

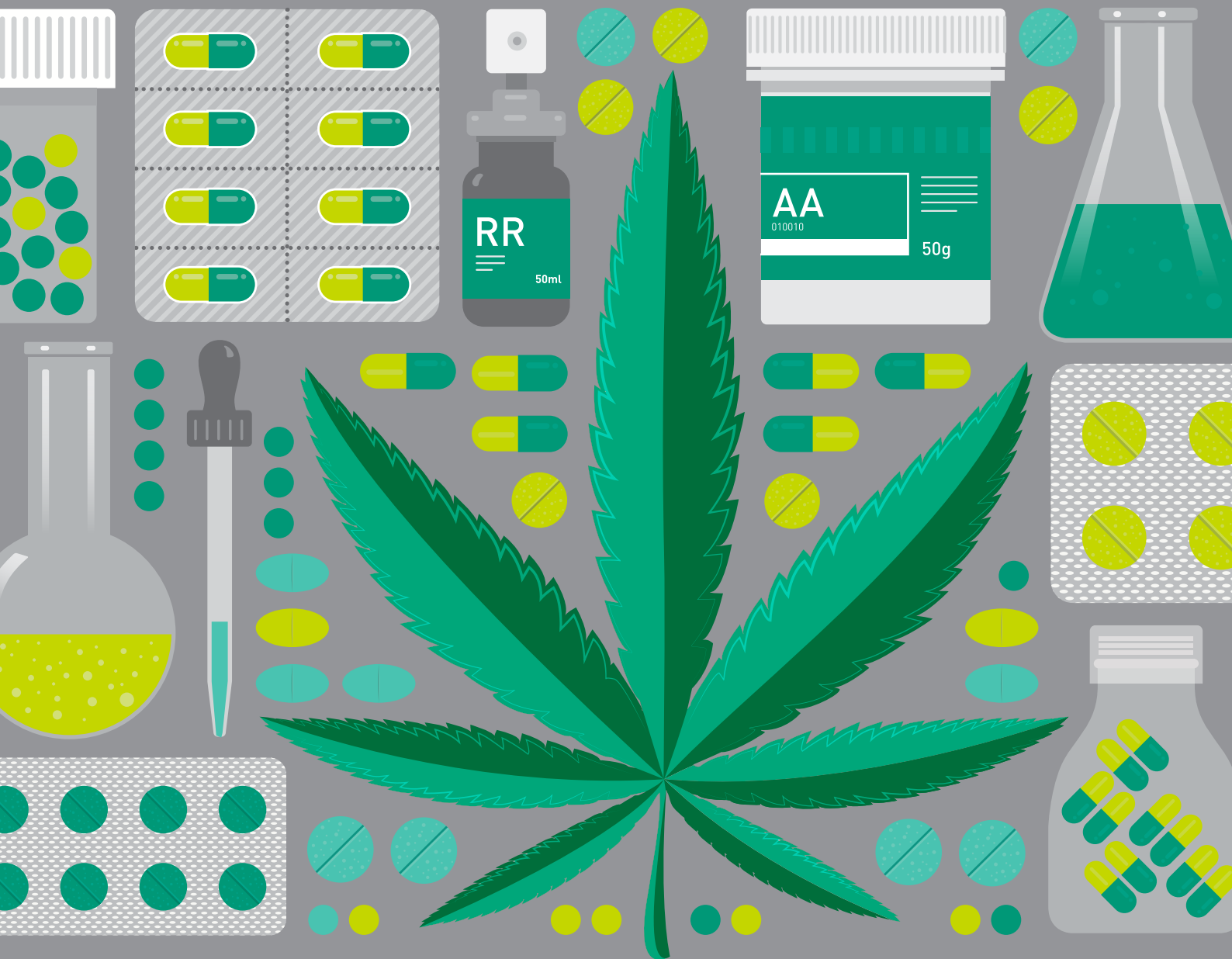
ANZCA BULLETIN

“Medicinal” cannabis: Where’s the evidence?



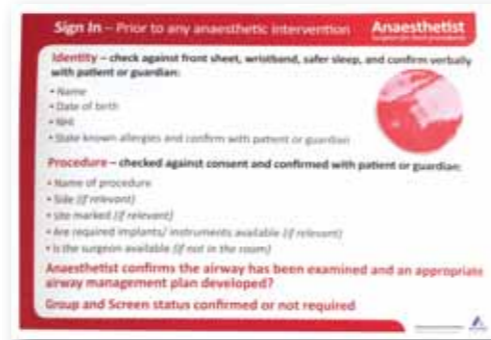
Workforce:
Survey shows
we’re on track

Farewell:
Remembering
Garry Phillips





32 Vale Professor Garry Phillips, AM Professor Garry Phillips made a remarkable contribution to anaesthesia, intensive care and emergency medicine, writes Professor Barry Baker.



34 Checking the checkers Simple improvements can be made to the Surgical Safety Checklist to improve its effectiveness, write Associate Professor Simon Mitchell and Professor Alan Merry.

24 Workforce: The right balance A report shows the anaesthesia workforce to be in balance until 2030 and the Graduate Outcomes Survey shows us new Fellows are feeling positive.

37 Cosmetic surgery update Regulations in relation to cosmetic surgery have been tightened, but do they go far enough?



62 Facelift for training program After 18 months' review by a series of working groups, the ANZCA Training Program is about to undergo several improvements.



20 The "medicinal" cannabis story FPM Dean Chris Hayes explores the legalisation of cannabis due to popular demand and what this means for pain and anaesthesia physicians.



Contents

4	President's message	37	Safety and quality: Cosmetic surgery regulations tightened – but far enough?	72	The next era of the ANZCA Educators Program
6	Chief executive officer's message	38	Safety and quality: New ANZCA airway assessment resource	76	ANZCA Overseas Aid Scholarship: Bringing regional anaesthesia to Rwanda
8	Letter to the editor	40	Safety and quality: News	79	Anaesthetic history: Lives of the Fellows
8	Presidential portrait unveiled	46	Faculty of Pain Medicine	79	Ulimaroa opens to the public
8	PNG prize	48	FPM: Geelong GP broadens pain medicine skills	80	Anaesthetic history: The discovery of Dr Pugh's missing journal
9	ANZCA and FPM in the news	50	FPM Fellow puts unique perspective to good use	81	Anaesthesia and Pain Medicine Foundation update
10	ANZCA and government: Elections, budgets – what they mean	52	Library update	82	ANZCA Clinical Trials Network news
14	ANZCA's professional documents: What would you do?	56	Working towards better outcomes for the obese patient	84	Tri-nation Alliance: Connecting ANZCA to the global network
14	Professional documents – update	58	Award-winning anaesthesia machine to help developing countries	85	Hong Kong meeting
16	Dr Bridget Effney starts a conversation	60	2017 New Fellows Conference	86	Special Interest Group event
18	A few weeks until National Anaesthesia Day 2016	61	CPD update: Are you end-of-triennium ready?	87	CME classifieds
20	Medicinal cannabis	62	Training program to get a facelift	88	New Zealand news
24	Workforce: ANZCA on track	68	Training: The challenge for regional anaesthesia educators	90	Australian news
26	Workforce: Graduate outcomes survey	69	Training: Pilot study tests new teaching tool in operating theatres	95	Meeting to explore the future of anaesthesia
32	Remembering a remarkable contribution to medicine: Professor Garry David Phillips, AM	70	Training: Junior trainees benefit from mentoring scheme	100	Obituaries
34	Checking the checkers: Keeping surgical teams on track			103	Future meetings
36	Safety and quality: Bankstown-Lidcombe tragedy – lessons learned				



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.
ISSN: 1038-0981 (print) 2206-5423 (online)
Cover: Cannabis has been legalised for "medicinal" purposes despite a lack of evidence in its efficacy or safety.

Medical editor: Dr Rowan Thomas
Editor: Clea Hincks
Art direction and design: Christian Langstone
Production editor: Liane Reynolds
Advertising manager: Vivienne Forbes
Sub editor: Kylie Miller

Submitting letters and other material
We encourage the submission of letters, news and feature stories. Please contact ANZCA Bulletin Editor, Clea Hincks at chincks@anzca.edu.au if you would like to contribute. Letters should be no more than 300 words and must contain your full name, address and a daytime telephone number. They may be edited for clarity and length.

Advertising inquiries
To advertise in the ANZCA Bulletin please contact communications@anzca.edu.au.

Contacts
ANZCA
630 St Kilda Road, Melbourne
Victoria 3004, Australia
Telephone +61 3 9510 6299
Facsimile +61 3 9510 6786
communications@anzca.edu.au
www.anzca.edu.au
Faculty of Pain Medicine
Telephone +61 3 8517 5337
painmed@anzca.edu.au
www.fpm.anzca.edu.au
Copyright: Copyright © 2016 by the Australian and New Zealand College of Anaesthetists, all rights reserved. None of the contents of this publication may be reproduced, stored in a retrieval system or transmitted in any form, by any means without the prior written permission of the publisher.
Please note that any views or opinions expressed in this publication are solely those of the author and do not necessarily represent those of ANZCA.

President's message



Training and careers in anaesthesia

When considering a path for future specialisation in medicine, medical students and junior doctors weigh up a number of factors. These include interest in the area of practice, accessibility of the specialist-training program, opportunities for specialist work after fellowship and, of course, factors such as work-life balance.

Our purpose in anaesthesia and pain medicine is to serve the community with safe and high-quality care. To this could be added accessible care, which includes patients in rural and regional areas.

It is important that ANZCA promotes career and workforce opportunities for our Fellows because this achieves these aims and encourages the best of doctors to embark on a career in anaesthesia.

ANZCA has an accessible world-class training program, which is only "restricted" by a requirement for training sites and programs to be accredited, and by the need for sufficient volume of practice for trainees to meet training needs. The *Australia's Future Health Workforce – Anaesthesia* report released by the Australian Department of Health on August 1 (www.health.gov.au/internet/main/publishing.nsf/Content/australias-future-health-workforce-anaesthesia-report), examines anaesthesia workforce

by modelling service demand, training "pipelines" and workforce movement until 2030 (see report summary page 25).

Many assumptions underpin such a report, including the current state of the workforce (assumed to be in numerical "balance"); attrition due to practitioners leaving or reducing work (including personal or family reasons and retirement); overseas specialist numbers; non-specialist anaesthesia providers; and intentions of junior doctors to enter anaesthesia training.

During consultation, ANZCA provided data on trainee numbers and advised on changing work practices affecting demand. The modelling from the report concludes – providing overseas specialist numbers continue with their current trends – that workforce will be in balance until 2030.

It points out that anaesthesia remains a popular career ambition for junior doctors. An issue of concern, however, is the availability of specialist anaesthetists in regional and rural areas. ANZCA realises the critical importance of supporting our trainees throughout their transition into the specialist workforce, and also in addressing the needs of rural and regional communities in Australia and New Zealand.

A working group to develop College policy, led by ANZCA Vice-President Dr Rod Mitchell, is examining current workforce assumptions and concerns, such as maldistribution. This working group is planned to have representation from the Australian Society of Anaesthetists and New Zealand Society of Anaesthetists to ensure the best-informed recommendations are made. ANZCA takes training and workforce planning seriously, to support our trainees and Fellows in providing the best possible care in anaesthesia and pain medicine to our community.

Research is not a luxury

All our patients benefit from skilled and evidence-based practice, given each and every day by us as anaesthesia and pain medicine specialists. Often we make decisions and give treatment on information derived from high-level scientific investigations, sometimes by expert consensus, sometimes common sense.

All of these elements are valid, but our aim must be to improve clinical outcomes, safety and efficiency. Research is how we improve. Research enables the development and safe adoption of innovative techniques, equipment and medications.

We also must be able to understand and critically appraise research, ask questions and, if our interests and opportunities enable us, to conduct or participate in investigations.

Research needs direction and resources. ANZCA is working towards a coherent strategy to optimise our support for individual and collaborative research in Australia and New Zealand.

The ANZCA Clinical Trials Network is a world leader in facilitating such collaborative activities, and the Anaesthesia and Pain Medicine Foundation supports the Research Committee by funding high-quality projects – more than \$A1.4 million in research grants were awarded last year. Research differentiates us as a specialty and profession from simple providers of care.

Elsewhere in this issue of the *Bulletin*, the revised scholar role for the curriculum is described (page 64). This is the first stage of a project involving significant updating (and simplifying) of the 2013 training curriculum.

The changes to the scholar role with the 2013 curriculum were intended to broaden the scope of "scholarly activity" and enable activities other than a mandatory formal project to be undertaken to achieve these goals.

The five core elements of the revised scholar role for 2017 are an attempt to refine and clarify the intended goals. While critical appraisal of the literature remains an important element of the scholar role, there is no compulsory research activity per se.

A well-conducted and presented research project can, however, fulfil three of the five core elements. Trainees should be encouraged and supported in participating or undertaking at least one research project during their training, even if they already meet the requirements of the scholar role by other means.

It is only by "doing" anaesthesia that we fully understand it; likewise it is only by actually doing research that it can be fully understood, and its strengths and weaknesses identified. This requires time.

Many health services face pressure to reduce costs and maximise clinical "throughput", at the expense of clinician time for teaching and research. Research is not a luxury; it underpins almost everything we do. Loss of research

and teaching time and endeavour will ultimately lead to less efficient and less effective patient care, and should be strongly resisted.

We are privileged in our specialty to have some of the world's leaders in research. Such leaders must start somewhere and, for the future of our profession, we must foster and support our trainees and junior Fellows in research activities and the capacity and willingness to understand and implement improved knowledge and practices when they arise.

Steuart Henderson Award

I am very pleased to announce the establishment of a new award to recognise the profile of educators within the College. The Steuart Henderson Award is awarded to a Fellow who has demonstrated excellence and provided outstanding contribution, scholarship and mentorship to medical education in the field of anaesthesia and/or pain medicine.

All Fellows of ANZCA and FPM are eligible for the award, which was named after Dr Steuart Henderson, who served as an ANZCA councillor from 1992 to 2004, working particularly in education and training and as assessor. Please see below for further information on the new award.

Professor David A Scott
ANZCA President

Chief executive officer's message



Foundation supporting research

The Anaesthesia and Pain Medicine Foundation is an important part of ANZCA's resources in supporting research. The acquisition of new knowledge through research is one of the key elements that ensures anaesthesia and pain medicine are progressive medical specialties.

In 2016 ANZCA will have contributed more than \$A1.4 million to Fellows' research projects. This is a remarkable contribution for an organisation of ANZCA's size. All Fellows contribute to this effort through subscriptions.

The recent Clinical Trials Network annual workshop showcased the diversity of projects that are currently funded through that program alone. It was also encouraging to see the number of younger Fellows present who were exploring the possibility of participating in research.

With the foundation corpus now sitting at just over \$A7.5 million, the foundation committee is considering the future strategy. ANZCA Council's vision for the research will determine the projected size of the corpus and we are confident that there is much more potential for research among the anaesthesia and pain medicine fellowship.

In the meantime the foundation team is working hard continuing to secure donations and bequests to support valuable research.

Rural training

The Australian government has introduced a new program for training specialists in rural centres as a means of boosting the medical workforce in those areas. The Integrated Rural Training

Pipeline (IRTP) initiative provides an additional 100 Specialist Training Program posts over two years across all specialties in Australia.

Colleges were asked in early 2016 to submit proposals for the allocation of IRTP-STP training posts in 2017 and only 50 posts can be allocated in 2017. It is pleasing to report that ANZCA was successful in acquiring three posts for training in pain medicine. The details of the training positions still have to be finalised, including their locations, but this is very good news for FPM and regional Australia.

Health of doctors

ANZCA, in common with other medical colleges, believes that doctors have a responsibility to themselves, their families and their patients to take care of their own health. There are a number of resources available through the Welfare of Anaesthetists Special Interest Group (www.anzca.edu.au/fellows/special-interest-groups/welfare-of-anaesthetists) and this belief is also reinforced by *PS49 Guidelines on the health of specialists and trainees* (www.anzca.edu.au/resources/professional-documents) which includes the following recommendations:

- Specialists and trainees should have identified general practitioners and consult them regularly.
- Specialists and trainees should not self-prescribe medication (except for simple over-the-counter medications).
- Specialists and trainees should seek arranged, formal consultations with colleagues about personal health issues rather than informal or "corridor" consultations.

The Medical Board of Australia (MBA) and the Australian Medical Association (AMA) have entered into an agreement for the national delivery of health services to medical practitioners and medical students. While the MBA is funding the national delivery, it is not operating the services which are being co-ordinated through a subsidiary of the AMA, Doctors Health Services Pty Ltd (DrHS).

The intention of the MBA and the AMA is to ensure that doctors, no matter where they live, have access to readily available services. The services include health-related triage, advice and referral services and online resources where appropriate.

The providers will also deliver education programs for doctors and training for doctors to treat other doctors.

There is no connection between the service provider and the MBA. Similarly the new arrangements are not intended to replace the MBA's regulatory responsibilities.

DrHS is in the process of rolling out services and engaging with medical colleges to raise awareness of the service among their members.

A key objective for DrHS in the next phase of its development is to raise awareness of doctors' health issues and the services and resources that are available.

In New Zealand there are a number of well-established national providers whose services are quite well known throughout the medical profession.

ANZCA will continue to support the work of these agencies in both countries and from time to time will publish contact details of providers as they become available.

Pain implant device registry

FPM has completed significant work towards establishing a world-leading, independently administered Australian national registry for implantable pain devices. The purpose of the registry is to provide objective independent analysis of device safety, performance and efficacy. It is designed to collect clinical and contact data from all Australian patients implanted with high-risk implantable pain devices so that the performance and safety of devices can be assessed.

ANZCA, through the Faculty, is seeking funding of around \$A1.6 million over four years from government and the health industry to establish and operate a permanent registry. While government has expressed support for the registry it has advised that no funding is available from that source.

This is a high priority patient safety initiative by the Faculty and it will be escalated in 2017 to achieve a breakthrough with both government and the health industry providers of implants.

John Illott

Chief Executive Officer, ANZCA

Letter to the editor

It's up to us to make ORs safer



In 2002, I made a visual and oral presentation at the Australian Society of Anaesthetists General Scientific Meeting in Adelaide. This was followed by an invitation to become a clinical surveyor for the Australian Council for Healthcare Standards (ACHS), which I continued until 2012.

From 2002 until 2012, I surveyed hospitals across Australia, NZ and Grooteschuur Hospital in Cape Town, taking many photos, with an emphasis on safety and quality in acute care areas, including electrical standards. Some of my reports caused concern to these organisations.

I made presentations to WorkCover SA, chief executive officers of SA public hospitals at a department of health meeting, a perioperative nurses' conference, became a member of a Department of Labor and Industry committee in 2003 to examine good design and safe ergonomic work patterns in operating rooms, the interim report of which resulted in it being closed down.

I must admit it was déjà vu to read the safety and quality article by Dr Grant Brace ("Our operating rooms: A safe place for patients but not always for staff", *ANZCA Bulletin*, June 2016).

My interest began with a fall of an anaesthetic colleague in an angio suite; he sustained a spiral fracture of his femur, which ended his career.

In my capacity as a visiting medical officer, I encouraged trainees and theatre staff to explore solutions to the obvious problems, which were not always received positively by the theatre nurses ("we don't do it that way here"). Change is painful. Even presentations on human-factor engineering were not well received. My eventual conclusions to registrars were don't tangle things that tell you the patient is alive with the things that keep them alive.

If Holden's production line looked like an operating room, the unions would stop production. It is up to us to stop the exponential increase in hazards.

Where there is a will there is a way; then, as now, there is no will.

Dr Tony Swain, FANZCA (retired)
Ashford, South Australia



Presidential portrait unveiled

At a dinner in July to farewell three retiring ANZCA councillors (Dr Lindy Roberts, Professor Alan Merry and Professor Ted Shipton) the official portrait of Immediate Past President Dr Genevieve Goulding was unveiled.

Dr Goulding's is the first photographic portrait of a former College president and will also be the first to hang in the ANZCA House Council Room rather than in the boardroom of the College's historic Ulimaroa building where the oil paintings there are considered a "formed collection", meaning they won't be added to further.



PNG prize

Dr Hilbert Tovirika, of Port Moresby General Hospital in Papua New Guinea, received the 2015 ANZCA sponsored award for the best result in the Diploma of Anaesthesia course. The \$400 prize is for a student going on to study the Masters of Medicine in Anaesthesiology (MMed), at the School of Medicine and Health Sciences (SMHS), University of Papua New Guinea (UPNG). Dr Tovirika had previously won the ANZCA-sponsored Best Medical Student in Anaesthesia book prize in 2011. ANZCA supports three academic prizes each year for anaesthesia trainees in Papua New Guinea as part of the work of the Overseas Aid Committee.

Above from left: Dr Yasmin Endlich, Dr Chris Acott (both from Adelaide) and Dr Hilbert Tovirika, Port Moresby General Hospital, PNG.

ANZCA and FPM in the news

Pain Week leads media coverage



Pain Week, which began on Monday July 25, led to media demand for interviews with Fellows of the Faculty of Pain Medicine.

Faculty Vice-Dean Dr Meredith Craigie was interviewed by ABC radio and television in Adelaide on how that city needed more services for children with chronic pain. The story was also run in print. Across the three platforms, Dr Craigie reached a cumulative total audience of 361,000 people. She also spoke to radio outlet Triple J on July 25 in an interview that was run in Adelaide, Brisbane, Canberra, Darwin, Hobart, Melbourne and Perth, as well as online, reaching 143,000 people.

FPM Dean Dr Chris Hayes spoke to the *Sunday Age* on July 31 about beating pain without pills, a story that also ran in the *Sydney Sun Herald* and the *Sunday Canberra Times*, reaching 153,700 people. He was also interviewed by ABC Newcastle on the subject of chronic pain on July 25 (audience of 11,000). FPM Fellow Dr Michael Vagg spoke to ABC Perth on chronic pain from migraines on July 22 (also an audience of 11,000).

On July 29, ANZCA issued a press release with FPM Fellow Professor Stephan Schug titled "Sharing prescription opioids with others is risky,

patients warned". Professor Schug warned that too many patients were sharing leftover opioid pain relievers with friends and family who might be vulnerable to the drugs' side effects, such as depression of breathing and impairment of judgment while driving.

He was interviewed by ABC Sydney and radio station 2GB, with his quotes also run on Wave FM, Wollongong, and Curtin FM Perth, reaching a total of 134,700 people. Separately, he spoke to Radio National in Canberra on July 5 to discuss whether over-the-counter opioids should be harder to get.

FPM Dean Dr Chris Hayes was interviewed by wire service AAP, which wanted to know whether it was true that the taking of painkillers and other drugs might have combined to make Australian football celebrity Eddie McGuire less tactful than usual when he made controversial comments about footballer Adam Goodes.

The story ran in five regional newspapers across NSW and Queensland, including the *Newcastle Herald*, as well as in Tasmania's *Launceston Examiner*. Total audience: 92,150.

Karen Kissane
Media Manager, ANZCA

Media releases since the previous Bulletin:

Friday July 29:

Sharing prescription opioids with others is risky, patients warned.

Friday June 24:

Patients warned of anaphylaxis during surgery.

Friday June 3:

'Painkiller' drugs linked to Prince's death do not work on chronic pain.

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

Since the June 2016 edition of the *ANZCA Bulletin*, ANZCA/FPM have featured in:

- 12 print reports .
- 20 radio reports.
- 3 online reports.



Elections, budgets – what they mean

Australia

Malcolm Turnbull's Coalition government was re-elected in the July 2 federal election and holds 76 seats (a one-seat majority) in the lower house. The last House of Representatives seat to be declared was finalised on July 30 with the Labor candidate ahead by only 37 votes. The Labor Party won 69 seats.

Appointment of health ministers and government officials

- Ms Sussan Ley has been re-appointed to the roles of Minister for Health and Aged Care and Minister for Sport and Ms Fiona Nash has been re-appointed as Minister for Rural Health.
- Dr David Gillespie has been appointed as Assistant Minister for Rural Health. Dr Gillespie was a gastroenterologist and consultant physician based on the northern coast of NSW before entering Federal Parliament.
- Austin Health chief executive Professor Brendan Murphy has been appointed as Australia's new chief medical officer (CMO). Dr Tony Hobbs has been appointed deputy CMO and will act in the role until Professor Murphy commences on October 4.

Health funding

- The Liberals have announced an additional \$2.9 billion in public hospital funding will be provided over four years (a 6.5 per cent increase per annum). This will be delivered through an agreement with the states and territories and will focus on patient outcomes, particularly in the areas of chronic and complex needs. Find out more via www.liberal.org.au/our-plan/world-class-healthcare.
- The Australian Government and Committee of Presidents of Medical Colleges (CPMC) have signed a three-year agreement to provide new funding for rural specialists' continuing professional development (CPD) and up skilling. As part of the transitional arrangements for the Rural Health Continuing Education program (RHCE), the new Support for Rural Specialists in Australia program (SRSA) will build upon the existing infrastructure and services, but will grow and modernise to reflect new ways of learning.
- The Turnbull government has indicated it expects to secure \$66.2 million over four years from 2016-17 through tougher Medicare compliance approaches that will use data and analytics to better detect fraud, abuse, waste and errors in Medicare claims as part of their Healthier Medicare package of reforms.

- The government has indicated it intends to find efficiencies in the operation of health programs worth an estimated \$182 million. All existing contracts will be honoured and future spending will be prioritised towards frontline services.
- Efficiencies and savings from these measures will be distributed between the Turnbull government's health, aged care and sport programs and budget repair.

Health policy

- Health Minister Sussan Ley has indicated she will be focusing on the Medical Benefits Schedule review, the Health Care Homes trial, pilots of the My Health Record e-health system and reforms to mental health following her re-appointment.
- The Health Care Homes Initiative aims to better co-ordinate comprehensive care for chronically ill people and to ensure better management of their conditions with an emphasis on keeping them out of hospital. This fresh approach to what was previously developed as models of co-ordinated care will have the GP as the central co-ordination point for all medical, allied health and out-of-hospital services required by chronically ill persons on an ongoing basis. About 65,000 Australians across about 200 general practices will participate in the pilot program from July 1, 2017. A full rollout of the program is to follow. Find out more via www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-y2016-leyo21.htm.

The CPMC has made a number of recommendations, including that the new government:

- Move swiftly to ensure equity in health access across the primary, acute, aged and disability sectors by making system reform a priority within the context of consistent strategic policy development.
- Continues to fund the Specialist Training Program and open up new areas for trainees in non-hospital settings across Australia on the priority listing for first briefings.
- Lift the freeze on Medicare rebates, properly fund the new Primary Health Networks in the longer term and make mental healthcare a priority, especially in terms of enabling access and equity for people with mental illness across the care systems.

Jurisdictional changes

Almost all of Australia's health departments are undergoing changes that are intended to create greater efficiencies.

New Zealand

There were no major surprises for health in the eighth New Zealand government budget released on May 26, which outlines spending over the next four years.

The overall health budget will be \$16.1 billion for the 2016/17 financial year, up from \$15.9 billion in the 2015/16 financial year. There is continued focus on elective surgery, with \$96 million budgeted over four years to continue to increase the number of elective operations by about 4000 per year.

A total of \$39.3 million will be budgeted over four years for the rollout of a national bowel screening program. The program was piloted in the Waitemata District Health Board, and rollout is set to begin in 2017 in the Hutt Valley and Wairarapa district health boards (DHBs).

A total of \$124 million will be provided to Pharmac over four years to improve access to new medicines, and DHBs will receive an extra \$400 million in 2016/17 to meet cost pressures and population growth, and to invest in new services.

Despite increases, the Council of Trade Unions and Association of Salaried Medical Specialists have provided an analysis suggesting the health budget is underfunded by approximately \$248 million and now represents a lower percentage of New Zealand's gross domestic product.

Stakeholder meetings

Development of the therapeutic products regulatory regime to replace the Medicines Act 1981 was discussed at a meeting with Ministry of Health representatives and a joint ANZCA New Zealand National Committee (NZNC) and New Zealand Society of Anaesthetists (NZSA) meeting in June.

This was a valuable opportunity for NZNC and NZSA members to ask questions and provide feedback to the ministry, in advance of an exposure draft of the new Bill due to be released later this year.

Dr Gary Hopgood and ANZCA staff also represented ANZCA at a Council of Medical Colleges meeting that included presentations from the Pharmac Medical Director Dr John Wyeth, and Ombudsman Professor Ron Patterson, who has publicly released his opinion on requests for surgical complications data.

Dr Leona Wilson represented ANZCA at a meeting with Health Workforce New Zealand to discuss vocational training funding, and ANZCA staff attended the Medical Council's annual executive meeting, a health summit hosted by the Labour Party, and a Ministry of Health workshop on the New Zealand Health Research Strategy.

Sarah Kleinitz,
Manager, Policy, ANZCA

Virginia Lintott,
Acting General Manager, Policy, ANZCA

ANZCA submissions

Australia

- Australian Commission on Safety and Quality in Health Care (ACSQHC) – Consultation on draft Clinical Care Standard on Osteoarthritis of the Knee.
- Medical Board of Australia (MBA) – Public-consultation: Draft revised registration standard for specialist registration.
- Queensland Health – Allied health expanded scope strategy.
- Queensland Health – Planning Framework for Highly Specialised/Complex Services.
- Queensland Health – Physician Assistants in Queensland: Consultation Paper.
- Victorian Department of Health and Human Services – Simplifying Medical Treatment Decision Making and Advance Care Planning: Position Paper.

New Zealand

- Ministry of Health – Review of deceased organ donation and transplantation.
- PHARMAC – Proposal to award sole supply status to sevoflurane, desflurane, isoflurane.
- Health Quality & Safety Commission – Atlas of Healthcare Variation: Domain of opioids sector.
- Medical Council of New Zealand – Primary source verification.
- Medical Council of New Zealand – Statement on providing care to yourself and those close to you.

ANZCA wins funding extension for training programs

The Australian Government has announced that funding managed by ANZCA for training in settings beyond traditional public teaching hospitals – the Specialist Training Program (STP) and Training More Specialist Doctors in Tasmania (TMSDT) – will be extended into 2017.

ANZCA currently manages 58 STP training posts – 36 in anaesthesia, five in pain medicine and 17 in intensive care (on behalf of the College of Intensive Care Medicine). ANZCA has administered STP posts since 2011. TMSDT differs slightly from standard STP funding as it also funds supervisors of training, co-ordinators of training and a program support officer.

STP and TMSDT funding flows to the employer to support the salary of the trainee or international medical graduate specialist (IMGS) occupying the post. There are loadings for remote area applicants and additional allowances for supervision in private settings.

The department is expected to release information soon about the allocation of Integrated Rural Training Pipeline training posts and will seek feedback from colleges on its review of the Specialist Training Program.

More information about the STP can be found at www.anzca.edu.au/training/specialist-training-program or by contacting STP Manager Ellen Pascoe on +61 3 9510 6299 or via stp@anzca.edu.au.

- Geelong GP broadens pain medicine skills – page 48.

What would you do?

Dr Peter Roessler explains ANZCA's professional documents.



“Prof docs”: An interface between the College and Fellows, and the community

“Danger, danger!” For those old enough to remember, this was the alert that was sounded by a robot in the science fiction series *Lost in Space* during the mid to late 1960s. The series followed the adventures of a family of pioneering space colonists whose ship went off course in the futuristic 1997! On board was a robot, which had little capability other than advanced reasoning and sounding the alarm in response to a perceived threat.

