing bubbles! The dance floor was full from beginning to midnight, after which many partied into the early hours. The venue at the Viaduct Events Centre allowed our delegates to experience the 21st century excesses surrounded by multi-million dollar yachts in the vibrant heart of Auckland Harbour.

It's always a challenge to keep delegates until the end of the conference. We chose to make the closing ceremony one of our high points and to our great relief had a fantastic attendance. The closing plenary talk was delivered by Dr Michelle Dickinson or "Nanogirl", a nanotechnologist at the University of Auckland, who showed the radical and innovative ways that this technology can and will affect our speciality. The audience was enthralled by the talk, which included many examples of how nanotechnology will change our practice. These included: physiological monitors that can be printed out using your existing inkjet printer; nanobots to assist with drug delivery and diagnosis; and surface coatings that will limit the spread of infection.

If that was not enough, the final debate pitted the best of our plenary speakers to debate which country had contributed the most to the field of anaesthesia. While the chair of this session had suggested the only real winner could be Scotland, the audience favourite was Dr John Pereira, of Canada. His prize was, of course, a stuffed sheep, which we understand got through Canadian Customs and is enjoying a place in John's Calgary home!

Most Fellows are probably not aware that the vast majority of planning and running of our ASM is now undertaken by our in-house ASM and events team. We have a highly skilled, professional and talented group of individuals that would be highly sought after in the commercial sector, and we are fortunate to have them in our ASM team. Under the leadership of Jan Sharrock, they have made the ASM process seamless for both ANZCA and the ROC and their huge contribution should be recognised.

We had a ball hosting our colleagues and new friends in Auckland. Thanks to all who attended and for those left to work, have a look at the talks on the website – they are worth it!

All the best.

Associate Professor Michal Kluger
Convenor, 2016 ANZCA ASM

EXPLORING UNUSUAL CORNERS OF ANAESTHETIC KNOWLEDGE

It's a strange feeling finishing an annual scientific meeting (ASM). You spend several years crafting the program and then, quicker than you like, it's all upon you, gone by and then it all goes a bit quiet with time for reflection … well it would be, except "winter is coming", along with far too many patients at work.

First and foremost I'd like to thank Jan Sharrock and her stellar staff in ANZCA's Events team. They are the lifeblood of these meetings and have an amazing ability to herd cats. I'm very grateful for their skills (and tolerance!).

For our scientific program, in an effort to explore unusual corners of anaesthetic knowledge and give a nod to the outdoor experiences for which New Zealand is famed, we settled on a theme of "Closer to the edge". As if asking/cajoling us to take on roles in the Regional Organising Committee wasn't enough, our convenor, Michal Kluger, managed to twist a few of our arms to take a wander around the Auckland Sky Tower (but outside). Our healthcare industry liaison convenor Rachelle Lumsden still hasn't forgiven him…

The workshops and small group discussions were organised by Vincent Fong and Tim Hall, and credit should go to them for the quality of moderators for these. I think they ably balanced the mix of emergency response activities with wider interest as well as combining human interest and learning for zoo, trauma and aeromedical workshops. Hopefully that is the only time our colleagues get to slide down aircraft emergency chutes!

I believe the ANZCA ASM is primarily a forum for scientific discussion and exploring the boundaries of our discipline. As scientific co-convenors, Tim Short and I aimed to introduce us all to new areas and ideas in our specialty, to make us question what we hold as accepted canon, and I'm indebted to all those who co-ordinated various sessions around our theme. I hope the delegates found the program achieved this.

I undertook to hold up a mirror to what we do in a variety of areas and ask whether our brainstem responses (because that's what we've always done) are valid.

Why do we throw on a Hudson mask and put up fluids for every patient who lands in a hospital bed? Given that hypervoluaemia and hyperoxia are two physiological conditions protomammals and protohumans could never evolve to adapt to, are these interventions as benign as we've always accepted?

Why do we put "race" as a study data point? Dr Alan McLintic gave a very eloquent and carefully considered argument as to the invalidity of race as a surrogate for genetics and the casual way it is incorporated into medical research.

Dr Doug Campbell reported on some very interesting results of "big data" analysis, suggesting the inflexion point where post-operative mortality transitions into background "native" mortality is significantly longer out from surgery than we ever realised.

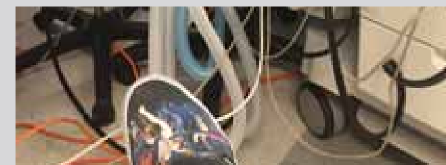
We were lucky to have had so many good speakers with an enviable international reach. Professor Carol Peden (US), Dr Cynthia Wong (US), Professor John Myburgh (Australia) and Professor Matthew Chan (HK) gave great plenary talks and I was humbled to see the amount of thought and concern they put into their talks. These plenaries served as a counterpoint to the "edgy" science.

The audit and assessment of what we do, concentrating on applying the knowledge to clinical practice, doing the simple things well and then the process of change management, is easily as important as the "gee whiz" developments.

Cynthia's observations on perinatal mortality were a salient follow up to this and I sincerely hope we as a body can explore ways to implement a similar QA/change-management approach to our obstetric patients.

In addition to the meeting-funded plenaries, I thank Dr Paul Baker and Dr Kerry Gunn for their work in constructing some fascinating specialty sessions with sponsored international experts. This, and the kind assistance of Professor Hugh Montgomery, Professor John Fraser and Dr Dawn Martin in providing video links, gave us privileged access to a breadth of international knowledge and relevance that can only cement our ASM's reputation as one of the best conferences in terms of scientific content. I'm sure an enthusiastically embraced social program helps as well!

I hope these ideas can permeate into our thinking and enable our trials group and College as a whole to keep questioning, keep investigating both the murky corners hiding at "the edge" as well as re-examining the "accepted wisdom" in the light of contemporary scientific thought. Thank you to all who presented at the 2016 meeting and to all who attended. I hope you found the visit to our shores worthwhile.



And yes, those were my shoes in Nanogirl's photo… Not planned at all! (I'm not that organised.)

Haere rā

Dr Matt Taylor
Scientific co-convenor

NZ EDUCATION LEADER WINS ANZCA MEDAL

Dr Steuart Henderson with wife Honor Henderson.

Dr Steuart Henderson was awarded the ANZCA Medal in recognition of his major contribution to the College and the profession at the College Ceremony in Auckland in May.

Dr Henderson was recognised in particular for his leadership in education, training and continuing education. He was a member of the New Zealand National Committee for 16 years, was the NZ national education officer and chaired the NZ Continuing Education Committee.

He also was the anaesthesia director of Wellington Hospital – a major ANZCA-accredited training hospital – for more than 20 years, becoming a role model to many younger anaesthetists. Dr Henderson began a program of inviting annual visitors to the department, fostering links between Wellington and other centres of excellence.

The visitors spent time in the operating room talking with anaesthetists, surgeons, cardiologists and other staff, stimulating thought and learning.

"Steuart is widely respected by Fellows, trainees and staff as a role model of dedicated, persistent and focused contribution to the College, undertaking his role quietly and effectively, and with courage," Professor Alan Merry said in the citation.

Dr Henderson also served as an ANZCA councillor for 12 years. When he left the council in 2004, the then-president Dr Dick Willis said: "Steuart has obviously been a voice of significant reason and often has taken a very sound and very well-based view which is different from the rest of the council. I think this has been a very good stimulus to help the council think … Steuart's contribution has been huge over a long period of time."

During his time on the ANZCA Council, Dr Henderson served as chair of the Education and Training Committee, as College assessor and as an examiner and examiner trainer assessor.

Professor Merry told the audience at the College Ceremony: "Additionally, what Steuart doesn't know about our regulations and processes is not worth knowing!"

Based on the citation by Professor Alan Merry at the College Ceremony during the 2016 ANZCA Annual Scientific Meeting in Auckland.

FROM WELLNESS RESEARCH TO NUTRACEUTICALS, THE PAIN PROGRAM HITS ITS MARK

Following a successful FPM Refresher Course Day on Friday, the Faculty of Pain Medicine launched into the "ASM proper" with the workshops on Saturday.

Pain workshops were a popular new development for this meeting with strong interest from delegates. John Pereira followed his talk at the Refresher Course Day with a fascinating session on wellness, which was well attended and prompted lively discussion.

The informal setting of a workshop/small-group discussion worked well and delegates seemed to relish the opportunity presented by an interactive session. Similar reports came from most sessions, particularly the POPE (pain-oriented physical exam) workshop, and we have had requests from trainees and experienced clinicians to run this workshop again.

Sunday dawned bright and the Faculty's component of the ASM kicked off with the Michael Cousins' lecture delivered by Tony Dickenson, who recapped on his Refresher Course Day lecture on pain mechanisms, then spoke about novel analgesics and future targets for pain research. Tony delivers high quality technical science in a digestible form and I was left thinking perhaps we should have had him speaking every day.

The pain stream continued with a session "Ideals and the law". Kate Davenport QC, Newman Harris and Ron Paterson (a professor of law at the University of Auckland and government ombudsman) presided over an interesting session, which attracted non-pain anaesthetists and Faculty members.

Next up, Marc Russo chaired a varied session during which we heard from Steven Cohen about the latest research on facet joint interventions. Our former dean Brendan Moore revealed some of the challenges of the proposed implant registry and John Pereira educated and entertained us on the topic of nutraceuticals.

Day one wrapped up with a session on pain and culture and the audience was captivated by personal insights from Leinani Aiono-Le-Tagaloa; challenged and unsettled by Maori speaker Hinemoa Elder; and left hopeful by Luke Arthur, a trainee from Victoria who is addressing the dearth of research involving pain and indigenous Australians.

Monday began with the FPM NZ Visitor's lecture, during which Steven Cohen recounted his experience of pain medicine in the US military and the similarities and differences between civilian and military populations in their response to common pain experiences.

The Free Paper Session was well attended and hotly contested. The judges awarded the Dean's Prize to Dr Linda Trang for "Post-operative analgesic efficacy of continuous wound infusion of local anaesthetic compared to opioid patient-controlled analgesia after laparotomy: a prospective study (NSW)". The Best Free Paper went to Associate Professor Philip Peyton for "Reduction of chronic post-surgical pain with ketamine (ROCKet) pilot trial (VIC)".

The afternoon saw a high-quality psychology session, with Malcolm Johnson presenting a comprehensive review of pain and sleep; Keith Petrie following on from his Friday after-dinner talk on the influence of expectation; and Dieter Dvorak explaining psychological flexibility and the hexaflex model based on the relational frame theory of Stephen Hayes. The nature of psychology trials with not only deception, but also administration of nocebo, sparked discussion and got people thinking.

Lastly, in what might be termed the grand finale, Stephan Schug delivered the much-awaited fourth edition of *Acute Pain Management: Scientific Evidence* – the new "grey book". We knew this session would be popular but the packed lecture suite was surely a testament to the work which has gone into producing this document and a credit to the authors.

I would like to thank all the speakers, who went to great lengths to deliver a fantastic meeting. My thanks also go to Jane Thomas, convener of the FPM Refresher Course Day, Kieran Davis, scientific adviser, Mick Vagg, FPM representative, Penny McMorran from the Faculty, and Jan Sharrock and the Events team from ANZCA, who really made the event happen.

It was a pleasure to be involved in planning and executing the ASM. We had a lot of fun and I recommend getting involved. Now what's next?

Dr Jim Olson
FPM Scientific Convenor

ACUTE PAIN BOOK LAUNCHED

The fourth edition of *Acute Pain Management: Scientific Evidence* was launched at the Auckland ASM. The 700-page book, edited by Professor Stephan Schug, is a world-renowned guide in the treatment of acute pain.

The book summarises, categorises and evaluates the complete literature on the management of acute pain.

Fellows and trainees who would like a copy of the book and have not yet registered their interest should email apmse4@anzca.edu.au with their name and College ID. Additional hard copies are available for purchase.

Right: *Acute Pain Management: Scientific Evidence* editor Professor Stephan Schug with FPM Dean Dr Chris Hayes.

Above: FPM Dean, Dr Chris Hayes, acknowledging the members of the fourth edition of *Acute Pain Management: Scientific Evidence* working group Associate Professor David A Scott, Professor Stephan Schug, Associate Professor Greta Palmer, Dr Richard Halliwell and Dr Jane Trinca.

RAISING OUR PROFILE

Media

The Auckland ASM received widespread media coverage across Australia and New Zealand in print, online and on radio, with a record total of 790 reports discussing the meeting. These reports had a potential cumulative audience of six million people according to our media monitors, iSentia. If the reports had been paid advertising, they would have cost $A1.4 million.

Fifty articles were published in print media: 699 reports, or 88 per cent of the total, appeared on the internet; New Zealand aired 28 of the 41 radio reports.

ANZCA hosted four reporters at the meeting – Fairfax health reporter Rania Spooner, News Ltd health reporter Evonne Madden, Australian Associated Press national medical correspondent Margaret Scheikowski and Eileen Goodwin of the *Otago Daily Times*, who filed stories that were syndicated across Australia and New Zealand. Ten media releases produced by the Communications team generated separate stories across a wide range of outlets in print, online and on radio.

Among the most popular topics were the use of bees to investigate anaesthetic jetlag (Dr Guy Warman); the way clot retrieval has revolutionised treatment for stroke (Professor Alan Barber); questions about the safety of anaesthesia for infants (Associate Professor Andrew Davidson); findings that kind doctors lead to healthier patients (Dr Robin Youngson); the dangers of post-anaesthetic delirium (Associate Professor David A Scott); and the fact that exercise has more impact on health than diet (Dr Chris Hanna).

The 2016 FPM Refresher Course Day and the ASM's pain stream also received widespread media coverage. Professor Stephan Schug was interviewed about the launch of the fourth edition of the *Acute Pain Medicine: Scientific Evidence*, in conjunction with a media release prepared by the Communications team, resulting in more than 20 news reports across Australia and New Zealand. Dr John Pereira from Canada was interviewed about pain and obesity, supported by a media release from the Communications team. His work was covered in 28 media reports across Australia and New Zealand.

Social media

As in previous years, the use of social media in the lead up to and during the ASM was centred on Twitter.

There was a significant growth in social media engagement compared to 2015; a 258 per cent increase in the number of hashtag impressions, a 221 per cent increase in the number of tweets from @ANZCA and a 136 per cent increase in number of participants using the ASM hashtag.

On Sunday May 1, #ASM16NZ was the top trending hashtag in New Zealand and from April 30 to May 3 it was the top trending healthcare conference hashtag in the world.

We made a total of 185 tweets (an average of 37 a day) using the @ANZCA account. The average engagement rate was 3 per cent. The benchmark average is 0.5 to 1 per cent.

Our most popular tweet (photos from the College Ceremony) was engaged with 82 times – and had an engagement rate of 14.7 per cent.

Tweets from the @ANZCA account received a total of 106,623 impressions during the ASM.

ANZCA established a conference hashtag – #ASM16NZ – in advance of the ASM and used it in promotional material to build up momentum.

For the first time, Twitterfall was used to stream Twitter around the venue. This made the conference newsfeed accessible to all delegates and encouraged people to "join the conversation".

ASM E-Newsletter

The daily *ASM E-Newsletter* was designed to keep delegates up to date with daily activities at the ASM but also, importantly, to give Fellows and trainees unable to attend, a taste of what the conference had to offer.

It included video interviews with all keynote speakers, access to daily and event photo galleries and media coverage.

The e-newsletter was well received, with between 42 and 50 per cent of all emails opened. An average of 23.2 per cent of people opening an email clicked on at least one link. These figures are well above the benchmarks for these metrics.

Photographs were by far the most clicked on content, followed by video interviews. Staff photographers and an external professional photographer were used throughout the FPM Refresher Course Day and the ASM to capture the full flavour of the event.

About 60 per cent of e-newsletters were opened on a mobile device. A vast number of emails were opened within the first 10 hours of mail out.

Communications engaged an external video production team to record and edit 20 interviews with all invited speakers as well as College leaders about important ANZCA and FPM issues. We also did a series of vox pops in which delegates gave their thoughts on the meeting.

Photos, video interviews, the ASM e-newsletters and our media coverage can be viewed at https://asm.anzca.edu.au/photos-videos-e-newsletters-media/.

PRIZES

Gilbert Brown Prize – Dr Adrian Chin for "A randomised controlled trial comparing ultrasound and palpation assisted combined spinal epidural anaesthesia for elective caesarean section".

Trainee Academic Prize – Dr Adam Hollingworth for "Does formalisation of handover and the use of a joint structured visual aid improve postoperative handover?"

ASM 2016 Open ePoster Prize – Ms Ianthe Boden for "Lung infection prevention post-surgery major abdominal with pre-operative physiotherapy (LIPPSMAck POP) trial: a bi-national multi-centre randomised controlled trial".

ASM 2016 Trainee ePoster Prize – Dr Adam Hollingworth for "Should a pre-procedure ultrasound scan be gold standard for all neuraxial techniques in obstetric anaesthesia?"

FPM Dean's Prize – Dr Linda Trang for "Postoperative analgesic efficacy of continuous wound infusion of local anaesthetic compared to opioid patient-controlled analgesia after laparotomy: a prospective study".

FPM Best Free Paper Award – Associate Professor Philip Peyton for "Reduction of chronic post-surgical pain with ketamine (ROCKet) pilot trial".

ASM SLIDE PRESENTATIONS AVAILABLE TO ALL

All ANZCA Fellows and trainees, including those who did not attend the ASM, can access speaker-approved presentations via the Virtual ASM at https://asm.anzca.edu.au/virtual-asm.

NEW FELLOWS INSPIRING THE FUTURE

The 2016 New Fellows Conference (NFC) was held from April 27-29 on Waiheke Island, a 45-minute ferry ride from Auckland. The conference site was The Venue, set on beautiful Onetangi beach. We welcomed 29 delegates, ANZCA President Genevieve Goulding, the New Fellow Councillor, Dr Scott Ma, the 2017 NFC convenor Dr Mark Young, the FPM Board member-in-residence Dr Meredith Craigie and the ANZCA councillor-in-residence Dr Vanessa Beavis. Delegates came from all ANZCA regions as well as Malaysia, Singapore, and Hong Kong. An international scholar was selected from Fiji. The theme was "Inspiring the future".

The conference began with delegates introducing themselves and answering two questions:

"Thinking back to your time as a trainee, what advice would you give a new trainee and why?" and "What is the one aspect of your specialty that you think you will always love and why?" Responses were varied, entertaining and thought-provoking. ANZCA CEO John Ilott then facilitated a short opening session.

A team-building exercise organised by Destination Waiheke followed. Delegates were divided into four teams and put into vans with a list of "challenges" to complete around Waiheke Island. Examples included scenery to photograph, iconic Waiheke activities to carry out, building sand castles, discovering the island's nude beach and interacting with the locals. Points were scored based on the creative content of photographic evidence handed in at the end of the challenge. The weather played its part and delegates were given the opportunity to drive around Waiheke, enjoy the scenery and sunshine, and get to know each other. At dinner that evening, the photographs were presented in a slideshow, much to everyone's amusement.

On Thursday morning, the Key-2-Me Process Communication Model Seminar was conducted by Dr Helen Frith (specialist anaesthetist at Middlemore Hospital, Auckland). The seminar demonstrated individual differences in communication and stress patterns and how to manage them. Delegates had completed a questionnaire before the conference, which Dr Frith used to develop individualised personality profiles.

After lunch, Professor Ron Paterson presented on "the good doctor". A professor of law, Professor Paterson was the New Zealand Health and Disability Commissioner (2000-2010), and is now the New Zealand parliamentary ombudsman. He is also the author of *The Good Doctor: What patients want*. This session presented medico-legal cases and explored the characteristics of quality healthcare from the perspective of the patient.

A session titled "Effecting change within our systems" was facilitated by Dr Dale Bramley, a public health physician and chief executive officer of Waitemata District Health Board, Auckland. The session gave us insight into how effective change occurs, providing ideas and tools to implement change, helping us to collaborate within and outside our operating theatres by taking a different approach to innovation. The day ended with delegates attending a formal dinner at Cloudy Bay vineyard and restaurant.

Friday morning began with Dr Craigie (FPM Board member-in-residence) speaking on her journey from childhood to medical school, and her career stages in anaesthesia and pain medicine. Later that morning, Dr Tony Fernando (psychiatrist and sleep specialist) presented a session on happiness and the health of doctors. He discussed the importance of happiness in our practice, for our future lives and for our patients.

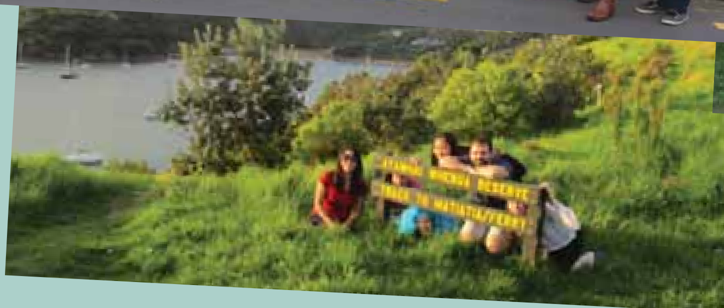
The final session on Friday was an interactive Q and A with Dr Goulding, Dr Beavis, Dr Ma and Dr Craigie. Topics discussed included careers as future leaders, discrimination and bullying, ANZCA training and examinations.

By accounts, the 2016 NFC was a success and the objectives of the conference were met. We thank all delegates for their involvement and for making the NFC as enjoyable as it was. Friendships and professional links were forged, and delegates continue to maintain an active Whatsapp group and Dropbox facility for sharing ideas and resources. An informal reunion is planned at future ANZCA events. A special thanks to Eleni Koronakos, who was instrumental in ensuring the smooth organisation of the NFC.

Dr Nav Sidhu

Dr Chao-Yuan Chen

2016 New Fellows Conference Co-Covenors



Above, from left: All New Fellows Conference delegates in a farewell photo; participants enjoying the scenic setting; one of the groups in a "pirate ship" during a team-building activity.

Faculty of Pain Medicine

Dean's message

On May 2, I had the honour of taking over as dean of the Faculty of Pain Medicine from Professor Ted Shipton. In stepping into this role I am conscious of the strong foundations on which we continue to build. Since the foundation of the Faculty in 1998, we have seen the recognition of pain medicine as an independent medical specialty in Australia in 2005 and New Zealand in 2012. The revised training program based on a restructured curriculum was launched last year. We now have more than 400 Faculty Fellows and extensive links across health professional and consumer networks in Australia, New Zealand and internationally.

Strategic planning is critical as we build our Faculty. The current five-year plan (2013-2017) was developed during the deanship of Brendan Moore and consolidated under the leadership of Ted Shipton. Three key priority areas focused on building fellowship and Faculty; curriculum and knowledge; and advocacy and access. Substantial gains have been made in all areas. In addition to the revision of the training program, other major achievements include initiation and co-development of the electronic Persistent Pain Outcomes Collaboration (ePPOC), publication of *Acute Pain Management: Scientific Evidence 4th Edition* (with thanks to Stephan Schug and his editorial team) and rollout of the Better Pain Management online education program. An opioid dose equivalence table has been developed and with it a smart phone app to calculate oral morphine equivalent daily dose. Funding for a Pain Device Implant Registry is under negotiation.

Now is the time for us as a Faculty to begin to collect our thoughts as we move, over the next 12 months, to develop the 2018-2022 Strategic Plan. We will work in parallel with ANZCA as their strategic planning is refined under the leadership of new president, Associate Professor David A Scott. In the background to this planning phase I would like to encourage dialogue about our sense of identity as specialist pain medicine physicians. Our revised training program inverts the familiar biopsychosocial approach and commends the sociopsychobiomedical. We need to discuss what this means in our daily practice of pain medicine and how this might translate to future direction for the Faculty.

Clearly one of our key roles is the provision of multidimensional treatment to our patients and with it, protection of the multidisciplinary team environment in which this treatment occurs. Yet the details of how different treatments are emphasised within this broader approach needs clarification. Outcome measurement and benchmarking must remain high priorities as we seek to refine our treatment programs according to best evidence and secure enhanced funding. With regard to biomedical pain treatments, further discussion is needed as we better define the place of opioids and interventional procedures. The issue of cannabinoids also will benefit from further research and discussion given the political priority it has been accorded. Is part of our core identity as pain physicians the defence of multidisciplinary teams and outcome measurement?

With the new training program in place, the first year, or core training stage, has been well defined. This covers essential areas of pain medicine. In contrast, the second year of training, or practice development stage, offers flexibility. Dialogue across our fellowship is needed as we consider the opportunities that may arise. Might we, for example, be able to define particular sub-specialty areas worthy of specific training at accredited sites? Such areas might include paediatric pain, pelvic pain and interventional procedures.

There also may be opportunities for us to bring a strategic voice to workforce planning and model-of-care discussions. Are we positioned to provide brief, non-fellowship training in pain medicine suitable for an interested general practitioner or surgeon? However this conversation might develop, our skills and experience as pain physicians will help to inform plans for greater integration between primary care and specialist services.

I bring to the position of dean 20 years of experience in pain medicine and an enduring interest in education, health-system redesign and outcome measurement. I bring gratitude for the achievements of the Faculty to date and hope for our ongoing contributions to the future of health care in New Zealand, Australia and beyond.

We move towards the Faculty's next five-year strategic planning process with confidence in our foundations and a sense of excitement in the future building program. I invite you all to play a part in the building process as it proceeds.

Dr Chris Hayes
Dean, Faculty of Pain Medicine

Departing dean leaves Faculty in good shape

It is a great pleasure to acknowledge immediate past dean Professor Ted Shipton for his work as leader of our Faculty from May 2014 to May 2016.

Ted has a unique blend of collegiality and determination along with a great willingness to fly back and forth across the Tasman. He is an effective listener who can prioritise issues and see them through to project closure.

Ted's time as dean has been marked by highly effective consolidation of strategic Faculty direction and completion of key projects. The rollout of the new training program and curriculum in 2015 has been a major achievement. We now offer a truly world-class program.

In addition, the electronic Persistent Pain Outcome Collaboration has prospered and grown. There are now 50 participating sites and an established team at the University of Wollongong. This Faculty initiative will undoubtedly prove to be of great value in refining our treatment programs and campaigning for resources within a hard-pressed health sector.

The recent publication of *Acute Pain Management: Scientific Evidence 4th Edition* represents a major achievement of the Faculty under Ted's guidance. The Better Pain Management program and Opioid app projects also have progressed under his leadership, their success flowing from his desire to support the education of a wide range of health professionals.

Ted has been a strong advocate for pain medicine in his position on ANZCA Council. The robust relationships he has developed have paved the way for a smooth transition as I join the council. In addition, Ted has developed enduring friendships among Faculty and ANZCA staff.

The respect with which he is held makes it easier to follow in his footsteps. To the board of the Faculty, Ted has consistently brought wise guidance and firm direction. We continue to value his presence, reassurance and corporate memory on the board as 2016 progresses.

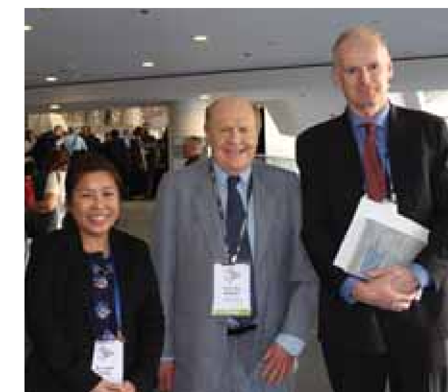
On behalf of the fellowship, FPM Board, the general manager and staff, I thank Ted for the time, effort and leadership he has invested as dean. We are all the stronger for his efforts.

Dr Chris Hayes
Dean, Faculty of Pain Medicine

Above left: FPM Dean, Professor Ted Shipton, with incoming Dean Dr Chris Hayes.

Above right: Dr Linda Trang, Professor Ted Shipton and Associate Professor Philip Peyton.

Original research wins Faculty awards



ANZCA trainee Linda Trang, from NSW, is this year's winner of the Dean's Prize, awarded at the Faculty of Pain Medicine's annual general meeting in May.

Dr Trang won the award for her paper titled "Postoperative analgesic efficacy of continuous wound infusion of local anaesthetic compared to opioid patient-controlled analgesia after laparotomy: a prospective study".

The Dean's Prize is awarded to the Fellow or trainee judged to have presented the most original pain medicine/pain research paper. Dr Trang was awarded a certificate and a grant of $1000 for educational or research purposes.

Associate Professor Philip Peyton, from Victoria, won the Best Free Paper Award, which is for original work judged to be the best contribution to the free papers session of the Faculty of Pain Medicine. Associate Professor Peyton won a certificate and a grant of $500 for educational or research purposes for his paper "Reduction of chronic post-surgical pain with ketamine (ROCKet) pilot trial".

The Faculty free paper session is open to all registrants of the ANZCA and FPM annual scientific meeting.

Faculty of Pain Medicine (continued)

Faculty celebrates successful Refresher Course Day

The Faculty's Refresher Course Day and annual scientific meeting (ASM) programs were a tremendous success and a tribute to the hard work of the Faculty's Refresher Course Day Scientific Convenor, Dr Jane Thomas, FPM ASM Scientific Convenor, Dr Jim Olson, and organising committee member Dr Kieran Davis.

The Refresher Course Day attracted 188 delegates and received strong support from the healthcare industry with three major sponsors and one exhibitor present. One of the international speakers, Dr John Pereira, from Canada, was additionally sponsored by BNZ.

The program, "Extremes of pain", explored the many challenges involved in managing pain in the morbidly obese, chronic spinal pain and cancer pain.

The academic sessions were followed by a dinner at The Northern Club, which included an entertaining after-dinner talk by Professor Keith Petrie, the professor of health psychology at Auckland University Medical School, entitled "What the dominatrix didn't tell you – increasing your personal nocebo power". Professor Ted Shipton was thanked for his leadership and significant contribution as dean in advancing the Faculty's strategic initiatives.

The 2016 FPM Refresher Course Day and the ASM's pain stream received widespread media coverage in print and online.