Sound familiar? Fifty years on and things haven't changed all that much, except that “robots” appear in a multitude of formats. Having emerged from the ether, anaesthetists also are now assisted by “robots”, in the form of monitoring equipment, which alert us to potential danger. However, nothing is infallible when it comes to digital logic in electronic equipment or emotions driving human actions, of which the latter is often the overriding factor in the decision-making process.

With all the potential risks we face on our journeys, many are addressed through the benefits of training, reasoning and experience, along with sophisticated monitoring. However, there is still a void.

Enter the ANZCA professional documents or prof docs, as they are fondly known. In order to assist anaesthetists, perioperative medicine practitioners and specialist pain medicine physicians, the College has developed a number of prof docs, which identify aspects of clinical practice and behaviours that may impinge on outcomes and quality, and recommend solutions.

Originally developed to support anaesthesia departments seeking funding from administrators for the provision of safe services, the prof docs have progressed well beyond this. Now they define expected standards and inform Fellows and the community of those expectations. They also make recommendations to enhance safety and quality.

ANZCA prof docs serve as an interface between the College and Fellows, and the community. While the regulatory authorities occasionally refer to prof docs as standards, ANZCA is not a regulator and instead develops prof docs as a vehicle to facilitate anaesthetists to be aware of expectations and to achieve the highest standards of practice.

Prof docs are distinct from clinical guidelines and are deliberately different to specific clinical guidelines, which are resource intensive, may be interpreted as prescriptive and consequently limiting, and many clinical guidelines are already available. Prof docs are designed to retain flexibility

and individuality, recognising the multitude of techniques and approaches in any given situation, thus promoting individual management.

The process of development and revision is clearly stated in professional document A01 (www.anzca.edu.au/resources/professional-documents). Information about the process can be found on the website.

In 2010 the categories of prof docs were simplified into three distinctive types. Since then, all new prof docs have been allocated on this basis and existing ones are re-allocated as they come up for review.

The three types are:

- **Policy.** This applies to administrative issues and arises as a result of the application of the rules and regulations derived from the ANZCA Constitution. Presently, there are two such prof docs, A01 and A02.
- **Statement.** This type of document sets out information identifying ANZCA's position on an issue. Examples include smoking, assistants to the anaesthetist, and standards of practice.
- **Guideline.** This type of document offers advice by way of recommendations that are evidence-based, where feasible, or expert consensus where evidence is lacking.

Since 2010 there have been six new professional documents developed and 21 existing ones reviewed. Several of our prof docs are co-badged and/or endorsed by other colleges and societies. Our co-badged documents demonstrate ANZCA's leadership and collaboration with other colleges, including the Royal Australasian College of Surgeons, the College of Intensive Care Medicine, the Australasian College for Emergency Medicine, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the Royal Australian and New Zealand College of Psychiatrists. It also highlights the respect extended by our sister colleges.

The volume of work and collaboration represents a considerable amount of effort on the part of Fellows and staff in ANZCA's Policy unit. I sincerely thank Fellows for participating on document development groups, expert groups and for feedback provided during the pilot phases of our prof docs. I also thank internal stakeholders including the regional committees, New Zealand National Committee, special interest groups, and the Australian Society of Anaesthetists for their contributions during consultations preceding the pilot phase. I extend my gratitude to the ANZCA staff, who work tirelessly under the auspices of a tyrant (me).

The process of prof docs is ongoing and evolving with the intent that they continue to be contemporaneous with respect to knowledge and latest research findings, technological changes, community expectations, cultural factors, and regulatory changes. As a result, they should serve and guide Fellows in the future, so that when the alarm sounds “Danger! Danger!” reference to the relevant prof doc will hopefully be helpful in averting the danger.

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 safety and quality of patient care. They provide guidance to trainees and Fellows on standards of clinical care, define policies, and serve other purposes that the College deems appropriate.

Government and other bodies refer to ANZCA's professional documents as an indicator of expected standards, including in regard to accreditation of healthcare facilities. The professional documents are subject to regular review and are amended in accordance with changes in knowledge, practice and technology.

Recent releases:

PS62 Statement on Cultural Competence

The July 2016 ANZCA Council approved the newly developed ANZCA professional document PS62 and accompanying background paper (PS62 BP) for promulgation on the ANZCA website for a 12 month pilot period.

PS08 Statement on the Assistant to the Anaesthetist

The July 2016 ANZCA Council approved the release of the revised ANZCA professional document PS08 and accompanying background paper (PS08 BP) for promulgation on the ANZCA website.

Patient blood management guideline: Module 6 neonatal and paediatrics

The July 2016 Professional Affairs Executive Committee

(PAEC) supported the Safety and Quality Committee's recommendation to endorse *Patient blood management guideline: Module 6 neonatal and paediatrics*.

ANZCA's review of this module occurred in October 2015. ANZCA previously reviewed and endorsed PBMG modules 1-5. All of these modules are available on the ANZCA website.

Delirium Clinical Care Standard

The Australian Commission on Safety and Quality in Health Care has developed the *Delirium Clinical Care Standard* to provide a national approach to improving the prevention, diagnosis and management of delirium and will help identify older patients at risk so preventive measures can be put in place and help improve the early diagnosis and treatment of delirium to minimise harm. This new Clinical Care Standard has been supported by ANZCA.

Feedback is encouraged during the pilot phase for all professional documents. Queries or feedback regarding professional documents can be directed to profdocs@anzca.edu.au.

The complete range of ANZCA professional documents is available via the ANZCA website – www.anzca.edu.au/resources/professional-documents. Faculty of Pain Medicine professional documents can be accessed via the FPM website – <http://fpm.anzca.edu.au/resources/professional-documents>.

Dr Bridget Effeney starts a conversation

“Ms Bryce’s message was that as medical specialists we are uniquely placed to take a leading role in advocacy for our patients, our colleagues and ourselves and work towards ending domestic and family violence”.



Princess Alexandra Hospital staff heard from a range of key figures in addressing domestic violence at a forum organised by Queensland anaesthetist Dr Bridget Effeney.

The closing event of the Princess Alexandra Hospital (PAH) Health Symposium was at times thought provoking and challenging. Why? It raised awareness of one of our society’s too often hidden, too often shameful and all too frequent issues: domestic and family violence.

I am proud to have co-ordinated this lunchtime forum “Let’s Start the Conversation” on Friday August 5, which focused on domestic and family violence, looking at how it affects us all, how as clinicians we treat the issue and importantly how we can make a difference to break the cycle. I am equally proud of the people who agreed to join us as speakers and panellists, their willingness to take a stand and share their opinions and their commitment to making real change.

These distinguished speakers included former Governor General Dame Quentin Bryce, Mr Cameron Dick MP, Minister for Health, Mr Anthony Lynham, Minister for State Development and Minister for Natural Resources and Mines, maxillofacial surgeon, Mr Glenn Horton, Acting Assistant Commissioner for Queensland Police and Ms Cynthia Morton, a survivor of domestic and sexual abuse and executive coach, author and blogger. I especially want to thank Dr Genevieve Goulding, Immediate Past President, ANZCA for being a superb chair; setting the scene, asking probing questions and engaging everyone in the room.

The audience of more than 280 medical and allied staff at the hospital were captivated by the 90-minute seminar that explored the endemic nature of domestic violence and how it knows no shows respect to any social, cultural or professional boundary.

They heard from the Queensland government and about the Queensland police force response to the “Not Now Not Ever Report” produced by Ms Bryce in February 2016. The panel discussion explored a victim’s journey through the Princess

Alexandra Hospital and highlighted the systems and people already available for these vulnerable individuals and also sadly the failings of our service.

Ms Bryce’s message was that as medical specialists we are uniquely placed to take a leading role in advocacy for our patients, our colleagues and ourselves and work towards ending domestic and family violence, something that for the most part is committed against women.

She asked us to think about where this violence starts and what we can do. Is it as simple as not tolerating derogatory remarks against women which may be said in jest in a social setting or make sure we know that our patients when they return home will be safe?

Well done to the leadership of the PAH whose Executive Director of Medical Services Dr Stephen Eyre, who signed a statement of commitment in front of the audience that will ensure ongoing education and awareness of domestic violence will be included in medical and nursing training in the hospital.

I was thrilled to have the attendance of Professor David A Scott, President of ANZCA, and several representatives of ANZCA present. There were also many senior medical clinicians from around Brisbane who attended and will hopefully guide and support the staff in their departments to work hard to make a difference for victims.

It will be a great honour to listen to Ms Bryce deliver the Tess Cramond Oration at the ANZCA ASM 2017 College Ceremony. Her experience, expertise, leadership and enthusiasm for real solutions for social change are second to none. THINK BIG #ASMBRIS17.

Dr Bridget Effeney

Convenor, 2017 ANZCA Annual Scientific Meeting

Clockwise from left: Domestic violence survivor and motivational speaker and wellness coach, Ms Cynthia Morton with Dame Quentin Bryce at a forum on domestic violence at the Princess Alexandra Hospital in Brisbane; Forum organiser, Dr Bridget Effeney addresses the forum; Forum chair, ANZCA immediate past president Dr Genevieve Goulding.

National Anaesthesia Day – nearly here

ANZCA will again be co-ordinating National Anaesthesia Day, which falls on Monday October 17 this year, with the aim of lifting the profile of anaesthesia in the community.

The theme for National Anaesthesia Day for 2016 is, “Is regional anaesthesia for you?”

In preparation for National Anaesthesia Day, ANZCA has asked heads of department across Australia and New Zealand to nominate a National Anaesthesia Day co-ordinator and to notify us of any research being done into regional anaesthesia that might lend itself to media stories.

Last year National Anaesthesia Day attracted strong Fellow, hospital and community participation and widespread media coverage. Some hospitals and clinics set up comprehensive foyer displays, others simply displayed National Anaesthesia Day posters and patient information. More information about last year's National Anaesthesia Day can be found at www.anzca.edu.au/communications/2016-national-anaesthesia-day.

This year marks the 170th anniversary of the day in 1846 that ether anaesthetic was first demonstrated in Boston, Massachusetts. Normally National Anaesthesia Day falls on October 16 to coincide with this anniversary but this year the 16th is a Sunday so we will be celebrating National Anaesthesia Day on Monday October 17.

National Anaesthesia Day aims to raise awareness of the role anaesthetists play in patients' preparation for surgery, their well-being during surgery and their recovery.

A community attitudes survey commissioned by ANZCA three years ago found that, while 96 per cent of people had either experienced a general anaesthetic or knew someone close to them who had, only half were aware that anaesthetists are doctors; of those, only 41 per cent knew anaesthetists were doctors with similar training and qualifications to other specialists. Half did not feel informed about anaesthesia.

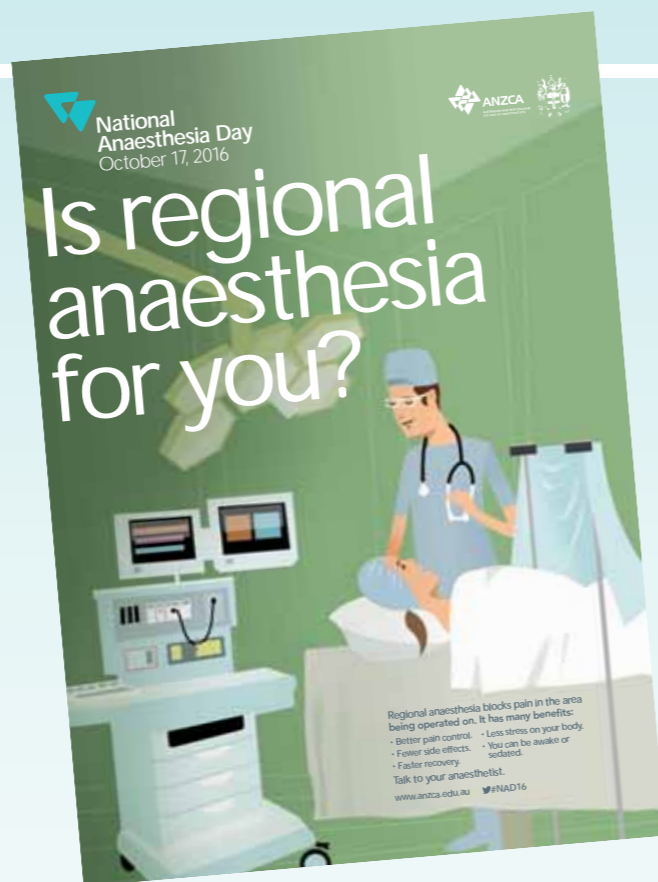
Key messages for patients

This year's theme, “Is regional anaesthesia for you? Ask your anaesthetist”, is to raise awareness of the potential benefits of regional anaesthesia during surgery, either alone or in conjunction with general anaesthesia. Up to one third of operations in some large teaching hospitals now involve regional blocks, and the teaching of regional anaesthesia techniques has become a focus of ANZCA training.

The key messages for patients are that regional anaesthesia involves:

- Good pain control, during and after surgery.
- Faster recovery.
- Fewer side-effects.
- Less stress on the body.

Patients will also be told that it is not suitable for every patient or for every procedure, and that they should speak to their anaesthetist, who will advise on what is best for their individual case.



ANZCA's media campaign and other support

In September heads of departments (or their nominated “champions”) will be sent kits containing:

- A cover letter explaining the key messages.
- “Is regional anaesthesia for you?” posters.
- National Anaesthesia Day balloons.
- “Is regional anaesthesia for you?” fact sheet sample (available for download from ANZCA website).
- “Who is your anaesthetist?” flyer sample (available for download from ANZCA website).

ANZCA's Communications team is available to support or discuss any initiative for National Anaesthesia Day 2016 and we can send more promotional materials if required.

We will also be distributing media releases to newspapers, TV and radio stations throughout Australia and New Zealand, talking to our health and medical reporter contacts, and organising interviews between key College officers and the media.

Last year print, radio and television media outlets across Australia and New Zealand enthusiastically covered the National Anaesthesia Day theme “Obesity complicates anaesthesia”, reaching a combined audience of 1.8 million via more than 30 individual news reports (excluding dozens of syndications) across all media platforms.

Please join in

More than 40 hospitals and private practices contacted the Communications unit about their activities last year (other hospitals participated without advising Communications). Anaesthetists, trainees and medical students also acknowledged National Anaesthesia Day at Port Moresby General Hospital in Papua New Guinea, where ANZCA's Overseas Aid Committee was running a course.

In Australia, hospitals across the nation marked the day with displays in their foyers and departments. At Western Health (Sunshine Hospital) in Melbourne, a booth with patient information, balloons as well as an anaesthetic machine, airway equipment and an epidural trainer attracted more than 80 people over four hours. At Fiona Stanley Hospital in Perth, anaesthetists and other staff set up a stand with posters, anaesthetic equipment and a simulation mannequin, while a video played showing anaesthetists discussing obesity.

In New Zealand, more than 50 per cent of hospitals participated in National Anaesthesia Day with some using the opportunity to create extensive interactive displays. Auckland City Hospital, for example, co-ordinated a display in the main foyer, featuring simulator training equipment, an anaesthetic machine with full monitoring equipment and an ultrasound machine with targets. The display included a historical section with equipment nearly 100 years old.

We are hoping for the support of as many Fellows and hospitals as possible. Please consider:

- Displaying National Anaesthesia Day posters prominently – in hospital foyers or the pre-admission clinic.
- Setting up a display of equipment and mannequins, with anaesthetists on hand to answer questions and to hand out our flyers and patient information sheets.
- Drawing attention to your display or poster by attaching National Anaesthesia Day balloons.
- Taking photos of your display for ANZCA's December *Bulletin* and to help us promote National Anaesthesia Day next year.

Here to help

If you would like any help or information, please contact Media Manager Karen Kissane at communications@anzca.edu.au, +61 3 8517 5303 or +61 408 259 369. In New Zealand, NZ Communications Manager Susan Ewart is available at communications@anzca.org.nz or +64 4 499 1213 or +64 274 152 815.

Clea Hincks
ANZCA General Manager, Communications

What hospitals are planning

Anaesthetists at Whangarei and Kaitia hospitals in northern New Zealand are working with their Northland District Health Board communications team to promote National Anaesthesia Day in October.

Northland patients have been interviewed by the communications team about their experiences with regional anaesthesia such as spinal blocks and epidurals, and they have spoken about the benefits they have experienced compared with a general anaesthetic, including a better recovery, fewer side effects and better pain relief.

These will be submitted as articles about residents to their local newspapers.

Northland has also:

- Gathered data for 2015-16 on the number of anaesthetics performed in that year, broken into categories.

- Looked at developing hospital displays in Whangarei and Kaitia.
- Taken photographs of anaesthetists in theatre.

The use of ultrasound in regional anaesthesia will also be highlighted.

At New Zealand's Bay of Plenty District Health Board, anaesthetists at Tauranga Hospital will raise the profile of anaesthesia by building displays and putting on education sessions for perioperative staff about the benefits of regional anaesthesia.

They are also planning to launch their revamped “Block Bay” to coincide with National Anaesthesia Day. The Block Bay is a purpose-designed space fully equipped for performance of major regional anaesthesia.



Last year's National Anaesthesia Day activities included from left: Dr Nigel Robertson and Dr Helen Lindsay at Auckland City Hospital, NZ; Dr Charlie Ho (in white) and team at Fiona Stanley Hospital, WA; Dr Kerstin Wyssusek (fourth from left) and anaesthesia staff at Princess Alexandra Hospital, Qld.

Medicinal cannabis

When advocacy and legislation move ahead of evidence: the “medicinal” cannabis story

GP’s letter to FPM – a dilemma for specialists

“I have a patient who is keen to find out more about how to obtain medicinal cannabis to better control his chronic pain.

“I have seen the NSW Health application form which, as I understand it, only invites specialists to apply. I called the local hospital pain clinic, but they are not prescribing it, nor do they have a clinical trial relating to cannabis.

“I would be grateful if you could give me some more information about where my patient could access medicinal cannabis to treat his chronic pain, or any other information that could steer him in the right direction.”

– GP’s letter to NSW FPM Regional Committee.

Full report – see FPM Dean’s message on page 46.

The legalisation of cannabis is progressing rapidly in Australia in spite of evidence that queries its efficacy and safety. FPM Dean, Dr Chris Hayes, explores what this means for specialists in pain medicine and anaesthesia.

In recent years the community voice requesting access to so-called “medicinal” cannabis has risen to a crescendo.

All major political parties have heard the cry and consequently legislation is progressing through Commonwealth and state parliaments in Australia to make cannabis and related products available for research and clinical use. Similar legislation is under consideration in New Zealand.

This will dramatically expand the existing frameworks available in both countries which provide limited access to nabiximols (Sativex) for muscular spasticity associated with multiple sclerosis¹.

What is the response of FPM and ANZCA?

The term “medicinal” applied to cannabis and the cannabinoids in general gives us licence to contribute to the debate as medical specialty groups. Therefore, while not wishing to write a comprehensive review, I would like to raise key issues for our fellowship to consider.

These thoughts supplement the 2015 FPM and ANZCA Professional Document *PM10: Statement on “Medicinal Cannabis” with particular reference to its use in the management of patients with chronic non-cancer pain – 2015* (see <http://fpm.anzca.edu.au/resources/professional-documents>).

Reason for caution

I had an enlightening discussion recently with Jenny Martin, Professor of Clinical Pharmacology at the University of Newcastle. She and colleagues, with targeted funding from the NSW government, are investigating the pharmacology of vapourised cannabis leaf in an end of life setting.

She made the point that there is an absence of basic pharmacological information about cannabinoids in the literature. There is a lack of characterisation of specific cannabinoid products for testing and a lack of the requisite dose response curves.

Until such information is available there is no foundation on which to base analysis of potential risk and benefit in volunteer and patient populations.

Community exposure

Beyond the lack of pharmacological data there are multiple reasons for caution and to avoid an overly optimistic extrapolation from community advocacy to clinical practice.

Cannabis use is already widespread and any “medicinal” access is likely to increase community exposure. A total of 34.8 per cent of Australians aged 14 years and over have used cannabis one or more times in their life and 10.2 per cent have used cannabis in the previous 12 months². The figures are similar in New Zealand with 11 per cent of those aged 15 years and over reporting cannabis use in the last 12 months³.

Clinical experience

The POINT study⁴ of 1500 Australians using prescribed opioids for chronic non-cancer pain shows that one in six people using prescribed opioids for chronic pain also use cannabis.

In the POINT cohort past-year cannabis use was more than three times higher than in the general population. In addition other substance use disorders and complex social and mental health problems were prevalent.

At the pain service where I work in Newcastle we have not formally surveyed the rate of cannabis use among patients. However use is commonplace and I suspect that the POINT cohort proportion of one in six would not be far from the mark.

From our team’s perspective the use of cannabis consistently flags the likelihood of poor outcome. Demotivation is a major problem, physical activity is low and as in the POINT cohort, poor mental health and related substance use disorders are strongly correlated.

Scientific evidence

Such evidence that is available regarding efficacy is not encouraging. A 2014 systematic review of cannabis in neurological conditions⁵ showed that oral cannabis extract, tetrahydrocannabinol (better known as THC) and nabiximols have modest efficacy for patient reported but not objective measures of spasticity in multiple sclerosis. There was insufficient information to gauge efficacy in epilepsy.

A 2015 systematic review⁶ investigated efficacy and adverse effects of smoked or vapourised cannabinoids in chronic non-cancer pain. Five of six randomised controlled studies assessed cannabis for neuropathic pain as an adjunct to other agents including opioids and anti-convulsants.

Maximum study duration was only five days and all studies lacked adequate masking of the active treatment, contributing to the risk of reporting bias. Each study found statistically significant pain reduction with cannabinoid use. However physical function did not improve or was not reported. Heterogeneity of methods precluded analysis of pooled data.

The evidence of harm is substantial particularly with regard to the nervous system. A recent meta-analysis raised concerns that long term cannabis use may cause neurotoxicity especially in brain areas enriched with cannabinoid receptors such as the hippocampus⁷.

(continued next page)

Medicinal cannabis (continued)

There is even more concern about cannabis induced neurotoxicity in developing adolescent brains.

The Dunedin study continues to follow a cohort of 1000 New Zealanders born in 1972-73. Study results⁸ suggest that use of cannabis alone, smoked on occasion and after 18 years of age does not present a high risk. However when cannabis is used regularly and early (13-15 years old) it leads to an average loss of eight IQ points, and this reduction is not fully reversed by cannabis cessation.

The drop in IQ is of an order expected to affect educational attainment and employment prospects. In addition for those with the COMT gene, there is a 10-fold increased risk of schizophrenia.

Lessons from the opioid story

For many years the Holy Grail in opioid research has been the attempt to isolate a preparation that will deliver benefit without side effects. Yet to date, this has been unattainable.

There is a similar challenge in cannabinoid research. In treating pain it seems that the psychoactive THC component is required for any meaningful analgesic activity. This correlates with the clinical observation that unless a patient is "stoned" there is little analgesic impact. Other cannabinoids such as cannabidiol have little analgesic activity. Thus to differentiate analgesia from central nervous system adverse effects may prove difficult.

The opioid experience has led us to recognise that context is critical. There is clear evidence of opioid benefit in acute pain, cancer pain, palliation at the end of life and opioid dependency. Yet in chronic non-cancer pain any analgesic benefit is likely to be modest, short lived and outweighed by harm.

Context is likely to be just as critical with cannabinoid use. It is possible that careful research will define situations in which benefit outweighs harm. End of life symptom management could be one such area. Chemotherapy induced nausea and vomiting and refractory paediatric epilepsy could be others. However until the evidence is available caution is warranted.

Where to now?

Legislation has already changed in NSW with other jurisdictions poised to follow. On July 31, the NSW premier and the minister for medical research announced a new regulation applying to unapproved schedule 8 medicines and cannabis-based products.

The Poisons and Therapeutic Goods Amendment Regulation 2016 under the *Poisons and Therapeutic Goods Act 1966* took effect from August 1, 2016. The regulation covers the manufacture, supply and use of cannabis-based products and other schedule 8 substances not on the Australian Register of Therapeutic Goods.

The regulation enables doctors to apply for approval from NSW Health to prescribe unregistered cannabis-based medicines where there is "evidence supporting use and the balance of potential benefits and harms is reasonable".

The product must be legally produced and manufactured to appropriate quality standards. Applications from prescribers to NSW Health will be reviewed by a sub-committee of the NSW Medical Committee and approval from the Therapeutic Goods Administration for supply of an unregistered therapeutic good will also be required.

As specialist pain medicine physicians we may soon find ourselves called upon to adjudicate clinical decisions about cannabis prescription at a time when the evidence base remains unclear or perhaps when the evidence might oppose use. Anaesthetists too may need to consider the peri-operative implications of increasing cannabis use across the community.

FPM and ANZCA Fellows and trainees are encouraged to maintain vigilance about the cannabis issue and continue professional dialogue.

We have a responsibility to speak out about the risks to our society of well-intentioned advocacy and legislation when it moves ahead of or is out of step with the evidence.

Dr Chris Hayes
Dean, Faculty of Pain Medicine

The issue of legalised cannabis is explored further in the FPM dean's message on page 46.

References:

1. Shipton EA, Shipton EE. Should doctors be allowed to prescribe cannabinoids for pain in Australia and New Zealand? *Aust N Z J Psychiatry* 2014;48(4):310-3.
2. Australian Institute of Health and Welfare. National Drug Strategy Household Survey detailed report 2013. Canberra: AIHW.
3. Ministry of Health. 2015. Cannabis Use 2012/13: New Zealand Health Survey. Wellington: Ministry of Health.
4. Degenhardt L et al. Experience of adjunctive cannabis use for chronic non-cancer pain: Findings from the Pain and Opioids IN Treatment (POINT) study. *Drug and Alcohol Dependence* (2015) 147, 144-150.
5. Koppel BS, Brust JCM, Fife T et al. Systematic review: efficacy and safety of medical marijuana in selected neurological disorders. Report of the Guideline Development Subcommittee of the American Academy of Neurology. *Neurology* 2014; 82(17): 1556-1563.
6. Deshpande A, Mailis-Gagnon A, Zoheiry N et al. Efficacy and adverse effects of medical marijuana for chronic noncancer pain: Systematic review of randomized controlled trials. *Can Fam Physician* 2015;61(8):e372-381.
7. Rochetti M, Crescini A, Borgwardt S et al. Is cannabis neurotoxic for the healthy brain? A meta-analytical review of structural brain alterations in non-psychotic users. *Psychiatry Clin Neurosci* 2013;67(7):483-492.
8. Meier MH, Caspi A, Ambler A et al. Persistent cannabis users show neuropsychological decline from childhood to midlife. *Proceedings of National Academy of Sciences* 109(40):E2657-E2664, 2012

Workforce – ANZCA on track

ANZCA has been heavily involved in workforce activities over many years, and this has increased significantly in the last few months.

We made strong representations to the recently released Australian Government's report *Australia's Future Health Workforce – Anaesthesia* which found the anaesthesia workforce is projected to be in balance until 2030.

Our recent Graduate Outcomes Survey of new ANZCA Fellows, and for the first time new FPM Fellows, also found nine out of 10 new ANZCA Fellows overall had entered the specialist workforce. Even more FPM Fellows had – almost 93 per cent of FPM graduates had entered the workforce and most of these (92 per cent) were providing pain medicine services.

The survey shows that over time, ANZCA Fellows usually successfully enter the workforce with 100 per cent of respondents who graduated in 2013 working, 96 per cent of those who graduated in 2014, 87 per cent per cent in 2015 and 79 per cent per cent working by the date of the survey in 2016. This is an improvement on the outcomes of the 2014 survey, where only 67 per cent had entered the workforce by the date of the survey. Of those who have not entered the workforce, almost two-thirds were female.

Further is being done to understand why Fellows have not entered the specialist workforce, but this could include family reasons, continuing work in a fellowship position, as well as difficulty finding appropriate specialist work.

Of those 90 per cent of ANZCA Fellows who have entered the specialist workforce, 5 per cent were not providing services regularly and the reasons were primarily family

or professional, however 1 per cent stated that they were unable to find regular work as a specialist anaesthetist. This latter point is of concern to the College and an area we are examining further.

There is a positive trend in the levels of satisfaction with working hours. This year, 77 per cent are satisfied, up from 70 per cent in 2014 and 66 per cent in 2013. For FPM, two thirds (64 per cent) are satisfied with the amount of hours although one in three would like to work more hours.

There is increasing optimism in ANZCA graduates about their future employment prospects, with 62 per cent feeling there will be quality career options available to them in locations (up from 48 per cent in 2014). Nonetheless, there remains work to be done to improve this situation.

There is still an imbalance in regional/rural areas, an issue canvassed in both the report and our surveys. To this end, ANZCA has established a Workforce Strategy Working Group chaired by Vice President, Dr Rod Mitchell, and are working with the Australian Society of Anaesthetists and also the New Zealand Society, to develop the best solutions.

The surveys tell us many other things about the experiences of our new graduates and these will all help inform the College of where we should direct our attention and resources, for example, how we can improve continuing professional development (CPD), what educational resources to develop, the critical importance of improving professionalism and addressing workplace bullying, and where to invest in online technology.

Professor David A Scott
President, ANZCA

Anaesthesia workforce in balance: report

Projections through to 2030 indicate a balanced anaesthesia workforce although imbalance persists between regional and urban areas.

Current workforce status 2014

The number of employed anaesthetists has been growing at an average of 4.4 per cent per annum. The average age is 49 years, with 28 per cent being 55 years or over. Females account for 27 per cent of the workforce (44 per cent of trainees).

Fifty-one per cent of total clinical hours are provided in the public sector. The anaesthetic workforce worked an average of 39.8 hours/week, which represents a slight decline (one hour/week) compared to previous estimates.

The regional/urban imbalance is repeatedly highlighted.

GP anaesthesia

The importance of general practitioners (GPs) equipped to offer anaesthesia services in rural areas is noted.

Fifty seven per cent of the GP anaesthesia workforce who billed Medicare Benefits Schedule (MBS) numbers are located in major cities, and more than half of all billing was for pre-anaesthesia assessment, with most of the balance being for endoscopic sedation.

The proportion of GP anaesthetists who work as visiting medical officers (VMOs) in rural hospitals (and hence do not use MBS item numbers) is not defined, but anecdotally is substantial.

Workforce projections

Supply predictions have been generated using the National Health Workforce Data Set (collected under the auspices of the Australian Health Practitioner Regulation Agency) and projected forward with inflow and exit trends.

Demand projections have been generated through analysis of acute inpatient hospital (representing public hospital) and MBS (representing private hospital) data. Population growth and ageing, and clinical trends, have been factored.

A 3 per cent margin of error is suggested as being acceptable. As such, the projections suggest a workforce "in balance" (that is, the imbalance between supply and demand is less than 3 per cent) through to 2030.

Of note, this is based on the premise that the workforce is in balance now, though no effort is made to justify this assumption.

Training

The training "pipeline" analysis projects the numbers of domestic and international medical graduate specialist (IMGS) new Fellows into the future.

ANZCA does not control the numbers of IMGSs presenting for assessment, though our expressed expectation that there will be a steady decrease into the future has been heeded. It is encouraging to see support for removing anaesthesia from the Skilled Occupations List.

It is envisaged that the number of new Fellows entering the workforce each year after completing training has stabilised, and will remain relatively constant through to 2030.

Trainee responses suggest that those who may wish to train in very remote or regional locations are limited by the opportunities available. It is thus pleasing to see continued Specialist Training Program funding is recommended.

The capacity for vocational training is expected to come under increasing stress, as the recent large cohort of new medical graduates transitions from internship and pre-vocational training. The report urges an open mind in considering the potential need for further increases in vocational training positions.

Australia's Future Health Workforce – Anaesthesia report – key points



- Workforce projections through to 2030 indicate an anaesthesia workforce that is in balance, with the potential to shift into oversupply.
- An imbalance persists between regional and urban distribution of specialist anaesthetists.
- The number of medical students graduating will continue to exert pressure on the vocational training pipeline.
- Intake into the anaesthesia training program should take into account business fiscal interests, medical student vocational aspirations and evolving community requirements.
- Updates to workforce modelling will occur every two years.
- Workforce modelling is acknowledged as not being "an exact science", premised on a number of assumptions.

The full *Australia's Future Health Workforce – Anaesthesia* report can be found here – www.health.gov.au/internet/main/publishing.nsf/Content/australias-future-health-workforce-anaesthesia-report.

Business fiscal interests, community requirements and the vocational aspirations of medical graduates are each recognised as being the key drivers in determining intake into the training program. No comment is offered on the role of the College in this regard. Funding for vocational training comes from many sources, and the need for collaboration between governments, employers, ANZCA, and other professional bodies is stressed.

It is suggested that productivity of anaesthetists may increase, alongside ANZCA's response that as our patient cohort becomes older and more complex, retaining current productivity level will probably become more, not less, challenging.

In summary, and notwithstanding the limitations of the report, the anaesthesia workforce is predicted to be in balance through to 2030, with the potential for oversupply if IMGS numbers do not fall and/or trainee numbers increase.

The College is working with other key stakeholders (New Fellows, rural practitioners, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists) as we consider ANZCA's current workforce strategy in light of AFHW-A, and alongside the recently completed Graduate Outcome Survey and the 2014 fellowship survey.

Dr Rod Mitchell
ANZCA Vice-President and
Chair, ANZCA Workforce Strategy Working Group

The Australian Department of Health's Australia's Future Health Workforce – Anaesthesia (AFHW-A) report was guided by the National Medical Training Advisory Network (NMTAN). This represents an updating on the projections contained in Health Workforce 2025, which was completed by (the now former) Health Workforce Australia in 2013.

The College acknowledges that NMTAN is attempting to provide a framework within which the many stakeholders involved in vocational training and workforce can collaborate.

Graduate outcomes survey

Surveys show new Fellows are feeling positive

The report from our third online Graduate Outcomes Survey shows a high level of positivity among new Fellows.

Levels of satisfaction among new ANZCA and FPM Fellows is continually improving, according to this year's Graduate Outcomes Survey.

The survey will be used by ANZCA and FPM to deliver services that are relevant, effective and beneficial to Fellows. These include:

- The ongoing development of the workforce strategy by the ANZCA Workforce Strategy Working Group.
- Making improvements to continuing professional development (CPD) including improved promotion and communication on using the program.
- The development of educational resources to support training and practice delivered through the online learning platform, Networks.
- Increased use of online technology with examples like the Virtual ASM, Library Guides and the FPM Opioid calculator app as well as an increased presence by the College on social media to enable better communication and engagement with Fellows.

The 2016 surveys were distributed in the first week of June and were open for about six weeks. For the first time, the Faculty of Pain Medicine (FPM) conducted a separate Graduate Outcomes Survey.

The first FPM Graduate Outcomes Survey was a great opportunity for the Faculty to start collecting information from Fellows to help enhance services and develop new initiatives. The FPM working group (Dr Mick Vagg, Dr Meredith Craigie, Dr Harry Eeman with the support of the FPM team) was established

to develop and work on this inaugural survey and has been pleased with such a proactive response from FPM new Fellows and the quality of this feedback. Both surveys included a new section with questions focussed on bullying, discrimination and sexual harassment (BDSH).

Distribution was to all new Fellows (ANZCA and FPM) within three years of receiving their fellowship with surveys going to:

- 813 ANZCA Fellows.
- 28 FPM Fellows.
- 53 Fellows with both FANZCA and FPMANZCA.

Fellows who completed the BDSH sections of both surveys (full report page 30) were also asked if they consented to having their comments shared with the College and if they would like to be contacted by the College to discuss their feedback.

We have included some of the key findings of the ANZCA and FPM 2016 Graduate Outcomes Surveys that are broken into top-line headings that provide a snapshot of how new Fellows feel about training and services, working status and hours worked, confidence in the future as well as bullying discrimination and sexual harassment.

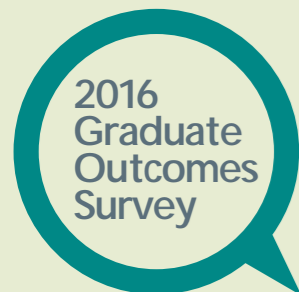
Thank you to everyone involved with the 2016 Graduate Outcomes Surveys.

Your support, enthusiasm and willingness to share contributed greatly to their success. We are always pleased to hear from new Fellows and would be happy to answer any questions relating to the Graduate Outcomes Survey and the results. Please do not hesitate to contact us via our dedicated email address graduateoutcomes@anzca.edu.au.

Dr Scott Ma
New Fellow Councillor

Dr Mick Vagg
Chair, FPM Graduate Outcomes Survey Working Group

“The survey will be used by ANZCA and FPM to deliver services that are relevant, effective and beneficial to Fellows.”



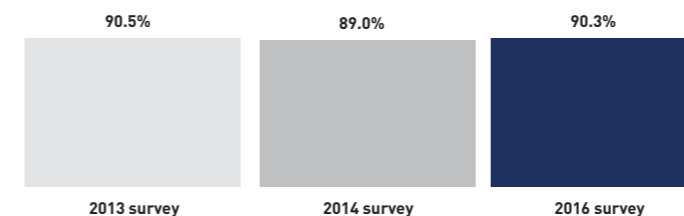
ANZCA – key findings

Responses to the survey were up on previous years with a total of 452 new ANZCA Fellows or 52 per cent completing the ANZCA survey and of these 413 or 91 per cent choosing to complete the BDSH section.

In line with previous studies, nine in 10 (90 per cent) of the graduates have entered the workforce, and of these, 95 per cent are regularly providing anaesthesia services.

This is consistent with 89 per cent in 2014 and 91 per cent in 2013 having entered the workforce as specialist anaesthetists; and of those who had entered the workforce, 95% (unchanged from 2014/13) report they are providing services on a regular basis.

Whether have entered the workforce



Satisfaction with working hours has significantly increased (77 per cent are satisfied, up from 70 per cent in 2014 and 66 per cent in 2013).

This is a very positive trend.

Only 13 per cent want to work more hours (down from 18 per cent in 2014). The ideal working week continues to comprise around 40 hours (those satisfied with their hours are working, on average, 39.7 hours per week).

The reported average hours worked per week has very marginally decreased (from 39.5 to 38.6 hours).

More graduates now report working, on average, 31-40 hours per week (from 33 per cent to 44 per cent), and in particular, fewer are working 41-50 hours (from 34 per cent to 28 per cent).

This decline is mostly due to those who are practicing in NZ and other countries. The average hours worked for those in NZ has slipped from 48.0 (2013 survey) to 45.9 (2014 survey) and now sits at 42.6.

The proportion of graduates undertaking unpaid or low paid work continues to decrease.

Only 13 per cent of respondents in 2016 are doing unpaid or low paid work, which is significantly down compared to the 2014 and 2013 survey result (19 per cent and 24 per cent).

Comments reveal that there continues to be concerns among graduates about employment opportunities and working hours.

These concerns should not be dismissed. Concerns expressed include potential oversupply of anaesthetists, concern about opportunities for future graduates, and quality/quantity of work; alternatively, some graduates are concerned about finding an appropriate work-life balance.

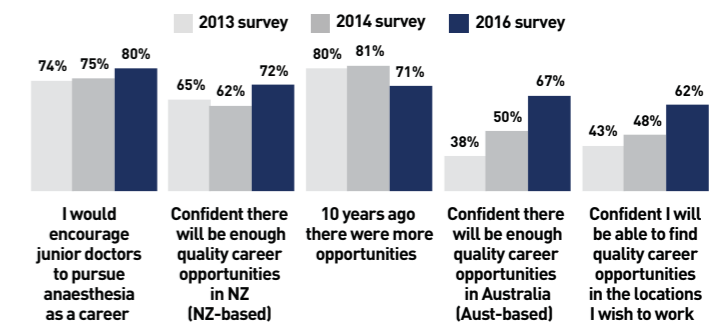
Graduates appear somewhat more optimistic about their future employment prospects.

While there is still room to improve results, there has been a notable increase in the proportion who feel that there will be quality career options available to them in locations they want to work (62 per cent, up from 48 per cent in 2014).

A similar proportion of Australian based graduates feel that there will be sufficient career opportunities for them in Australia (67 per cent, up from 50 per cent). NZ-based graduates are even more optimistic (72 per cent, up from 62 per cent). The majority would encourage a career in anaesthesia to junior doctors (80 per cent, up from 75 per cent).

Attitudes to future employment prospects

% Agree a lot / agree a little with each statement



Consistent with 2014 results, slightly more than half expect to remain in their current location for more than 10 years.

Those who plan to move are predominately planning to move to a metropolitan area within Australia (20 per cent).

There is little expectation among these graduates that they will move to a regional or rural area in the future. A total of 48 per cent are not planning to move to other locations at all.

Graduates' perceptions of their anaesthesia training have improved over the past three years.

A strong majority continue to rate the relevance of their training as excellent/very good (87 per cent); and an increased proportion are positive about their level of practical experience (84 per cent excellent/very good – up from 80 per cent three years ago) with satisfaction of quality of supervision at 74 per cent, up from 69 per cent, three years ago.

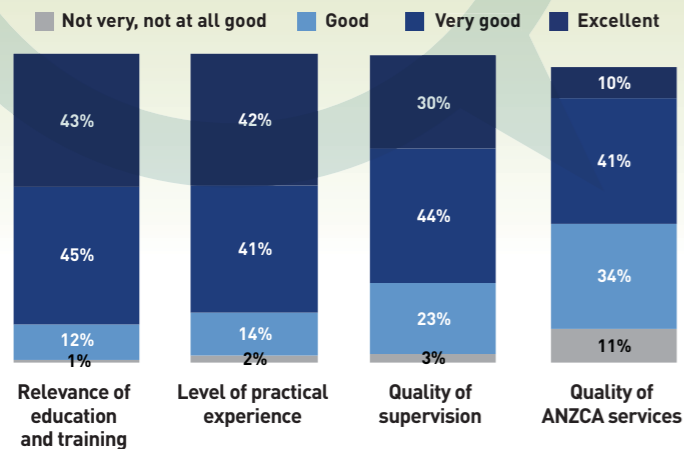
While there is still room for improvement, perceptions of the quality of ANZCA services are significantly up (51 per cent rate as excellent/very good, with this at 42 per cent in 2014 and 44 per cent in 2013).

(continued next page)

Graduate outcomes survey (continued)

ANZCA – key findings (continued)

Rating of key aspects of anaesthesia training



Graduates feel well prepared for practice as a professional, and medical expert – but less so as a health advocate, scholar and particularly as a manager.

The majority of graduates rated their preparation for practice as a professional (83 per cent) and medical expert (80 per cent) as being excellent/very good.

A more moderate proportion were satisfied with the level of preparation for practice as a collaborator (65 per cent) and communicator (64 per cent).

However, satisfaction was lower for health advocate (53 per cent), scholar (52 per cent) and manager (35 per cent).

Usage of the continuing professional development (CPD) program has significantly increased – but there are some declines for other ANZCA services.

Those using CPD “often” is significantly up since 2014 (from 48 per cent to 59 per cent) – and CPD is now the relatively most frequently used ANZCA service.

Frequent usage of the ANZCA website remains at a good level (56 per cent), but is starting to trend down (was 65 per cent three years ago); an emerging downward trend in usage can also be seen for safety alerts and courses.

FPM – key findings

More than 90 per cent of FPM graduates are finding work but a third would like to work more hours.

FPM key findings

The Graduate Outcomes Survey response rate for FPM was very positive with a total of 53 FPM new Fellows or 62 per cent completing the survey and 50 or 94 per cent of those completing the BDSH section.

Key findings have been identified in the areas of attitudes towards training and the services provided by the Faculty, working status and hours worked and future employment prospects.

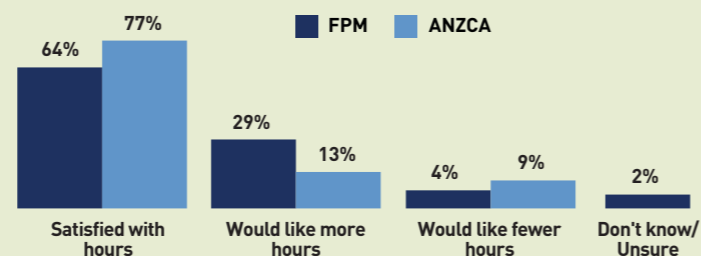
Almost all (93 per cent) FPM graduates have entered the workforce.

Of these, most are regularly providing pain medicine services (92 per cent).

Close to two thirds (64 per cent) are satisfied with the amount of hours worked.

However, one in three (29 per cent) would like to work more hours.

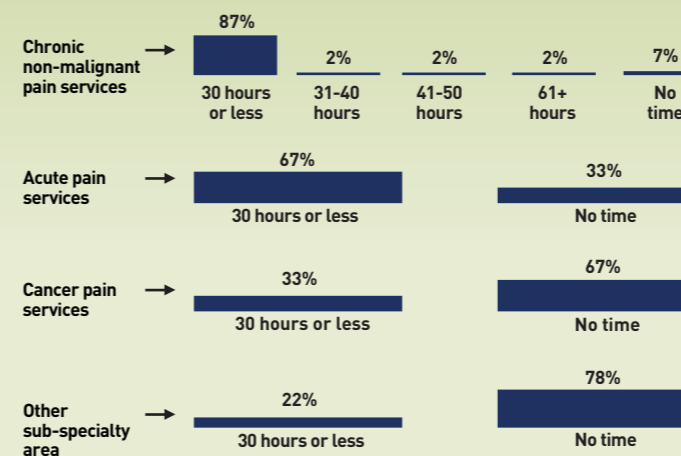
Those regularly working: Satisfaction with reported hours of work



The reported average hours worked per week is 21.5.

The majority of graduates (84 per cent) are working fewer than 30 hours per week. This is a lot lower when compared to ANZCA graduates who are working 38.6 hours per week on average.

Those regularly working: Reported average hours of work per week by service



24 per cent are undertaking unpaid or low paid work.

These graduates are spending an average of 8.4 hours per week doing unpaid or low paid work.

Most graduates are positive about their future employment prospects.

Almost all (94 per cent) Australian-based graduates feel confident that there will be sufficient quality career opportunities in Australia – 67 per cent of ANZCA graduates agree.

Close to half (47 per cent) of all graduates who are providing pain medicine services on a regular basis are not planning to move to other locations.

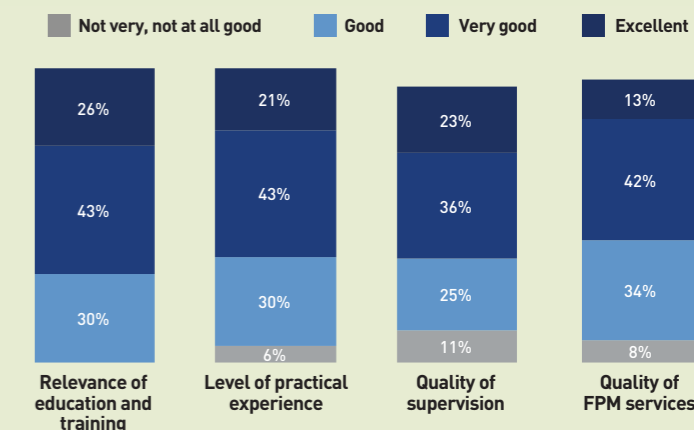
Those who plan to move are planning to move to an Australian metropolitan area (20 per cent), followed by 13 per cent planning to move to an Australian regional or rural area.

The majority cite family related circumstances as barriers to moving to regional and rural areas.

Graduates’ perceptions of their pain medicine training are mostly positive.

Seven in 10 (70 per cent) rate the relevance of their education and training as being very good/excellent, closely followed by satisfaction with the level of practical experience received (64 per cent). However, satisfaction levels concerning the quality of supervision (58 per cent) and FPM services (55 per cent) are more moderate, with about half being positive.

Detail: Rating of key aspects of pain medicine training

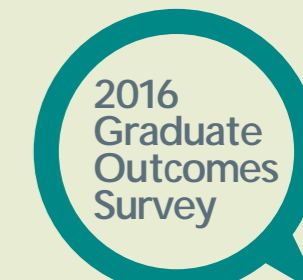


FPM graduates feel well prepared as a professional and medical expert.

FPM graduates feel well prepared for practice as a professional and medical expert – but less so as a health advocate, scholar and particularly as a manager.

The library, closely followed by the website are the most frequently used FPM services.

This contrasts the ANZCA survey findings where the CPD program is the most frequently used ANZCA service.



Graduate outcomes survey (continued)

ANZCA surveys new Fellows on BDSH

The Graduate Outcomes Survey included, for the first time, an optional section on bullying, discrimination and sexual harassment (BDSH) in both the ANZCA and FPM-specific surveys.

The optional BDSH section was completed by 96 per cent of participating Fellows (ANZCA and FPM). The questions were carefully designed to provide a clear definition of BDSH in each relevant section, and also provided information on where to report events or where to seek assistance, including contacting the College.

The questions specifically referred to the experience of events in the last three years either directly or witnessed. It should be noted therefore that this reflects workplace experiences over this time which were spread over senior trainee roles as well as those as junior consultants.

We sought information about the perpetrators, what action was taken and how effectively it was resolved. Finally participants had the option to indicate whether they wanted further contact with the College about any concerns.

ANZCA survey on BDSH

Bullying

Of the respondents to the survey, 34 per cent had personally experienced workplace bullying and 59 per cent personally witnessed it in the last three years.

This is not very different to figures published by the Royal Australasian College of Surgeons (RACS) and indicates that despite the different clinical supervision structures in the ANZCA program and workplace, an unacceptably high level of bullying is occurring.

As shown in figure 1 on the opposite page, both anaesthesia trainees and consultants experienced bullying, and the perpetrators were usually anaesthetic or surgical consultants. Although not surprising, this is important information and reinforces the need for improved professional behaviours at a consultant level.

Almost half of the events (45 per cent) had not yet been actioned, and a concerning 16 per cent of respondents reported that bullying was ongoing. In regard to training and support around BDSH, 64 per cent of respondents felt adequately prepared and supported to deal with bullying and discriminatory behaviors, but training could be improved. In relation to reporting BDSH, Fellows are significantly more aware of how to report and seek help within their hospitals and departments than through the College.

Discrimination and/or sexual harassment

Discrimination and/or sexual harassment was experienced personally by 18 per cent of respondents, and 20 per cent had witnessed it. Recipients were equally anaesthesia consultants and trainees with two-thirds of perpetrators being anaesthetic consultants.

There is legal protection against workplace discrimination or sexual harassment, but only 64 per cent of recipients felt adequately supported. Such support lies within the responsibility of the employer but also ANZCA Fellows acting as designated delegates of the College (for example, supervisors of training) and indeed every person in the workplace. We are working towards developing improved training and support for Fellows in these areas.

Performance assessment

Consultants involved with providing feedback and review to trainees (or other consultants) should be reassured that, provided this is undertaken respectfully and fairly, that such feedback is an appropriate, expected, and essential as part of training and/or professional development.

ANZCA summary of key results

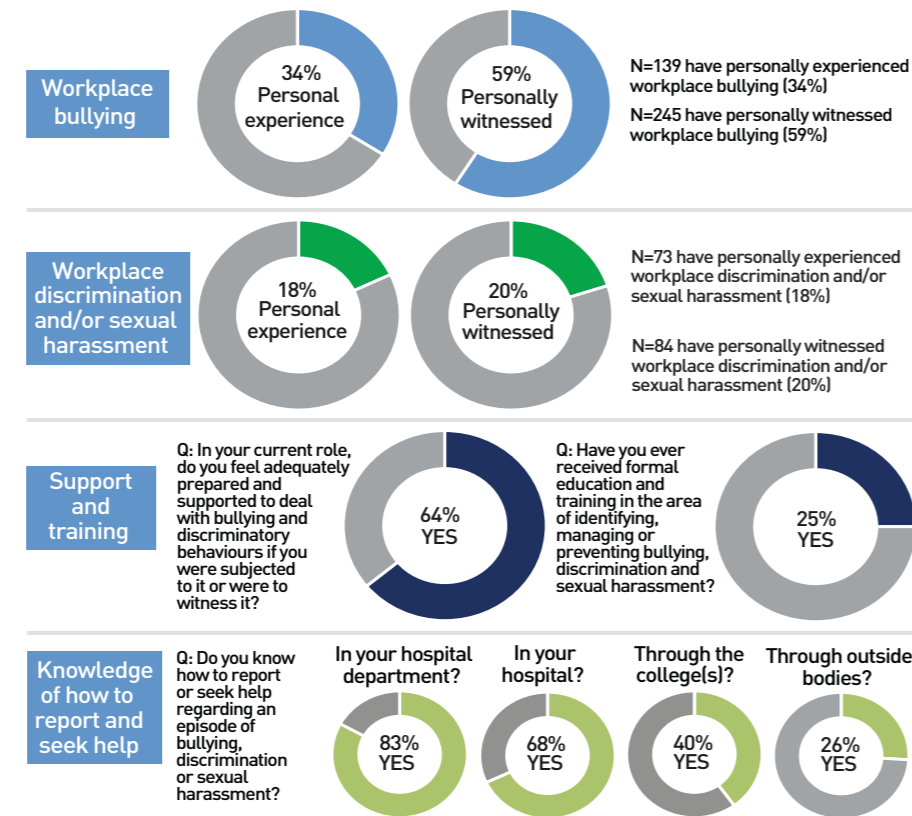
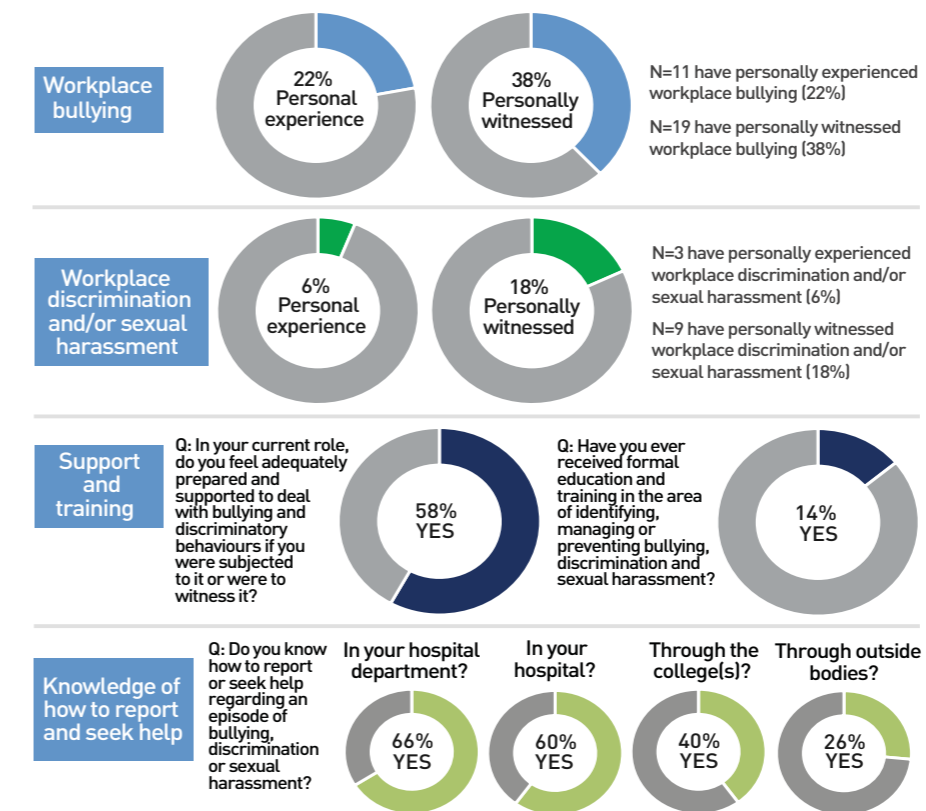


Figure 1. Analysis of recipient events of bullying in ANZCA respondents (n = 290 events).



FPM summary of key results



FPM survey on BDSH

Bullying, discrimination and sexual harassment key findings in FPM (75 per cent also FANZCAs) show that, of the respondents to the survey, 22 per cent personally experienced work place bullying and 38 per cent personally witnessed it.

Six per cent had a personal experience with discrimination and/or sexual harassment and 18 per cent personally witnessed it. Perpetrators of the 19 reported bullying events were almost always consultants, with recipients equally divided amongst consultants and registrars.

In regard to training and support around BDSH, 58 per cent of respondents felt adequately prepared and supported to deal with bullying and discriminatory behaviours. As noted above, in relation to reporting BDSH, FPM Fellows are significantly more aware of how to report and seek help within their hospitals and departments than through the College.

Summary on BDSH

This information and these reports are concerning and are being taken and considered seriously. There clearly remains much to be done. A report will be provided by the end of the year to guide the direction for the College in these areas.

In the meantime, the College will be following up those who indicated a desire to be contacted, advising on support and/or improving our information.

Should help be desired, please feel free to access the following resources of the College in addition to your employer if needed:

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

Professor David A Scott
Chair, BDSH Working Group

Remembering a remarkable contribution to medicine



Professor Barry Baker remembers Professor Garry Phillips' (November 7, 1936 – July 25, 2016) lifelong contributions to anaesthesia, intensive care, emergency medicine and to medical education.

Professor Garry Phillips, one of Australia's best known academic anaesthetists and the fifth president of ANZCA (1996-1998), died quietly at home after battling motor neurone disease (MND) for his last few years. He was most respected as a good clinician and as a very sound opinion on both medical and medico-political issues.

Garry contributed greatly to ANZCA over a long period not just during his years on ANZCA Council but later as the first director of professional affairs (DPA) for the College (1999-2005). His period as DPA was so successful that the council rapidly moved to employ a number of DPAs for different administrative professional activities.

During these years that Garry continued to sit as a resource person on council his opinion was constantly sought because of his corporate knowledge as well as his balanced opinion on all matters. Often he appeared to be asleep at council and committee meetings only to suddenly become aroused to pronounce the only sensible words that immediately brought what had been a tedious discussion to a sudden close.

His presidency is commemorated in the College by a sculptured bust by Margery Ralph and etchings of him by his daughter Anna Phillips. These are an indication of his independent view of such things as all other presidents are remembered with portraits either in oil or most recently as a studio photograph.

Garry was born, the middle child of three, in Bendigo Victoria where he attended the Marist Brothers College. Later, following the death of his general practitioner father when he was 12, he boarded at St Ignatius' College Riverview in Sydney where he represented the school in the senior teams for athletics, rowing and rugby.

Following school Garry "spent a year doing a variety of things" one of which was three months in the Watsonia Seminary in Melbourne where he quickly decided that the priesthood was not for him; "and then made up my mind to go to Papua New Guinea as a cadet patrol officer".

As a patrol officer, Garry was exposed to trauma, chronic illnesses, and infections among the population. He himself contracted malaria, hepatitis and dengue. These experiences, along with a query from an oil expedition leader about what he was going to do when he had enough of New Guinea, set him thinking and in the last week before term started in 1958 he enrolled in medicine at the University of Sydney. These days he would have not been able to be selected and medicine would have been much the poorer.

He graduated MB BS in 1965 (final year 1964) following an intercalated year for a BSc(Med) on *Induced Autoimmune Colitis in Animals*. As a student he drove taxis and later had quite a reputation for driving fast through narrow traffic gaps on Glen Osmond Road, and more recently this skill was transferred to his wheelchair.

Garry and Marcia (née Overton) married as final-year students and then, as married interns were not favoured at the same hospital, Garry went to St George Hospital, Sydney, and Marcia to Canterbury & District Hospital, and for their second year to Mersey Hospital, Tasmania where marrieds were acceptable!

In both hospitals Garry did anaesthesia terms finding a natural aptitude. He thus decided to train in anaesthesia back at St George Hospital over the next three years as one of two registrars with Dick Young as the director.

Then they were off overseas to Westminster Hospital London with Organe, Scurr and Feldman – high names in British anaesthesia at the time. Later, working at East Grinstead, Garry was "offered a job with a future at the London Clinic" but Australia beckoned. On the way home he worked six-month terms in intensive care with Bertil Lofstrom at the Serafimer Hospital in Stockholm and at the Hospital for Sick Children in Toronto with Al Conn.

Garry returned as foundation director of intensive care to St George Hospital in 1973, but soon was appointed as chief of intensive care at the then new Flinders Medical Centre Adelaide in 1976 with Michael Cousins as Head of the University Department of Anaesthesia.

Michael remembers Garry for many attributes but one stands out – "blinding sanity!" – an attribute that everyone who knew Garry would endorse. He also mentioned "integrity, reliability, loyalty, equanimity and generosity".

At Flinders Garry honed his administrative skills within the hospital and more widely in intensive care and anaesthesia with the then Faculty of Anaesthetists, Royal Australasian College of Surgeons (RACS); and also becoming director of Accident & Emergency which led to being integral to the foundation of the Australasian College for Emergency Medicine (ACEM) and subsequently its censor-in-chief. He was awarded ACEM's Foundation 20 Medal in 2003 for his contributions to that college.

Garry had the honour to be an examiner for the final specialist examinations for anaesthesia, intensive care and emergency medicine. He retired from emergency medicine when Chris Baggoley returned to Flinders, and then when Michael Cousins went to Sydney, Garry elected to retire from intensive care to become director of anaesthesia and professor – finally retiring from Flinders in 2001 as emeritus professor. In 1986 he was elected to the Board of the Faculty of Anaesthetists RACS and retired from the ACEM Council in 1988 because of a potential conflict of interest.



As an early Australian intensivist, Garry was very involved in the establishment of intensive care as a specialty, and was a founding member of the Australian and New Zealand Intensive Care Society (ANZICS) and the Section of Intensive Care, and became a Fellow of the College of Intensive Care Medicine (CICM) on the foundation of that college after its many metamorphoses within ANZCA.

He had a major research interest in parenteral nutrition with many publications on this topic, and his administrative skills were well utilised in workforce studies particularly for intensive care and anaesthesia.

At the time of his final retirement from ANZCA in 2005 Garry was awarded the Robert Orton Medal for distinguished service. This award is the highest that the College bestows. In the same year he was appointed a Member of the Order of Australia (AM) "for service to medicine, particularly in the areas of anaesthesia, intensive care and emergency care, and to medical education".

Soon after arriving in Adelaide Garry had established a close working and teaching relationship with the St John Ambulance Service later the SA Ambulance Service. He strongly supported the introduction of the BHSc(Ambulance) at Flinders University steering it through university administration including relocating the Ambulance Education Unit to integrate with Flinders.

In recognition of his contributions he was made a Serving Brother of the Order of St John in 1984 and an Officer of the Order in 1996. In 1988 Garry had been an early enthusiast and instructor for the RACS's Early Management of Severe Trauma (EMST) course which cemented the close association between surgeons and anaesthetists on this course.



In 1993 following the first EMST course in PNG he was invited to teach anaesthesia and became a visiting professor four times per year within the School of Medicine UPNG from 1997 until 2004. There have been very many letters of condolence sent from anaesthetists in PNG all of whom report on Garry's tremendous mentoring, and expressing their heartfelt thanks for his encouragement and leadership.

ANZCA established the Professor Garry Phillips Prize and Medal for the best candidate in the MMed(Anaes) UPNG in recognition of his raising of the standards in anaesthesia in PNG.