Professor Stephan Schug was interviewed about the launch of the fourth edition of the *Acute Pain Management: Scientific Evidence*, in conjunction with a media release prepared by the Communications team, resulting in more than 20 news reports across Australia and New Zealand.

Dr Pereira was interviewed about his presentation on pain and obesity, which also was supported by a media release from the Communications team. His work was covered in 28 media reports across Australia and New Zealand.

Above clockwise from left: FPM Refresher Course Day Scientific Convenor Dr Jane Thomas; Dr David Jones and Dr Paul Vroegop; Morning tea at the FPM Refresher Course Day; FPM ASM Visitor Professor Tony Dickenson; FPM Dean, Professor Ted Shipton, with Dr Jane Thomas (FPM Refresher Course Day Scientific Convenor), Dr Kieran Davis (Organising committee member) and Dr Jim Olson (FPM ASM Scientific Convenor); FPM Dean, Professor Ted Shipton, with the international speakers Dr Steven Cohen (FPM New Zealand Visitor), Dr John Pereira and Professor Tony Dickenson (FPM ASM Visitor).

News

Opioid calculator app success

The FPM opioid calculator app is enjoying great success, with 7683 users completing 37,709 sessions in the six months since its launch. The top five countries for active users of the app are Australia (62 per cent), US (20 per cent), NZ (6 per cent), Canada (3 per cent) and the UK (2 per cent).

To download the free app, search for ANZCA Opioid Calculator in the iTunes or Google Play store, or use the QR code.

New library tool – Library Guides

The ANZCA Library has introduced a new resource called Library Guides, which collates recommended resources, such as library databases, journals, books, web pages and other useful links for finding information around specific areas. Two pain medicine library guides have been created: Pain Medicine and Foundations of Pain Medicine. The first includes resources aimed at pain medicine Fellows and trainees while the second has been designed for applicants preparing to sit the foundations of pain medicine exam. Other library guides cover areas such as the roles in practice, resources for educators, continuing professional development and medical apps. Further information about these new resources can be found on page 36 of the *Bulletin*.

Committee restructure

The Faculty of Pain Medicine Board has approved the formation of a Training and Assessment Executive Committee (TAEC) to align, co-ordinate and strategically advise the board on the activities of the Learning and Development Committee, the Training Unit Accreditation Committee and the Examinations Committee and to provide guidance to the assessor(s) in relation to training and accreditation. This purpose is to ensure alignment of the curriculum with the training and assessment processes. The Education Committee has been dissolved. Terms of reference for the TAEC can be found on the website at http://fpm.anzca.edu.au/About-FPM/Committees.

Discussion has begun on the formation of a Professional Affairs Executive Committee.

Admission to fellowship

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

Dr Michael George Veltman, FANZCA, WA.

Dr Leinani Salamasina Aiono-Le-Tagaloa, FANZCA, NZ.

This takes the total number of Fellows admitted to 426.

2015 Fellowship exam report available now

Examination reports are designed to assist candidates and supervisors of training to prepare for future Faculty fellowship examinations. View the 2015 Fellowship examination report at: http://fpm.anzca.edu.au/Documents/FPM-2015-Examination-Report-20160414-v1-0.pdf

Faculty of Pain Medicine long-case assessment

The first round of long cases recently was held in Auckland (April 4), Sydney (April 6), Brisbane (April 15) and Melbourne (April 15). Fifteen of 25 candidates were successful. Thank you to the local convenors for co-ordinating the assessments.

The next round of long-case assessments will be held in the week of September 5-9. Further information, including dates and venues, will be available on the website soon.

2016 Fellowship examination dates

The written exam will be held across FPM regional and national offices on Friday, November 4. The clinical exam will be held in Melbourne on Saturday, November 26. The closing date for exam registrations (written and clinical) is Wednesday, September 30.

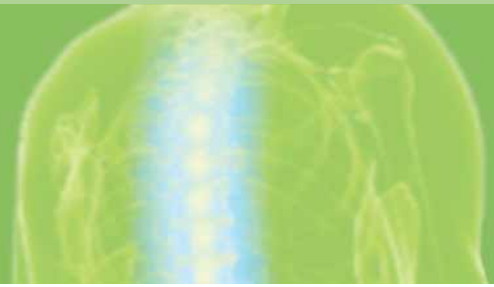
Training unit accreditation

The following hospitals have been reaccredited for pain medicine training after successful reviews:

- Alfred Health Services.
- Barbara Walker Centre (St Vincent's Hospital, Melbourne).
- Burwood Hospital.
- Canberra Hospital.
- Melbourne Pain Group (level 2).
- Pain Matrix (level 2).
- St Vincent's Hospital, Sydney.
- The Auckland Regional Pain Service.
- Townsville Hospital.

The number of accredited pain units stands at 34.

Faculty of Pain Medicine (continued)



Samoan specialist celebrates a new achievement

The Faculty of Pain Medicine welcomes Satualafaalagilagi Dr Leinani Aiono-Le-Tagaloa as Samoa's first specialist pain medicine physican.

Satualafaalagilagi Dr Leinani Aiono-Le-Tagaloa's presentation as a new Fellow of the Faculty of Pain Medicine (FPM) at the College Ceremony in Auckland on April 30 marked another notable first for this proud Samoan, being the first anaesthetist and now the first pain medicine specialist from her country. "Satualafaalagilagi" is Dr Aiono-Le-Tagaloa's chiefly title and is the respectful way to refer to her. In this article it is shortened to "Satuala", as it often is at home.

Born and raised in Apia, Samoa, Satuala is the second of four siblings, all high achievers: her brother is a surgeon, one sister is a school principal, the other sister is a published author and the first Samoan-born person to gain a PhD in law from Otago University.

Their father is Le Tagaloa Pita, a high chief matai, teacher and a former long-serving member of parliament in Samoa. Their late mother was Aiono Fanaafi Le Tagaloa, also a matai, a professor and an authority on Samoan culture and language, with a PhD in educational philosophy and applied linguistics from the University of London.

After completing her schooling in Samoa, Satuala took her medical degree at Otago University in Dunedin, graduating in 1991. She began pursuing a medical career in surgery at Palmerston North Hospital, resisting suggestions by anaesthetists that she would be well suited to their specialty. A transfer to Dunedin Hospital after about six years saw her working closely with anaesthetists in the intensive care unit, where Satuala says she "saw the light". As a strong Christian, it also was important to her to seek spiritual guidance for her decision.

Satuala appreciated the different teaching style anaesthetists had and switched to train in anaesthesia at Southland Hospital in Invercargill, at Dunedin Hospital and then completing her FANZCA at Auckland Hospital in May 2005. She became the first anaesthetist from Samoa, where she hoped to work.

"I was very passionate about going back to Samoa. I am very aware of the need there, but I couldn't get a job in Samoa," Satuala says.

Her interest in obstetric anaesthesia saw her take a job at National Women's Hospital in Auckland before being accepted for a fellowship at Stanford University in California for a year, following which she taught as assistant professor at Davis University in California. Satuala returned to New Zealand to be closer to her Samoan-based parents. She worked at Whanganui Hospital for two years before moving back to Auckland.

An enounter in 2012 with her first mentor – Dunedin pain medicine specialist and former FPM dean Dr David Jones – triggered a decision to add the pain medicine qualification to her name. He repeated that he thought she would be suited to the specialty, Satuala says.

"I have always been fascinated by pain, especially doing obstetrics. A lot of my focus and research at Stanford was around labour pain. If you look at the biomechanics, the muscle contraction shouldn't hurt like that, but it does and that fascinates me."

Satuala undertook her FFPMANZCA studies at Auckland Hospital and at The Auckland Regional Pain Service (TARPS), after which she returned to Whanganui Hospital, where she had hoped to build a pain service. She now holds a specialist position and works at TARPS in Green Lane, Auckland.

She sees pain medicine as one of the frontiers of contemporary medicine.

"There is so much we don't understand about the neuroscience and the intricate way our bodies are put together," Satuala says.

"There is also the human side. No matter how much we do understand about the neuroscience, we are not going to reach someone unless we also understand who they are as a person. This is still very much an area in need of research."

Satuala notes that pain medicine requires a different mindset from anaesthesia, where there are greater certainties around the results you can achieve.

"Patients in pain are looking for a cure and it is hard to say that you might not be able to provide that. Despite that, or perhaps because of that, I find it an intensely satisfying area to work in. I never get bored."

Brought up with a culture of service to one's country, Satuala would still like to practise in Samoa but says for now she hopes to become involved in teaching at the Faculty of Medicine of the National University of Samoa.

As well as presenting at the College Ceremony as an FPM new Fellow, Satuala was among the presenters in the FPM session on "Pain and culture" during ANZCA's annual scientific meeting in Auckland. Her address included the importance of "faaaloalo", respect or consideration for other people.

"This can make a huge difference as to whether a person is open to receiving the message you have to give. It is highly applicable in medicine and pain medicine, and is a topic dear to my heart."

Susan Ewart
ANZCA Communications Manager, NZ

Above: Satualafaalagilagi Dr Leinani Aiono-Le-Tagaloa at the College Ceremony in Auckland on April 30.

Looking after the interests of trainees

Many Fellows and trainees are unaware of the work that goes on behind the scenes at ANZCA. This article, about the ANZCA Trainee Committee, is part of a series on the activities undertaken by ANZCA committees.

The ANZCA Trainee Committee comprises representatives from each Australian state and territory and a representative from New Zealand. This year co-chairs Adriana Bibbo (Vic) and Christine Velayuthen (NSW) are joined by Grace Ho (WA), Jennifer Hartley (ACT), Lizi Edmonds (NZ), Robert Easther (Tas), Maryann Turner (Qld) and Marni Calvert (SA/NT).

The role of the ANZCA Trainee Committee is to consider and provide input on trainee-related matters referred to it by the ANZCA Council and other College committees.

The main issues are education, training and accreditation, and, importantly, to consider any issues referred to it by the regional trainee committees.

The ANZCA Trainee Committee has two all-day face-to-face meetings and three teleconferences each year. It is supported by a large number of staff, including Olly Jones (General Manager, Education), Paula Stephenson (General Manager, Training Assessment) and Suzanne Grogan (Administrative Officer, Training Assessment), who provide an integral role within the College and to this committee.

It is important that trainees are aware of their representatives in each region, as these committees are there to support improvements and the management of registrar training. Trainee committees allow trainees to have a voice and a means to communicate any problems they may be experiencing to a higher level. Regional committees have played an integral role in providing input to improve the revised anaesthesia-training curriculum, training portfolio system, Part Zero course and much more.

The regional training committees have meetings or teleconferences, with their frequency varying between regions. The number of committee members varies each year, depending on the number of trainees in each region. Membership of these committees is for one year, and new members are nominated at the end of each year.

Last year, each state and territory and New Zealand circulated a trainee survey, which asked questions about the training portfolio system, curriculum content, supervision and feedback, support for trainee learning, and bullying and harassment. The surveys were anonymous and the results enabled the ANZCA Trainee Committee to communicate to the College issues from the trainees' perspective, and seek methods of improvement. It enabled problems experienced by anaesthetic trainees, such as bullying and harassment, to be investigated and addressed.

This year the ANZCA Trainee Committee will undertake a national trainee survey, to be circulated in July/August. It is important that all trainees complete the survey to provide feedback regarding anaesthesia-training issues. This will enable a stronger representation of trainee needs.

The committee maintains close contact with the Australian Society of Anaesthetists (ASA) Group of ASA Clinical Trainees (GASACT) to ensure all issues are directed to a higher level, promptly and appropriately.

The ANZCA Trainee Committee also plans to work with the Royal Australasian College of Surgeons Trainee Committee to discuss trainee issues across the board. This collaboration was initiated last year and, interestingly, many trainee issues were found to be similar. We aim to hold a collaborative trainee meeting at the next joint annual scientific meeting to explore issues facing both colleges, including bullying and harassment.

Members of the ANZCA Trainee Committee look forward to working to further improve the training and education of anaesthetic trainees, and we welcome input from trainees. If you would like to join a trainee committee, please refer to the ANZCA website and keep an eye out for nominations.

Dr Adriana Bibbo and **Dr Christine Velayuthen**
Co-Chairs, ANZCA Trainee Committee

Meet the ANZCA Trainee Committee

Australian Capital Territory
Dr Jennifer Hartley

Jennifer Hartley is the chair of the ACT Trainee Committee. She is in advanced training and has been a member of the committee for two and a half years. The committee consists of five elected members and several co-opted members who work tirelessly and are enthusiastic about training in the ACT.

The committee feels privileged to have a small yet supportive group of trainees in the ACT which allows the committee to actively engage with all trainees and implement improvements specific to the region. The committee has organised many successful teaching opportunities for trainees, including guest presentations and workshops, and has also co-ordinated several social evenings.

New South Wales
Dr Christine Velayuthen

The NSW Trainee Committee is co-chaired by Christine Velayuthen and Monique McLeod and has nine members, two co-opted members and two GASACT representatives.

The committee aims to provide a vehicle where trainee issues can be raised and improvements made. These issues can be taken further to the regional committee or other ANZCA committees to continue to develop training and education. The committee played a large role in the roll out of the ANZCA trainee survey. Results have been collated and used to promote issues facing trainees to both the NSW Regional Committee and the ANZCA Trainee Committee. The committee provided input into the Bullying and Harassment Working Group, as well as many other committees to improve training. It also help convene the Part Zero course, with the assistance of many valuable consultants and trainees.

New Zealand
Dr Lizi Edmonds

Dr Lizi Edmonds is chair of the New Zealand Trainee Committee. She is completing her provisional fellowship year in Wellington Hospital with a focus on pain medicine. She has been involved in the trainee committee for four years and this is her second year as chair.

The New Zealand committee has 10 members representing over 250 New Zealand trainees. Anaesthesia practice has many differences between Australia and New Zealand. A focus of the New Zealand committee is ensuring the training program recognises and supports those differences while raising the profile of New Zealand trainees within the College.

Queensland
Dr Maryann Turner

This year saw the arrival of nine new members on the Queensland Trainee Committee, which is chaired by Maryann Turner. The committee is fortunate to comprise a wide and representative spectrum of trainees covering basic training, advanced training and provisional fellowship training from metropolitan and regional locations.

A successful and well-received Part Zero course was run in February with high quality lectures presented by local consultants. The allocation of individual hospital representatives has facilitated insight into the issues facing trainees and made it possible for us to discuss, action and follow up concerns appropriately. Survey development and Part Zero 2017 planning are also underway thanks to the hard work of our members.

South Australia and Northern Territory
Dr Marni Calvert

Marni Calvert commenced as chair of the SA/NT Trainee Committee in January 2016 having been a committee member on and off since 2011. She is undertaking a fellowship in vascular anaesthesia at Flinders Medical Centre and has the strong backing of a talented group of trainees on the committee.

We represent 65 rotational and 30 non-rotational anaesthetic trainees across South Australia and the Northern Territory. Our focus has been on ensuring that all trainees continue to be well represented and supported prior to commencing training with the Part Zero course right throughout training until completion with the Part 3 course.

Tasmania
Dr Robert Easther

The Tasmanian Regional Trainee Committee is made up of five members from across the state, representing our three training locations, and is chaired by Robert Easther.

The committee regularly meets by teleconference and considers local issues relating to education, training and other matters affecting trainees.

Tasmania has been at the forefront of many changes to the content and delivery of the ANZCA curriculum over the past two years. The Networks resource has been rolled out across the state providing a valuable tool for trainees. New learning tools, ongoing improvements to trainee education, and consolidation of programs that aim to protect trainee welfare have also been implemented.

Victoria
Dr Adriana Bibbo

Adriana Bibbo is in her second year as the chair of the Victorian Trainee Committee. She is a third-year registrar through the Eastern Training Scheme (The Alfred).

This year, the Victorian Trainee Committee comprises 11 representatives, with an even distribution across the Victorian hospital network and the various levels of training, including for the first time this year a first-year registrar.

It meets approximately five times a year to discuss issues affecting Victorian trainees. Last year the committee undertook a trainee survey, and this year will be involved in the development of a national survey. The committee has had input into the Part Zero course and many members have positions on additional working groups and sub-committees within the College.

Western Australia
Dr Grace Ho

Grace Ho is an advanced trainee year 1 in the (mostly) sunny city of Perth. She is undergoing her paediatric anaesthesia term where she has discovered a newfound respect for magic tricks and bad jokes, and a deep-seated fear of clowns.

She has been involved with the WA Trainee Committee for the past three years and was delighted to take on the role of chair for 2016, with Gary Devine as deputy chair. The committee consists of nine members, with representatives from all stages of training to ensure we can provide support and advocacy for all anaesthetic trainees. This year, our priorities include tackling unhealthy workplace behaviours, improving trainee welfare, and the implications of a dynamic state hospital system for fulfilling training requirements and future workforce issues.

A full list of trainee committee members can be found on the ANZCA website – www.anzca.edu.au.

Early indicator checklists

New resources have been developed to guide supervisors of training to assist trainees.

Many trainees experience hurdles in their training, be it organising childcare that fits with an ICU roster; realising they won't complete their volume of practice requirements before the end of a paediatric placement; being the go-to medical advisor for a sick family member; or failing an exam. For a small but not insignificant number of trainees, their hurdle becomes a mountain.

As a supervisor of training, it can be hard to know how to help.

The College has concluded a project to develop support tools to help supervisors of training to identify when a trainee needs assistance and may need to move to a trainee experiencing difficulty process (TDP).

Supervisors of training can find intervening tricky for many reasons. They may have a large number of trainees in their hospital, some of whom are in placements of short duration.

It can be hard to find the time to identify a trainee experiencing difficulties and initiate remediation before a trainee moves to a new placement.

There often is caution about addressing issues raised about a trainee or by a trainee. Barriers to engagement include a lack of confidence, time or resources for the supervisor of training, reluctance to face a difficult conversation, concern about bullying or harassment, or hesitancy to commence a formal process. These barriers can occur on part of both the supervisor of training and the trainee.

With the 2013 curriculum comes clear limits on training time and number of exam attempts. This puts more impetus on identifying areas of difficulty early, and offering timely assistance to struggling trainees.

The identification of early indicators that may lead to a TDP can pave the way for trainees to get the support and remediation they need and help drive a successful career in anaesthetics.

About the early indicator checklists

A review of the literature confirms early indicators of a trainee experiencing difficulty almost always fall into one of the following categories:

- Examination failure.
- Clinical performance.
- Professionalism and/or insight deficiencies.
- Illness.
- Global assessment concerns.

The project group developed an introduction document and five checklists, each addressing one of the areas in which a trainee might be struggling.

The checklists provide guidance on how to confirm there is a problem, how to raise the problem with the trainee and how to plan an appropriate course of action to assist the trainee.

Each early indicator checklist has been developed to guide supervisors in how to approach this issue with a trainee.

The checklists assist in developing a plan of action appropriate to the trainee's needs. They provide links to the wealth of College resources, tailored to the area of need, to support both the trainee and their supervisor as they work through remediation.

There is a general introduction on how to assist and then individual checklists tailored to the identified early indicator. There also is a checklist for global concern for use when a specific issue is difficult to identify.

By gaining a better understanding of what is going on, a supervisor of training can work with the trainee to develop an individualised plan. This may include providing additional support for the trainee, a review of their training plans, simple remediation, or initiating a TDP.

Where to find the checklists

The introduction document and five checklists are available on the ANZCA website on the 2013 training program page in the appendices to the handbook: www.anzca.edu.au/Training/2013-training-program/Early-indicator-checklists

The project group

The College formed a project group to identify and develop resources on early indicators of a trainee experiencing difficulty. Dr Sarah Nicolson (NZ) chaired the project, with representation from director of professional affairs (DPA) assessors, supervisors of training, trainees, the Welfare of Anaesthetists Special Interest Group and relevant ANZCA units.

The project group includes: **Dr Sarah Nicolson**, FANZCA, Chair, ANZCA rotational supervisor (NZ); **Dr Navdeep Sidhu**, FANZCA, ANZCA ETADC representative (NZ); **Dr Vaughan Laurenson**, FANZCA, ANZCA DPA assessor (NZ); **Dr Maggie Wong**, FANZCA, ANZCA DPA deputy assessor (Vic); **Dr Michelle Moyle**, FANZCA, ANZCA education officer (NSW); **Dr Marion Andrew**, FANZCA, Chair, Welfare of Anaesthetists Special Interest Group (SA); **Dr Belinda Phillips**, FANZCA, ANZCA provisional fellowship trainee (Vic) (now FANZCA); **Dr Adam Mahoney**, ANZCA advanced trainee (Tas); **Mr Olly Jones**, General manager, ANZCA Education Unit; **Ms Paula Stephenson**, General manager, ANZCA Training Assessment Unit; **Ms Tamara Rowan**, Operations manager, ANZCA Training Assessment Unit; **Mr Maurice Hennessy**, Learning and development facilitator, ANZCA Education Unit; **Ms Gina Lyons**, Operations manager, ANZCA Education Unit; **Ms Shana Tan**, Training portfolio systems analyst, ANZCA Training Assessment Unit.

Conclusion

ANZCA is exceedingly grateful to the project group for their time and contribution to the development these valuable resources to support supervisors of training and trainees in tackling and overcoming challenges.

Dr Sarah Nicolson
Chair, TDP Early Indicators Project Group

Bringing video-guided debriefing to an exam course

"We believe confidence and performance in fellowship exams can be improved by addressing human factors, such as communication style and non-verbal communication."

Anaesthetists at Fiona Stanley Hospital use video recordings to help prepare trainees for the FANZCA Part 2 viva course.

Examination viva practice plays a significant educational role in the development and training of junior doctors throughout medicine. Arguably, viva practice is one of the most common forms of simulation in modern medical training.

Medical simulation is of increasingly high fidelity and much is invested to create immersive environments where trainees can safely experience a wide variety of clinical situations. The number of exam viva courses has grown internationally, increasing in realism, with examiners taking great care to prepare questions of appropriate complexity and to accurately recreate the stresses and pressures of daily practice.

In simulation education, debriefing and the structured analysis of human behavioural factors have developed hand-in-hand with their technological counterparts, but in exam courses there is often little debriefing beyond feedback on knowledge performance.

We believe confidence and performance in fellowship exams can be improved by addressing human factors, such as communication style and non-verbal communication: body language, hand/arm gestures and how candidates deal with stressful situations.

In September 2015, the Department of Anaesthesia and Pain Medicine at Fiona Stanley Hospital, WA, ran its second FANZCA Part 2 viva course. The department has a strong commitment to training and education and has an established simulation fellowship program where its fellows receive high-quality training in simulation and debriefing using advocacy inquiry with good judgement. The simulation fellows were co-opted to observe and debrief candidates.

There was significant preparation prior to the first video. The faculty were keenly aware of the power of simulation and their responsibility towards candidates only a few weeks prior to their final exam. Cameras recorded the examiner and candidate concurrently and the process was made as unobtrusive as possible. We were keen not to distract the candidates.

Video-guided feedback

- Assessment of body language.
- Insights into non-verbal communication.
- Commentary on technique, personal tics and habits to be aware of.
- Just watching how I came across and being able to judge myself externally.
- Unconscious (poor) posture/pauses identified.

Twelve candidates (nine from WA and three from Singapore) attended the course and each consented to have one viva video recorded. The viva lasted 15 minutes during which the observer took detailed, timed notes. Once the candidate had moved to the next station, brief feedback was sought from the examiner.

Debrief sessions lasted at least 15 minutes and were conducted in a private room. The debriefing sessions proved enjoyable for debriefers and informative for candidates. Behaviours and styles were identified in a collegiate fashion and honestly analysed using "advocacy inquiry" style questioning. Video playback allowed the debriefers to better make their points and the candidates to view themselves going through a stressful situation.

After the course, we collected anonymous electronic feedback. All candidates said they found the feedback/debrief session useful and that video playback added to this. One candidate felt they were distracted by the recording, but only initially.

Based on this feedback we altered our video arrangements to further reduce distractions for our next course in April 2016 with 17 candidates. We asked candidates to wear the formal clothes they intended to wear for the actual exam. This time the recorded viva took place in a separate room with the observer out of the candidates' view to make the process as unobtrusive as possible. The candidates were well briefed and introduced to the "video room" to maintain a safe learning environment. Video debriefing was provided immediately after the viva.

All candidates felt the debrief sessions and video guidance were helpful, none felt the recording was a distraction and all agreed or strongly agreed that their confidence in dealing with vivas has increased as a result of the course.

We feel high quality debriefing is useful because it:

- Increases knowledge of strengths and areas for development.
- Increases confidence.
- Allows clarity of purpose and goals.
- Influences future behaviours and decision-making[1].

We find the "advocacy inquiry" style of questioning, where debriefers offer clear, perhaps critical, but respectful judgement together with a genuine curiosity to understand why things happen the way they do[2] leads to very interesting discussions, with the candidates identifying most potential issues themselves.

Adding recorded vivas and immediate video-guided feedback to a viva course adds significant complexity and workload to a time-pressured faculty. However, the process is immensely rewarding, especially in those "light bulb" moments when our junior colleagues realise the fruits of their hard work. We encourage other course organisers to employ video recording during their sessions and provide high-quality debriefing to improve non-technical exam performance.

Dr Abhijoy Chakladar, Dr Ing-Kye Sim, Dr Daniel Anderson, Dr Mei Mei Westwood
Department of Anaesthesia and Pain Medicine, Fiona Stanley Hospital, WA

Dr Christine Ong
Department of Anaesthesia, Joondalup Health Campus, WA

Acknowledgement:
We thank the Department of Anaesthesia and Pain Medicine for its continued support in hosting the course and for releasing so many senior staff to examine. We are indebted to our examiners from hospitals around Perth who often attend in their free time. Special thanks to Dr Malcolm Thompson and Dr David Wright for agreeing to be filmed (repeatedly!) and to our junior colleagues sitting the exam – good luck!

References:
1. Adapted from: RC(UK) Generic Instructor Course. Debrief as a learning conversation. November 2011.
2. Rudolph JW, Simon R, Rivard P, Dufresne RL, Raemer DB. Debriefing with Good Judgment: Combining Rigorous Feedback with Genuine Inquiry. Anesthesiology Clinics 2007; 25: 361-76.

Candidate's comments regarding video feedback (2015 and 2016)

- Constructive criticism is helpful.
- The video session is great and the feedback is very personalised.
- Insight into non-theoretical/non-textbook performance is very valuable.
- Really good practice on how I will feel during the real event and how I'll perform under pressure. Also useful to watch how I present in other peoples' eyes (through video feedback).
- Able to see your own body language.
- Personalised feedback allows for personal improvement.
- Able to hear myself speak and identify bad habits.
- Allows targeted/personalised feedback.
- Very confronting; immensely useful.
- Very constructive and appropriately focused.
- Allows more objective assessment, extremely valuable for observing body language and viva dynamics and technique.
- Allows feedback of body language that's frequently overlooked.
- Very useful in terms of answering technique and mannerism.

Successful candidates

Court of examiners for the February/April 2016 primary examination.

Primary fellowship examination February/April 2016

One hundred and thirty seven candidates successfully completed the Primary Fellowship examination at this presentation and are listed below:

AUSTRALIA

Australian Capital Territory

Mitchell David Blake
Benjamin Darby
Martin Michael Dempsey

New South Wales

Ahmad Sabah Bakir
Caroline Ban
Christopher John Bell
Daniel Carayannis
Oliver Mark Carson
Ronald Cheung
Phillip Collins
Timothy David Cooper
Tara Kristen Dalby
Zoe Daskalopoulos
Anushka Oshadhie De Alwis
Varun Himanshu Desai
Monica Joy Diczbalis
Thomas Christopher Egan
Daniel Fletcher
Damitha Viraj Anton Fonseka
Bernard Frost
Tiffany Alexandra Fulde
Michael A Ginsburg
John Paul Harper
Nathan Andrew Hewitt
Phillip Martin King
Swaetha Koneru
Kenrick King Fai Ku
Anisha Kulkarni
Bianca Gkin-Hui Lan
Avery Lou Lim
Andrew Peter Lindberg
Joel Brian Menzies
Parita Patel
Lauren Nicole Pilz
Gordon Edward Pirie
Rebekah Susan Potter
Patrick James Rubie
Victoria Sabbouh
Kanan Shah
Kate Smith
Michael Tran
Nilru Priyanka Vitharana
Nikitha Vootakuru
Aleksandar Vukomanovic

Queensland

Christopher David Arnott
Rafal Bacajewski
Cameron Morton Bell
Hanna Denise Burton
Rebecca Kathleen Caragata
Konika Chatterjee
Diana Da Silva
Corey Dore
Zahra Farzadi
Nathan Flint
Nicholas James Gerbanas
Alice Hazel Gynther
Ashton Jeffery
Alison May Jones
Claire Jane Maxwell
Kathryn Alice Loyna Meldon
Tony James Miller-Greenman
Martin Misevski
Amos Moody
Fraser James Andrew Morton
Stephen Naughtin
Luke Bradley Nottingham
Adrian Pregelj
Lilyana Putri Satiowijaya
Anna Catherine Imelda Shirley
Jessica Teresa Taylor
Iain C Walker-Brown
Mark A Wynne
Xianglin Yeaw

South Australia

Brian Lindsay Ambrose
Lisa Biggs
Andrew Bryan Gillard
Rebecca Anne John
Adelaide Denise Schumann
Steven Robert Wilson

Tasmania

Amit Ganguly
Peter Michael Mulcahy
Dasha Faith Tjanara Newington

Victoria

Benjamin Daniel Biles
Isabelle Laura Cooper
Sean John Davies
Cameron Gibson Galbraith
Andrew John Goldberg
Megan Elizabeth Haysey
Timothy Boh Chu Ho
Seyed Soheil Hosseini
Akshay Hungenahally
Nicole Jacqueline Hunt
Patricia Ky
Bianca Antoinette Macula
Matthew David Mathieson
Christopher John Moran
Michelle Minh Tuong Lam Nguyen
Reshma Shridhara Pawar
Alice Elizabeth White
Luke William Willshire