Garry showed an early interest in historical matters with a publication in 1962 on Hippocrates. This interest continued when a trainee at St George with his friendship with Gwen Wilson, the Australian doyen of historians in anaesthesia. During his DPA and retirement years this interest flourished with a number of historical publications including two landmark books on the history of intensive care – *The History of ANZICS in Australia and New Zealand – a record of events* (2000 with Ron Trubuhovich) and *Intensive Care Medicine in Australia – Its origins and development* (2014).

He was renowned for his attention to detail but occasionally that got the better of him. In his final year as ANZCA president, the Adelaide Crows had a good season, winning their first premiership. During the finals period the then ANZCA chief executive officer, Joan Sheales herself an avid Australian football supporter asked Garry what he thought about the Crows this year to be astounded by his reply "I don't know, are there a lot around this year?"

"Michael (Cousins) remembers Garry for many attributes but one stands out – 'blinding sanity!' – an attribute that everyone who knew Garry would endorse. He also mentioned 'integrity, reliability, loyalty, equanimity and generosity'."

Garry relied heavily on Marcia for support and is on record as saying "I did not realise until after I retired how supportive and tolerant Marcia was and how much she had to compensate to practice regularly, and to manage home and five children through school and university!"

He was close to his father-in-law who advised him to "plan to leave the world a better place for you having been born", which as his family said was his *raison d'être*.

Garry and Marcia shared a deep and abiding faith which helped them to deal with his difficulties with MND which were approached with grace and equanimity.

He is survived by Marcia, his children (Helen, Madeleine, Anthony, Anna and Stephen) and 13 grandchildren. Our sincere condolences go to them and to all his many friends much saddened by his passing.

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

Above from left: Professor Garry Phillips was ANZCA president from 1996-98; ANZCA presidents Dr Richard Willis (2002-04), Professor Michael Cousins (2004-06), Professor Teik Oh (2000-02), Professor Garry Phillips 1996-98; Professor Phillips' presidency is commemorated in the College by a sculptured bust by Margery Ralph; etchings of Professor Phillips by his daughter Anna Phillips.

Checking the checkers: Keeping surgical teams on track

There is a way to improve patient safety that is cheap, easy and extremely effective. Simon Mitchell and Alan Merry report on new findings about the surgical checklist.

Everyone knows the drill, but not everyone obeys the drill. The Surgical Safety Checklist developed by the World Health Organization (WHO) in the mid-2000s is not followed as widely as it should be.

The checklist is designed to improve communication and prevent errors or omissions in operating-room patient care. The process has three phases:

- Sign in, when the patient arrives in the operating room. Do we have the right patient? What is this procedure? Do we have the right equipment?
- Time out, just before the first incision, when all members of the team – nurses, anaesthetists, surgeons – raise potential problems.
- Sign out, before the patient leaves theatre. Are any specimens labelled correctly? Are all instruments and swabs accounted for? Are there concerns for post-operative care?

The benefits of the checklist have been confirmed by at least six clinical trials; when conducted meticulously, the process has been shown to significantly reduce perioperative mortality and/or complications. Its use is a medical no-brainer.

But its use can be patchy. At Auckland City Hospital, despite participation in the original WHO checklist study and persistent reminders to staff, we saw a progressive fall in checklist compliance after its adoption in 2009. We ran periodic audits with trained observers in our five operating suites and found that often the checklist simply wasn't done (especially the sign out phase). When it was done, some items were not read out; and many operating room staff continued working while the checklist was being read, rather than stopping to pay attention.



For example, the anaesthetist would continue applying monitoring equipment or inserting a cannula during sign in; the surgeon would continue to arrange the sterile field during time out; and often everyone would effectively ignore sign out. Not surprisingly, this discouraged the nurse leading the process from trying to administer it all. In our 2013 audit, sign out was attempted in 22 per cent of operations.

We identified two contributing problems that could be easily addressed. Firstly, the checklist was on a piece of paper that was read aloud by one member of staff, which meant other members of the team could not see it and remained disengaged.

Secondly, that member of staff was the circulating nurse (an administration approach common worldwide), allowing doctors imbued with the “hero model” of medicine – “If I just run the show and am diligent and competent it will all be fine” – to ignore the process. Making nurses the only checklist leaders created a sense that the checklist was a nursing procedure, rather than a process owned by the entire operating-room team.

We noted a different checklist leadership model at another local hospital where engagement of operating room staff seemed better and we decided to trial a similar process in our suites. Firstly, we abandoned paper checklists and mounted large checklist posters (one for each checklist phase) on the walls of the theatres where they could be viewed by the whole operating room team. This had two advantages: It meant members of the team could see if an item was omitted – or erroneously added – by the person leading that phase; and it meant members of the team who were gowned and gloved and working in the sterile field could share in running the process.

And this became the second big change. We shared responsibility for leading the three-phase process between the three professional groups in theatre – nurses, anaesthetists and surgeons.

Leadership of each checklist phase was allocated to the team most central to the processes occurring at the time. The sign in phase was led by the anaesthetists, who would be preparing the patient for anaesthesia; time out was led by the surgeons, who would be about to make the first incision; and sign out was led by the nurses, who would have just completed the first swab and instrument count. In preparation for the change, a Checklist Revision Group visited at least one regular meeting of each operating room sub-team to explain the new process and answer questions.

A study to evaluate the effectiveness of this change took place in January 2015 after a two-month “bedding-in” period. Data was collected over four weeks by a single observer, whose purpose in the operating room was not explicitly explained to staff; 111 operations were observed, involving a total of 261 checklist domains (85 sign in, 100 time out and 76 sign out).

The results: There was no change in compliance with administering the sign in and time out phases, which had always been good, but compliance with administering the sign out phase improved substantially, from 22 per cent of cases in 2013 to 84 per cent of cases in 2015.

Compliance with administration of the individual checklist items at all stages also increased: sign in, to 91.9 per cent (up from 59.9 per cent); time out to 92.9 per cent (up from 84.4 per cent); and sign out to 98.9 per cent (up from 80 per cent). Crucially, there was a remarkable

increase in engagement in the process by operating room staff – effectively paying attention by ceasing other activities. For example, engagement of at least one member of each sub-team (nursing, anaesthesia, surgery) during time out went from 15 per cent to 92 per cent of cases.

The principle of asking the recidivist offenders for non-engagement at each phase (anaesthetist at sign in and surgeon at time out) to lead that phase had clearly worked. In addition, anecdotally, it seemed the directed gaze of the leading person often seemed to draw the attention of other operating room staff to the checklist, engaging them more.

The most unexpected gain was the big rise in compliance with administration of time out. In informal discussions following this study, nurses consistently said their higher compliance was due to a more supportive environment.

Having the anaesthetists and surgeons initiate and lead their “own” phases (sign in and time out) seemed to improve the doctors’ understanding of, and co-operation with, their nursing colleagues’ leadership. Consequently, the nurses felt motivated and empowered to proactively initiate their sign out phase. In the past, they said, it had “seemed more like an imposition on the flow of work”, and they had often felt more comfortable omitting it.

This was a single-centre study, so the results may not apply everywhere. But it certainly suggests that the paperless wall-mounted checklist with rotating leadership is a simple, cost-effective way

“The benefits of the checklist have been confirmed by at least six clinical trials; when conducted meticulously, the process has been shown to significantly reduce perioperative mortality and/or complications. Its use is a medical no-brainer.”

to make better use of a tool that has been proved to make a substantial difference to patient outcomes.

Our hospital has now halved its rate of critical specimen-labelling errors. And the patient whose appendix was discovered to be missing from the specimen pot at sign out (left in his body in a plastic bag after keyhole surgery) is one of many who can be grateful for the changes.

Associate Professor Simon J Mitchell, FANZCA

Professor Alan F Merry, FANZCA
Department of Anaesthesiology,
University of Auckland

A full report on this study was published in BMJ Quality and Safety Online First, December 30, 2015. It was titled “A ‘paperless’ wall-mounted surgical safety checklist with migrated leadership can improve compliance and team engagement”.

Above: Associate Professor Simon Mitchell standing next to a wall-mounted checklist poster.

Bankstown-Lidcombe tragedy – lessons learned

The recent tragic incident at Bankstown-Lidcombe Hospital, where a series of errors led to the failed resuscitation of two babies with nitrous oxide instead of oxygen, is not the first time disaster has resulted from a pipeline misconnection.

Those of us who have been around since the last millennium, and have retained long-term memory, will recall the disaster that occurred in Australia several decades ago that resulted in the introduction of pin-index and sleeve-index connectors.

This, however, did not protect against the misconnection behind the wall.

The Food and Drug Administration (FDA) in the US have identified seven deaths and 15 injuries over the four years between 1997 and 2001 that have resulted from delivery of wrong gases due to misconnections.

Since that time the relevant Australian Standards have undergone several reviews and modification to minimise the risks of pipeline misconnections. Strict processes were introduced, which when followed, have been successful in eliminating the problem.

Unfortunately, when processes are not followed safety may be severely compromised as evidenced by the tragic outcomes witnessed at Bankstown-Lidcombe Hospital. In this incident, one baby died and the other has been left with serious health issues.

The report into the incident states that the hospital's department of anaesthesia was unaware of the installation works, and that the commissioning of the outlet was done without the presence of an anaesthetist.

"The lesson for us in anaesthesia, perioperative medicine and pain medicine is that despite the safeguards inherent in standards, they are dependent on strict compliance."

Details of the report are available here – www.health.nsw.gov.au/Hospitals/Documents/bankstown-lidcombe-incident-final-report.pdf.

One of the offshoots of the earlier disaster was the mandating of in-circuit oxygen analysers on all anaesthesia machines. However, with advances in technology these have been incorporated into the realm of gas monitoring built in to modern anaesthesia workstations.

Clearly, administering gases that bypass anaesthesia workstations reintroduces the low-risk but potentially lethal possibility of unintentionally delivering a non-respirable gas.

The review into the disaster at Bankstown has highlighted a combination of system errors, governance issues, and failure to comply with standards.

The lesson for us in anaesthesia, perioperative medicine and pain medicine is that despite the safeguards inherent in standards, they are dependent on strict compliance.

Whilst validation of correct gas supply during commissioning new operating theatres, intensive care units and emergency departments must follow strict protocols, equal attention must be given to ensuring correct gas delivery whenever and wherever pipeline "works" are undertaken. This includes refurbishment, modification or expansion of operating theatres.



Additional safeguards over and above the standards are needed. Maybe oxygen analysers should be re-introduced in situations where gases are being administered that are not otherwise being monitored.

Dr Peter Roessler
Communication and Liaison Portfolio
Safety and Quality Committee

Cosmetic surgery regulations tightened – but far enough?

The Medical Board of Australia has moved to strengthen guidance for cosmetic surgery procedures.

While the recommendations are appropriate, more needs to be done to protect patients, particularly with regard to the use of anaesthesia and sedation in unlicensed premises.

As described in "Cosmetic surgery in the spotlight" (March 2016 ANZCA Bulletin, page 22), several loopholes leave patients at risk. These have been highlighted by concerning incidents of cardiac arrest, seizures and pneumothorax in otherwise healthy, young patients having breast implants, and a series of complaints that patients at a particular clinic were rendered unconscious without their consent.

Following a public consultation, the MBA issued new guidelines on May 9, 2016 stating there must be cooling-off periods for major cosmetic procedures (seven days for adults, and three months for under-18s with a mandatory psychological evaluation).

There is also a new requirement for the treating medical practitioner to take explicit responsibility for post-operative patient care, and for making sure there are appropriate emergency facilities when they are using sedation, anaesthesia or analgesia.

However, the board also pointed out that there were important safety concerns that it did not have the authority to address. Consequently, it has made recommendations to other authorities about dealing with inconsistencies in drugs and poisons laws across jurisdictions, and about strengthening and aligning the licensing of private health facilities, including regulating the use of sedation and anaesthesia.

The board said it had wanted to "help keep patients safe, without imposing an unreasonable regulatory burden on practitioners". There are other issues the board could have addressed to improve patient safety, without imposing an unreasonable regulatory burden.

In formulating its guidelines, the board seems to have had in mind the needs of the physically healthy, but perhaps psychologically vulnerable, young person who might make an impulsive decision to have a major procedure – hence the focus on cooling off and psychological evaluation. But there is an equal need to ensure proper physical evaluation to exclude or manage underlying conditions that make surgery or anaesthesia more complex or even inadvisable.

The patient with morbid obesity who wants liposuction and the middle-aged man seeking a facelift who fails to disclose his heart condition are patients at risk. Most cosmetic surgery patients are self-referring.

But for major cosmetic surgery it should be recommended that patients be referred by a GP, who will know the patient's history and be able to warn of underlying conditions that pose a risk for surgery or anaesthesia, such as obstructive sleep apnoea, allergies, heart disease or diabetes.

The MBA recommendations concerning the consent process are also inadequate as they pertain largely to financial consent.

"ANZCA and the Royal Australasian College of Surgeons are both concerned about the safety issues surrounding cosmetic surgery, and are considering taking a combined approach to this issue."



It should be compulsory for practitioners, in the absence of an anaesthetist, to explain the processes and risks of the sedation or anaesthesia that will be used in an effort to ensure that patient consent is actually "informed".

In June, the NSW Department of Health amended its legislation that governs private day-facility licencing in response to growing concerns about the safety and regulation of cosmetic surgery. The NSW Private Health Facilities Act 2007 was amended to add "cosmetic surgery" as a new 19th class of private health facility (in addition to the anaesthesia and surgical classes of facilities that already existed).

The regulations define the cosmetic class by specifying a list of 16 cosmetic procedures, and by including "any cosmetic surgical procedure that is intended to alter or modify a person's appearance or body and that involves anaesthesia (including a Bier's Block)".

The amendment means that any of the 16 defined procedures, or any cosmetic procedure involving anaesthesia, must be performed at a facility subject to the same licensing standards that apply to private health facilities in NSW.

The NSW amendments are a significant step in the right direction. However, it would have been preferable to have a requirement that any facility providing intravenous sedation be licensed (as stated in ANZCA's submission to NSW on the proposed change in February 2016).

Licensing facilities based on a list of surgical procedures may also have limitations, as surgical procedures may change, and new procedures will be developed over time.

It is likely that other states may begin examining their licensing requirements following on from NSW's changes, and in response to safety concerns.

ANZCA and the Royal Australasian College of Surgeons are both concerned about the safety issues surrounding cosmetic surgery, and are considering taking a combined approach to this issue, to promote appropriate standards and provide advice to state governments about strengthening the regulations that govern the licensing of facilities.

Dr Phillipa Hore
Chair, ANZCA Safety and Quality Committee

New ANZCA airway assessment resource

The *Airway Assessment* report aims to help anaesthetists develop the most appropriate airway plans to minimise the chance of having a CICO situation.

The role of airway assessment is to identify potential problems with the maintenance of oxygenation and ventilation during airway management. It is the first step in formulating an appropriate airway plan, which should incorporate a staged approach to manage an unexpected difficult airway or the institution of emergency airway management. It also remains an integral component of managing the unexpected airway – “reassess, formulate a new plan and execute”.

Airway assessment should be done for all anaesthesia encounters, including regional anaesthesia or monitored care cases. This is despite the evidence that current airway assessment tools have a low positive predictive value for a difficult airway. This, in turn, is due to low test sensitivity, modest test specificity, and the low prevalence of difficult or failed intubation in the general population. The aim of airway assessment is to ensure that abnormalities are detected and a safe and appropriate strategy is considered and employed – make a diagnosis (assessment) and treat (airway plan). Dr Yentis’ editorial made this point very eloquently in 2002¹.

Or quoting Associate Professor Segal from one of his presentations: “Predicting difficulties in airway management is not completely reliable however there are some take home points:

- An airway predicted to be easy very rarely turns out to be difficult.
- A high proportion of patients with potentially difficult airway indicators turn out to be relatively easy to manage. However, this is not a free pass to ignore or omit the assessment.
- Anaesthetists get into trouble when they ignore, trivialise or fail to appreciate those signs.”

It has been mentioned that anaesthetists’ diagnostic accuracy for predicting a difficult airway is 7 per cent (that is, 93 per cent unanticipated)². This low value may not be a true reflection of the situation for a variety of reasons including the inclusion criteria, missing data, data could be retrospectively added (always better to have an unanticipated airway difficulty than admit you did not pay attention to the test), and the confounders that no difficult airway anticipated was the database default setting during the study period. We know that in 2006, airway assessments for general anaesthesia were not performed in 33 per cent of the cases by European anaesthetists and 44 per cent by UK anaesthetists³.



We’d like to think we do it better in Australia but in an audit of 850 anaesthesia records, airway assessment documentation was deemed to be compliant in 59 per cent of cases and intraoperative airway device documentation was complete in only 76 per cent of cases⁴. This is not reassuring or helpful for subsequent anaesthesia on the same patient.

The United Kingdom National Audit Project of Difficult Airway Management (NAP4) noted⁵:

- There were deficiencies in the undertaking and/or recording of an airway assessment.
- Even when abnormalities were detected, the strategies adopted were not always likely to manage the problem successfully.
- Poor judgement was the most common contributory factor.

Similar factors are mentioned in the Danish anaesthesia database report which included failure to note a difficult airway alert, poor planning, and judgment⁶. When tracheal intubation was anticipated to be difficult, almost 50 per cent of patients were scheduled for direct laryngoscopy. This may suggest that other airway strategies were not considered often enough.

Even more concerning was that if the rescue techniques were anticipated to be difficult 42.9 per cent of patients were managed by direct laryngoscopy² rather than an alternate technique. This is frequency gambling with the expectation that it will probably be okay 75 per cent² of the time. Unfortunately every time this is done we remove a layer of safety and increase the potential for an adverse outcome as described in the Parmesan cheese model of error⁷. Seemingly little has changed with regards to airway assessment and planning since NAP4.

“We’d like to think we do it better in Australia but in an audit of 850 anaesthesia records, airway assessment documentation was deemed to be compliant in 59 per cent of cases and intraoperative airway device documentation was complete in only 76 per cent of cases.”

This *Airway Assessment* resource attempts to restore this balance. It aims to assist in providing guidance about the components of the airway examination and the nine-overview airway questions (see table below) to help develop the most appropriate airway plans so as to minimise the chance of having a “can’t intubate, can’t oxygenate” (CICO) situation.

Core airway assessment overview questions

- 1 History of previous difficult airway.
- 2 Effect of surgery or the condition on the airway.
- 3 Altered cardiorespiratory physiology.
- 4 Aspiration risk.
- 5 Difficulty to oxygenate by bag mask ventilation.
- 6 Difficulty to oxygenate by supraglottic airway.
- 7 Difficulty to intubate.
- 8 Difficulty to oxygenate by infraglottic airway.
- 9 Extubation risk.

Table 1: Core Airway Assessment Overview Questions

The Model for Direct Laryngoscopy and Tracheal Intubation⁸ expands on the traditional airway assessment. This is a functional classification based on a deconstruction of direct laryngoscopy and tracheal intubation⁹. It provides a structured approach to airway assessment (that is, diagnosis followed by the treatment plan) and is relevant preoperatively as well as for reassessment when an unexpected difficult airway is encountered. This approach is used to lay a foundation for diagnosis and implementing management.

Finally, in the event of a difficult airway being encountered, it is mandatory to provide written information to the patient and their medical practitioner, as well as to advise them to wear a medical alert bracelet.

Dr Pierre Bradley, Dr Gordon Chapman, Dr Ben Crooke, Dr Keith Greenland and Professor David A Scott
Authors, *Airway Assessment*
www.anzca.edu.au/resources/college-books-and-reports

References:

1. Yentis SM. Predicting difficult intubation--worthwhile exercise or pointless ritual? 2002;57:105–9
2. Nørskov AK, Rosenstock CV, Wetterslev J, Astrup G, Afshari A, Lundstrom LH. Diagnostic accuracy of anaesthesiologists' prediction of difficult airway management in daily clinical practice: a cohort study of 188 064 patients registered in the Danish Anaesthesia Database. *Anaesthesia* 2015;70:272–81
3. McPherson D, Vaughan RS, Wilkes AR, Mapleson WW, Hodzovic I. A survey of anaesthetic practice in predicting difficult intubation in UK and Europe. *Eur J Anaesthesiol* 2012;29:218–22
4. Elhalawani I, Jenkins S, Newman N. Perioperative anesthetic documentation: Adherence to current Australian guidelines. *J Anaesthesiol Clin Pharmacol Medknow Publications*; 2013;29:211–5
5. Cook TM, Woodall N, Frerk C, on behalf of the Fourth National Audit Project. Major complications of airway management in the UK: results of the Fourth National Audit Project of the Royal College of Anaesthetists and the Difficult Airway Society. Part 1: Anaesthesia. *Br J Anaesth Oxford University Press*; 2011;106:617–31
6. Rosenstock CV, Nørskov AK, Wetterslev J, Lundstrom LH. Danish Anaesthesia Database. Emergency surgical airway management in Denmark: a cohort study of 452 461 patients registered in the Danish Anaesthesia Database. *Br J Anaesth* 2016;
7. Moloney J. Error modelling in anaesthesia: slices of Swiss cheese or shavings of Parmesan. *Br J Anaesth Oxford University Press*; 2014;113:905–6
8. Greenland KB. A proposed model for direct laryngoscopy and tracheal intubation. *Anaesthesia* 2008;63:156–61
9. Greenland KB. Airway assessment based on a three column model of direct laryngoscopy. *Anaesth Intensive Care* 2010;38:14–9

New standard for neural application devices

ISO 80369-6 Implementation of Neuraxial “NRFit” devices

The ISO standard for connectors for devices used for neural applications has been published.

The devices on which this connector will be used are neuraxial, including spinal and epidural access and anaesthesia equipment, cerebral intraventricular drainage and access devices, peripheral nerve anaesthesia devices, and the associated devices required such as syringes, infusion connectors (patient end) etcetera (see www.iso.org/iso/catalogue_detail?csnumber=50734).

The ISO 80369-6 connector design is similar to Luer but of smaller dimensions. There are both “slip” and “lock” configurations. The slip version has a non-engaging collar on the male component (such as a syringe), that prevents connection with non neural devices.

Although California legislation requires neuraxial devices which are non interconnectable only for epidural use by January 2017, the intention in California and the whole of the US is to introduce equipment for all neural use incorporating the ISO 80369-6 connector.

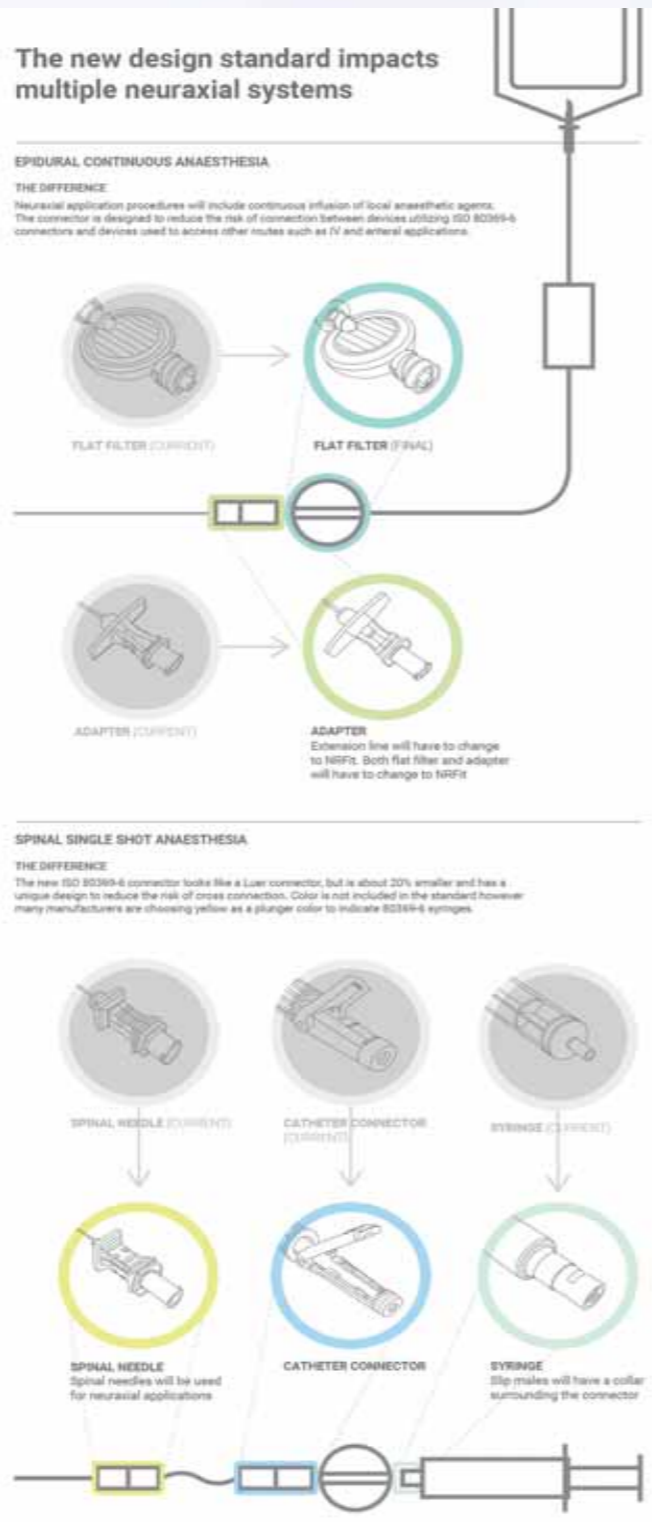
In preparation for the changes, several patient safety and communication bodies have published information. These include FAQ from “StayConnected” an initiative of the industry group Global Enteral Device Supplier Association (GEDSA) (see <http://stayconnected.org/wp-content/uploads/2015/10/GEDSA-Neuraxial-FAQv1.4.pdf>) and involvement by the (US) Institute for Safe Medication Practices (ISMP).

In England, the NHS England Small Bore Connector Clinical Advisory Group also plans a single phase process to supply a comprehensive range of medical devices utilizing the ISO 80369-6 connectors (see www.england.nhs.uk/patientsafety/medical-device-incidents/small-bore-connectors/).

In Australia, the Australian Commission on Safety and Quality in Healthcare and the Therapeutic Goods Administration (TGA) are now engaging in discussions with clinicians’ bodies such as ANZCA and other stakeholders.

The introduction of these devices will affect clinicians, including anaesthetists, and other stakeholders, including pharmacy, supply, logistics, procurement and manufacturers. Information and education of stakeholders is regarded as vital. A clear and comprehensive education and training program regarding the introduction and use of these devices is considered essential.

Dr Phoebe-Anne Mainland, FANZCA
Member ISO/TC210/JWG4 Small bore connectors
And ISO/TC210/WG5 Connectors for reservoir delivery systems



webAIRS news



Professor Michael Cousins, who retired from full-time practice in May 2016, initiated many valuable and important contributions to anaesthesia, pain medicine and patient safety.

In the latter context, Professor Cousins set up a number of working groups including the Quality and Safety Taskforce and the Data Taskforce. From the findings of these taskforces, the ANZCA Quality and Safety Committee and the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) were formed in 2006.

These two committees are now regularly creating resources to improve patient safety, with ANZTADC’s webAIRS initiative providing an enduring repository of patient safety information.

webAIRS has now collected more than 4000 incident reports. A total of 128 sites report data and, in addition, many individuals are independently registered. For the local administrators of sites there are new analysis features in webAIRS. Accessed via the administration tab on the homepage, “Incident charts” gives the opportunity to view local statistics in specified date ranges.

There is ongoing analysis of webAIRS data with articles detailing findings and themes featuring in the publications of the parent organisations and peer reviewed journals. Scientific meetings also provide opportunity for shared learning. The recent Australian Society of Anaesthetists (ASA) National Scientific Congress (September 17-20 in Melbourne) featured the following webAIRS presentations in

the session “Error reduction strategies – how you can improve your practice”:

- The Bowtie Diagram – a concept that incorporates causal analysis and event management (Dr Daniel Clarke).
- Are all human errors also system errors? (Professor Neville Gibbs)
- What do you do when the unexpected happens? (Associate Professor Kersi Taraporewalla)
- Show us the evidence! An analysis of webAIRS data. (Dr Martin Culwick).

The October 2016 issue of *Anaesthesia and Intensive Care* will feature an article summarising the concept of the bowtie diagram. A relatively new analysis tool in the healthcare setting, patient safety organisations worldwide are increasingly using this simple and effective tool for communicating risk assessment. As demonstrated at the recent ASA congress session, webAIRS’ utilisation of the tool puts it at the forefront of healthcare incident analysis.

For those who are not yet registered for webAIRS, the process has never been simpler. Streamlined registration involves a tick box approval of site terms and conditions. Anaesthetists can choose to link with an already registered site, set up a new site or enter incidents as an individual. Reports can be submitted completely anonymously and CPD points are earned with every incident that is logged in the database. Ultimately, contributing to this important safety and quality initiative leads to unique learning opportunities and practice improvement.

Analyse incidents - from 2009 onwards

Figure 1. Snapshot of bi-national reporting figures as at June 27, 2016.

- Select all
- This month
- Last month
- Last quarter
- Last half year
- This year
- Last year



More information

Please follow the links on the home page (www.anztadc.net) to download an information brochure and register online, or contact ANZTADC via anztadc@anzca.edu.au.

Nomenclature compendium of commonly used Chinese herbal medicines

The Chinese Medicine Board of Australia has commissioned the development of a *Nomenclature compendium of commonly used Chinese herbal medicines* (compendium), based on *The Pharmacopoeia of the People's Republic of China* 2010 edition (PPRC 2010). In the interest of public safety the use and knowledge of the compendium is being promoted among medical practitioners and is available here: www.chinesemedicineboard.gov.au/Codes-Guidelines/Guidelines-for-safe-practice.aspx

Comparison of available ephedrine injections

ATTENTION

Comparison of available ephedrine injections

	Ephedrine Hydrochloride	Ephedrine Sulfate
Concentration	25 mg/1 mL	30 mg/1 mL
Amplitude contents	Each mL contains 25mg of ephedrine hydrochloride in Water for injections in an amber (yellow) glass ampoule.	Each mL contains 30mg of ephedrine sulfate and 3mg of sodium chloride in Water for injections in a clear glass ampoule.
Dilution instructions	Dilute to 10 mL with 0.9% saline	Dilute to 10 mL with 0.9% saline
Fluocinonide concentration	2.5 mg/mL solution (equivalent to 2.05 mg ephedrine)	3 mg/mL solution (equivalent to 2.31 mg ephedrine)
IV dosage	Slow IV injection of 2.5 to 5 mg (maximum 10 mg), repeated as needed every 3-4 min to a maximum of 30 mg.	Slow IV injection of 10 to 25 mg which may be repeated every 5 to 10 minutes until the desired response is obtained. Precaution: 3 mg/kg/day or 100 mg/m ² /day via the IV/SC route, given in 4 to 6 divided doses.
Routes of administration	Intravenous only	Intravenous, intramuscular or subcutaneous
Indications	Hypotension secondary to spinal anaesthesia	Hypotension secondary to spinal anaesthesia Shock unresponsive to fluid replacement Bronchial asthma and reversible bronchospasm although more selective agents (beta adrenergic agonists) are now available.
Precautions	Not intended for use in children	May be used in children
Storage conditions	Store below 25°C, protect from light	Store below 25°C, protect from light
Shelf life	3 years	3 years

For all Medical Information and Adverse Event reporting, please contact: 1300 988 840
 Mayne Pharmaceuticals Pty Ltd ABN 62 011 011 011, 228 New South Road, Sydney, NSW, 1588, 1100 001 011, 1111 020 000
 Mayne Pharmaceuticals Pty Ltd ABN 62 011 011 011, 228 New South Road, Sydney, NSW, 1588, 1100 001 011, 1111 020 000
 © 2016 Mayne Pharmaceuticals Pty Ltd. All rights reserved. This document is the property of Mayne Pharmaceuticals Pty Ltd. It is not to be
 reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or by any information storage and retrieval system, without the prior written permission of Mayne Pharmaceuticals Pty Ltd.
 100% Australian owned. Mayne Pharmaceuticals Pty Ltd. (MPL) is a trademark of Mayne Pharmaceuticals Pty Ltd (MPL) in Australia.
 Date of preparation: August 2016 (MPL) 20160816

Mayne Pharma is soon to release a different presentation of ephedrine injection - Ephedrine HCl MYX (Ephedrine Hydrochloride). A comparison poster has been developed to assist clinicians with product differentiation and specifications.