Western Australia

Natalie Akl
Simon Peter Bradbeer
Suze Dominique Bruins
Maya Calvert
Peter Benjamin James Garnett
Jodie Lisa Jamieson
Carl Lee
Ryan Maslen
Michael Tak Kwan Miu
Simon Don Papaelias
Hannah Perlman
James Franklin Preuss
Craig Melville Rainbird
Scott Cameron Sargant
Bojana Stepanovic

NEW ZEALAND

Sarah Jane Ashcroft
Michael J Barlev
Melvin Mingwen Chong
YanYi Chuah
Nicola Anne Delany
William Ian Esson
Malindra Clive Illekuttige Fernando
Shadi Nabil Zaki Gadalla
Dana Rae Hirsch
Sanna Maria Aulikki Huhtamaki
Alisa Kim Ireland
Andrew James Johnson
Sebastian Paul Karalus
Calum John McHugo Donald
Leesa Jane Morton
John Anthony Newland
Estee Alexandra Parsons
Benjamin John Simpson
Matthew James Sumner
Syed Muhammad bin Syed Abdul Hamid
Simon John Berndt Versteeg
Nicole Kyla Vogts

Renton Prize

The Court of Examiners recommended that the Renton Prize at this sitting of the primary examination be awarded to:

John Anthony Newland, New Zealand

Merit certificates

The Court of Examiners recommended that merit certificates were awarded to:

Alice Hazel Gynther, Queensland
Rafal Bacajewski, Queensland
Craig Melville Rainbird, WA
Natalie Akl, WA
Simon Don Papaelias, WA
Simon Peter Bradbeer, WA

Final Fellowship examination March/May 2016

One hundred and thirty eight candidates successfully completed the final fellowship examination at this presentation and are listed below:

AUSTRALIA

Australian Capital Territory

Kalyna Harasymiv
Jennifer Anne Hartley
Katie McCloy

New South Wales

Peter Alexander Baird
David William Bell
Solmaz Bezyan
Romy Catherine Busbridge
Joseph David Byrne
Steven Ciwen Cai
Philip Cheung
Monica Li-Meng Chew
Daniel Friedgut
Hugh Patrick Harricks
David Healy
Vivian Wei-Ying Ho
Megha Jain
Anne Veena Nilakshi Jayamaha
Gowri Jegasothy
Blake Gordon Kesby
Ananth Kumar
Edward Lee
Katherine Jialynn Lee
Louisa Frances Lowes
Georgina Stewart Mahony
Alyson Patricia McGrath
Sharon Lisa McGregor
Rachel Amanda McLennan
Ross Mortimer
Lois Gayeon Oh
Jacqueline Louise Robson
Natalie Russell
Brad Alexander Sheridan
Timothy Richmond Sullivan
Shanthi Widana-Pathirana
Hoi Tin Rex Yuan
Matthew Gerard Van Zetten

Queensland

Anthony James Baird
Meredith Ann Betts
Danielle Isabel Crimmins
Malaka Devinda Dias
Iain Doherty
Christopher L Futter
Babitha Kudakandira Basappa
Sarah Louise Maguire
Paul Robert Mills
Scott Martin Popham
Shaun J Roberts
Bernadette Louise Roebuck
Paul Daniel Slocombe
Francia van der Merwe
Samuel James Walker
Courtney Louise Williams
Winnie Man Wai Yu

South Australia

Stewart Robert Anderson
Armin Baghini
Kirsty Georgina Belfrage
Wilson Ted Sin Chee
Sheng Kai Lim
Praveen Babu Mamillapalli
John Pieterse
Tanya Przybylko
Mei Quinn Tan
Peter Francis Webb

Tasmania

Kate Elizabeth Drummond
Robert Gregory Easther

Victoria

Catherine Margaret Algie
Babak Amin
Kate Emma Barrett
Erin Kate Bourke
Christopher Raoul Clemens
Michael Itiel Cukierman
Marissa Ferguson
Jessica Gillett
Robert William James
Alison Margaret Jarman
Julia Kuchinsky
Nicholas James Lanyon
Fung Nien Lim
Madeline Jia-Yue Lim
Melissa Li-Ping Lim
Anna Jane Loughnan

(continued next page)

Successful candidates (continued)

Olivia Millay
Gregg Miller
Christopher Jensen O'Loughlin
Francis James Parker
Christopher Neale Rees
Sohrab Salarzadeh
Hannah Shoemaker
Shervin Hedayat Tosif
Yen Tran
Lucinda Johnson Verco
Sarah Therese Wallis
Tzu-Yen Wang
Robert Matthias Wengritzky
Danielle Catherine White
Suran Aravinda Wickramaarachchi
Andrew Thomas Woolley
Hamish Donald John Woonton

Western Australia

Johnny Lester Burston
Conor Patrick Day
Yael Katinka Fiebelkorn
Ryan David Juniper
Kristen Lorraine Kiroff
Dennis William Millard
Emil Martin Peska
Sigrid Elisabeth Pfeiffer
David Brian Anthony Rawson
Milena Wilke
Jing Xiao

NEW ZEALAND

Gareth Shivantha Ansell
Martin Andrew Bailey
Alexander James Bates
Edwin Coates
Owen William Davies
Daniel Fung
Penelope Louise Geens
John Hay
Luke Kain
Henry Cecil Milne
Matthew Paul Musker
Samantha Seelawathie Paul
Greta Claire Pearce
Alastair John Proud
Sathishlingham Shanmuganathan
David Ernest Silverman
Claire Francis Smith
Nicola Smith
Michael Warwick Tripet
Irene Maree Whyte
Stephen Chun Young

HONG KONG

Chan Chor San Alfred
Chun Man Wai
Lam Chi Cheong
Luk Ting Hin

MALAYSIA

Chong Howe Yee
Shahir Hamid Mohamed Akbar

SINGAPORE

Charis Ern Huey Khoo
Ambika Paramasivan

IMGS examination March/May 2016

Five candidates successfully completed the International Medical Graduate Specialist Exam at this presentation and are listed below:

Farhood Tofighi, ACT
Ranga Jeevanie Vitiyala, NSW
Kingsley Paul Storer, SA
Judit Orosz, Victoria
Lekha Dilrukshi Walallawita, WA

Cecil Gray Prize

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended June 30, 2016 be awarded to:

Christopher Raoul Clemens, Victoria

Merit certificates

Merit certificates were awarded to:

Christopher Jensen O'Loughlin, Victoria
Shaun J Roberts, Queensland
Irene Maree Whyte, NZ
Julia Kuchinsky, Victoria
Lucinda Johnson Verco, Victoria

Research showcased at ASM

Above: Ms Clea Hincks, Professor Ngan Kee and Professor Alan Merry.

Experienced and emerging researchers and interested delegates came together for two fabulous sessions at the 2016 ANZCA Annual Scientific Meeting (ASM). Fellows and trainees can catch up with these presentations on the Virtual ASM at https://asm.anzca.edu.au/virtual-asm.

The Breaking Trials session is a highlight of the ASM every year. The aim of the session is to give ANZCA Fellows a chance to hear the first presentation of results from major studies, particularly those endorsed and run by the ANZCA Clinical Trials Network. This year presentations ran the gamut from major cardiac surgery through to anaesthesia for caesarean section to sedation for gastrointestinal endoscopy.

Professor Paul Myles presented results from the tranexamic acid limb of the Aspirin and Tranexamic Acid for Coronary Artery Surgery (ATACAS) trial. This trial recruited 4662 cardiac surgery patients, and randomised them to aspirin or placebo, and tranexamic acid or placebo. The study took more than 10 years to complete and represents a mammoth effort by Professor Myles, the ATACAS trial manager Ms Sophia Wallace, the ANZCA Clinical Trials Network and participating sites in Australia, New Zealand and around the world. The results are embargoed so watch for alerts about their publication in coming months!

Professor David Story presented results from the MUM Size study, which was conducted in University of Melbourne-affiliated hospitals. In 1457 women, median total operating room time was 72 minutes for normal body mass index (BMI) women and increased by 10 per cent for the 27 per cent who were obese (BMI: 35 to 45kg/m2) and increased by 30 per cent for the 5 per cent who were very obese (>45kg/m2). Both anaesthesia and surgical times were increased. Increased delivery BMI was associated with increased risk of maternal intensive care unit (ICU) admission but no increase in neonatal admission to higher acuity care. These results have major implications for health services and studies are underway to assess methods of helping pregnant women limit weight gain.

Professor Kate Leslie presented results from a study of the safety of endoscopy sedation in University of Melbourne-affiliated hospitals. 2,132 patients were included. Half of the patients were aged over 60 years, half of them had a BMI >27kg/m2 and 42 per cent of them were American Society of Anesthesiologists' physical status 3-5. Propofol doses were commensurate with general anaesthesia. Significant hypotension was the most common significant unplanned event (11.8 per cent). Seven patients (0.3 per cent) required unplanned endotracheal intubation and two patients (0.1 per cent) required advanced life support. The overall 30-day mortality rate was 1.2 per cent (6 per cent in emergency patients and 0.2 per cent in elective patients).

The aim of the second ANZCA Clinical Trials Network session is to update researchers and delegates on the keys to successful research. This year the session was titled "Publishing your results".

Professor Ngan Kee – a renowned speaker and former Australasian Visitor to our ASM, offered 10 "tips for survival" for presenters, including advice to have a plan, to keep it simple, to use PowerPoint wisely and elegantly, to practice (and practice!) and always to keep to time. Professor Alan Merry offered advice on how to get research studies published. Based on his extensive experience (and success), Professor Merry suggested careful framing of the initial research question is the real key. Meticulous preparation of the paper and following the journal's guide for authors also were highlighted. Finally, ANZCA General Manager Communications Ms Clea Hincks spoke about lifting the profile of ANZCA research and investigators through the media and through government advocacy. Good research stories are enthusiastically pursed by the media and, through them, the community. Politicians become interested when their constituents are engaged. Careful control of the message is important and that's where good advice from experienced media managers comes in.

The ANZCA research community also greatly enjoyed the Gilbert Brown Prize Session (won by Dr Adrian Chin for "A randomised controlled trial comparing ultrasound and palpation assisted combined spinal epidural anaesthesia for elective caesarean section"); the Trainee Prize Session (won by Dr Adam Hollingworth for "Does formalisation of handover and the use of a joint structured visual aid improve postoperative handover?") and the ANZCA Research Grant session. These sessions included many wonderful studies from researchers around the ANZCA regions, funded by grants from the Anaesthesia and Pain Medicine Foundation. Visit the Virtual ASM to check these out!

The ANZCA Clinical Trials Network Executive, investigators and trial co-ordinators greatly appreciate and enjoy the opportunity to participate in the ASM each year, and to meet with the hundreds of anaesthetists who help with our studies and who are the end-users of our results. We look forward to our Strategic Research Workshop August 12-14 this year and the ANZCA ASM in Brisbane in 2017.

Professor Kate Leslie AO
Chair, Clinical Trials Network Executive

Foundation features at the ASM

Research highlights at foundation function

Thank you to all those who attended the foundation's successful "Research on the edge" function at Auckland Town Hall during the ANZCA Annual Scientific Meeting in May. Speakers Dr Hartley Atkinson of AFT Pharmaceuticals, Foundation Committee Chair Dr Lindy Roberts and Professor Alan Merry, Chair of the ANZCA Research Committee were well-received. It was a great opportunity to recognise our new major sponsor, Perpetual, our emerging researcher grant recipients, and of course all of the foundation's generous donors and patrons.

Professor Merry shared some highlights of the increasing recognition of Fellows and their research in the specialties. These include:

- Professor John Myburgh's involvement in the $A5,914,816 NHMRC grant for the Plasma-Lyte 148® vs Saline trial.
- Professor Ian Seppelt's NHMRC Research Excellence Award for the top-ranked project grant in 2014.
- Professor Paul Myles' team's NHMRC grant of $A2,285,290 for the ITACS trial in 2015.
- The landmark appointment of Melbourne Medical School Foundation Chair of Anaesthesia, Professor David Story being appointed to NHMRC Council in 2015.
- ANZCA Clinical Trials Network (CTN) Chair Professor Kate Leslie's prestigious Officer of the Order of Australia award (AO) in the Australia Day honours in January 2016.

Highlights also include the publication in February 2016 of the results of the CTN's ATACAS trial on aspirin and coronary artery surgery, led by Professor Myles' team including several other ANZCA Fellow investigators, in the *New England Journal of Medicine*.

Research awards at the ASM

One of the annual high points for ANZCA and foundation-funded research is the presentation of research awards by Professor Alan Merry after the Gilbert Brown Prize Session at the annual scientific meeting.

At the Auckland meeting this year, awards went to Professor Matthew Chan (Harry Daly Award), Professor Michael Paech (John Boyd Craig Research Award), Professor Stephan Schug (Pfizer ANZCA Research Award), Dr Philip Finch (Russell Cole ANZCA Memorial Research Award), Dr Hugh Taylor (ANZCA Melbourne Emerging Researcher Award), Dr Joel Symons (the Robin Smallwood Bequest), and Dr Nicole Tan (Perpetual ANZCA Emerging Researcher Award).

(continued next page)

Above clockwise from left: Foundation Committee Chair Dr Lindy Roberts; A good turn out for the Foundation reception; President Genevieve Goulding, Associate Professor Jenny Weller and Professor Dave Story; Keynote speaker Dr Hartley Atkinson of AFT Pharmaceuticals.

Foundation features at the ASM (continued)

Both the Perpetual award and the Robin Smallwood Bequest were awarded for the first time in 2016, representing the importance of Perpetual's corporate partnership, and of the generous contribution in perpetuity established by the Smallwood family in memory of Dr Robin Smallwood and his significant leadership and contribution to anaesthetics.

The Russell Cole award, now in its third year, continues to make an outstanding ongoing contribution to the development of pain medicine.

Congratulations to all established and early career grant and award recipients on their outstanding grant applications.

Supporting emerging researchers appeal 2016

While our established researchers are generating increasing impact and evidence for practice, it is just as encouraging to see our early-career researchers getting an increasing share of the foundation's annual grant funding.

Supporting them is an important investment in the future of investigation and excellence in the specialties, their contributions across perioperative medicine.

The foundation's recently mailed appeal features personal reflections from emerging researchers and foundation grant recipients Dr Nicole Tan, Dr Julie Lee, Dr Jonathon Hiller, Dr Alwin Chuan and Dr Raymond Hu. Please support the appeal, and thank you to all those who have already donated!

Thanking new Patrons Program members

A huge thank-you to all new Patrons Program members for your support. Patrons commit to annual donations of $A1000 or more to support research and education, and are some of the foundation's most committed and valued supporters.

From April to June this year, nearly 20 Fellows have joined the program. We look forward to providing them with special reports and insider updates on studies, investigators, publications and other research highlights in 2016 and beyond.

Australian Executor Trustees

In May, Australian Executor Trustees advised the foundation that its invited submission for a grant of $A35,000 to support a South Australian researcher and project had been successful.

The foundation was delighted to receive the funding, which is a valuable encouragement of South Australian research in the specialties at a time when research funding in the state is at a premium.

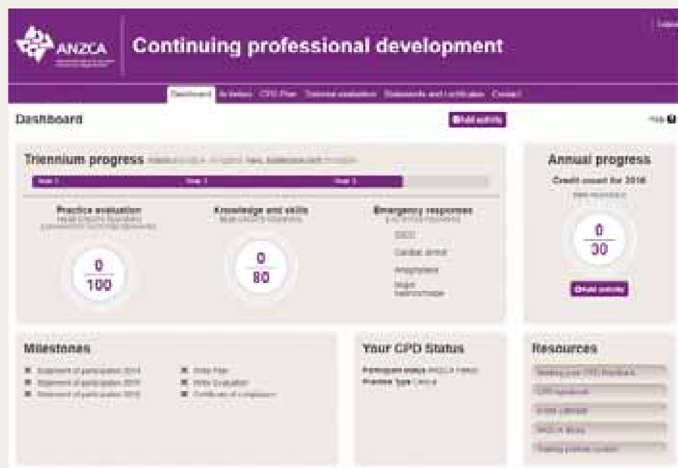
Supporting in perpetuity

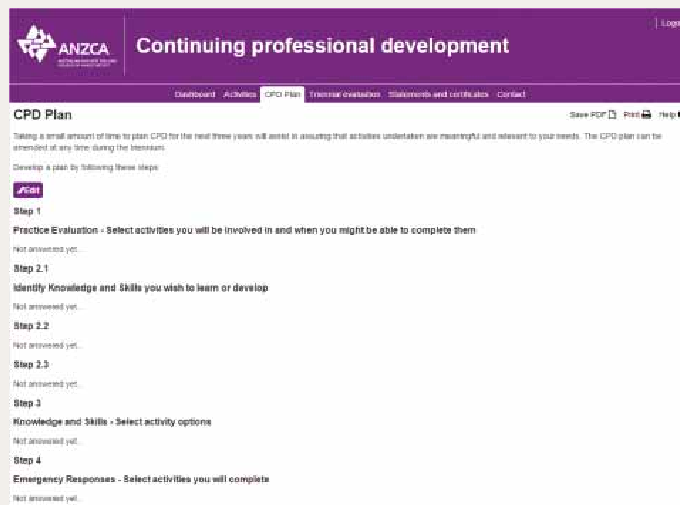
Any supporter who is interested in creating a perpetual future contribution to delivering great outcomes to patients by including a bequest in their will should contact Rob Packer at the foundation on +61 3 8517 5306 or rpacker@anzca.edu.au.

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**

End of triennium – what needs to be done





Is 2016 the last year of your triennium?

The 2014-2016 continuing professional development (CPD) triennium finishes on December 31.

Below are the requirements you will need to have completed by this date:

Triennial requirements

- Complete all six sections of your CPD plan.
- Complete all six sections of your triennial evaluation.
- Practice evaluation – 100 credits in total (including at least two mandatory activities).
- Knowledge and skills – 80 credits.
- Emergency responses – at least two activities (CICO, cardiac arrest, anaphylaxis and/or major haemorrhage).
- A minimum of 30 credits annually each for 2014, 2015 and 2016.

End of triennium tips

Now is the time to review your current status.

Ensure you have completed every step of your CPD plan to unlock your milestones, this will help you track that you have met your annual requirements for 2014, 2015 and 2016. If you have entered the required 30 credits for each year, your statements will appear with a tick next to them.

You can complete the same practice evaluation activity twice in order to meet the two mandatory activity requirements, so long as they are one year apart.

Assistance

Have your circumstances changed, or is there something that has prevented you from completing a certain part of your triennium?

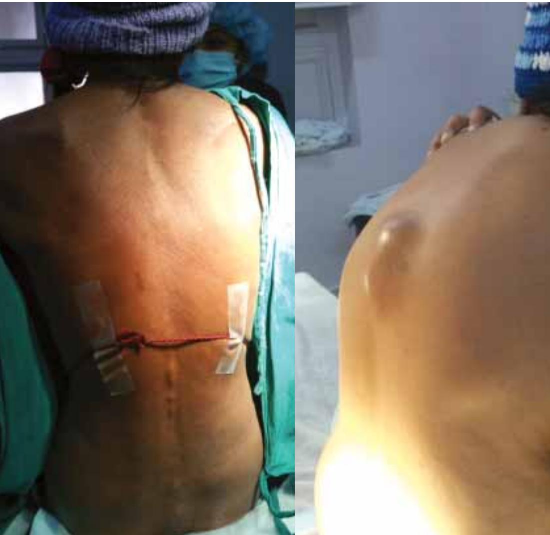
Participants who are unable to meet the minimum CPD requirements due to exceptional circumstances may apply for special consideration. The chair of ANZCA's CPD Committee will assess all applications on an individual basis. Examples of circumstances that may be considered are serious illness, loss or bereavement, or hardship.

Are you unsure about where to log an activity in your portfolio? Or is there something you need to do that you are unsure where/how to do?

If so, please contact the CPD unit well in advance for assistance via **cpd@anzca.edu.au** or **+61 3 9510 6299**. We will be happy to talk you through it.

Volunteer specialists change lives in Nepal

"The patients lie quietly during the surgery. I have to ask them frequently whether everything is OK. Stoicism and forbearance is the norm. Acceptance makes life tolerable."



"I feel conflicted. On an individual level this is rewarding but the problem is too great, the work immense."

Dr Kenny Lewis from Sydney Adventist Hospital in Wahroonga NSW was a volunteer with the Women's Health Team of Open Heart International, which visited Nepal in March.

Day seven on our mission to alleviate Nepal from its scourge of pelvic prolapse: I find myself puffing up a dusty hill halfway between our hotel in Dhulikeil and the Scheer Memorial Hospital in Banepa. It is 6.45am but already the Nepal countryside is awake and active. Elderly women carry heavy pails up rocky paths, children trip down mountain roads in an assortment of school uniforms, men repair tattered roofs on buildings bent and broken. Everywhere the bleating, barking, yelping, cooing of resident creatures, tame and wild.

I summit the hill and descend to the town. In the streets there is dust and smoke and noise and litter and colour and life. A heaving melee of bicycles, scooters, children playing in ditches, dogs sampling yesterday's rejected meals, old men pulling food wagons where anything sells. A woman throws her turbid washing water into the streets. A dog runs away. A truck with colourful medallions hoots a jingle as it swerves to avoid a man pushing a cart burdened with fruit. A tailor using a sewing machine with a foot pedal plies his trade oblivious to passers by. The sweet smell of incense. A temple bell. Everywhere the dust and fumes of a town choking on its own waste.

The welcoming gates of the hospital appear unexpectedly through the haze. The crowd before the registration clerk parts to let me through. In the open courtyard, patients and their early visitors mingle and talk in hushed tones. An orderly mops the stone theatre floor with disinfectant.

In the theatre annex I meet my first patient: Mrs DS, an old woman, skin creased and folded like the Himalayan foothills. A lifetime of physical exertion imprinted on her face. Small hands and feet. Average height and weight – 146cms, 41 kg. (I am 186 centimetres in my theatre clogs; Gulliver in the land of Lilliput). A student nurse is my stand-in interpreter. "Namaste Amah," my greeting. I learn that the patient is 61 (she looks 80), has had 12 pregnancies, seven children still living. "What happened to the children who died?" The patient tells they died from disease. She couldn't get them to the clinic to immunise them. Does she smoke? No. Gave up three years ago. I soon learn that the answer to this question is irrelevant. Passive smoking affects everyone and cooking is done indoors over open fires. Never been to hospital before; denies diabetes or hypertension (quite prevalent); takes no medication. I don't ask about herbal remedies. I don't know enough about them.

We proceed to the tiny theatre. Plaster cracking off walls. An antique voltmeter in the corner to regulate the theatre lights. The strong smell of Lysol is overpowering. Our Ulco-Campbell anaesthetic machines are vintage Australian, made obsolete by new technology. The ventilators don't work. An enormous oxygen cylinder dominates the workspace. The pressure valves on the cylinder are broken, a low whistle from the fail-safe valve on the machine our only warning of impending gas failure. I check the batteries in the flashlight – essential backup in a country where electricity fails four or five times a day.

My attention turns to the anaesthetic drugs and equipment. I review the syringes and needles we brought with us, which are adequate for the simple anaesthetic required: spinal anaesthesia with light sedation. In older patients who have endured a lifetime of hard work, spinal anaesthesia can be challenging. Small intervertebral spaces, degenerative spine disease, calcified interspinous ligaments. Variations in technique are required but are ultimately successful. The patients lie quietly during the surgery. I have to ask them frequently whether everything is OK. Stoicism and forbearance is the norm. Acceptance makes life tolerable.

It is only when I see my patients the next day that the real person emerges. The surgical ward is filled with relatives bearing small gifts or good wishes. The patients lie quietly on stretchers stacked six abreast within the whitewashed walls. I recognise my patient from yesterday. A woollen blanket, so large it makes a mockery of her diminutive frame. She sits up and offers me a gapped-tooth smile. Presses her hands together and offers a diffident nod of the head. Her lips crease to allow a smile through. "Dunyabad" (thank you). Namaste!

I head back to the theatre for a teaching session with the students before my afternoon list. I feel conflicted. On an individual level this is rewarding but the problem is too great, the work immense. What to do, where to start? Are we making a difference? I am reminded of the proverb: "Charity sees the need not the cause". For Mrs DS, a short visit by a group of inspired volunteers from Australia has changed the world.

Dr Kenny Lewis,
Sydney Adventist Hospital, NSW

Opposite page from left: Banepa, Kathmandu Valley; shared communal bath; postoperative ward; Dr Kenny Lewis with patient; thyroid goitre; Registration desk at Scheer Memorial Hospital; Hindu Kalava or sanctified thread; TB spine.

Specialists fly in to assist cyclone ravaged Fiji

Three New Zealand anaesthetists were among 23 volunteers who made up the NZ Medical Assistance Team (NZMAT) response after Tropical Cyclone Winston devastated parts of Fiji on February 20.

The participating anaesthetists were Dr Wayne Morriss from Christchurch, Dr Tony Diprose from the Hawke's Bay Regional Hospital in Hastings and Dr Alan Goodey from Waikato Hospital in Hamilton.

The Australian Medical Assistance Team (AusMAT) also sent 23 people to Fiji, including Dr Andrew Magness, an anaesthetist from the Royal Darwin Hospital.

Dr Morriss was one of a four-person initial assessment team that worked with Fiji's Ministry of Health to determine the most appropriate medical response. Networks and relationships are critical in the South Pacific and Dr Morriss' previous practice in Fiji (2000-02) proved invaluable.

A few days after the cyclone, Dr Morriss flew to Vanuabalavu Island in the northern Lau group, along with Fijian medical colleagues.

"As we approached the island, the massive destruction caused by the cyclone was very evident," Dr Morriss said. "We learnt that as many as 90 per cent of the homes on the island were destroyed. Fortunately, the number of deaths and injuries – five people were killed and three were admitted to hospital for injuries – was way below what was originally feared. This was really a testament to the good preparation done by the Fijians."

The scale of the devastation was similar on Koro Island, which Dr Morriss visited with two colleagues from AusMAT.

Based on the initial assessment team's recommendations, the NZMAT deployed 19 people to provide medical support on several fronts. These included surgical support for the main hospital in the capital, Suva, a five-person team on Koro Island, a four-person team to the northern Lau group of islands, and a two-person team to the Combined Task Force Headquarters established by the New Zealand Defence Force.

Dr Diprose and Dr Goodey each worked with a surgical team at the Colonial War Memorial Hospital in Suva. The team managed cyclone-related injuries so local medical staff could focus on other emergency and elective work.

Dr Morriss described his two-week deployment to Fiji as a very sobering experience.

"It was sad to see the immense loss and devastation suffered by the people of Fiji," he said. "But I am glad I was able to go back and help as part of the NZ Medical Assistance Team."

Colonial War Memorial Hospital medical superintendent Dr Jemesa Tudravu was quoted in the *Fiji Times* as saying the New Zealand medical personnel had greatly assisted the work at the country's largest referral centre.

Susan Ewart
Communications Manager, NZ

Opposite page from left: Eseta Kaitani and her three daughters show cyclone damage to their village of Nasau on Koro Island (photo taken by the New Zealand Defence Force); Dr Wayne Morriss with Fijian colleagues on Vanuabalavu Island in the northern Lau group; the eight-person surgical team outside the Colonial War Memorial Hospital in Suva with Dr Tony Diprose (far left) and Dr Alan Goodey (fifth from left).

New Zealand news

Research workshop attracts interest

Thirty-four people took part in ANZCA's second New Zealand research workshop, demonstrating that there is keen interest in learning how to conduct successful research.

The workshop, entitled "A toolkit for emerging investigators", was held at Auckland City Hospital on March 11.

Convenor Dr Thomas Fernandez, supported by Dr Kerry Gunn and Dr Doug Campbell, organised an excellent program presented by eminent New Zealand researchers together with Professor Scott Beattie from Toronto, Canada, who was in New Zealand for the Auckland City Symposium the following day.

Professor Beattie presented on "Achieving high quality clinical evidence in anaesthesia". The other topics were: "The question, the methods and the significance" (Professor Alan Merry); "So you want to be a researcher?" (Dr Bob Boas); "The value of a PhD" (Associate Professor Simon Mitchell); "Establishing a research department" (Associate Professor Tim Short); "ANZCA Scholar Role" (Dr Jennifer Woods); "Utilising database research" (Professor Scott Beattie); "The open field of neuroscience of anaesthesia research: clinical and laboratory possibilities" (Professor Jamie Sleigh); "Research in pharmacogenomics" (Dr Dean Bunbury); and "Conducting a pilot study" (Dr Doug Campbell).

The program closed with a moderated question and answer session, "Meet the experts", with a panel involving Professor Beattie, Professor Merry, Associate Professor Short and Professor Sleigh.

Very positive feedback indicated the workshop gave the registrants inspirational ideas on conducting successful clinical research. They also appreciated the opportunity to network, establish research-related contacts and develop themes for clinical research.

This workshop was supported by the ANZCA NZ National Committee and the Joint Anaesthesia Faculty Auckland (JAFA) Trust. The next research workshop will be held in 2018.

Network for obstetric anaesthetists

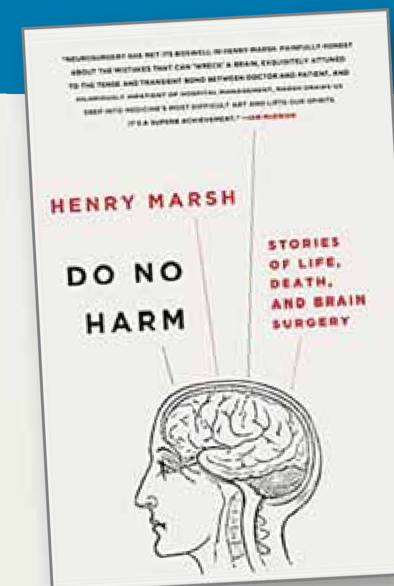
ANZCA's NZ National Committee and the NZ Society of Anaesthetists are jointly supporting a network of obstetric anaesthetists, which plans to meet several times a year to share information and experience, and to discuss issues. Dr Douglas Mein from Wellington Hospital is chairing the network, which comprises obstetric anaesthetists from all district health boards.