Weekend surgery riskier; maternal deaths decline but AFE a concern: NZ mortality reports

One recent mortality report in New Zealand has found that there is a slightly greater likelihood that people will die following surgery carried out on the weekend, while another shows that maternal deaths are declining but that 13 per cent of perinatal deaths are potentially avoidable. Both reports have recommendations of relevance for anaesthetists.

Perioperative mortality – “weekend effect”

The “weekend effect” on surgical death rates is examined in the fifth report from the Perioperative Mortality Review Committee (POMRC). This committee reviews deaths related to surgery and anaesthesia that occur within 30 days of an operation, advises New Zealand’s Health Quality & Safety Commission (HQSC) on how to reduce these deaths and makes recommendations to make surgery safer for patients.

POMRC Chair Dr Leona Wilson says that while overseas figures on weekend surgical death rates have been available for some time, this is the first time such figures have been published using New Zealand data.

“As is the case internationally, the New Zealand figures show a small increased risk of death following weekend operations compared with those carried out on a weekday.

“In New Zealand, the death rate was 1.71 deaths per 100 operations on a Saturday and 1.48 deaths per 100 operations for Sunday. On Monday to Friday, rates were between 0.48 and 0.52 deaths per 100 operations. The difference in weekend compared with weekday death rates is greater for patients undergoing elective surgery than for those undergoing emergency surgery.”

She says understanding the underlying reasons for this “weekend effect” is challenging, with two main suggested causes.

“The first is that patients having operations in the weekend may differ from weekday patients because they could be sicker when they arrive at hospital,” she says.

“The second suggested cause is that the quality of weekend care may differ from weekday care. Staff levels can vary, with fewer senior consultants, and fewer diagnostic services available. It may also be that hospitals are more equipped to provide emergency care on weekends and may lack the appropriate mix of expertise to manage postoperative care.”

POMRC wants hospitals to investigate weekend surgical deaths further with these possible causes in mind.

As well as day-of-the-week mortality, the other new clinical area that the POMRC examined for this report was 30-day mortality following operations and procedures under general anaesthesia. Previously, the committee had been able to report on only same or next day mortality; extending it to 30 days has allowed capture of deaths that occur more distal to the operative procedures, many after discharge from hospital.

For this category, the committee found that, as with other clinical areas previously examined, higher 30-day mortality rates were consistently associated with: increasing age; comorbidities and poorer overall health status (higher CCIs and ASA scores); and emergency admissions. They were also significantly higher for Māori than for Europeans, after socio-demographic and clinical factors were adjusted for. Cardiovascular causes were the most common reasons for death following a general anaesthetic.



The report also contains mortality rates for cholecystectomy, general anaesthesia (same or next day mortality), hip arthroplasty, knee arthroplasty, colorectal resection, coronary artery bypass graft (CABG), percutaneous transluminal coronary angioplasty (PTCA) and admissions with an ASA score of 4 or 5. The POMRC report recommends:

- Not operating on patients assessed as being very unwell (but providing other treatment).
- Discussing the risk of dying from surgery with all patients contemplating an operation with a significant risk.
- Healthcare institutions investigating in depth all deaths that follow elective surgery performed on the weekend, assessing all potentially contributing factors.
- All patients having their ASA status recorded in their clinical anaesthetic record.
- The difference in mortality between patients having procedures in the weekend compared with weekdays, in particular those admitted electively, being investigated.

- The reasons for increased perioperative mortality of Māori being further investigated.
- The impact that the Māori population age structure has on analyses of perioperative mortality being investigated.
- The Charlson Comorbidity Index being considered to strengthen future analyses and better understand how severity of illness impacts Māori perioperative mortality.

The last two recommendations were developed by the HQSC’s Māori Caucus, the rest by the POMRC.

The POMRC is continuing work towards developing local multidisciplinary perioperative review systems in New Zealand. Pilot sites at the Waikato, Whanganui, Waitemata, Counties Manukau and Nelson Marlborough district health boards will help trial and refine the local review processes. Consultation with the private Southern Cross Hospitals is also informing this work.

The committee is also working towards developing a national web-based system that will allow consistent reporting at a local level, easier collation of information and then dissemination of key themes and quality improvement lessons nationally.

Maternal deaths decline but amniotic fluid embolism of concern

In its 10th report, New Zealand’s Perinatal and Mortality Review Committee (PMMRC) noted a drop in maternal deaths. This committee advises the HQSC on how to prevent perinatal and maternal mortality and morbidity. The report covers perinatal deaths from 2007 to 2014, maternal deaths from 2006 to 2014, and neonatal encephalopathy from 2010 to 2014.

In 2014, there were only four deaths of mothers during pregnancy or within the first 42 days of the end of pregnancy, the lowest number since the PMMRC began reporting in 2006.

Maternal mortality is more common among mothers aged 40 years of age and older, and among Māori, Pacific and Indian women. It also increases with higher levels of socioeconomic deprivation, with smoking and obesity also being significant factors.

The report also identified a continuing significant reduction in the number of stillbirths, which PMMRC Chair Dr Sue Belgrave credited to improved care before and after birth, and lower smoking rates. However, babies of Indian mothers remain at increased risk of stillbirth, and increasing socioeconomic deprivation is associated with stillbirth and neonatal death rates.

Looking at maternal suicide, the report found many women who completed suicide had two or more risk factors for major depression, two-thirds had a prior psychiatric history, and most were experiencing relationship stress. In some cases, the PMMRC identified that there had been a lack of recognition of risk factors and that communication between health care services could have been better.

“It is imperative clinicians work together to prevent the consistent leading cause of death among new and expectant mothers,” Dr Belgrave said.

The PMMRC emphasises the importance of all clinicians involved in a woman’s care having knowledge of her mental health history so they are able to provide the best care. The committee also recommends that a perinatal and infant mental health network be established to provide a forum to discuss perinatal mental health issues.

Reviewing 13 deaths and five survivors of amniotic fluid embolism (AFE), the PMMRC found:

- The maternal mortality ratio from AFE in New Zealand is 5.6 times higher than in the UK, with the retrospective review concluding that death from AFE was accurately diagnosed in New Zealand.
- There was no evidence that fatal cases were more severe in New Zealand; in fact, the data suggested that the opposite may be true.
- The review suggested resuscitation could have been improved in some cases of AFE death and concluded that all clinicians involved in maternity care need to be able to recognise the possibility of AFE early in its presentation and need to be able to respond with timely and effective resuscitation.



Consequently, the PMMRC reiterated a previous recommendation that all clinicians involved in the care of pregnant women should undertake regular multidisciplinary training in management of obstetric emergencies, to improve the recognition of AFE and resuscitation of women who collapse.

Other recommendations were that:

- The Perinatal Society of Australia and New Zealand perinatal death classification (PSANZ-PDC) system be modified to allow the classification of babies dying with placental pathology outside of unexplained antepartum death.
- District health boards with rates of perinatal-related mortality and neonatal encephalopathy significantly higher than the national rate review, or continue to review, those higher rates and identify areas for improvement.

The reports are available at www.hqsc.govt.nz/our-programmes/mrc/.

Dr Geoff Laney
Safety and Quality Officer, ANZCA
New Zealand National Committee

Simulated training to improve theatre safety



Team training for smoother, safer surgery

Simulation training for all New Zealand anaesthetists and their operating room colleagues will be rolled out nationally from the start of 2017, making New Zealand the first country to implement nationwide team training in healthcare.

New Zealand's 20 district health boards (DHBs) have been grouped into four cohorts for training, with the first to start in February 2017 and the others rolling out at nine-month intervals. The Accident Compensation Corporation (ACC) has guaranteed funding for cohorts 1 and 2, but funding for cohorts 3 and 4 depends upon successful implementation in cohorts 1 and 2.

Known as MORSim (multidisciplinary operating room simulation), the new course involves realistic simulated surgical cases that challenge communication and co-ordination between members of operating room teams with the aim of improving the safety and efficiency of care for patients. It is multidisciplinary, training surgeons, anaesthetists, nurses and anaesthetic technicians to work more effectively together.

Associate Professor Jenny Weller says that placing the training in a realistic surgical environment promotes active engagement in decision-making and clinical tasks relevant to each of the four professional groups. MORSim involves around eight hours of face-to-face training, including simulations, debriefs, and communication skills stations.

MORSim was developed at Auckland University's School of Medicine by a project team involving Associate Professor Weller and fellow anaesthetists Professor Alan Merry and Dr Jane Torrie as well as surgeon Professor Ian Civil, anaesthetic technician Kaylene Henderson and clinical nurse educator Penny Johnstone.

During 2012/13, the team trained 120 theatre staff at Auckland University's simulation centre. Evaluations showed consistently positive gains in teamwork and communication, and the potential for a 14 per cent reduction in the risk of patient morbidity and mortality. Further testing at Auckland's North Shore Hospital supported the feasibility of local delivery.

ACC is funding simulators and simulation models, instructor training and delivery of MORSim courses at each DHB by the project team. As local instructors are trained, DHB staff will take over the training program for ongoing delivery, with central co-ordination and support from the university team.

Training for those interested in becoming MORSim instructors will commence three months before the start of MORSim at each DHB. Further information is available from the project coordinator Kaylene Henderson (k.henderson@auckland.ac.nz) or Associate Professor Weller (j.weller@auckland.ac.nz).

Releasing surgical complications data – NZ ombudsman

At the end of June, Ombudsman Professor Ron Paterson published his opinion on the refusal by five district health boards (DHBs) to release surgical complications data requested by the *NZ Herald*. The reporter had sought data about individual surgeons, including the number and type of procedures they performed, and their standardised and crude rates of major complications, readmissions and deaths.

The DHBs had refused the request in order to protect the privacy of the surgeons and because the information could not be made available without substantial collusion or research.

The Ombudsman said the DHBs should not have refused the request for the number and type of procedures performed by individual surgeons, and recommended they provide that information.

However, he said they were entitled to refuse the request for information relating to major complications, readmissions and deaths, since that information was not currently held.

"Releasing individual surgeons' outcome data in its current state would do more harm than good given the current state of information in the New Zealand health sector. Public reporting of data that is misleading, incomplete

or otherwise of poor quality could erode public confidence in the health system, undermine teamwork and result in surgeons seeking to avoid complex procedures," Professor Paterson said.

He noted, however, that New Zealand lagged behind other comparable healthcare systems in disclosure of performance and outcomes information, and said: "Professionalism in a 21st century doctor should include a commitment to the collection and publication of meaningful outcomes data," with medical colleges having an important leadership role to play in this.

Professor Paterson recommended that the Ministry of Health and the Health Quality & Safety Commission publish regular annual updates, starting in June 2017, on progress towards publication of meaningful quality of care measures, including outcomes data, across specialties by June 2021.

"The issue of whether outcomes data by individual practitioner should be published is undoubtedly a question for further debate and, potentially, for consideration by a future Ombudsman," he said.

The full opinion is available at www.ombudsman.parliament.nz.

New Zealand Maternity Clinical Indicators

The *New Zealand Maternity Clinical Indicators* present comparative maternity interventions and outcomes data for pregnant women and their babies by maternity facility and district health board (DHB) region.

These indicators are the result of collaboration between the Ministry of Health and maternity stakeholders representing consumer, midwifery, obstetric, general practice, paediatric and anaesthetic perspectives. In 2011, an expert working group established a set of 12 maternity clinical indicators that could be measured using the available data collections at that time.



The expert working group has continued to review and revise the maternity clinical indicators since then. The latest report in the New Zealand Maternity Clinical Indicators series presents 21 indicators that reflect care during pregnancy and the postnatal period, severe maternal morbidity and outcomes for babies at birth. Its focus is on women giving birth and babies born in the 2014 calendar year.

As the five previous reports demonstrated, reported maternity service delivery and outcomes for women and babies vary between DHBs, and between individual secondary and tertiary facilities. The report says these findings merit further investigation of data quality and integrity as well as variations in local clinical practice management.

Since 2012, DHBs and maternity stakeholders have used national benchmarked data in their local maternity quality and safety programs to identify areas warranting further investigation at a local level. Using the data in this report, DHBs and local maternity stakeholders can expand the scope of their investigations and view trends over a six-year period. The report is available at: www.health.govt.nz/publication/new-zealand-maternity-clinical-indicators-2014.

Safety alerts

Recent alerts:

- Presence of white spots on the outer surface of blood bags.
- Ketamine ampoules – labelling alert NZ.
- Hydroxyethyl starch (Voluven and Volulyte) – update.

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

Compiled by Dr Peter Roessler, Communication and Liaison Portfolio, ANZCA Safety and Quality Committee, and staff from the Safety and Quality team in the ANZCA Policy unit.

Above: Theatre teams use simulated training to improve communication and co-ordination.

Dean's message



Following recent legislative change in NSW the FPM Regional Committee received an email from a Sydney GP.

"I have a patient who is keen to find out more about how to obtain medicinal cannabis to better control his chronic pain. I have seen the NSW Health application form which, as I understand it, only invites specialists to apply. I called the local hospital pain clinic, but they are not prescribing it, nor do they have a clinical trial relating to cannabis. I would be grateful if you could give me some more information about where my patient could access medicinal cannabis to treat his chronic pain, or any other information that could steer him in the right direction".

There is a strong likelihood that Faculty Fellows will be receiving more such emails in the near future. We need to be prepared. The article on page 20 entitled "When advocacy and legislation move ahead of evidence: the 'medicinal' cannabis story" raises issues for debate across FPM and ANZCA.

Our ANZCA mission statement urges us to "serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine". It follows that we have a responsibility to be guided by scientific evidence as we pursue patient safety and quality care. We do not have a responsibility to support community advocacy or legislation that is out of step with the evidence.

The 2015 FPM, ANZCA professional document *PM10: Statement on "Medicinal Cannabis" with particular reference to its use in the management of patients with chronic non-cancer pain*, summarises the evidence base and the position of the Faculty.

A reply to the GP inquiry might therefore point to the lack of evidence to support cannabis use in chronic pain and also the risk of harm with prolonged use. The "right direction" for that person may involve an exploration of the broader dimensions of pain treatment via a sociopsychobiomedical approach.

This discussion touches on our sense of identity as specialist pain medicine physicians. Do we feel under pressure to deliver biomedically focused interventions as requested by the GP above? Alternatively, do we feel comfortable in bringing therapeutic boundaries to bear and reining in the GP's interest in non-evidence based treatment? Can we use those boundaries to motivate engagement by GP and patient in a multi-dimensional approach?

This is not to suggest that biomedical treatments should not be used, simply that such treatments should be supported by evidence or part of clinical trials to collect that evidence. Furthermore, where such treatments are used they should be incorporated within the sociopsychobiomedical framework.

Perhaps part of our make-up as specialist pain medicine physicians and trainees is the capacity to stand firm in difficult spaces and defend scientific evidence and multidisciplinary approaches in the face of those who request simplistic solutions to complex problems.

If we are to be champions of evidence then we need to be aware of the strengths and limitations of randomised controlled trials. Further, we need to recognise a place for "real world" research methodologies such as the electronic Persistent Pain Outcomes Collaboration (ePPOC). As part of our capacity to explore difficult spaces, one area of particular interest is the procedural intervention component of biomedical treatment. Procedural intervention is a component part of the practice of many of our Fellows and a challenge is therefore to develop ePPOC to the point where it becomes accessible to proceduralists in analysing their results and comparing them to less invasive therapies.

Graduate Outcomes Survey

The Graduate Outcomes Survey is an additional source of information relating to our identity and culture. Results are presented on page 28. The response rate among new FPM graduates was 62 per cent. A majority completed the section on bullying, discrimination and sexual harassment. Of these, 22 per cent commented on personal experience of workplace bullying and 38 per cent had observed bullying of others. The rates of discrimination and sexual harassment were lower. We need to give careful consideration to these findings as we reflect on culture and identity within pain medicine.

Many positive opportunities lie before us if we are prepared to stand in those difficult spaces and speak courageously into the healthcare sector and wider community.

Dr Chris Hayes
Dean, Faculty of Pain Medicine

News

Training unit accreditation

After successful reviews, the following hospitals have been reaccredited for pain medicine training:

- Royal Prince Alfred Hospital, NSW.
- Austin Hospital, Victoria.

The Royal Children's Hospital, Victoria is no longer accredited for training in the core training stage. There are 33 accredited pain units.

Admission to fellowship of FPM

By examination:

- Dr Khaldoon AlSaeed, FRANZCP, Qld.
- Dr Anandhi Rangaswamy, FANZCA, ACT.
- Dr Preshanth Rajeevan, FAFRM (RACP), NSW.
- Dr Guy Robert Buchanan, FANZCA, ACT.
- Dr Michael Bassett, FANZCA, Vic.
- Dr Shaun Clarke, FANZCA, NSW.
- Dr Noam Winter, FANZCA, Vic.

By election:

- Professor Sonia Grover, FRANZCOG, Vic.
- Dr Peter Herriot, FRANZCP, MRCPsych, SA.
- Dr Andrew Jeffreys, FANZCA, Vic.

This takes the total number of Fellows admitted to 436.

Better Pain Management program

Fellows and trainees can now access modules seven to 12 of the Better Pain Management program in Networks. The development of these modules would not have been possible without the significant contribution and expertise by numerous Faculty Fellows. Work is progressing on making the modules more easily accessible to primary healthcare providers. Modules seven to 12 cover:

- Visceral and pelvic pain.
- Soft tissue and non-joint musculoskeletal pain.
- Post acute pain management.
- Understanding pain-related procedures.
- Management of high-dose problematic opioid use.
- Pain in children.

Geelong GP broadens pain medicine skills



More patients are leading better lives thanks to the government-funded Specialist Training Program, which allows doctors to train as specialists in non-traditional settings.

Dr Arvind Jhamb comes from Chandigarh, India, the capital of the northern state of Punjab. When he sent back photographs of the Victorian country town of Ararat – his first long-term post as a regional GP after arriving in Australia – his friends and family were bemused. “Where are all the people?” they wanted to know.

“There was no one around,” he smiles. “In India, every street has hundreds of people on it.”

So, one of the first things Dr Jhamb noticed was how much quieter Australia is – a form of peacefulness he enjoys. “India is wonderful but it can get a little bit overwhelming at times,” he says.

In terms of his medical practice in Ararat, one of the first things he noticed was how many patients were presenting with pain-related problems; up to one in four patients seen by an Australian GP are suffering some kind of pain. He often found it difficult to manage the patients with chronic pain: “I felt, ‘My God, I am just seeing this all the time, but I’m not sure what the answers are.’” This has led him to Geelong, where he is now working and studying in the Pain Management Unit of the University Hospital, Geelong, as a Faculty of Pain Medicine trainee. He is in the first year of a two-year curriculum, having requalified as a GP under the Australian system – he had already achieved his Indian fellowship as a GP – in 2014.

Dr Jhamb is part of ANZCA’s Specialist Training Program (STP). This is an Australian government initiative that helps to fund accredited specialist training rotations outside the traditional metropolitan public health setting. ANZCA has been funded to manage the Specialist Training Program and the contracts for training posts in anaesthesia, pain medicine and intensive care medicine (the last on behalf of the College of Intensive Care Medicine) until the end of February 2018. The program aims to increase the capacity of the health workforce to train specialists in ways that match demand and reflect the way health services are delivered, with a particular focus on the needs of regional and rural Australia.

As Dr Jhamb will tell you after four years in Ararat, pain medicine is in great demand in the country, where there is a dearth of specialist pain medicine physicians. In his general practice, “If you referred a patient to a specialist pain medicine physician, it could be 18 months before they were seen.”

The most important thing he has learned from his study to date, he says, is that opioids are not the answer for chronic pain: “They cause enormous economic and social burdens and worst of all, they may not help the patients and can even cause harm.”

Patients need to take responsibility for managing their pain with non-pharmacological measures such as exercise, diet and meditation, which can be tough advice to sell, he has found: “Education and understanding in the community is lacking. Many seek a quick or simple remedy to complex and often longstanding issues, and patients can be focused on surgery or medication. A passive approach without personal effort invariably leads to poor or limited outcomes.”

But Dr Jhamb has also learned that, over time, it is possible to build a relationship with the reluctant patient that helps the patient to take on more responsibility for managing their overall health: “As an example, there might be a patient whose physiotherapist sees them once a month to take them through their exercises and give them a massage. The patient will tell you they feel better after that.

“But if they don’t do the self-directed exercise program every day, things aren’t going to get better. Being active is the best way of maintaining function and controlling pain. Psychological education is also vital, as there is no magic wand. But often you need to see them a few times before they become open to those approaches.”

He has discovered that the pain physician is not so much a one-man-band as the conductor of an orchestra. “We collaborate with a lot of specialists and allied health professionals. There might be an acute pain team involved; there might be a psychologist involved, as well as a physiotherapist and a dietician (some kinds of abdominal pain can be helped by modifying the diet). We have a team of people who are doing different things from different aspects to get the patient to where they need to be. It’s partly the role of the pain physician to be at the centre of that, helping things along.”

As part of his training, Dr Jhamb has online training and assignments, regular tutorials – including at ANZCA House – and daily case discussions with the consultants working with him in Geelong, on topics including diagnosis and management.

His supervisor of training, Dr Richard Talbot, says STP has been invaluable. Having an extra member of staff means the clinic has increased throughput in terms of numbers of outpatients being seen. More importantly, it is now able to train two specialist pain medicine physicians a year rather than just one.

Dr Talbot says, “The program has seen good, tangible results. One of our last two candidates will be coming back to practise locally. Another is the new director of the pain management unit at the Lady Cilento’s Children’s Hospital in Brisbane, and our trainee before that became the solo specialist pain medicine physician in Tamworth. These are people who are bringing pain medicine to places where it previously didn’t exist. This shows what can be done with this funding.”

His only concern about STP is that it might disappear: “Funding is not guaranteed by the federal government, and I fear it could be one of the things that falls off the radar as the state and federal governments argue about costs and responsibilities.”

After he qualifies as a specialist pain medicine physician, Dr Jhamb hopes his practice will be part general practice and part specialist pain medicine. “I know other doctors who have gone into pain totally, but most specialist pain medicine physicians practise in two areas, their primary area and pain, and I am still very interested in general practice.” Doctors from all kinds of relevant backgrounds, including psychiatry, rehabilitation, acute hospital care and general practice, can train for an FPM fellowship.

Dr Jhamb plans to stay in Australia. “Australia is one of the best countries in the world. It’s a relaxed place, the lifestyle is very good, it is safe and relatively stable. And the government takes care of patients and of the community. I wanted a change, and to get a different perspective on life, and I am getting that here. Australia rocks!”

Karen Kissane
Media Manager, ANZCA

“Pain medicine is in great demand in the country, where there is a dearth of specialist pain medicine physicians.”

Specialist Training Program – pain medicine

The Specialist Training Program (STP) is an Australian government initiative that helps to fund accredited specialist training rotations in settings beyond traditional public teaching hospitals.

ANZCA manages the program for anaesthetists, specialist pain medicine physicians and intensive care medicine specialists.

Since 2012, there have been 25 pain medicine trainees involved in the program in NSW, Queensland and Victoria. Ten have finished training, 12 are still active trainees working towards fellowship and three are inactive trainees.

FPM Fellow puts unique perspective to good use



In a twist of fate Dr Harry Eeman ended up being a patient half-way through his training as a University of Sydney medical student.

Rapid onset ascending paralysis should ring a few bells to those of you who know anything about Guillain Barre Syndrome. I knew this as a second-year medical student but no idea that it would change my life's trajectory forever.

Five months in ICU, ventilated, and then a subsequent 16 months of inpatient rehabilitation and another year of hard outpatient physiotherapy, I was ready to return to my medical studies at the Canberra Clinical School.

I started in Canberra as a skinny young man in his early 20s but I left it as a more confident, albeit wheelchair-dependent doctor. This transition wasn't easy for me or for the "medical establishment". There were lots of questions, challenges and meetings to face and steer through.

My year as an intern was facilitated by being supernumerary so that I'd always work with a fellow junior colleague. As far as I'm aware this had never been done before, I was the first intern in Canberra with tetraplegia.

My residency year saw me flying solo. By this stage I had confidence in my skills and so did my colleagues. You may wonder about this – I actually spent 12 months working in the emergency department and loved it. I had a clear sense of what my physical limitations were and knew I could always count on my colleagues to lend a hand (or sometimes an index finger for a PR).

Dr Harry Eeman (right) with patient Mr Gary Sinclair. Others in the room (from left) are Annie Zin, Andrew Lin, Andrew Stewart and Melissa Lim.

I then tried my hand in radiology but found myself missing patient contact. I decided to train as a rehabilitation physician because I had a unique perspective that would benefit my patients. Being somebody who's "been there, done that" lends credibility when trying to motivate patients to achieve their optimal function.

Once I completed my rehab training I decided to tackle the most challenging type of patients, people with chronic pain. I liked the intersection between medicine, neuroscience, psychology and philosophy (I have an arts degree with a major in philosophy) that is needed to tackle something as complex as chronic pain.

I completed my pain fellowship at the Barbara Walker Centre for Chronic Pain Management (St Vincent's Hospital, Melbourne) where I continue to work as a consultant in the acute pain service and chronic pain clinic. I balance this interesting but emotionally challenging work with working a couple of days a week in rehabilitation medicine. You've got to stay sane somehow!

I've been privileged to be part of the FPM curriculum redesign project's steering committee (2012-2015) which saw the drafting of the new training program. I've met some wonderful people through this experience and feel very proud of the work we've achieved.

I'm very much looking forward to seeing where the next chapter of my professional life takes me.

Dr Harry Eeman, FFPMANZCA
Barbara Walker Centre for Chronic Pain Management,
Melbourne

New in the library

Handy new eBooks for trainees

ANZCA Fellow Dr Lachlan Rathie, a primary examiner and supervisor of training at Toowoomba Hospital, Qld, has provided two useful, customised resources for Australian and New Zealand trainees and supervisors of training.

Anaesthetic Emergencies Handbook – This is an Australianised version of the *Oxford Handbook of Anaesthetic Emergencies* except it is briefer, more relevant and practicable.

The First Year – This is the book you give to the trainee specialist who is about to embark on their anaesthesia training. It contains the information they need to formulate and develop a safe practice of anaesthesia.

Access the books through the Training Library Guide: <http://libguides.anzca.edu.au/library/training>



New journals on surgery, obesity and interprofessional education and practice

Three new journals have been added to the ANZCA Library collection in clinical areas related to anaesthesia and pain medicine.

The *International Journal of Surgery* (IJS) is dedicated to the global advancement of surgical research, education and clinical practice. It aims to promote continued developments in surgery by sharing knowledge, ideas and good practice across all surgical specialties.

Obesity Medicine focuses on health and disease, relating to the broad spectrum of research in and impacting on humans. Obesity is a disease of increasing global prevalence with serious effects on the individual and society.

Journal of Interprofessional Education & Practice provides innovative ideas for interprofessional educators and practitioners through peer-reviewed articles and reports. Each issue examines issues and trends in interprofessional healthcare topics, offering progressive solutions to challenges facing the profession.

Browse these and hundreds of other online journals at the ANZCA Library: www.anzca.edu.au/resources/library/journals



New books for loan

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

MCQs in Regional Anaesthesia and Pain Therapy

Sehmbi, Herman; Shah, Ushma J. -- UK: London Radcliffe Publishing, 2012.

The Final FRCA Structured Oral Examination

A complete guide / Krishnachetty, Bobby; Darshinder, Sethi. -- Boca Raton, FL: CRC Press, Taylor and Francis Group, 2015.

The History of Anaesthesia

Proceedings of the fifth international symposium on the history of anaesthesia, Santiago, Spain, 19-23 September 2001 / Diz, Jose C [ed]; Franco, Avelino [ed]; Bacon, Douglas R [ed]; Ruprecht, Joseph [ed]; Alvarez, Julian [ed]. -- Amsterdam: Elsevier, 2002.

The Leading Edge

Innovation, technology and people in Australia's Royal Flying Doctor Service / Langford, Stephen. -- Crawley, Western Australia: UWA Publishing, 2015.

Vascular Anesthesia

Chitilian, Hovig V [ed]. -- Hagerstown, MD: Wolters Kluwer / Lippincott Williams and Wilkins, 2016.

Yao and Artusio's Anesthesiology

Problem-oriented patient management / Yao, Fun-Sun F [ed]; Malhotra, Vinod [ed]; Fong, Jill [ed]; Skubas, Nikolaos [ed]. -- 8th ed -- Philadelphia, PA: Wolters Kluwer/Lippincott Williams and Wilkins, 2016.

Spotlight on: The Welfare of Anaesthetists

The Welfare of Anaesthetists Library Guide highlights relevant books, articles, journals and suggested apps for anaesthetists to enhance their wellbeing. The guide also collates useful networks and newsletters related to the welfare of medical professionals. It is regularly updated with the latest information in the area, including articles such as:

- Tartas M, Walkiewicz M, Budzinski W, Majkowicz M, Wojcikiewicz K, Zdun-Ryzewska A. The coping strategies during medical education predict style of success in medical career: A 10-year longitudinal study. *BMC Med Educ.* 2016;16(1):186.
- Soares DS, Chan L. Stress and wellbeing of junior doctors in Australia: A comparison with American doctors and population norms. *BMC Med Educ.* 2016;16(1):183.

Access this library guide here: <http://libguides.anzca.edu.au/library/welfare>

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

Anesthesia

A comprehensive review / Hall, Brian A. [ed]; Chantigian, Robert C. [ed]. -- 5th ed. -- Philadelphia, PA: Elsevier, 2015.

Anesthesia Management for Electroconvulsive Therapy

Practical techniques and physiological background / Saito, Shigeru [ed]. -- Tokyo, Japan: Springer, 2016.

Brown's Atlas of Regional Anesthesia

Farag, E; Mounir-Soliman, L. -- 5th ed -- Philadelphia, PA: Saunders/Elsevier, 2017.

Comprehensive Textbook of Perioperative Transesophageal Echocardiography

Savage, Robert M [ed]; Aronson, Solomon [ed]; Sherman, Stanton K [ed]. -- 2nd ed -- Philadelphia, PA: Lippincott Williams and Wilkins, 2011.

Monitoring in Anesthesia and Perioperative Care

Reich, David L [ed]; Kahn, Ronald A [ed]; Mitnacht, Alexander JC [ed]; Leibowitz, Andrew B [ed]; Stone, Marc E [ed]; Eisenkraft, James B [ed]: Cambridge University Press, 2011.

Neuroanesthesia and Cerebrospinal Protection

Uchino, Hiroyuki [ed]; Ushijima, Kazuo [ed]; Ikeda, Yukio [ed]. -- Tokyo, Japan: Springer, 2015.

Pediatric Atlas of Ultrasound and Nerve Stimulation-guided Regional Anesthesia

Tsui, Ban CH [ed]; Suresh, Santhanam [ed]. -- New York, NY: Springer, 2016.

Simulation in Healthcare Education

An extensive history / Owen, Harry :Springer International Publishing, 2016.

Regional Nerve Blocks in Anesthesia and Pain Therapy

Traditional and ultrasound-guided techniques / Jankovic, Danilo; Peng, Philip WH. -- 4th ed --Switzerland: Springer, 2015.

Yao and Artusio's Anesthesiology

Problem-oriented patient management / Yao, Fun-Sun F [ed]; Malhotra, Vinod [ed]; Fong, Jill [ed]; Skubas, Nikolaos [ed]. -- 8th ed -- Philadelphia, PA: Wolters Kluwer/Lippincott Williams and Wilkins, 2016.

Working towards better outcomes for the obese patient



The theme of last year's National Anaesthesia Day was obesity. The Australasian Society for the Perioperative Care of the Obese Patient is working towards safer outcomes.

Obesity – defined by a person's weight being 20 per cent more than normal or having a body mass index of 30 or more – has become a global public health issue of staggering proportions.

The majority of respondents in the 2015 ANZCA National Anaesthesia Day survey 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.

This is not surprising as Obesity Australia (2014) quotes the population rate of overweight and obese adults at 63 per cent. Many obese patients have no appreciation of the problems that they pose for anaesthesia. While the work is getting harder, patient expectations for safe care remains high.

It has been shown that a physicians' attitude about obesity will affect their practice. Many people, including doctors, rate obese patients negatively and feel that they are to blame for their obesity and co-morbid conditions. They are seen as less worthy of care and the doctor does not want to deal with them as they are hard work and will have poor outcomes. (Foster et al, Obesity Research, 2003).

Historically there has been less focus and experience in managing these patients and the acceptance of their surgical needs has changed with many procedures previously refused, now being offered to them.

The good news is that with training and experience, negative stereotypes can be modified, and as clinicians gain confidence and skill in dealing with obese patients, the work can be rewarding and positive for both doctor and patient.

The way to improve this situation is through shared expertise, knowledge and adherence to the principals of good medical practice. However,

greater research is required into the physiology, pharmacology, monitoring and perioperative management of this challenging patient cohort

Obesity is increasingly being recognised as a disease process in its own right, and is probably a combination of complex processes. The underlying pathology of tissue hypoxia and low-grade inflammation due to excessive adipose tissue may explain the multisystem effects.

Obesity affects every system in the body and difficulty is encountered from vascular access, positioning and airway management to post-operative problems of sleep apnoea, atelectasis and venous thromboembolus.

Everything is more difficult and takes longer when an obese patient has surgery.

Excess adipose tissue will interfere with all aspects of anatomy and physiology, as well as influence drug dosing, metabolism and related diseases.

Emerging evidence-based guidelines and recommendations for how to manage these patients safely together with expert opinion and clinical experience is able to give us some direction.

While most physicians are aware of the problem of obesity, not all are aware that there are ways to manage risks, starting with the preparation of obese surgical patients.

There are a number of areas where intervention and a short course of optimisation will help reduce complications. These include optimisation of medical conditions such as asthma, diabetes and hypertension, investigation and treatment of obstructive sleep apnoea, anaemia and reflux.

A short period of very low calorie dieting will reduce liver size for laparoscopy and starting an exercise program can make a big difference to

functional status and strengthening of the respiratory reserve. A few weeks of treating OSA with CPAP can improve cardiac function and restore normal respiratory responses to hypoxia and hypercapnia.

The current opinion is that the best anaesthetic outcomes are related to good preparation, attention to detail, safe methods of induction and intubation, good positioning, special equipment for heavy patients, avoidance of long acting opiates and sedatives, deep neuromuscular block and full reversal and appropriate post-operative care and monitoring.

Guidelines on the peri-operative management of obese patients were published jointly by AAGBI and SOBA in the UK (Nightingale et al, Anaesthesia 2015).

Finding the cost of obesity is complicated, and in 2008 it was estimated to be \$58 billion dollars to the Australian economy, mostly from loss of wellbeing.

While weight loss has numerous physiological and disease modifying benefits, it is the improvement in functionality that is reported as the main benefit by patients.

Bariatric surgery provides the best weight reduction results by far with published figures showing a sustained 50 per cent reduction in excess weight. Long term data is emerging for the different operations available, with the gastric band having a high re-operation rate.

As surgeons and techniques have improved, a gastric sleeve takes about 60 to 90 minutes to complete with minimal tissue damage and a fast recovery. Gastric banding can be completed in less than 30 minutes and same day discharge is possible. The gastric bypass can be completed as a routine procedure and has excellent weight loss results.

The Australasian Society for the Peri-Operative Care of the Obese Patient (ASPCOP) is a group that was set up in 2013 to further interest in the management

“Obesity Australia (2014) quotes the population rate of overweight and obese adults at 63 per cent.”

of obesity as it relates to surgery and anaesthesia. ASPCOP is federated with the already formed European Society for the Peri-Operative Care of the Obese Patient (ESPCOP) and International Society for the Peri-Operative Care of the Obese Patient (ISPCOP).

The group has held education sessions with endocrinologists, intensivists and haematologists as well as holding satellite meetings and study days.

ASPCOP is hosting a one-day meeting in Sydney on October 28, 2016. It will be an opportunity to hear talks from some world leaders in their fields and also take part in relevant workshops. The meeting is being held in partnership with the Obesity Surgical Society, (OSSANZ).

For anyone who wishes to join ASPCOP or for further meeting details please email admin@aspcop.org.

Dr Peter Baumgartner
Member, ASPCOP
Joondalup Health Campus
and Royal Perth Hospital, WA

Award-winning anaesthesia machine to help developing countries



Developing countries will benefit from a new invention developed by a New Zealand anaesthetist and his medical engineer business partner.

Christchurch anaesthetist Dr John Hyndman has been hitting the headlines this year by winning awards for helping to invent a compact, cheap and reliable anaesthesia machine for use in developing countries.

In February, Dr Hyndman and his business partner, medical engineer Ivan Batistich, won the 2016 Sanitarium New Zealand Innovator of the Year Award for their HYVAN compact anaesthesia machine.

Dr Hyndman had already won the World Federation of Societies of Anaesthesiologists' (WFSA) inaugural innovation prize for the same machine, with that award being presented during WFSA's world congress in Hong Kong from August 28 to September 2 this year. The HYVAN was also demonstrated at that world congress, with the aim of promoting its suitability for developed and developing country anaesthesia.

Aiming for a career in geology, John Hyndman's father persuaded him to try medicine. He undertook his medical degree at Otago University in Dunedin and qualified in anaesthesia in England (FFA) and Dunedin (FANZCA), working in England and in New Zealand in Dunedin, Invercargill, Marlborough and Christchurch. However, it was working as a volunteer anaesthetist in several developing countries that led to him developing the HYVAN machine.

"I found the anaesthetic equipment unsuitable, inadequate and poorly maintained. Much of it had been donated. It struck me that a reliable, affordable, simple, safe anaesthesia machine that could be easily maintained in the local hospital workshop would improve provision of anaesthesia in these hospitals."

So in 2003, he teamed up with Mr Batistich of Auckland.

"Ivan had made the very successful IVENT ventilator, which was in widespread use in Australasia, India and South East Asia. We decided to make a compact anaesthesia machine (the HYVAN) with an upgraded IVENT ventilator as the nucleus. We have spent about a decade building and testing five prototypes.

"We built and tested the first prototype on sheep. This was a 'Heath Robinson' machine made in Ivan's garage workshop. We then engaged a designer and a software engineer. It has taken a lot of time and energy and considerable (self) funding. We considered building the HYVAN in India with Sir Ray Avery but finally elected to manufacture it in Christchurch."

However, Dr Hyndman has retained a nod to his Otago roots with the machine being in blue and yellow, the colours for Otago sports teams.

Dr Hyndman says the highly sophisticated and complex technology behind the GE Aisys machine that he uses in Christchurch makes such machines vulnerable in developing countries, which often don't have the knowledge or parts to repair the high-tech electronic gear. They also cost around \$200,000 or more (depending on specifications).

"In contrast, the HYVAN is simple and easy to maintain. It is around one tenth of the cost and the emphasis is on affordability, simplicity, reliability and longevity. The concept of 'inbuilt obsolescence' is an anathema to us."

"I use the analogy of a Ferrari and a manual Toyota Corolla. Both cars do the same job but the Corolla is a better bet for developing country situations (it is cheaper, more reliable, easier to maintain and technologically simpler).

"The HYVAN is a circle-based machine and we supply a monitor (with gas bench) if required. Portability is an advantage – it weighs 15 kilograms and is easily carried. It requires one litre of oxygen per minute to operate and the pneumatic ventilator can be driven by compressed air or oxygen". In the event of mains electricity failure, the anaesthetist can carry on with bag ventilation.

While it might look old-fashioned compared with the huge, electronic machines used in first world countries, the HYVAN does everything those machines can do – monitoring ECG, heart rate, blood pressure, inspired and expired gases, volatile agents, oxygen saturation and temperature. It also has parts that can be easily maintained in a basic hospital workshop.

Above from left: Medical engineer Mr Ivan Batistich and Dr John Hyndman with their invention; The HYVAN compact anaesthesia machine.

"Dr Hyndman has retained a nod to his Otago roots with the machine being in blue and yellow, the colours for Otago sports teams."

This gives developing countries with few resources an excellent chance of providing advanced safe anaesthesia – something that fits well with the recent report from the Lancet Commission on Global Surgery. Its report "Global Surgery 2030" highlights the need for a dramatic improvement in surgical and anaesthesia care in low-income and middle-income countries. The HYVAN would also be ideal in emergency and disaster situations.

Dr Hyndman and Mr Batistich are not stopping with the HYVAN, however. They are also designing a small 12 volt DC "blower" to drive the ventilator.

So far, development of the HYVAN has cost the pair more than \$300,000 and John Hyndman expects that it will cost as much again to get the HYVAN to market.

"We have had a lot of fun with this project and it has been an altruistic endeavour," he says.

"However, to be successful requires a business-like approach and financial discipline. Sales, marketing, distribution and so on involve a skill set neither Ivan nor I possess. We have had to engage people to take the project to the next stage and this involves considerable financial input and risk. This is not a game for the faint hearted!"

The final prototype was completed in June and a clinical evaluation trial was done in July. Manufacturing is scheduled to begin later this year once the ISO 13485 (medical device) certification and CE mark have been obtained.

While the HYVAN has been designed for use in developing countries, Dr Hyndman says they have already also received inquiries from Australia for small hospital and office-based anaesthesia as well as military interest from a few countries.

He would like to see the HYVAN in widespread use and is willing to travel to developing countries to teach and demonstrate the machine.

Susan Ewart
ANZCA Communications Manager, NZ

Are you end-of-triennium ready?

More than 3000 Fellows and other participants will finish their CPD triennium at the end of the year.

As the end of the triennium approaches for most of us, there are a number of things to catch up on.

Firstly, I'd like to introduce myself. I'm a specialist at Auckland City Hospital and a new ANZCA councillor. I became chair of the CPD Committee in July and I'd like to thank my predecessor, Dr Vanessa Beavis, for all her dedication, hard work and prescience in creating a continuing professional development (CPD) program that is fit for purpose and is well regarded by many other organisations.

The CPD program was revised to reflect and record many of the activities that specialist anaesthetists undertake as a matter of course during their professional careers. Despite this, many of the calls received by the CPD unit are from Fellows requiring assistance with the mandatory Practice Evaluation activities.

While these may seem onerous the first time around, there is very good evidence that completing them does enhance vital aspects of professional practice. More importantly, they encourage self-reflection and refining of the non-technical skills that define us as specialist doctors.

There is a common misconception that the CPD program is designed to assess competence to practice (or to detect incompetence); this has never been its purpose and the College has stressed this both to Fellows and to the jurisdictional bodies in Australia and New Zealand.



However, it is a useful assessment framework to record activities that are markers of good practice.

Both the Medical Board of Australia and the Medical Council of New Zealand are in the process of designing competence assessment frameworks for re-licencing of doctors and no one will have escaped the debate around "revalidation" in the United Kingdom. The existing ANZCA CPD program is well-regarded by both national bodies and preliminary advice is that it contains the necessary elements to comply with a competency assessment and "revalidation of practice" process for anaesthetists.

More than 3000 Fellows will finish their triennium on December 31, 2016. As you might expect, the CPD unit is geared up to assess and assist Fellows with completion (I've checked mine to make sure I don't have to write to myself – "Dear Dr Robertson...") so please take a moment to make sure that your portfolio is updated and that you have completed all of the required elements.

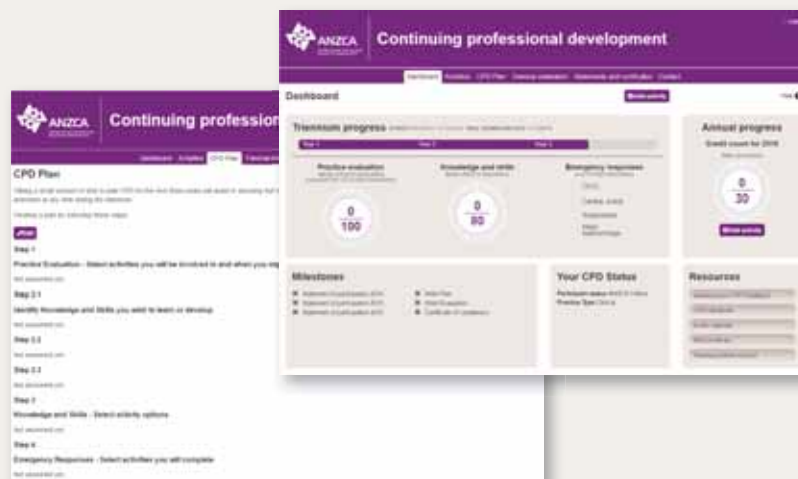
The CPD unit is there to help you and they will refer any more complex queries directly to me. I'm happy to call you, if required, to help out.

Looking forward, we will be working on improving the online interface and creating some toolkits for different types of practice. We will also review the practice evaluation activity landscape, as new types of courses and group activities are arising that need a place in the program structure.

Please get in touch with the CPD unit for advice as early as possible if you need assistance – we are here to help you.

Dr Nigel Robertson
Chair, CPD Committee

"There is a common misconception that the CPD program is designed to assess competence to practice (or to detect incompetence). This has never been its purpose."



Training program to get a facelift

The story so far

The ANZCA Training Program is about to undergo several improvements following an expansive review by a series of working groups over the past 18 months.

The review of the program has resulted in close to 180 recommendations that the College will begin rolling out over the coming months.

The aim of the project is to streamline the program and reduce unnecessary complexity. Other goals are to enhance trainee learning and where possible make it easier to understand the training program requirements, while reducing the workload of Fellows who support the training program.

The current ANZCA Training Program was launched at the start of the 2013 hospital employment year.

A review of the program began in March 2015 with a three-month project by the Training Program Document Review Working Group, that sought to revise the training program documents to be better aligned, more manageable in size and less complex. To achieve this, work was required to clarify and better explain the training program structure, rules and processes. In June 2015, the Education, Training and Assessment Executive Committee (ETAEC) approved a series of recommended changes to the ANZCA Training Program.

Between September 2015 and April 2016, work to determine the detail of how the recommendations would alter the training program was undertaken. This stage of the project involved more than 70 Fellows, trainees and ANZCA staff. It included a detailed review by members of expert implementation groups and working groups that considered training time, volume of practice, assessments and review of trainee progress, as well as scholar role activities. These groups were overseen by the Training Program Project Expert Advisory Group that maintained close links with the ETAEC.

In April 2016, the ETAEC approved a further set of specific recommendations and in June 2016 the drafted changes to regulation 37 were also approved.

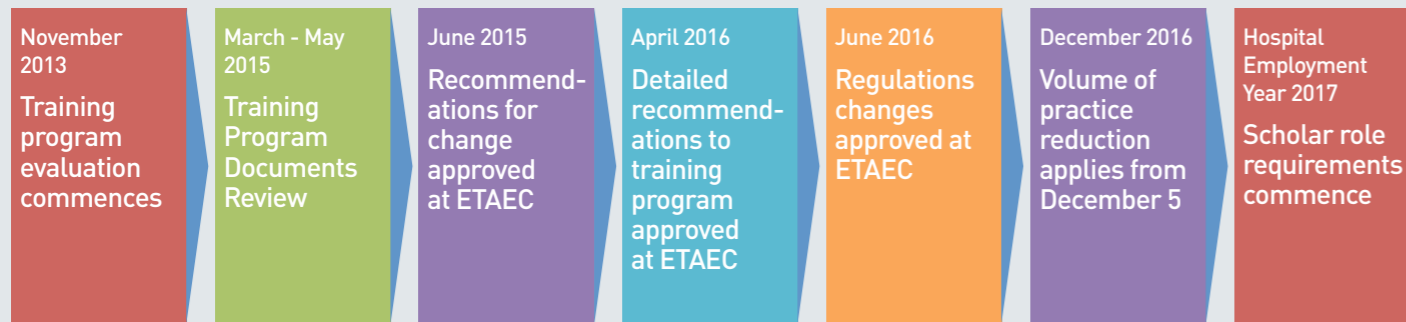
Key changes arising from the College approved recommendations that you can expect to see in the 2017 hospital employment year include:

- Changes to volume of practice targets (see opposite page).
- Changes to scholar role activity requirements (see page 64).

Transition arrangements have been developed to ensure that trainees can move across to the new scholar role activity and volume of practice target requirements smoothly, with no unintended disadvantage and irrespective of their stage of training.

“The aim of the project is to streamline the training program and reduce unnecessary complexity.”

ANZCA Training Program 2013 – review



Future improvements

There are many more changes to come and these will be rolled out in stages with adequate time for education and communication.

The reason for this incremental change is to ensure that there is time to develop and implement improved technology systems and this work will continue throughout 2017 and 2018. There is also a need to carefully determine what transition arrangements may be applicable for the various changes and to ensure that they do not disadvantage trainees.

Additional changes that you will see in the future include:

- Modification to the way training time is managed throughout the duration of the training program that will be easier to understand for both the trainee and supervisor.
- Enhancements to formative assessment tools and an improved review process.
- Further volume of practice improvements.
- Greater consistency of terminology throughout training program documents.
- Simplification of training program documents.
- Improved resources to support trainees and supervisors across the training program.
- Improved technology for recording progress and accessing training program information.
- Additional training portfolio system (TPS) functionality to improve useability.

These changes aim to address issues and concerns raised during the evaluation phases and have been developed through rigorous consultation and analysis using the expertise of many Fellows and trainees.

With so many changes in the pipeline, a communications and change management plan is being carefully developed so that trainees, supervisors, scholar role tutors and any others affected are aware of anything that impacts on them.

A key stipulation of the roll-out is that no trainee will be disadvantaged by any of the changes. We will also be seeking the assistance of trainees and Fellows to share their knowledge and experience of the training program and its existing tools, so that we can make the necessary improvements.

Information will be made available on the ANZCA website under the training tab – www.anzca.edu.au/training and as the hospital employment year approaches, trainees will be further advised. Further support can be accessed through training@anzca.edu.au.

Dr Ian Graham
Dean of Education, ANZCA

Reduced volume of practice requirements

In line with the education, training and assessment principles, learning throughout the training program is trainee driven.

To focus trainees on achievement of the required learning outcomes rather than meeting minimum assessment targets, the volume of practice requirements are reduced for specific skills in the Clinical Fundamentals and Specialised Study Units.

These reduced targets have been communicated directly via email in early September 2016 and will come into effect for Australian and New Zealand trainees on December 5, 2016.

Trainees should continue to log all anaesthetic cases, procedures and sessions to confirm their experience across the breadth of the specialty during a training period, and demonstrate progress towards achieving the learning outcomes of the curriculum. Planning is underway to enhance the recording of cases and procedures in the Training Portfolio System (TPS).

More information

The updated *Anaesthesia training program curriculum*, *ANZCA Handbook for Training and Accreditation* and regulation 37 are available via www.anzca.edu.au/training/2013-training-program.

Updated scholar role information is available at www.anzca.edu.au/training/2013-training-program/scholar-role-training.

New scholar role education resources are available from the “Scholar role support resources” network under “Anaesthesia learning” in Networks – <https://networks.anzca.edu.au/d2l/home/7052>.

If you have any queries relating to the transition arrangements, please email training@anzca.edu.au so that your inquiry can be directed to the appropriate person.



Training program to get a facelift (continued)

Re-visiting the purpose of the scholar role

The scholar role ensures that trainees maintain and improve practice through ongoing learning, demonstrating knowledge and skills appropriate to fostering scientific inquiry and facilitating the learning of others. These are all crucial competencies that anaesthetists should develop.

Research is important to advance knowledge, practice and standards in anaesthesia. Trainees need to be able to understand and critically appraise research, ask questions, and where able, conduct or participate directly in research activity. This includes a greater understanding of how evidence is generated, evaluated and applied in practice.

All anaesthetists have a role in the teaching and supervision of medical students, junior colleagues and other health professionals, so trainees are also expected to develop proficiency as teachers. Commencing continuing professional development (CPD) in training facilitates the value of lifelong learning.

The scholar role equips trainees with the knowledge that once training is completed, specialists are responsible for managing their own learning. This includes self-evaluation of practice, identification of own learning needs and activities to achieve these.

Streamlined scholar role activity requirements

Rather than separating activities into options A and B, which will be discontinued (with transition arrangements in place), the requirements are better articulated in the changes that commence in the 2017 hospital employment year.

Put simply, trainees will be required to undertake five core activities in addition to attending conferences or meetings and participating in quality assurance activities.

What this effectively means is that all trainees will gain skills fundamental to audit, teaching, and research through the core activities. This is an improvement on the current training program, where it has been possible for trainees to select options that focused all of their scholar role activity on teaching rather than a combination of research and teaching.

Trainees who wish to make a significant contribution to a research project, undertake a systematic review to a publishable standard or complete more substantive qualifications in research and teaching may still do so through application to Scholar Role Sub-Committee.

“All trainees will gain skills fundamental to audit, teaching, and research through the core activities.”

Scholar role changes in 2017

The scholar role requirements from the 2017 hospital employment year are as follows:

Attending/participating in scholar role meetings

- Attend regional or greater conferences/meetings.
- Participate in existing quality assurance programs (may include clinical audit, critical incident monitoring and morbidity and mortality meetings).

Core scholar role activities

1. Teach a skill (with evaluation, feedback and reflection).
2. Facilitate a small-group discussion or run a tutorial (with evaluation, feedback and reflection).
3. Critically appraise a paper published in a peer-reviewed indexed journal for internal assessment.
4. Critically appraise a topic for internal evaluation and present it to the department.
These activities will be completed under the supervision of scholar role tutors or their nominee.
5. Complete an audit and provide a written report.
This activity will be completed under the supervision of scholar role tutors only.

To progress from basic to advanced training, trainees must have completed any two of the five scholar role activities.

To progress from advanced to provisional fellowship training, trainees must have completed all five of the scholar role activities.

Prior to the provisional fellowship review, trainees must have attended/participated in all of the scholar role meetings.

It will be possible for trainees to seek approval for a recognition of prior learning and for an exemption from completing some requirements.

Recognition of prior learning and the exemption approval process

Teach a skill and facilitate a small-group discussion

Trainees who have completed a postgraduate certificate in teaching or equivalent, up to five years prior to the commencement of the training program, may apply to the Scholar Role Sub-Committee for recognition of prior learning for the teach a skill and facilitate a small-group discussion activities from the 2017 hospital employment year.

Trainees considering the completion of a postgraduate certificate in teaching or equivalent during training may apply to the Scholar Role Sub-Committee from the 2017 hospital employment year for prospective approval of the course to achieve an exemption from these activities. Prospective approval is not mandatory, but is suggested so that trainees are aware if an exemption will be granted.

Please note, recognition of prior learning or exemption will only be granted for courses within which there is an observation of the trainee's competency to teach a skill.

Critically appraise a paper and topic

Trainees who have completed a postgraduate certificate in research or equivalent, made a significant contribution to a research project or completed a systematic review to a publishable standard up to five years prior to commencement of the training program, may apply to the Scholar Role Sub-Committee from the 2017 hospital employment year for recognition of prior learning for both critical appraisal activities.

Trainees considering the completion of a postgraduate certificate in research or equivalent during training may apply to the Scholar Role Sub-Committee from the 2017 hospital employment year for prospective approval of the course to achieve an exemption from these activities. Prospective approval is not mandatory, but is suggested so that trainees are aware if an exemption will be granted.

Complete an audit and a written report

There is no recognition of prior learning or exemption process for completion of the audit activity. All trainees must complete this activity which has been modified significantly.

If a research activity has included an appropriate audit project or component, this may address the scholar role requirement for completing an audit activity, however, a written report addressing the audit evaluation form criteria will still need to be submitted for assessment.

Enhanced evaluation forms

The evaluation forms of the five core scholar role activities will be improved to include detailed information and consistent rating scales for each evaluation criterion item to support trainees to satisfactorily address the assessment requirements.

The explanatory information will be useful for both departmental scholar role tutors and trainees and will be published ready for the new hospital employment year.

Additions to the form include an opportunity for the tutor to document areas that exceeded the expected standard and those that need improvement, and a requirement that the trainee document personal reflections and an action plan.

The forms will be published on the College website on December 5, 2016.

Simplified audit activity process

The audit is an important component of the scholar role activities for trainees. To improve the audit process, the scope has been redefined to be more achievable and aligned with the CPD standards for audit.

All trainees must have completed their audit, provided a written report and had it assessed by the end of advanced training in order to progress to provisional fellowship training.

Redefined audit scope

In keeping with the scope of the other scholar role activities and in order to ensure that it is a manageable task, an audit should be able to be completed in a six-month placement without involving multiple trainees. Trainees are required to plan the audit, sample and evaluate against established criteria, and plan an intervention if indicated. Although implementation of the intervention and resampling is not required, the trainee may decide to undertake resampling in provisional fellowship training.

From 2018, the audit report will be submitted to the departmental scholar role tutor for assessment rather than the Scholar Role Sub-Committee. During the 2017 transition year, the audit can be assessed by either the Scholar Role Sub-Committee, as it is today, or by the supervising departmental scholar role tutor. The decision will lie with the scholar role tutor.

(continued next page)

Training program to get a facelift (continued)

Increased support for departmental scholar role tutors

Communications to hospital departments will emphasise the opportunity to appoint multiple scholar role tutors in each department, so that individuals with experience in areas of research, education, or audit may contribute their expertise.

Recommendations have been approved to establish audit champions to guide and mentor departmental scholar role tutors to expand their expertise in audits. Resources to support trainees and departmental scholar role tutors have been produced and are available in Networks. The establishment of the audit champions and the provision of the support to the Scholar Role Tutors is planned for 2017 and will be supported by the Scholar Role Sub-Committee.

Greater flexibility in audit topic

Trainees may complete an audit of personal practice or contribute to a more significant departmental audit. Trainees must select the audit topic in consultation with the departmental scholar role tutor prior to commencing the audit, and during the transition in 2017 this would be an ideal time to confirm if the departmental scholar role tutor is able to assess the audit as well.

Reduced audit time requirement

The mandatory requirement for a trainee contributing a minimum of 100 hours has been removed due to the redefined scope of the audit activity. A satisfactory audit could be completed by a trainee within a six-month clinical placement requiring a commitment of one to two hours each week.

Rationalised reporting requirement

Trainees are required to provide a written report in the form outlined by the Standards for Quality Improvement Reporting Excellence (SQUIRE) 2.0 guidelines. Trainees should consider every SQUIRE item, however it may be appropriate or necessary to include every SQUIRE element in the report, depending on the scope of the audit.

Dr Ian Graham

Dean of Education, ANZCA

Launching scholar role support resources

The scholar role support resources provide ANZCA trainees with knowledge to assist them to achieve the revised scholar role competencies in the newly re-released curriculum. These resources offer practical advice about completing scholar role activities and include links to further resources and reading on scholar role related topics.

For supervisors of training, departmental scholar role tutors, and other interested Fellows, the resources provide a snapshot of the level required for ANZCA trainees to achieve competence in their scholar role. The resources can be used to support the learning and development of individual trainees.

The resources include interactive, online modules, each with additional further reading and helpful resources. The module topics cover:

- 10 modules on critical appraisal, including basic statistics.
- Three modules on learning and teaching.
- One module on audit.

The resources are available to all ANZCA Fellows and trainees from the “Scholar role support resources” section under “Anaesthesia learning” in Networks. (<http://networks.anzca.edu.au/d21/home/7052>).



Interested in research?

Build on the skills you have developed through the scholar role activities: Critical appraisal of a paper, critical appraisal of a topic and completion of an audit and written report.

Support for emerging researchers and pilot grants are available through the ANZCA Clinical Trials Network – ctn@anzca.edu.au.

Novice grants funding can be accessed to contribute to the academic discipline of anaesthesia practice through the Anaesthesia and Pain Medicine Foundation. Applications are from December 1, 2016 to April 1, 2017. Scholarships are also available in conjunction with research project grants.

For more information see www.anzca.edu.au/fellows/research or contact foundation@anzca.edu.au.

Innate ability: The challenge for regional anaesthesia educators

A team at Liverpool Hospital has developed a tool to help educators identify trainees who need help with ultrasound-guided regional anaesthesia.

Wouldn't it be useful if educators were able to pick which students were in need of extra help – before they started failing exams?

We did a study to determine whether it might be possible to assess the innate visual-spatial skills of students to predict who would struggle more with ultrasound-guided regional anaesthesia (UGRA). There has been very little published on whether such testing will identify anaesthetists who will be “gifted” in procedural skills where hand-eye co-ordination is critical.

We found that we can use a standardised test battery to divide participants into streams according to their visuospatial ability, and that people with lower innate ability perform worse than those with higher innate ability when using ultrasound to scan the brachial plexus – even after being given practice time between tests.

For the study, 33 ultrasound novices were recruited from among undergraduate health science students who had never used ultrasound. They were given a standardised battery of five cognitive tests that assess four visuospatial factors: spatial visualisation (ability to use two-dimensional ultrasound images to visualise three-dimensional anatomy); flexibility of closure (ability to identify objects in a distracting visual field, important in discriminating nerves from non-neural images under ultrasound); spatial relations (visualisation with an emphasis on performance speed, important for efficiency in ultrasound scanning); and speed of closure (ability to complete visual tasks when provide with incomplete information, which is often seen with partial views of nerves under ultrasound). The blinded trial was performed in the Ingham Institute Clinical Skills and Simulation Centre, Sydney in March 2015.

The participants were given the aptitude tests; watched an instructional video on upper limb sonography relevant for brachial plexus UGRA; performed a baseline exam on a healthy



male subject; had a 45-minute discovery learning session, again on a human model, but with no feedback provided; and performed a second, final exam.

All participants improved their raw sonography proficiency scores and their speed scores from baseline to final exam, but the improvement was statistically significant only in those who scored high or intermediate on the ability tests.

Visuospatial testing might therefore be useful in identifying novices who will find UGRA difficult to master, and teaching resources can be directed to those most in need.

Dr Alwin Chuan, FANZCA
Liverpool Hospital, NSW

Dr Alwin Chuan is a consultant anaesthetist at Liverpool Hospital, Sydney, and a senior lecturer at the University of NSW. His PhD is on novel education and training interventions in ultrasound-guided regional anaesthesia. He has published a textbook and iPhone app on regional anaesthesia.

A full report on this study was published in Acta Anaesthesiologica Scandinavica, an international journal of anaesthesiology and intensive care, pain and emergency medicine, on June 22, 2016.