The group aims to provide national representation of obstetric anaesthetists, consolidate and amalgamate good practice, share guidelines and good practice, give support for clinical practice in difficult cases, and encourage and support members to foster training and education. It also hopes to improve professional connections with colleagues in obstetrics and midwifery.

After an inaugural planning meeting in November, about 20 obstetric anaesthetists attended the first national meeting held at ANZCA's Wellington office on March 7. The meeting also was attended by Ministry of Health information technology staff and representatives from the company developing the Badgernet maternity records management system, who discussed how the system was working.

ANZCA hosted a second face-to-face meeting at its Wellington office on May 30. The network also has been invited to join an obstetric and midwifery group meeting on August 15 at Wellington Hospital. A final meeting for the year is proposed for November.

Clockwise from top left: Professor Scott Beattie from Canada; Attendees at the 2016 Research Workshop soak up advice from top researchers; Mr Henry Marsh, keynote speaker at the forum exploring leadership in health quality and safety, and his new text; Obstetric anaesthetists sharing knowledge and experience at the first national meeting of their new network.



Team leadership vital for safety

Leadership that works within a team is safer than old-style leadership, which risks errors because juniors may be too scared or deferential to speak up. This was a key message arising from a Health Quality & Safety Commission (HQSC) forum held in Wellington in March, which explored the place of clinical leadership in health quality and safety.

ANZCA's NZ Safety and Quality Officer, Dr Geoff Laney, and NZ General Manager, Ms Heather Ann Moodie, attended the forum, which featured top British neurosurgeon Mr Henry Marsh, a pioneer of using awake craniotomy for intrinsic brain tumours and the author of *Do No Harm*. Mr Marsh spoke on role modelling; openness and learning from mistakes; communication with colleagues and patients; team work; making hard decisions; stepping up; and patient involvement in choices.

He was joined by an impressive line-up of senior New Zealand health and other professionals, who shared their insights and practical experience, and drew on what clinical leadership meant for them in practice. These included Health Minister Dr Jonathan Coleman and the Director-General of Health, Mr Chai Chua.

The forum acknowledged that leadership styles have changed significantly since the 20th century and that contemporary leadership works in a team environment. The danger of sole leaders who did not listen to those around them was illustrated using examples from the aviation industry where planes had crashed because junior staff were too scared to speak up in deference to their leader.

A successful leader not only leads from the front but also from the middle or from behind. Leaders are not just great problem-solvers, they deliberately build and leave behind even greater leaders. Mr Marsh summarised his take on clinical leadership as: visibility, continuity of staff, trust, charisma, open to discussion and criticism, but able to make and execute decisions.

He said he believed the European working time initiative had adversely affected junior staff by diluting experience, breaking up the "team" and demoralising/alienating many junior staff. He also said "zero harm" was unobtainable and mentioned the General Medical Council's 2015 paper, the "Duty of Candour", explaining when and how to apologise.

In his second presentation, Mr Marsh pointed out that patients can be ambivalent about information – wanting to know but also fearing the truth. Top cricketer and sports administrator Mr Martin Snedden, who organised New Zealand's hosting of the Rugby World Cup in 2011, said a leader must start with a great story, which people understand and agree with, paint the picture with conviction and simplicity, and have resilience, great relationships, the ability to make key decisions and a willingness to genuinely listen.

The consultant/junior dynamics and the patient/doctor relationship also were discussed. Videos of the presentations are available on the HQSC website at www.hqsc.govt.nz.

Australian news

Australian Capital Territory

Scan and ski workshop, July 15-16

The ACT Regional Committee will host a new workshop in July entitled "Scan and ski: Regional ultrasound scanning workshop for peripheral nerve blocks". Dr Ross Peake will convene the workshop, featuring world-renowned ultrasound specialists Dr Alwin Chuan, Dr Peter Hebbard, Dr Brad Lawther, Dr Andrew Lansdown and Dr David Scott. It 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 only a few places remain available so register now to avoid missing out. Event details can be found on the ANZCA ACT web page.

Art of Anaesthesia – registration now open

The 2016 combined Art of Anaesthesia meeting will be held in Canberra over the weekend of October 15-16. The theme of this year's meeting is "Back to the future" and registration is now open. During the Saturday program we will be providing presentations on the modern management of what might be considered old chestnuts: reflecting on the current "hoops" of hospital accreditation and continuing professional development through the prisms of two recently successful PhD candidates; trying to get our heads around care of the brain in various states of distress; and looking to the future of anaesthesia. On Sunday morning, there will be two emergency response workshops, Can't intubate can't oxygenate and Anaphylaxis management. In the afternoon, there will be a fibre-optic bronchoscopy workshop with Associate Professor Scott Parkes. The workshops will help those who wish to complete mandatory ANZCA Continuing Professional Development Program emergency response activities and those who wish to refresh their knowledge of the complex art of fibre-optic intubation.

We welcome everyone to the meeting and encourage all to attend the last week of the Floriade flower festival. Floriade is Australia's largest celebration of spring and showcases one million flowers in bloom throughout Commonwealth Park. Bring the family, stay for the weekend and enjoy a unique experience in the nation's capital. Event details, including online registration, can be found on the ANZCA ACT web page.

Preeclampsia and obstetric emergencies – a wonderful evening with Associate Professor Alicia Dennis

More than 50 local Fellows and trainees attended an evening presentation in Canberra on Thursday April 14 with the theme of preeclampsia and obstetric emergencies. Associate Professor Alicia Dennis delivered two wonderful 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".

Associate Professor Dennis is a specialist anaesthetist and director of anaesthesia research at the Royal Women's Hospital in Melbourne. She is also a National Health and Medical Research Council 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.

South Australia and Northern Territory

Above from top: Dr Tony Chadderton; Dr Christine Huxtable.

Continuing medical education event

Sixty-two delegates attended the first South Australian and Northern Territory continuing medical education event of the 2016 series, held at the SA Women's and Children's Hospital.

Dr Tony Chadderton, a specialist in addiction medicine from Drug and Alcohol Services SA, and Dr Christine Huxtable, FANZCA, an anaesthetist at Royal Adelaide Hospital, gave informative presentations on the topic of "Anaesthesia and recreational drugs".

Dr Chadderton spoke about addiction and drug profiles of methamphetamines, opioids and alcohol. Dr Huxtable presented on the acute management of the dependent patient.

The event was well received and presentations were professionally recorded and distributed to remote South Australian and Northern Territory hospital anaesthesia departments to assist with training and continuing professional development.

Preparing for the primary exam

The SA Regional Office has been hosting a range of exam preparation activities. The regional staff and SA and NT trainees are grateful to Dr Nicholas Knight for co-ordinating these sessions and appreciate the specialist consultants who give valuable time and expertise in offering practice vivas to our trainees.

Above from top: Dr Marni Calvert and Dr Perry Fabian speaking to attendees; Dr Andrew Gillard, Dr Nicholas Knight, Dr Brian Ambrose and Dr Adelaide Schumann at a primary exam preparation session.

South Australian colleges career evening

On Wednesday February 24, the SA and NT Regional Committee Chair, Dr Perry Fabian, and the SA and NT Trainee Committee Chair, Dr Marni Calvert, presented at a colleges career evening. The event was held at the Glenside Hospital campus and was attended by 55 medical students and postgraduate students (PGY1-5). Presentations were made by representatives from the AMA, AMP, ANZCA, and colleges representing rural medicine, emergency medicine, general practitioners, surgeons and psychiatrists.

Australian news (continued)

Queensland

Final practice viva evenings

The first ANZCA fellowship viva of the year is fast approaching and the Queensland Regional Office has run a series of practice evenings to help fine-tune candidates' skills and knowledge.

After recent efforts to improve examiner participation, it was pleasing to see a better ratio of examiners to candidates almost reaching 1:1 the first evening. We also had an interested Fellow come as an examiner observer with a view to participating as a mock later this year.

The Queensland Regional Office aims to improve the quality of our exam preparation sessions and will release a guide to writing and performing mock exams to participating examiners later in the year.

As always, the success of practice evenings depends on Fellows generously giving their time to be mock examiners. Thank you to all those Fellows who participated and good luck to the candidates sitting soon.

Supervisor of training meeting

The first of three supervisor of training meetings for 2016 was held in the ANZCA Queensland Regional Office on Friday March 4. The Queensland regional education and deputy education officer, ROT's and nearly 30 supervisors of training from metropolitan and regional Queensland attended the meeting. Queensland now has four rotations making up the Queensland Anaesthesia Rotational Training Scheme (QARTS), and the meeting provided a valuable opportunity for networking, discussion and interaction between new and more experienced supervisors.

During the morning, a formal business meeting included discussion of common issues relating to registrar training and supervision, updates from ANZCA about future education projects and updates on the ongoing curriculum review.

Two workshops in the afternoon provided further education for supervisors of training and a chance to practice and refine their knowledge and skills. The first, "Getting off to a good start", focused on the initial clinical placement review and maximising the value of the clinical placement plan for trainees and supervisors of training. This was followed by an interactive workshop on "Feedback - the what, the how and the when". Different models for providing feedback were discussed and participants practised giving and receiving feedback.

Suzanne Bertrand
ANZCA Deputy Education Officer (Qld)

Tasmania

Tasmanian combined mid-winter meeting

The Tasmanian combined mid-winter meeting will be held on Saturday August 20 and moves from the Tasmanian east coast to the stunning mountainous wilderness of Cradle Mountain for the first time.

The convenors of the one-day meeting, Dr Daniel Aras and Dr Peter Wright, feel this will bring a different and unique feeling to the meeting and provide delegates with an opportunity to explore the Tasmanian wilderness, as well as meet colleagues and hear relevant and interesting presentations in a setting that feels a long way from the pressures of work, but is only a couple of hours from the city and airport.

Dr Aras has been to Cradle Mountain on numerous occasions and says the area offers a unique and delightful experience in all seasons with its ancient rainforests, crystal clear lakes and alpine heathland. He believes the meeting will be a great opportunity for attendees to bring their families, plan a romantic weekend getaway or take the opportunity to go bush walking.

The theme of the meeting, "An anaesthetic mélange", reflects the broad and dynamic mix of topics. Dr Wright says delegates can attend presentations on subjects including the diagnosis and management of chronic pain; a panel discussion on current industrial issues; a personal perspective on humanitarian aid; an update on the use of intravenous iron supplementation pre-operatively; an innovative approach to the use of information technology in anaesthetic practice and *The Crimean War: How Modern Hospitals Began*.

There also will be a concurrently run ANZCA-accredited advanced life support refresher workshop. Dr Sandy Zalstein and Dr Malcolm Anderson will facilitate their popular refresher workshop with limited places available in two small workshop sessions. They look forward to maximising hands-on experience and learning, and encourage people to register early to avoid disappointment.

There will be a meeting dinner at the end of the day for delegates to enjoy local cuisine and socialise in a relaxed setting.

This meeting is limited to 40 delegates in an intimate and informal setting. The convenors urge people to register quickly to not only attend a meeting but also to gain an "experience".

To register or for more information please go to the Tasmanian web page.

Photo by Dr Roger Wong.

Australian news (continued)

Western Australia

Western Australian anaesthesia meetings

The ANZCA and Australian Society of Anaesthetists Autumn Scientific Meeting, titled "Updates in anaesthesia", was held on March 12 at the University Club, University of Western Australia. One hundred and fifty seven delegates and 45 anaesthetic technicians attended the meeting, which also attracted 18 healthcare industry sponsors.

Professor Michael Paech spoke on "Rapid sequence induction for GA caesarean delivery" and Dr Andrew Heard spoke on "Can't intubate, can't oxygenate, can it be avoided?" There were multiple concurrent workshops that made this event very attractive to delegates. Anaesthetists spoke on perioperative medicine, CPET interpretation, post-dural puncture headache, mentoring, major haemorrhage and CICO.

Dr Anna West was presented with the Dr Nerida Dilworth Prize for 2016 and Dr Aileen Donaghy presented on the DRC Bunny Wilson Lecture with her experience from North til South.

WA regional coordinator Melanie Roberts attended the Medical Careers Expo on April 12 with Dr Kev Hartley, Dr Grace Ho and Dr Gary Devine at Burswood on Swan. The ANZCA booth was very busy all night with questions from medical students and interns. Thank you to Kev, Grace and Gary for their assistance.

The Education Officer/Supervisor of Training meeting will be held on July 27.

The Country Meeting will be held October 21-23 at the Pullman Resort Bunker Bay. Registrations open in July.

Above clockwise from left: Dr Kev Hartley instructing a student at the medical expo; Autumn scientific meeting presentations in the auditorium; Dr David Borshoff presenting the Dr Nerida Dilworth Prize to Dr Anna West.

Victoria

Victorian quality assurance meeting and workshop

The Victorian Regional Committee held its first quality assurance meeting and workshop for 2016 at the College on Saturday May 14. The theme of the day was "devices and gadgets".

The meeting began with four interesting and engaging presentations/cases by Dr Param Pillai, Dr James McGuire, Dr Gwendolyn Stewart and Dr Laurence Weinberg.

Following afternoon tea, delegates broke into small group discussions that culminated with a larger group summary.

The meeting was a great success, as indicated by both the number and engagement of participants. The passion and dedication of the anaesthesia community was clearly evident on the day. Recurrent themes of discussion included "anaphylaxis" and "the quick add-on" at the end of endoscopy lists, both identified as requiring diligent specialist anaesthesia care.

The day was made possible by the hard work of the ANZCA administrative and facilities staff.

The next quality assurance meeting will be held at ANZCA House on October 8.

Dr Shiva Malekzadeh
Convenor, Victorian Regional Committee

Above: Standing: Dr Emad Hanna, Dr Rajesh Devarakonda, Presenter Dr James McGuire; Sitting: Convenor Dr Shiva Malekzadeh, Presenter Dr Gwendolyn Stewart, Chair, ASA Victorian Section Dr Jennifer King.

Right: Group discussions at the quality assurance meeting and workshop.

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

Norris Harvey Green 1947 – 2015

Norris and I met in 1966 in the anatomy dissecting labs at Sydney University while studying second year medicine and our subsequent career paths held many parallels.

Norris was born in England in 1947 and his family migrated to Australia when he was young, settling first in Brisbane and then in Sydney. With family movements his primary education spanned four different schools. His secondary schooling was more settled at Macquarie High School. In 1964 he gained a Commonwealth Scholarship, which he used to study medicine at the University of Sydney.

Our dissecting tables were just across the aisle during our pre-clinical years, but with different teaching hospitals, we next met as residents at Royal Brisbane Hospital (RBH) in 1972, and thereby hangs a tale. NSW had an archaic hospital allocation system. The top students went to the teaching hospitals while others were sent to smaller hospitals with less supervision. We felt this was inherently flawed and sent a petition to the hospital allocation body, which didn't even bother to reply. That year, 80 of 240 graduates left and moved interstate. It must have caused some embarrassment because the very next year, all graduating students were allocated to teaching hospitals, and rotated to the smaller ones. Those of us who left felt vindicated that we had taken our stand. Twenty came to Brisbane, and most stayed to establish careers in Queensland.