If you are concerned about yourself or a colleague, contact

The Doctors' Health Advisory Service

Hotline

nearest to you

Australia:
New South Wales/Northern Territory
+61 2 9437 6552

Australian Capital Territory
+61 407 265 414

Queensland +61 7 3833 4352

Victoria 1300 853 338

Western Australia +61 8 9321 3098

Tasmania 1300 853 338

South Australia +61 8 8366 0250

New Zealand: 0800 471 2654

Pilot study tests new teaching tool in operating theatres

ANZCA Fellow Dr Nav Sidhu, a consultant anaesthetist at North Shore Hospital in Auckland, is recruiting anaesthesia departments into a pilot study to evaluate a teaching tool for routine use in the operating theatre. We ask him about the study.

What is the teaching tool you are trying to evaluate?

We call it the CRAFT model. It is essentially a tool that allows supervising clinicians to target their teaching based on mutually agreed learning goals. In addition, it provides guidance on delivering feedback to trainees at the end of each list. It is designed to be simple and easy to use.

What's wrong with the way anaesthetists teach now?

I think most anaesthetists in general are good at teaching, but that doesn't mean we can't do better. Most teaching in the operating theatre is done in an ad hoc manner, with the supervising clinician deciding on topics based on the type of anaesthesia for the surgery, the patient's medical background, or their own area of interest. Opportunistic teaching also occurs with events that emerge during the course of the list. There are a small number of supervisors who do ask their trainees what they'd like to learn and some trainees will explicitly state what they want out of the list, but this is not the norm.

What occurs even less frequently is routine provision of feedback at the end of each list. There is strong evidence in the medical education literature that feedback on specific events, whether positive or corrective, should be provided soon after the event, as opposed to a mid or end-of-placement feedback by an individual with secondhand information.

The tool is designed to address these specific aspects of the teaching encounter.

Aren't there similar tools already in use?

Yes, there are, and your readers might be familiar with the One-Minute Preceptor (OMP) and SNAPPS models. Most of these tools were developed for use in the ambulatory clinic setting and aren't readily applicable to the operating theatre without modification. None of the tools has been evaluated in clinical anaesthesia. A colleague and myself are preparing a review article on this topic, to describe what is actually out there in the literature and to propose a definition for these tools.

How are these tools different from a workplace-based assessment (WBA)?

Both facilitate teaching in the operating theatre, but these teaching tools focus more on teaching and learning rather than formative assessment. There is no scoring of the trainee's



performance, there is no form to fill out, and it's designed to be routinely used in all teaching encounters. While WBAs also provide feedback, they don't give you a structure on how to provide that feedback.

I will state, however, that WBAs play an important role in our training program and participation in this study will not disadvantage any trainee who needs to perform WBAs as part of their training requirements.

What's the aim of your study?

We hypothesise that implementing the tool for all teaching encounters in the operating theatre during normal hours over a four-week period will improve the educational environment of trainees. The effects will be evaluated using a pre and post-intervention measure and, as this is a pilot, we will be looking at feasibility and power calculation for a larger, international study.

If you are interested in having your department participate in the study or would like more information, search for “craft study information” on YouTube to view a presentation or visit <https://youtu.be/dW8stuXpFVY>.



Contact the study investigators at craft.model@outlook.com



Junior trainees benefit from mentoring scheme

Doctors at Western Hospital in Melbourne have set up a mentoring scheme where trainees preparing for ANZCA's primary examination are supported by those who have recently completed it.

Mentoring is for life in medicine, as we adopt and, in turn, become role models, counsellors and professional guides. The classical concept of mentoring, from its Homeric origins, involves a compact between an experienced elder and a novice; one leading the other through stages of personal and professional development. Ideally, it is a collaborative and mutually beneficial relationship, and also can exist between close contemporaries.

Registrars in the North Western Training Scheme in Melbourne now have an opportunity to mentor their juniors based at the Western Hospital, supporting them through the arduous journey towards completing the primary examination.

Specifically aimed at a brief but vulnerable period for trainees, this peer-to-peer program involves volunteers who have recently passed the exam – perhaps the most qualified people for this task. The first cohort was recruited in November 2015, and have been working towards the second sitting this year.

The Primary Examination Mentoring Scheme (PEMS) was designed by Dr Phuong Pham, now in her second year of basic training, and encouraged by one of the supervisors of training at the Western, Dr Martin Nguyen. It aims to create a collegiate support network, acknowledging that social capital arising from pooling resources and sharing study and performance tips can be crucial to examination success; that “unwritten rules” are as concrete a resource as the must-have textbooks.

PEMS was inspired by a similar scheme initiated by Dr Derrick Wong, with the support of Dr Louise Ellard, at the Austin Hospital. Dr Wong felt that existing mentoring programs, which tended to focus on career advice, did not meet the needs of first-year trainees, who were “almost uniformly focused on passing the primary as their main goal”. Additionally, the introduction of the new curriculum meant that those who had sat in the last two to three years could provide more up-to-date scholarly input.

At the Western Hospital, Dr Pham acts as a co-ordinator and point of contact between mentors and mentees. Her interest in mentoring was inspired partly by her own positive experiences, including meeting a consultant surgeon as an intern who encouraged her to consider a surgical career. When she decided her interests lay in anaesthesia, he guided her towards a supernumerary position at the Peter MacCallum Cancer Centre, where she met further supporters of her clinical and educational pursuits. “I owe whatever I have achieved now to many mentors that I have collected along the way,” she said.



“‘Unwritten rules’ are as concrete a resource as the must-have textbooks.”

Dr Pham is passionate about linking the candidates who fall outside the main tertiary hospitals with formal teaching programs and social support networks. There also is special focus on candidates who have been unsuccessful at previous exam sittings. Debriefing with the co-ordinator helps to identify strategies to improve their performance for the next attempt.

Another aspect of particular interest is the concept of active “menteeship”, or “managing up”. Dr Pham is keen to see trainees gain the skills to be proactive in order to get the most benefit out of their relationship with their mentor. This can be challenging in a predominantly hierarchical profession, particularly for those who tend towards being timid rather than assertive. It requires both self-knowledge and motivation, which can be encouraged via the compulsory training prior to commencement of the scheme, but not necessarily taught.

Participation in PEMS is voluntary, and though most eligible trainees have taken up the option, the degree of active engagement varies. Mentees are asked to clarify their learning goals and study style at the start, and also to consider accessing the pool of resources beyond their mentor rather than relying on them as a sole source of support.

Mentors also undertake significant training and preparation for the scheme. Two mentors are assigned to each self-selected study group, though candidates who are studying alone may be assigned a sole mentor. Flexibility is the key, both for the time-poor trainee and in considering the learning needs of a diverse range of candidates. Trainees dispersed across different training sites also can find it difficult to arrange to meet, and some have overcome this by using online platforms.

Above: Dr Phuong Pham at the Western Hospital.

The benefits for mentors include building professional relationships, keeping in touch with the primary material and the satisfaction of giving back to a system that helped them through. Some mentors also choose to put educational techniques into practice by incorporating teaching into the program, an optional component.

Broadly, literature on mentorship indicates that having an identified mentor is a strong predictor of increased career satisfaction and professional advancement. Mentors also significantly influence the choice of and success in an academic career. The impact of mentoring in anaesthesia is less studied, but a planned audit and evaluation of PEMS will contribute to knowledge in the field.

For mentees, moral support and validation of their study approach and stage of progress are among the key benefits of participation. This personal contact can provide mental strength and reduce the isolation of exam study and learning to be a specialist registrar. The scheme may not benefit everyone, as Dr Pham acknowledges, but for those it does, “the work is worth it”.

Dr Alison Jarman,
Advanced trainee, Royal Children's Hospital, Melbourne

Dr Phuong Pham presented at the Australian Society of Anaesthetists National Scientific Congress. She led a small-group discussion on “How to find your mentor”. Thanks to Dr Derrick Wong, Dr Patrick Tan, Dr Peter Williams and Dr Jessica Fusella for providing additional material for this article.

Reading material:

- Zerzan et al. Making the most of mentors: A guide for mentees. *Academic Medicine*, Vol. 84, No. 1/January 2009.
- Howe, Peter. The mentor case: A proposed model for mentoring in anaesthesia departments. *Australian Anaesthesia*, 2007; p. 103-110.
- Flexman, Alana M and Gelb, Adrian W. Mentorship in anaesthesia. *Current Opinion in Anaesthesiology* 2011, 24; pp. 676-681.

The next era of the ANZCA Educators Program

The expansion of the ANZCA Educators Program will enhance accessibility and offer new modules and content.

Why does ANZCA have an educators program?

As ANZCA is the primary body in Australia and New Zealand responsible for educating anaesthetists and specialist pain medicine physicians, it is essential that the College enables all its educators to be skilled and knowledgeable in current educational theory.

The ANZCA Educators Program enables anaesthetists and pain medicine specialists involved in educating or supervising the work of trainees to gain the practical skills and knowledge required to enhance learning and assessment.

Supervisors, heads of departments and those responsible for organising training all have a part to play in the encouragement of excellence in anaesthesia and pain medicine.

The field of anaesthesia and pain medicine is progressing at a rapid rate and, as a consequence, more comprehensive learning is expected of trainees as part of training in perioperative care. The training programs of the College are based on learning from direct clinical practice (a variation of apprentice-master concept), possibly supplemented by simulation and modeling.

This method requires trainees to be taught by a clinical expert. It also requires that the expert possesses the necessary knowledge and skills of education, which has traditionally received little attention given the amount of time required to learn the clinical material.

The field of education is also changing at a rapid rate. This places the clinical expert at a further disadvantage in teaching trainees experienced with new methods from their school and tertiary education. Since 2010, the ANZCA Educators Program (formerly the Foundation Teacher Course) has educated anaesthetists and pain medicine specialists on foundational education principles and 2016 welcomed the next era for the program.

All Fellows, international medical graduate specialists (IMGS) and provisional Fellows of the College interacting with trainees or having responsibility for training are encouraged to complete the eight basic modules of teaching and learning of the ANZCA Educators Program.

Expansion of the ANZCA Educators Program

The program has traditionally been delivered by ANZCA's Learning and Development Facilitator in a face-to-face and interactive online format. With excellent feedback from participants, the demand for the course has always exceeded the resources and capacity for its delivery.

Moving to expand access and the offerings of the program, ANZCA's Teaching and Learning Sub-Committee has appointed 19 additional facilitators and supported a project group to develop five new modules.



Introducing the local facilitators

Nineteen ANZCA and FPM Fellows and provisional Fellows have been appointed as ANZCA Educators Program facilitators. The facilitators, representing all ANZCA regions and New Zealand, attended a two-day workshop in May 2016 to be inducted into the role. Terms of reference for the ANZCA Educators Program facilitator role can be found on the ANZCA website at: [www.anzca.edu.au/documents/eu-aep-local-facilitation-facilitator-tor-2016-1\).pdf](http://www.anzca.edu.au/documents/eu-aep-local-facilitation-facilitator-tor-2016-1).pdf)

Two key modules from the program are now being offered by the facilitators across all ANZCA regions and New Zealand:

- Planning Effective Teaching and Learning.
- Teaching in the Clinical Setting.

The Teaching and Learning Sub-Committee have plans to further expand the offerings by local facilitators to include more modules from the ANZCA Educators Program and to grow the network of facilitators across Australia and New Zealand; culminating in the ability of each ANZCA region to deliver the complete course and thus expose all Fellows of the College to the fundamental principles to enhance learning.

Launching five new modules

Five new modules have been developed to complement the existing eight modules of the ANZCA Educators Program. The new modules are now being piloted across Australia and New Zealand and will be officially inaugurated into the Educators Program in 2017.

New modules in pilot, launching in 2017:

- Technology in teaching and learning (authors – Dr Emelyn Lee, Dr Alistair Kan, Dr Jonathan Albrett, Dr Rebecca Kamp)
- Teaching in multiple settings (authors – Dr Elizabeth Gooch, Dr Amardeep Nanuan, Dr Bipphy Kath, Dr Linda Sung, Dr Christopher Wilde).
- Concepts in assessment (authors – Dr Anna Negus, Dr David Law, Dr Timothy Hodgson, Dr Pragya Ajitsaria, Dr Neil MacDonald).
- Organisation of education in departments (authors – Dr Natalie Smith, Dr Kerryn Bunbury, Dr Thomas Burrows, Dr Sara Allen).
- The trainee experiencing difficulty (authors – Dr Suzanne Bertrand, Dr Navdeep Sidhu, Dr Kara Allen, Dr Jing-Chen Jason Chou).

These add to the current modules:

- Doctor as educator.
- Planning effective learning and teaching.
- Feedback to enhance learning.
- Interactive learning and teaching.
- Teaching in the clinical environment.
- Teaching practical skills.
- Authentic assessment.
- Clinical supervision

CPD eligibility

Participants of the ANZCA Educators Program are eligible for continuing professional development (CPD) credits under the “Knowledge and skills” category. Participation provides the opportunity for two credits per hour for “Short courses, workshops, problem-based learning discussions and small group discussions” activities.

Further information

More information on the program and its modules can be found on the ANZCA Educators Program webpage: www.anzca.edu.au/resources/learning/anzca-educators-program. Inquires to education@anzca.edu.au.

Associate Professor Kersi Taraporewalla
Chair, Teaching and Learning Sub-Committee

Register to attend

Want to attend the eight current modules?

Registrations will open in November 2016 for the courses running in 2017.

The face-to-face courses will run over two-and-a-half days, with a two-day version held before the 2017 ANZCA Annual Scientific Meeting in Brisbane.

To place your name on the notification list when registration opens, please email education@anzca.edu.au.

Want to attend individual modules?

Select key modules from the ANZCA Educators Program are regularly being held across Australia and New Zealand.

There are currently two modules from the existing course and the five new modules that are being offered individually.

To find events near you and to register, visit the ANZCA Event Calendar (www.anzca.edu.au/events) and search for “ANZCA Educators Program” within your preferred location.

New events are continually being added so keep regularly checking the event calendar.

Above right: ANZCA Educators Program facilitators (clockwise from left): Dr Jonathan Albrett, Dr Bipphy Kath, Dr Robert Marr, Dr Anne Jaumees, Dr Rachelle Williamson, Dr Christopher Wilde, Dr Elizabeth Power, Dr Navdeep Sidhu, Dr David Law, Dr Timothy Hodgson, Dr Timothy McIver, Dr Claire McTernan, Dr Kara Allen, Dr Kirsty Forrest, Dr Rebecca Kamp, Dr Linda Sung, Dr Agnieszka Szremska, Dr Daniel Connor, Dr Emelyn Lee.

Bringing regional anaesthesia to Rwanda



“In a devastating blow, one of the staff anaesthetists abruptly resigned from the hospital due to burnout towards the end of my mission.”

An ANZCA Overseas Aid Scholarship contributed to Dr Matthew Ho's four-month mission in Rwanda, where there are just 14 anaesthetists for 12 million people. Dr Ho worked in Rwanda from January to May as part of a Global Health Anaesthesia fellowship at Dalhousie University, Canada.

Though I wasn't particularly fond of the Canadian winter, I felt a sad “snow nostalgia” as I walked across the frozen runway at Halifax airport in January 2016 to board a flight for warm Rwanda.

This is what happens to an Australian experiencing overwhelming trepidation. My family and I were leaving our western comforts for a four-month mission to Kigali, Rwanda. Until that point, my thoughts had centred on halothane hepatitis, malaria, glostavents and draw-over vapourisers.

But now I realised this journey would involve far more than mastering anaesthesia in the austere environment. This moment, though it seems a lifetime ago, was as vivid as it was prophetic. While I did learn much in operating theatres about safety and danger, wealth and poverty, order and chaos, my most profound experiences occurred in everyday life – through the relationships we invested in, within the hospital and outside.

A Rwandan and an Australian in Canada

I first met Dr Françoise Nizeyimana in March 2015 during Nova Scotia's harshest winter in 40 years. We had both recently arrived in Canada to work in the same anaesthesia department, but had travelled there from very different places – Françoise from Kigali, Rwanda, and myself from Sydney, Australia. Françoise was a third-year Rwandan anaesthetic registrar who had been selected for a three-month elective as part of the Canadian Anaesthesiologists' Society International Education Fellowship (CASIEF) residency exchange program.

Its aim is to improve access to safe surgery for all Rwandans, by supporting the anaesthesia residency program, established through partnership with the University of Rwanda in 2006. CASIEF started its partnership with the University of Rwanda in 2006, to establish the anaesthesia residency program. In 10 years, this program has increased the number of anaesthetists in Rwanda from one to 14.

I had left Australia with my wife and two young children, in order to take part in the program, as part of my fellowship in Global Health Anaesthesia at Dalhousie University.

Several elements drew me to Dalhousie: a four-month mission trip to Rwanda; the support network into Global Health projects offered by the Dalhousie Global Health Office and CASIEF; and a strong relationship that I developed with my fellowship director, Dr Patty Livingston. Above all, I saw in Rwanda a country in need.

There are only 14 anaesthetists for 12 million people. Technicians, nurses, or general practitioners with one year of anaesthesia-specific training, perform more than 95 per cent of anaesthesia. As a regional anaesthesia specialist, I discovered that there was no regional anaesthesia practice or training in any hospital! Dwarfing these statistics were the ongoing effects of the 1994 genocide: approximately one million people (10 per cent of the population) killed in 100 days, with countless more injured, orphaned and traumatised. Nearly everyone I met had lost a relative. If there was a place in which I could help (or try), this was it.

While our transition from Australia to Canada was straightforward, Françoise's experience was a contrast. She left her family back in Kigali. This homesickness, combined with the harsh winter, foreign working conditions and culture, made life very challenging. Françoise persevered through these trials, and I was blessed to witness her flourish through the clinical and cultural opportunities she embraced.

Becoming Rwandan

Ten months later, and it was my turn to experience life and anaesthesia practice in Françoise's home country. My personal goals reflected the opportunity this trip offered to integrate my values, faith and family with work: to foster relationships among locals in resource-poor communities; and to evaluate our suitability to live and work sustainably in these communities.

To say that we experienced culture shock doesn't capture the helplessness we felt in the first week in Kigali. Like Françoise in Canada, small and big tasks seemed either frustratingly difficult or entirely insurmountable: finding a place to live, getting furniture, fixing plumbing, buying SIM cards, getting visas, and grocery shopping. We had never felt so humbled.

We also felt isolated at times, as Asian Australians are a rare breed in Rwanda. Grappling with our own wealth among the poor was a daily dilemma: guilty for our excesses; torn by the desires to be generous and yet to promote sustainable living behaviours. “African time” was at first a frustrating experience, particularly for our kids at meal times – let no one convince you that fast food exists in Rwanda!

However, we couldn't be more thankful for the experience. Through persistence and adaptation, we learned valuable cultural lessons that shaped us for the better. For example, “African time” may seem inefficient to westerners, but it is because relationships are prioritised over tasks. It is far more important to embrace a friend on the way to a meeting than it is to arrive at that meeting on time.

Anaesthesia in Rwanda

These very relationships were the foundation of my work as a volunteer anaesthetist and visiting lecturer at the University of Rwanda. I planned the following goals during a needs-assessment trip in 2015: to establish a sustainable regional anaesthesia service in the University Teaching Hospital of Kigali (CHUK); build the anaesthesia residency curriculum through mentoring local teachers; and run a collaborative research project evaluating the barriers and facilitators to establishing this service.

My pre-trip planning included developing a simple regional anaesthesia curriculum and sourcing donated regional block equipment to perform these techniques.

The first week was a rude awakening. There was no room to perform blocks (no induction rooms in the hospital); only one anaesthetist in the whole country who had regional anaesthesia training; no system for identifying patients; lack of perioperative staff awareness of regional techniques; and no process for acquiring or storing regional anaesthesia equipment. Thus, in the second week, I drafted a strategic plan that categorised the problems (and hence solutions) into “the 4 Ss”: Space, Staff, Stuff and Systems. This helped Dr Bona Uwineza (head of the anaesthesia department) and I plan our implementation. (see table on page 78).

Two major barriers hindered us. Firstly, local anaesthetists worked many hours with heavy on-call duty and responsibility. It was difficult to get the time to teach basic regional blocks and to engage them in the efforts to establish this new service.

In a devastating blow, one of the staff anaesthetists abruptly resigned from the hospital due to burnout towards the end of my mission. Also, while getting hospital approval to purchase regional equipment was straightforward, the process of acquisition was complicated and time-consuming due to local policy. Equipment “ordered” at the beginning of my four-month teaching mission was still not due to arrive until three months after I left the country.

Yet I learned humility and resourcefulness from my colleagues who work in these conditions daily with minimal complaint. When I would grumble, they would smile, shrug their shoulders and find a solution. To keep the ultrasound probes clean, we used condoms instead of prohibitively expensive probe covers. ECG electrodes were made using wet gauze, ultrasound gel and sticky tape. I even made DIY phantom ultrasound models out of Metamucil and Aeroplane Jelly for our teaching workshops, due to a lack of cadaver facilities.

The regional anaesthesia impact

By the time I left in May 2016, all anaesthetic registrars in Rwanda, and anaesthesia technicians at CHUK had completed a comprehensive training course in regional anaesthesia. Regional anaesthesia was being performed regularly in a dedicated “block room” in the CHUK theatres.

Two collaborative research projects in regional anaesthesia had been approved by the local ethics committee and started, and CHUK had an organised system in which patients received safe regional anaesthesia.

Many patients thanked me for a painless perioperative experience, as I quickly learned that most Rwandans fear that they will never wake up from general anaesthesia. Word spread quickly about this new technique, and we had some patients asking about regional blocks when they were previously unknown in the country.

(continued next page)

Above from left: Dr Matthew Ho enjoys the Rwandan Gorilla Experience; Dr Ho with Dr Françoise (right) and two fellow volunteer anaesthetists as we instructed the SAFE course; Dr Françoise leading a simulation scenario for the anaesthetic registrars; The newly established CHUK regional block room; Rwandan staff leading the Safer Anesthesia from Education (SAFE) obstetrics course; Anaesthetists and surgeons watching as Dr Ho performs an ultrasound-guided paravertebral catheter.

Bringing regional anaesthesia to Rwanda (continued)

"I even made DIY phantom ultrasound models out of Metamucil and Aeroplane Jelly for our teaching workshops, due to a lack of cadaver facilities."



Above from left: The Rwandan registrars enjoying the ultrasound phantom model workshop; Dr Ho and the registrars in front of the simulation centre at CHUK.

Three months after leaving CHUK, I received updates from Dr Damascene Nyandwi (CHUK anaesthetist) and Dr Alain Irakoze (anaesthesia registrar) saying the service was thriving. Time will tell whether a truly sustainable regional service was established, but I have confidence and they have hope.

Relationships

As I reflect back on our two journeys – Francoise from Rwanda to Canada and back, and mine from Canada to Rwanda and back – I marvel at the changes the program has made in both our lives.

From being a timid (and culturally shocked) registrar in Canada, she is now a local champion for the plight of regional anaesthesia in Rwanda, harnessing the skills and confidence she gained in Canada.

Soon to graduate, she has begun to teach simulation to junior residents, started as a faculty teacher in CHUK, and has presented at several conferences in North America, advocating for safer surgery in Rwanda. People like Francoise are the future of safe anaesthesia in Rwanda.

Dr Matthew Ho, FANZCA

Assistant Professor and Fellow in Global Health and Regional Anaesthesia, Dalhousie University, Halifax, Canada

Acknowledgements:

My family and I are indebted to Dr Patty Livingston, the Dalhousie University Office of Global Health, and CASIEF for their emotional support, practical guidance, and the structured program they have built over many years, into which I was integrated.

Our work was supported by a generous grant through the ANZCA Overseas Aid Scholarship, and personal guidance from Dr Michael Cooper, Chair of the ANZCA Overseas Aid Committee. We are committed to working with the ANZCA Overseas Aid Committee and our fellow global health advocates in Australia to promote safer surgery for people in need.

Finally, we thank our Rwandan friends for adopting us as their own, and shaping our lives far in excess of the changes we affected.

The four Ss – a Rwandan strategic plan

Space	Marking a corner room in the preoperative area as the "block room" and providing signage, posters, and areas for monitors, ultrasound machines and documentation.
Staff	Delivering a 12-week practical regional anaesthesia curriculum, integrated into the anaesthetic registrar curriculum; identifying anaesthesia technicians as important points of training and developing a 20-session regional anaesthesia curriculum during morning rounds; rostering residents and technicians to the block room; and identifying "local champions" who would be equipped to continue teaching regional anaesthesia when I left.
Stuff	Stocking a "block trolley" with all equipment required for regional blocks; procuring monitors for the block room; and appealing to hospital administrators for the procurement of regular regional block equipment supply.
Systems	Educating surgeons and nurses; marking potential patients on the operating room list; and developing peri-procedure documentation and checklists.

Lives of the Fellows

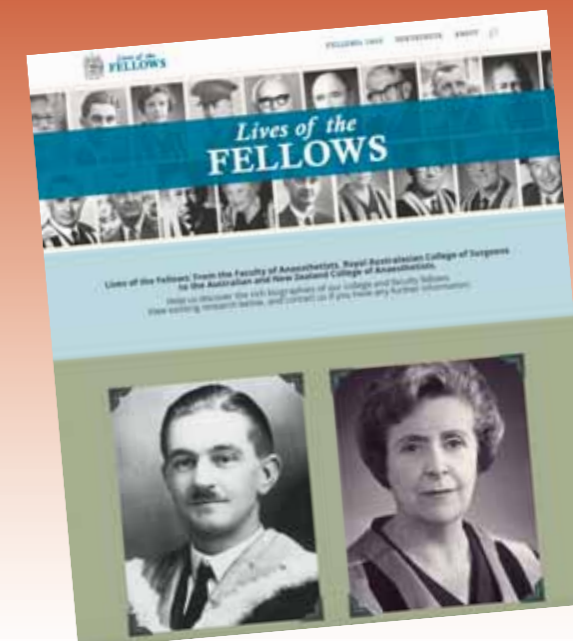
Lives of the Fellows launched at the 2016 ANZCA Annual Scientific Meeting (ASM) in Auckland. It is an online exhibition highlighting the professional lives of the foundation Fellows of the Faculty of Anaesthetists, Royal Australasian College of Surgeons.

The exhibition is on display in an online format (<http://anzca.online-exhibition.net/fellows/>). Although there are 40 foundation Fellows, at this stage half the biographies have been completed. This has been a large task incorporating the use of a range of archival material and the digitisation of museum objects to illustrate the stories being told. Rebecca Lush, a museum studies student from University of Sydney, undertook a placement with the Geoffrey Kaye Museum of Anaesthetic History in December 2015 to commence the research and get it ready for the online exhibition.

Fellows, trainees and researchers are encouraged to submit additional information to the publicly available biographies. Any public submissions will be held over for verification by the honorary historian, honorary curator and/or curator, before being added to the site. It is a site for active interaction and engagement with a range of potential audiences.

The Honorary Curator, Dr Christine Ball, and Curator, Monica Cronin, are preparing a training workshop for the 2017 Brisbane ASM, called Building the Lives of the Fellows. This will provide participants with the skills and knowledge to add additional information to the existing entries, as well as those being prepared for the 2017 launch of Lives of the Fellows: 1992.

The workshop will encourage participants to utilise the College archives, museum and library, as well as external sources such as Trove, the National Archives Australia and state



or regional archives, such as Public Records Office Victoria or State Library New South Wales.

Similar projects have commenced at a range of medical colleges throughout the world. The museum's project is based on the project of the same name by the Royal College of Anaesthetists (www.rcoa.ac.uk/lives-of-the-fellows).

The museum's aim has been to produce a visually appealing site with strong acknowledgement of original sources for biographical material. Rather than being a recitation of professional milestones, these biographic snapshots are aiming to be the basis for a much broader social history.

Monica Cronin

Curator, Geoffrey Kaye Museum of Anaesthetic History

Ulimaroa opens to the public

For the last eight years Melbourne homes, offices and other buildings of architectural interest, have opened their doors for the general public to have a good old fashioned sticky-beak. This year ANZCA was invited by Open House Melbourne co-ordinators to open historic building, Ulimaroa. A team of 12, including staff volunteers, Honorary Curator Dr Christine Ball, Dr John Williamson and Dr Ian Rechtman, guided more than 120 visitors through the historic house on July 30 and 31.

Visitors were delighted to view one of the few remaining examples of Melbourne "boom time" architecture on St Kilda Road, once a site for lavishly built and decorated homes. Among the visitors were architecture buffs, with a sound knowledge of the Victorian Italianate style. Art enthusiasts were impressed by the painted presidents' portraits but were dazzled by Athol Shmith's portraits of Robert Orton and Lennard Travers. All visitors, no matter their reason for visiting, were delighted by the play of winter sunlight through the stained glass windows.

Participating in this high-profile program enabled the College to engage the wider community in the story of anaesthesia and pain medicine in a way it never has before. The majority of visitors had no connection with the College and didn't come from medical backgrounds, although many promised to visit the museum again to learn more.

Monica Cronin

Curator, Geoffrey Kaye Museum of Anaesthetic History



Above from top: Laura Foley, Monica Cronin, Dr John Williamson, Sarah Chezan, Jan Sharrock and Ari Hunter.

Persistence pays: The discovery of Dr Pugh's missing journal



"Persistence pays: The Discovery of Dr Pugh's Missing Journal" was the title of the 5th Pugh Day Lecture delivered on Sunday June 19 at the Queen Victoria Museum and Art Gallery in Launceston, to an audience of more than 100.

Persistence certainly did pay as Dr John Paull, retired anaesthetist and Mrs Aileen Pike, a Launceston genealogist, told of the seven-year quest during which they tracked down the journal written by Dr Pugh, describing his journey from England to New Holland on the Derwent in August 1835.

Pugh's fame in Launceston, and indeed in Australia, depends on the fact that on June 7, 1847, in Launceston, he gave the first anaesthetic for a surgical operation in Australia.

In the journal's first few pages, Pugh, the ship's surgeon, made somewhat defamatory comments about a number of his fellow passengers but his eulogy of Miss Kirton, the only eligible single female on the ship suggested that the prospect of warm tropical nights spent in her company under the stars was something that he looked forward to.

Two weeks into the voyage a water shortage led to rationing, only remedied when they reached Santiago Island in the Cape Verde islands three weeks later. Seasickness kept Pugh busy providing remedies and he suffered an attack of jaundice and subsequent biliary colic himself.

In the Cape Verde islands they had a lucky escape from pirates, thanks to the skill of their captain. Neptune visited when they crossed the equator but celebrations got out of hand and the captain called a halt. The Derwent arrived in Hobart at midnight on the December 9, 1835, four months and one day after leaving Gravesend.

Miss Kirton rejected Pugh's marriage proposal in Hobart and he sailed on to Sydney. He came back to Hobart, walked to Launceston, where Miss Kirton was staying, proposed a second time and they married in May 1836.

The journal was sent to Pugh's father in England in May 1836. In 1934 a family friend brought it back to Tasmania where the *Illustrated Tasmanian Mail* published extracts describing Pugh's walk north and indicated that there was more.

Mrs Pike tracked down descendants of Pugh's sister who were living in England and it was found that they held the journal. Dr Paull negotiated with these descendants, Sheena Ronan, Alistair Henderson and their siblings, who very generously gifted the 64-page journal to Tasmania.

Dean Byass, a Bristol antique book dealer obtained the necessary export certificate from the British Arts Council and packed the journal for its long journey. It is now in Tasmania for the third time!