After our resident years, Norris and I were appointed as trainee anaesthetists at Royal Brisbane Hospital in 1974. It was a superb place to train, providing an immense range of clinical experience. It also had the advantage of being one of the few hospitals in Australia where adult, paediatric and obstetric anaesthesia were available on one campus. This gave us valuable ongoing experience in all areas throughout our training. We passed the final exam in 1977 and were admitted as Fellows of the Faculty of Anaesthetists (Royal Australasian College of Surgeons) in February 1978, then became members of the Australian and New Zealand College of Anaesthetists when it was inaugurated in 1992.

Norris moved straight into private practice. He had visiting sessions at RBH until 1983 and at the Repatriation General Hospital, Greenslopes, where he became a senior specialist in 1988. We both helped out at the Royal Australasian College of Surgeons exhibit at EXPO 88.

Norris began to look for more challenging work and took on visiting sessions at Princess Alexandra Hospital in the fields of kypho-scoliosis and major resection/reconstruction for orthopaedic malignancies.

In 1992, he planned an overseas sabbatical and the next year moved with his family to Plymouth. In March 1994, he completed an advanced trauma life support course, then returned to Australia where he worked as a locum at the Gold Coast hospital. In 1995 he joined the full-time staff at Princess Alexandra Hospital.

Norris was always looking to challenge himself. He became an early management of severe trauma (EMST) instructor in 1997 and obtained a post-graduate diploma in education from the University of Queensland in 1998, which led to teaching anaesthetics to medical students as an associate professor. He also took on the difficult area of liver transplant anaesthesia in what is acknowledged as a world-class unit. Later, when the hospital introduced an electronic record system, Norris was one of the "go-to" people in the event of problems.

He became interested and involved in anaesthetic simulation and worked closely with Dr Kirsi Taraporewalla at the Royal Brisbane Hospital simulator in the mid 2000s. He was an active member of ANZCA's Medical Education Special Interest Group. He retired in 2010, but continued to have an interest in anaesthetics, turning up from time to time for morbidity and mortality meetings over the next couple of years.

Norris was a colourful character, and I'm afraid this summary doesn't do him justice, but those who knew and worked with him will remember him with fondness. His dress sense, his humour and his clinical acumen marked him as special.

Norris died on December 6, 2015 after a slowly progressive neurological illness. His wife, Susie, and three children, Marnie, Damien and Katie, survive him.

Lawrence (Lou) Ferrari

Dr Thomas (Tom) Thomson 1920 – 2015

Tom Thomson was born on October 13, 1920 in Kilwinning, Ayrshire, Scotland and died in Hobart on September 12, 2015, a month short of his 95th birthday. During his childhood, his father was the manager of the Kilwinning ironworks, which closed during the Depression. The family moved to Lugar where his father managed coalmines. He had an older sister and a younger brother, who survives him.

Tom completed school at Cumnock Academy then went to Glasgow University where he finished medicine during the war years. These were very difficult times with rationing, limited travel and no sporting activities. In March 1941, following two heavy German bombing raids on Clydeside, he lost his student accommodation. He moved out of the city to live with two maiden aunts, travelling daily to Glasgow to attend classes. He graduated in 1945 and did his internship at the Glasgow Western Infirmary.

Tom joined the army and served in the Royal Army Military Corps in Egypt, Palestine and Cyprus. After his release from the army he worked in a maternity hospital and later moved to general practice, first in Wolverhampton, then to a country general practice. During this time he married Elma Champion. He decided to leave general practice and took up anaesthetics. He started in Lancaster, moving later to London and Sheffield where he got his FFARCS.

While doing his army service, Tom had rescued a young soldier from drowning and he subsequently developed an aspirational pneumonia, which left him with a persistent cough. A chest surgeon with whom he worked suggested he move to a warmer climate and he applied for the position as first director of anaesthetics in Tasmania at the Royal Hobart Hospital.

Tom and Elma moved to Tasmania in 1957. At that time his staff consisted of one registrar, a resident who rotated monthly and three visiting honoraries. This was a world away from the current staffing, which numbers over 50 anaesthetists. Tom was the only qualified anaesthetist on the full-time staff and requests for more staff were denied. He was very fortunate with his registrars over the three years he was director – Dr George Mackay-Smith, Dr John Mainland and Dr Alistair Miller Forbes.

Dr Benjamin Rank, a prominent plastic surgeon from Melbourne, used to come to Hobart to do all the cleft palate and hare lip surgery. Dr Rank brought his own anaesthetist and was very reluctant to change this arrangement, but finally accepted Tom when he discovered he had worked with a friend in Britain and was as competent as his regular anaesthetist.

When Tom threatened to leave, the hospital finally allowed him the right of private practice and he took off a half-day per week. The final straw came when the hospital refused his request for a laryngoscope for recovery.

Tom set up as a solo practitioner in July 1960 in what was to become The Hobart Anaesthetic Group, commonly referred to as "The Group". The private hospitals in Hobart provided very little in the way of equipment and Tom carried much of his equipment in the boot of his car. He was later appointed an honorary anaesthetist at the Royal Hobart Hospital. Dr Margaret Nicholson, who gained her fellowship while working in private practice, joined Tom in his practice. Margaret came to Hobart from New Zealand. Tom was soon to be joined by Alan Bond, an Englishman; Ron Tapson, from South Africa; and Englishwoman Jean Oakes. It had become a British Commonwealth group! By the early 1970s the group had increased to six.

Unfortunately Tom was plagued by health issues from the early 1960s and they would trouble him for the rest of his life. He developed atypical Meniere's disease and this caused problems with balance and hearing. In 1976 he had a spinal fusion. Before his health problems, Tom played squash and tennis, was a keen fly fisherman and was involved in the Naval and Military and Athenaeum clubs in Hobart.

Tom and Elma separated in the early 1970s. He remarried in 1981 and his wife, Kati, survives him. They were married for more than 30 happy years.

Tom was the anaesthetist's anaesthetist. There were still practising GP anaesthetists in Hobart in his early days of private practice, but Tom was frequently asked to look after surgeons and their families, even those who did not regularly give him work. He also was in demand to anaesthetise other medical and nursing staff and their families.

Tom continued to work until the early 1980s, but with difficulty. He retired in 1985. The practice he founded has continued to flourish and now has more than 25 members.

Tom was a tall and very handsome man and, despite his health problems, had a rosy complexion, which gave the impression that he was healthy. The young nurses were very attracted to him and his Scottish accent lent a special charm. He was a private person. He continued to take a keen interest in the practice he had founded. His subtle sense of humour was usually accompanied by the lift of an eyebrow. He shared his vast experience with those of us who joined him in the practice. He was of "the old school", a thorough gentleman. We mourn his passing.

Robert Brown

Dr Colin Hopper McCulloch 1934 – 2014

Colin Hopper McCulloch was born March 6, 1934, in Hexham, a thriving market town in Northumberland, England. He was the third child of Elsie and Colin McCulloch.

Colin obtained his medical degree in north-east England at Durham University where the motto was "Her foundations are upon the Holy Hills". Colin used to enjoy riding his pushbike through these hills.

Colin amassed many professional achievements during 42 years of anaesthetic practice from 1963 to 2005. He held several university appointments, including associate professor of anaesthesiology at the Southwestern Medical School, University of Texas (1964-65) and lecturer in anaesthesia at the University of NSW (1968-77). He was a staff specialist anaesthetist at Prince Henry Hospital, Sydney.

Colin left Prince Henry Hospital in 1977 to take up private practice in the beautiful NSW coastal town of Port Macquarie. He was the only specialist anaesthetist in the town for four years until I joined him in 1981.

Colin was instrumental in setting up the intensive care service at Hastings District Hospital and he was a co-founder of the establishment of the Port Macquarie Private Hospital.

Colin's life was very busy as the director of the intensive care ward and he provided 24-hour coverage for this and for anaesthesia at Port Macquarie and Wauchope hospitals.

I found Colin to be exceptionally diligent in his professional work. He was always calm and in control and he paid great attention to detail. Surgery would never commence before Col gave the okay to start. It was reassuring to have such a skilled colleague working in the same town.

Colin was a good friend and ally and was well liked and respected by all who knew him. His dry sense of humour was delivered with a wry smile and a twinkle in his eye.

I am frequently reminded of Colin when I look through previous admission notes of many of the patients I meet. I find his patient assessments were always very thorough, as were his anaesthetic records, written in his unmistakeable handwriting. These bring back fond memories.

Colin enjoyed the lifestyle of Port Macquarie and participated in golf, the Tacking Point Surf Club and bird-watching. He was keen on old-model sports cars and enjoyed the country life with his family.

Colin dealt with Parkinson's disease for around nine years before he died at age 80.

He leaves a wonderful legacy through his family. His dearly loved wife of 28 years, Maggie, previous wife Yvonne, and six children, Paul, Mark, Suzanne, Maya, Vaughan and Alistair, seven grandchildren and two great-grandchildren. He is sadly missed by his family and friends.

Dr Lindsay Bryant, FANZCA
Friend and colleague

Dr Margaret Matilda Patterson 1926 – 2016

Margaret Patterson was born in Warrnambool, Victoria, where her father was a teacher before receiving a post-war study grant and becoming a biochemist at the Commonwealth Serum Laboratories, working on the development of vaccines. Margaret was inspired by her father and this clearly influenced her career.

Margaret gained her medical degree from the University of Melbourne and a diploma of anaesthesia in England. She had a private anaesthetic practice in Brisbane for two years and also worked in Wellington, NZ, for around two years.

In the early 1960s, Margaret became an anaesthetist at Launceston General Hospital and was soon appointed director of anaesthetics. In the 1970s, she volunteered to teach anaesthesia in South Korea for three months, during long-service leave.

Her death in her 90th year brings to a close a period during which anaesthesia in Launceston was established as a professional specialty and high standards of practice and care became the norm.

ANZCA Fellow Dr Stewart Bath met Margaret when he was appointed as an anaesthetic resident at Launceston General Hospital in 1967.

Dr Bath recalls that Margaret "was at the height of her powers and was an outstanding anaesthetist, the mainstay of the department and the standard-setting director of a group of general practitioner anaesthetists, who had until her arrival provided the anaesthetic services".

While overseas or itinerant anaesthetists were appointed from time to time, Margaret was the only permanent anaesthetist with a full range of specialist skills, Dr Bath said.

"She was very particular about details of her work. She was a good teacher and I took a great interest in anaesthesia as a result," he said.

"To further this interest, I requested another three-month term in my second year at the Launceston General Hospital during which time she taught me many advanced techniques. As a result I sought training in the specialty. In 1977, having completed my specialty training, Margaret welcomed me back to her department. Unfortunately her health was starting to fail and a lack of organised out-of-hours anaesthetic cover increased stress associated with her responsibilities to the point where the superintendent of the hospital insisted that she be superannuated on the grounds of ill health."

After reluctantly resigning from the anaesthetic department, Margaret studied for a social sciences degree at the University of Tasmania and worked as a volunteer at Lifeline.

She also became a volunteer at the Queen Victoria Museum and Art Gallery (QVMAG) in Launceston.

Former museum director Chris Tassell wrote: "Margaret was an extraordinary volunteer at the QVMAG for many years. Working closely with the zoology staff and, in particular, curator Dr Brian Smith, she meticulously catalogued and entered specimen data into the museum's digital collection management system. This project, which continued for years, made a profound difference to the value and use of these collections. Nowhere was this more obvious than in the molluscan collection. Until Brian and Margaret began work on this collection, its usefulness was limited, in large part because of its very scale. Once the project was completed it became an extremely powerful resource for a variety of biological purposes."

Other collection managers at the museum actively sought Margaret's skills and, over time, she also helped transform the earth science collections and elements of the community history collections.

"Few volunteers have made such a profound contribution to the museum's collections as Margaret did," Mr Tassell wrote. "Although Margaret worked principally in the collection management area of the museum, her commitment, professionalism and delightful personality endeared her to staff throughout the museum."

Margaret's strong Anglican faith supported her throughout life. She was much loved and treasured by the extended family, friends and appreciative colleagues she has left behind.

Dr John Paull, FANZCA

Acknowledgements: Information was generously provided by Margaret's niece, Ms Serena Simms, and by Barbara Valentine, Chris Tassell, Dr Stewart Bath and Louise James.

Dr William (Bill) Hull Cochrane 1927 – 2015

Although his anaesthesia career took him around the world, William Hull Cochrane, known as Bill, was a loyal Ulsterman, born in Coleraine, Northern Ireland on April 15, 1927. He was educated at the Coleraine Academical Institute before qualifying MB, BCh and BAO at Queen's University in Belfast in 1949, the first in a string of medical qualifications that would follow.

After graduation, Bill worked at the Royal Victoria Hospital in Folkestone, England, in 1950, and completed national service as a surgeon lieutenant with the Royal Navy on the cruiser HMS Belfast (1950-54) during the Korean War. He then went on to study anaesthesia in Liverpool, obtaining his DA in 1955 and his FFARCS in 1956.

Bill's next move took him across the Atlantic as associate professor in anaesthesia with the University of Rochester in New York state for 1957-58, before moving to Alberta, Canada for about 15 years, during which time he added FRCP (1972) to his qualifications.

In Alberta, he worked as a consultant anaesthetist at the Royal Alexander Hospital in Edmonton (1958-66) and at the Foothills Hospital in Calgary (1966-73), where he also lectured in anaesthesia at the University of Calgary.

His next migration took him to Wellington Hospital in New Zealand in 1974, initally to work as a consultant anaesthetist, then as director of the anaesthetic department from 1975-85, and continuing as a visiting anaesthetist at Wellington Hospital 1985-90. Bill obtained his FFARACS in 1976.

There are many highlights of Bill's anaesthesia career including a challenge, virtually upon arrival at Wellington, when a senior political figure needed a prolonged procedure. The patient was an adverse anaesthetic risk, which would have caused many a lesser colleague to quail. Needless to say, the anaesthetic component of the procedure was successful.

His naval service ensured that Bill was nobody's handmaiden, and woe betide anyone who tried to push him around. If a staff or visiting senior surgeon did not treat Bill with the courtesy or respect required, he would simply leave, having asked a senior colleague to take over – and that surgeon would be denied Bill's many skills, sometimes thereafter.

The recovery room equipment was greatly enhanced, as was the status of the department, by his firm leadership, for which we all owe Bill a debt of gratitude.

Apart from his anaesthetic skills, Bill was very good with his hands and would tinker with and restore clocks and use his woodworking equipment to make furniture. He also was a skilled silversmith.

Bill married June in 1953 and she supported him throughout their 62-year marriage. Their two sons, Nick and Chris, gained their MB ChBs in New Zealand and are now practising in medicine; Nick in Auckland and Chris in Canada.

Bill and June retired to Tauranga in 1989 and enjoyed a happy retirement until Bill passed away on August 16, 2015 aged 88.

Dr Bruce Cook, FANZCA
Retired

Dr Graham Sharpe, FANZCA
Wellington