It is to be conserved, digitised and kept at the Tasmanian Archives and Heritage Office in Hobart, but will come north again to be displayed at the Launceston Library. Dr Paull is transcribing the journal and it will be published with the transcript and relevant commentary at a later date.

Dr John Paull, FANZCA
Launceston, Tasmania

From left: Dr John Paull (right) and Ian Morrison, Senior Librarian, Tasmanian Archive and Heritage Office open the precious parcel; the opening page of the 181 year old journal in Dr Pugh's handwriting; Dr Paull and Aileen Pike, a Launceston genealogist.

Foundation update

New chair for the foundation committee

ANZCA's Immediate Past President, Dr Genevieve Goulding, has been appointed as the new chair of the Anaesthesia and Pain Medicine Foundation Committee.

The appointment is a mark of the importance placed by the College on the role of research that several successive former presidents have served as chairs.

Dr Goulding brings a strong commitment to supporting research in anaesthesia, perioperative and pain medicine and a great appreciation of the generosity and importance of its donors.



Supporting emerging researchers appeal 2016

The president's message (page 4) is also a strong endorsement of the need to continue to invest in high-quality research.

Research plays a vital role in improving the evidence, information and answers available to clinicians and foundation donors therefore play a key role in research and helping to generate government funding for clinical trials.

Providing project funding to encourage the development of early-career researchers is one of the essential ingredients to future research success. Supporting novice investigator grants for emerging researchers is an excellent and strategic way to invest.

Perpetual Trustees IMPACT philanthropy grant

The foundation learnt in June that its submission to Perpetual Trustees' "IMPACT Philanthropy" grant funding round was successful, securing \$A76,009 towards Dr Jonathon Hiller's "Reducing anxiety and breast cancer metastasis risk at the time of surgery using blood pressure medication" project.

The generous grant has been made by the Harry Secomb Fund, through Perpetual Trustees.

Dr Hiller is a staff anaesthetist at Melbourne's Peter MacCallum Cancer Centre. His project, which is also supported by a grant from the National Cancer Institute, part of the United States' National Institutes of Health, will test the hypothesis that for women with breast cancer, using the beta-blocker agent propranolol to reduce surgery-related stress will change the behaviour of tumours and reduce cancer metastasis to other parts of the body.

In animals, beta-blockers have been shown to prevent breast cancer metastasis. This will be the first prospective study to test whether a beta-blocker drug can change the behaviour of human breast cancer tumours and reduce metastasis.

Grant applications for 2017

Applications for the foundation's 2017 grant round closed on April 1 and 60 applications were received; 39 project applications, eight novice investigator applications, four simulation/education applications; three academic enhancement applications and six Douglas Joseph Professorship applications.

This is a significant increase from the 46 grants received in 2015 for funding in 2016. Growth in applications helps maintain the quality of the research program along with the three-reviewer per project process overseen by the ANZCA Research Committee. The review process finished in early September.

Foundation branding and communications

The foundation has been working towards improving its core brand, including its mission and vision statements, to strengthen communications around supporting research to Fellows, trainees, allied health, and external audiences as well as prospective donors and sponsors.

After consultations with the Faculty of Pain Medicine, ANZCA's president, chief executive officer and Communications and Fellowship Affairs teams, the Board of Governors, fundraising consultants RobeJohn & Associates and communications consultants Cannings Purple recommendations have been presented to the foundation committee for consideration.

Once confirmed, the foundation will work with ANZCA Communications to develop a refreshed visual identity.

Supporting research through financial planning

The foundation reminds its supporters that anyone wishing to review their life, income protection, trauma and total or permanent disability insurance cover can do so through major sponsor, Perpetual, a leading financial advisory firm with a 28-year history supporting medical professionals. Perpetual will donate 20 per cent of their first year's brokerage fee directly to the foundation on behalf of those who proceed with its advice.

Please contact Ms Michelle Gianferrari on + 61 421 446 513 or michelle.gianferrari@perpetual.com.au for a no cost, no obligation offer.

Supporting in perpetuity

Anyone interested in creating a perpetual future contribution through a bequest in their wills should contact Rob Packer at the foundation on +61 3 8517 5306 or rpacker@anzca.edu.au.

Rob Packer,
General Manager, 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

Meeting attracts more than 150



The 8th annual ANZCA Clinical Trials Network (CTN) Strategic Research Workshop was the biggest and best yet as more than 150 investigators, trial co-ordinators and interested Fellows and trainees met at the Crowne Plaza Coogee Beach in Sydney to discuss new ideas and share triumphs and challenges.

The three-day meeting was held from August 12-14.

The main aims of the workshop are to develop proposals for new large multi-centre trials and to promote networking among the participants, enabling emerging investigators and sites to get involved in established trials and also get advice on new ideas. This year an additional focus of the meeting was to engage the major teaching hospitals in Sydney in ANZCA CTN-endorsed multi-centre trials.

The meeting opened with a workshop for emerging research leaders. Twenty-five hand-picked researchers joined Professor Kate Leslie (CTN Executive Chair), Associate Professor Philip Peyton (CTN Executive Deputy Chair) and Professor Paul Myles (CTN Executive Inaugural Chair) for three hours of strategic, tactical and operational advice, and a chance to share research trials and tribulations. This workshop fulfils our commitment to developing a sustainable network of investigators and sites. At the same time the Anaesthesia Research Co-ordinators Network met for their regular workshop and annual general meeting under the leadership of their chair, Ms Sofia Sidiropoulos.

The formal part of the meeting then opened with a keynote address from Dr Andrew Leigh (Federal Member for Fenner, ACT, and Shadow Assistant Treasurer). Dr Leigh addressed the audience on the use of randomised controlled trials in public policy research, emphasising the importance of community consultation and engagement, and a culture of accepting policy failure and trying something new. Dr Leigh then joined a panel of CTN leaders to discuss engaging politicians in the promotion of medical research in Australia. On Sunday Dr Leigh joined some of our fit investigators in Sydney's City to Surf fun run!

“In order to embed research deeply in the culture of the College and its Fellows, a more comprehensive policy is required.”

The CTN always invites a biostatistician to the workshop to enlighten us about the latest trends in the statistical management of large trials. This year Associate Professor Stephane Heritier from Monash University spoke about new trial designs, like the stepped-wedge study, and how to deal with unusual new endpoints, such as “days alive and out of hospital”. We love having our minds stretched by a bit of statistics and Associate Professor Heritier did not disappoint!

Our final keynote speaker was ANZCA President, Professor David A Scott, who gave a stimulating presentation on the development of an over-arching research policy for ANZCA. Currently research is included in many of the College's policies relating to training, continuing professional development and international medical graduate specialist assessment. However, in order to embed research deeply in the culture of the College and its Fellows, a more comprehensive policy is required. Delegates took the opportunity to ask lots of questions and contribute to the debate.

The majority of the meeting was spent discussing proposals for new clinical trials. We also heard progress reports about the RELIEF, Balanced, PADDI and ITACs studies. Opportunities were also presented to collaborate with multi-centre research teams in Europe, North America and here in Australia with ANZICS.

It was great to hear about plans to establish multi-centre trials in obstetric anaesthesia, presented by Associate Professor Nolan McDonnell, Dr Victoria Eley and Dr Nico Terblanche. We also discussed a proposal for a local multi-centre trial in Sydney about the use of sugammadex versus traditional methods to reverse deep neuromuscular blockade, led by Dr Ben Olesnicky from the Royal North Shore Hospital. A frequent topic of discussion was how we are going to find the time, centres and funds to do all these vital studies!

Coogee Beach proved to be a spectacular alternative to our previous venues in far north Queensland. While the weather was nowhere near as warm as it usually is, the sea views were sensational and the foreshore provided a great venue for exercise and relaxation before and after the sessions. It was also a very convenient venue for delegates travelling from interstate and overseas.

When closing the meeting, the ANZCA Clinical Trials Network Executive Chair Professor Kate Leslie congratulated the presenters on their work, pointing out that no other anaesthesia clinical trials network in the world could have presented so many fantastic ongoing studies and proposals. She thanked Sarah Chezan (ANZCA Events), Karen Goulding (ANZCA Clinical Trials Network Manager) and Sofia Sidiropoulos (Research Co-Ordinator Special Interest Group Chair) for organising a fantastic meeting, and invited everyone to the next meeting in 2017.

Professor Kate Leslie
Chair, CTN Executive

Opposite page clockwise from top left: Coogee Beach; Panel discussion with Professor Paul Myles, Professor David Scott, Dr Andrew Leigh, Professor Alan Merry and Professor Britta Regli-Von Ungern; Delegates listening to Dr Andrew Leigh's keynote address; Professor Kate Leslie at the emerging research leaders workshop.

Connecting ANZCA to the global network



Expanding horizons and connecting ANZCA to the global network – International Medical Symposium 2017

Being a world leader requires collaboration, exploration, vision sharing and continually reviewing standards with other experts.

ANZCA's invitation to become a part of the Tri-nation Alliance in 2015 has been very useful for ANZCA and the other participants, resulting in mutually beneficial educational, professional and strategic activities.

The Tri-nation Alliance comprises:

- Australian and New Zealand College of Anaesthetists (ANZCA).
- Royal Australian & New Zealand College of Psychiatrists (RANZCP).
- Royal Australasian College of Physicians (RACP).
- Royal Australasian College of Surgeons (RACS).
- Royal College of Physicians and Surgeons of Canada (RCPSC).

Above from left: The 2016 IMS Program Planning Group for the Day 2 workshop from ANZCA, RACS, RACP, RCPSC and RANZCP; Professor Olle ten Cate addressing the Day 2 workshop meeting on EPAs; International Medical Symposium 2016, Amora Hotel, Sydney.

On Friday March 10, 2017 ANZCA is honoured to be hosting the signature event of the Tri-nation Alliance, the International Medical Symposium, to be held in Melbourne at ANZCA House and other Melbourne venues. This will be a wonderful opportunity for Fellows and trainees of ANZCA and FPM to engage with like-minded individuals from all around the world on educational and professional matters.

A series of presentation videos from the 2016 International Medical Symposium in Sydney, co-ordinated by the RACP, are now available on Networks (www.networks.anzca.edu.au).

They are stimulating, thought-provoking videos, perfectly suitable for the knowledge and skills category of ANZCA's continuing professional development program. The videos cover topics such as:

- Future roles and responsibilities for doctors.
- Doctors and performance at work.
- Diversity in the profession and medical practice.
- The effect of ageing on physicians and their patients.

The program for the 2017 International Medical Symposium will build on previous symposia and focus on leading change in healthcare and the medical profession, including:

- Leading change in the culture of medicine – building respect and improving safety in medicine.
- Leading change in the practice of medicine – evolving scope of practice and competency-based lifelong learning.
- Leading change in healthcare systems – new models and systems of care, for example, in perioperative medicine, medical and surgical oncology.
- Leading change in indigenous health and healthcare across three diverse nations.
- Leading change in postgraduate medical education through evaluation, research and development.

Work is continuing on the themes, the detailed program and invited speakers. We also plan to use social media to keep you all up-to-date – keep an eye out for the hashtag #IMSmelb17. We look forward to welcoming everyone to Melbourne in 2017.

Dr Ian Graham,
Dean of Education, ANZCA

Hong Kong meeting



ANZCA President Professor David A Scott hosted an ANZCA networking evening for Hong Kong Fellows and trainees that coincided with the 16th World Congress of Anaesthesiologists, held at Assaggio Trattoria Italiana in the Hong Kong Arts Centre on Thursday September 1.

Clockwise from top left: Dr Ka Mei May Leung, FANZCA, Dr Si Ning Zhao FANZCA, Dr Scott Chern Yaw Ma, FANZCA (ANZCA New Fellow Councillor), Professor David A Scott FANZCA FFPANZCA (ANZCA President), Dr Chun Kwong Eric Chung, FANZCA and Dr Albert Chan FANZCA; Dr Nicole Phillips, FANZCA (ANZCA DPA ASM), Mr John Ilott (ANZCA CEO), Dr Po Tong Chui FANZCA, Dr Patrick K K Lam, FANZCA, Dr Rod Mitchell, FANZCA (ANZCA Vice-President); Dr David Wilkinson (President of the WFSA who stepped down at the end of the WCA) and in front of him is Dr Maria Moguna (who was sponsored by the Anaesthetic Services Group Victoria), Dr Lisa-Akelisi Yockopua, Dr Nora Dai who is president of the Society of Anaesthetists of PNG and Dr Pauline Wake and Dr Michael Cooper;

Professor David A Scott, FANZCA, FFPANZCA (ANZCA President), Professor Mike Irwin FANZCA (WCA 2016 Convenor), Professor Tony Gin, FANZCA (WCA Scientific Convenor), Dr Nicole Phillips, FANZCA (ANZCA DPA ASM), Dr Mark Priestley, FANZCA;

Dr Phil Lee, FANZCA, Dr Sze Ming Clara Wong, FANZCA, Dr Scott Chern Yaw Ma, FANZCA (ANZCA New Fellow Councillor), Dr Hiu Kwan Jannifer Man, FANZCA, Dr Ted Liu, FANZCA.

Special Interest Group event

2016 Rural SIG meeting



The Rural Special Interest Group (SIG) held its 9th annual meeting from June 17-19. In a slight departure from tradition, the meeting was city-based in Canberra as the ACT lacked a "rural" option. The meeting continues to prove popular and attracted 70 delegates, including many GP anaesthetists.

Rural intensive care was the theme and we were pleased to welcome the immediate past president of the College of Intensive Care Medicine, Ross Freebairn, as the keynote speaker. He was joined by Canberra-based speakers Simon Robertson, Peter Velloza and Karlee Johnston, Victorians Rob Ray and Craig Mitchell, Kenneth Gilpin and James Austin from NSW and Northern Territorian Brian Spain to cover intensive care unit topics ranging from respiratory, circulatory and renal support to toxicology and microbiology and the early management of trauma prior to retrieval.

The final plenary session explored the challenges of staffing rural intensive care units in a post-Faculty of Intensive Care era and maintaining paediatric resuscitation skills without access to

elective lists. Sean McManus (Qld) and Peter Cook (NSW) led the discussions.

Two workshops covered continuing professional development emergency scenarios with an advanced life support simulation co-ordinated by Carmel McInerney and a "can't intubate, can't oxygenate" workshop co-ordinated by Andrew Watson with support from local doctors. Di Khursandi and Sean McManus hosted the final workshop, leading an interesting and, at times, lively discussion on ways to fulfil the practice evaluation aspects of ANZCA's Continuing Professional Development program.

The social events are an important part of the meeting with delegates able to meet old friends and network. The drinks reception on the first night was held in the hotel's roof top bar with views over Parliament House. The dinner was a memorable night held at the Australian War Memorial. Delegates enjoyed a private tour, which included an opportunity to visit the Roll of Honour after dark then dine under the WWII Lancaster bomber, "G for George".

The meeting was a great success and I would like to acknowledge the assistance from Carmel McInerney and Sean McManus for helping put the program together and the great work done by Kirsty O'Connor of the ANZCA Events team and Elodie Garcia, who ensured the smooth running of the meeting.

The 2017 meeting will see the Rural SIG visit WA for the first time, completing a set of meetings in each state and territory. We invite you to join us at the Cable Beach Resort, Broome, from July 7-8 for "Delivering obstetric anaesthesia to the bush".

Dr David Rowe
Convenor and Chair, Rural SIG

Clockwise from top left: The Australian War Memorial; WWII Lancaster bomber "G for George"; Another view of the bomber; Delegates networking at the welcome reception; Delegates dining under "G for George".

CME classifieds

Saturday October 15 8.30am-12pm

Emergency Response Workshop: CICO and Anaphylaxis

Concord Hospital Medical Education Centre, Concord NSW
Cost: \$440
Anaesthesia.CRGH@sswhs.nsw.gov.au
www.advancelifesupport.com.au

October 21 and November 18

Anaesthetic Emergency Responses Workshop - ALS and CICO

Sunshine Hospital, St Albans, Melbourne, Victoria
Cost: \$980
www.whanaesthesia.org/aerw

November 5-6

Princess Alexandra Anaesthesia Conference "Perioperative medicine"

Princess Alexandra Hospital, Brisbane
Cost: \$130 to \$625
http://paac-anaesthetic.eventbrite.com.au

Saturday October 15 9.30am-3.15pm

MEPA FC (Managing Emergencies in Paediatric Anaesthesia - for consultants)

Education Centre, Level 7, Lady Cilento Children's Hospital, Brisbane
Cost: \$450
Stork@health.qld.gov.au

October 29-30

8th Sydney Ultrasound and Regional Anaesthesia Cadaveric Workshop and Masterclass

Macquarie University, NSW
Cost: \$1100, \$990, \$1650
www.surac16.com
rebecca@boss.net.au

April 3, 2017 and August 24, 2017

Paediatric Anaesthesia Crisis Management Course (PACMaC)

The Simulation & Skills Centre at Wellington Hospital in Wellington, New Zealand
Cost: \$NZ1000
wrcsse@ccdhb.org.nz

Advertise your continuing medical education (CME) event for free here

As a service to Fellows and trainees, ANZCA is piloting this "CME classifieds" section in the ANZCA *Bulletin*. Hospitals and other continuing medical education event organisers each have the opportunity to advertise one CME activity for free in the December edition of the ANZCA *Bulletin*. Please email communications@anzca.edu.au for a form. Space is limited, so please submit one activity per hospital and apply now to avoid missing out.



Visiting lectureship presentations

NZ Anaesthesia Visiting Lecturers will speak at the annual lower North Island symposium on Friday November 4 at Whanganui Hospital.

The Whanganui symposium is open to anaesthetists from Taranaki Base, Palmerston North, Hawke's Bay Regional and Masterton hospitals as well as Whanganui Hospital itself. Those planning to attend are asked to advise Dr Nigel Waters (nigel.waters@midcentraldhb.govt.nz) or Dr Marco Meijer (marco.meijer@wdhb.org.nz).

The symposium will feature:

- Dr Benjamin Griffiths from Auckland City Hospital presenting on "Emergency Laparotomy perioperative outcome and quality improvement pathways: A United Kingdom and NZ perspective". This presentation draws on Dr Griffiths' experience in the UK as clinical lead for the design and implementation of an emergency laparotomy quality improvement project including a care pathway.
- Dr Matt Jenks from Dunedin Hospital speaking on "operating theatre waste, climate change and the anaesthetist". Utilising his experiences at Tauranga and Dunedin hospitals, together with an up-to-date review of the literature, Dr Jenks will give practical guidance about how to make anaesthetic practice more environmentally sustainable.

This second lecture replaces one that was to be given by the 2016 visiting lecturer Dr Sabine Pecher, who is returning to Germany for family reasons. She presented her lecture on August 26 at Gisborne Hospital.

Dr Pecher recommends the experience as a two-way learning opportunity. She found it very interesting to hear the perspectives of a team of overseas-trained specialists working in a small isolated hospital, learning about what they struggle with and how they enjoy working in rural New Zealand.

The lectures are provided through the NZ Anaesthesia Visiting Lectureship program, facilitated by the NZ Anaesthesia Education Committee (NZAEC).

Nominations for the 2017 New Zealand Anaesthesia Visiting Lectureship close on September 30, as do expressions of interest in hosting a lecturer next year. More information can be found on the NZAEC website (www.anaesthesiaeducation.org.nz).



Hospital visits begin

ANZCA CEO John Ilott started off a busy round of meetings in New Zealand in June with a visit to Christchurch. ANZCA NZ National Committee Chair Dr Gary Hopgood and NZ General Manager Heather Ann Moodie accompanied him.

This was the first of a series of visits Mr Ilott plans to make to the main hospitals in each of New Zealand's training rotations. The visits are intended to provide an opportunity for dialogue about ANZCA's training program and other initiatives, and for John Ilott to gain a better understanding of the New Zealand scene.

The Christchurch visit involved meetings with the Canterbury District Health Board chief executive officer, its chief medical officer, the anaesthesia head of department, supervisors of training, Immediate Past FPM Dean Professor Ted Shipton, and time with ANZCA and FPM Fellows and trainees.

Professor Shipton was able to show Mr Ilott, Dr Hopgood and Mrs Moodie around the new Burwood Hospital premises.



Lively discussion at joint meeting

There was some in-depth and often spirited discussion at the annual joint meeting between ANZCA's NZ National Committee (NZNC) and the executive of the NZ Society of Anaesthetists on June 24. Topics included:

- The New Zealand workforce including the results of the census, workforce maldistribution and its relationship to the skilled occupation migrant list, and how to help smaller regional hospitals attract applicants for job vacancies.
- The training and qualification pathway for registered nurse assistants to the anaesthetist and anaesthetic technicians.
- Conscious sedation guidelines and the provision of sedation for endoscopy.
- A Ministry of Health presentation about the Therapeutic Products Bill, which will replace the Medicines Act 1981.
- The need to review the format of the NZ Anaesthesia Annual Scientific Meeting and provide further education opportunities.

ANZCA President Professor David A Scott and CEO Mr John Ilott attended the joint meeting as well as the NZNC meeting that followed and the committee's annual dinner where retiring NZNC member Dr Geoff Long was farewelled. The dinner also acknowledged Dr Nigel Robertson on his election to Council and Professor Ted Shipton on completing his term as dean of the Faculty of Pain Medicine.

Above from left: Dr Gary Hopgood talking to clinical directors at their annual meeting; Clinical directors 'speed-dating' at their annual meeting; Dr Sabine Pecher giving her lecture on sustainability at Gisborne Hospital; Dr Gary Hopgood, Professor Ted Shipton and John Ilott at the new Burwood Hospital in Christchurch; ANZCA's NZ National Committee with the ANZCA President and CEO, from left: CEO John Ilott, Dr Geoff Laney, Dr Vanessa Beavis, Dr Kerry Gunn, Dr Lizi Edmonds, Dr Rob Fry, Dr Rachel Dempsey, Dr Nigel Robertson, Dr Jennifer Woods, Dr Gary Hopgood, Dr Sally Ure, Professor David A Scott and Dr Brent Waldron.

Australian news

Australian Capital Territory



Art of anaesthesia – registrations 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. The Saturday program includes presentations on the modern management of what might be considered old chestnuts: reflecting on the current "hoops" of hospital accreditation and continuing professional development (CPD) 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 CPD 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 webpage: www.anzca.edu.au/about-anzca/council-committees-and-representatives/Committees/act-regional-committee/act-regional-events

Scan and ski workshop success

Blue skies and perfect snow conditions greeted the 30 delegates who arrived at Thredbo on July 15 for the inaugural ACT Scan and Ski workshop. The workshop focused on hands-on ultrasound scanning for upper and lower limb, spine, trunk and paravertebral nerve blocks. Six world-class instructors led the delegates through morning and afternoon scanning sessions, while leaving the middle of the day free for skiing or sightseeing. The superb venue, delicious catering, engaged delegates and knowledgeable instructors made this workshop so successful that we are planning to host it again in winter 2018. Watch this space!

A big thank you to the six instructors – Dr Ross Peake, Dr Alwin Chuan, Dr Peter Hebbard, Dr Andrew Lansdown, Dr Brad Lawther and Dr David Scott – for their commitment to the workshop and enthusiastic teaching.

Above clockwise from top: Dr Peter Hebbard leading a group session; Dr David Scott, Dr Alwin Chuan and Dr Brad Lawther enjoying après ski; Dr Andrew Lansdown leading a small group session; Dr Ross Peake leading a small group session.

New South Wales



Thinking ahead – optimising outcomes

The "Thinking ahead – optimising outcomes" meeting was held at the Hilton Sydney on June 18. The meeting attracted anaesthetists from across Australia and New Zealand and was very well received.

Some of the topics that the keynote lectures covered were: Which technique should I plan to use in a CICO situation; Perioperative blood management; New agents in the management of diabetes; Management of preoperative anaemia and the role of intravenous iron; Antibiotics; Planning the extubation of the difficult intubation; and, The problem with central lines.

The PBLDs and workshops as always, were a great success and addressed new techniques and equipment facilitated by expert presenters. A highlight of the workshops was the CICO workshop run by Dr Andrew Heard.

The winner of this year's registrar poster presentation session was Dr Andrew Couch on "Predicting outcome in geriatric major trauma patients – Utility of lean psoas area as an objective measure of frailty".

We congratulate the NSW ACE committee, convenors and NSW ANZCA staff on the success of this event and they are already planning for next year.

Above clockwise from left: Dr Michael Stone facilitating the CPR workshop; Dr Simon Martel and Dr Andrew Couch recipient of the first prize of the Registrars Scientific Session; Dr Greg O'Sullivan and Dr Jenifer Reynolds; Dr Andy Heard facilitating the CICO workshop.



Australian Medical Association Careers Day

Members of the ANZCA NSW Regional Committee and Trainee Committee attended the NSW Australian Medical Association Careers Day on August 6 at the SMC Conference and Function Centre in Sydney.

The day was designed to introduce the various careers available to junior doctors and around 150 junior doctors and medical students attended.

The NSW ANZCA table was well attended with questions ranging from "How do I become an anaesthetist?" to "How do I pass the primary exam?" and "How do I get a trainee job?"

Many thanks to NSW ANZCA staff and doctors who gave up their Saturday to talk about anaesthesia.

Australian news (continued)

New South Wales (continued)

New South Wales Part Zero Course

The ANZCA NSW Regional Committee is pleased to announce the Part Zero Course will be conducted at Royal Prince Alfred Hospital on Saturday March 4, 2017.

The Part Zero Course is aimed at basic trainees in their first year of training or doctors about to take up training positions in 2017. The course covers many topics ranging from how to deal with clinical errors, to what to expect in anaesthetic training and how to look after your own welfare, all delivered in a short and informal format.

The course has been so successful in previous years that many departments have made it compulsory for new trainees.

Look out for the flyers, which will be sent soon to anaesthetic departments across NSW.

The Part Zero Course is free to register.

Auditorium
Kerry Packer Education Centre, Bldg 72
Royal Prince Alfred Hospital
Saturday March 4, 2017
Register your interest: kathrichards@anzca.edu.au

New South Wales Part II Refresher Course in Anaesthesia

The course is a full-time revision course, run on a lecture/tutorial basis and is open to candidates presenting for their final fellowship examination in 2017.

Date: Monday February 6 – Friday February 17, 2017
Venue: Auditorium – Kerry Packer Education Centre
Royal Prince Alfred Hospital
Missenden Road
Camperdown NSW 2050

For information contact: Kathleen Richards

ANZCA NSW Regional Committee
117 Alexander Street, Crows Nest NSW 2065
Email: nswcourses@anzca.edu.au
Telephone: +61 2 9966 9085 Fax: +61 2 9966 9087

Queensland



40th Annual Combined ANZCA/ Australian Society of Anaesthetists Queensland meeting

Brisbane put on a display of beautiful Queensland winter sunshine on June 25 for the 40th Annual Combined ANZCA/ASA Queensland meeting, entitled “Perioperative care of the injured patient”.

We hosted 151 delegates at the always excellent Brisbane Convention and Exhibition Centre, for a very interesting insight into management of trauma from both an everyday but also a statewide perspective. The delegates were mostly ANZCA Fellows, with an increased number of trainees from previous years.

The Director of Trauma at the Alfred in Melbourne, Professor Mark Fitzgerald, gave a fascinating review of the benefit gained by viewing the whole system of trauma management in Victoria as one entity.

This was followed by a presentation from local orthopaedic surgeon Dr Nicola Ward and local anaesthetist Dr Paul Vella, who discussed a program instituted at the Princess Alexandra Hospital over the past nine years to improve access to surgery for patients with a fractured neck of femur.

Dr Cam Mackay and Dr Jayne Berryman presented on the topic of hand trauma and surgery from the view of a plastic surgeon and pain physician, respectively, and a panel discussion was held to allow interaction of the audience and speakers.

The afternoon was devoted to smaller group activities, with options such as a morbidity and mortality meeting, and workshops on upper limb regional anaesthesia and ultrasound, an update on blunt thoracic trauma, and massive haemorrhage.

The meeting was well supported by industry, and we were unable to take any more registrations. The catering was excellent, and the educational opportunities were great. I thank our committee and Ms Ailsa Brown for their hard work in staging this event.

Dr David McCormack
Convenor and Chair, ANZCA/ASA Continuing Medical Education Committee, Qld



Final exam preparation course

The final exam preparation course was held at the ANZCA Queensland Regional Office from July 11-15. Thirty-one trainees from Queensland and other parts of Australia attended the course, which included presentations on a range of topics focused on the content of the final exam. The feedback from trainees who attended was overwhelmingly positive and we wish candidates the best of luck in the upcoming exam. Thank you to all the presenters who made the time to research and present the topics.

Queensland supervisor of training meeting

The second supervisor of training meeting for the year saw 27 supervisors of training and ROTs from all over Queensland come together on June 10 to exchange ideas and discuss common issues. Thanks again to those who were able to attend, and to their departments for making this possible.

During the business meeting in the morning, we discussed hospital and training issues, received reports from the education officer and Queensland Anaesthetic Rotational Training Scheme, and reinforced updates from ANZCA relating to curriculum changes and education.

The afternoon comprised two workshops relating to basic training. The first, “What’s wrong with anaesthesia training” led by ANZCA primary examiner Dr Lachlan Rathie, focused on finding creative solutions to the decrease in hours and volume of cases seen by current trainees compared with previous years. We also discussed ways to encourage the transition to independent practice, and how to assess trainees when the opportunities for assessment are limited by rostering and employment conditions.

The second workshop was a question-and-answer session about the primary exam run by Dr Rathie and Queensland Deputy Education Officer Dr Suzanne Bertrand. Titled “Rules, regulations, remediation and how to approach the primary exam”, the session was a great opportunity for supervisors of training to learn about recent and proposed changes to the exam, and gain some firsthand knowledge and experience from a primary examiner to take back to their trainees. Unfortunately for trainees, it seems there is no easy way to pass the exam, and hard work with a focus on the learning objectives of the curriculum remain keys to a successful outcome.

We look forward to the next meeting in November.

Dr Suzanne Bertrand
Deputy Education Officer, Qld

Opposite page from top left: Dr Jane Beeryman, Dr Paul Vella, Professor Mark Fitzgerald and Dr Nicola Ward engage in a panel discussion; Dr Jane Beeryman; Professor Mark Fitzgerald.

Tasmania



A mélange in the remote heart of Tasmania

Thirty-seven delegates from all areas of Tasmania and Australia travelled to remote Cradle Mountain to attend this year's Tasmanian winter meeting. Weather was typical of the Tasmanian highlands in winter with many attendees looking forward to the forecast snowfalls, which were light but still brought a touch of "winter wonderland".

The Peppers Cradle Mountain Lodge is located at the edge of the World Heritage-listed Cradle Mountain Lake St Clair National Park and provided a warm and cosy venue, with a large open fire to welcome guests.

Feedback from delegates was very positive with many positive remarks on the location and venue. Catering also was of a high standard.

An advanced life support refresher course was again available and received very favourable reviews with participants appreciating the small class sizes, hands-on learning and teaching by experienced and knowledgeable facilitators Dr Sandy Zalstein and Dr Malcolm Anderson.

As the theme "An anaesthetic mélange" suggests, talks were varied with delegates enjoying the variety and professionalism of the presentations.

The morning sessions were mixed and included topics such as "The Crimean War: How modern hospitals began", "What's the cost of humanitarian aid" and "An innovative approach to the use of information technology in anaesthetic practice", as well as an update on the use of intravenous iron supplementation pre-operatively.

The MDA guest speaker Associate Professor Michael Steyn provided an update on closed claims. He then took part in a panel discussion on current industrial issues, including workforce planning and upcoming changes to revalidation.

The afternoon saw three interesting presentations on chronic pain, which provided delegates with new perspectives on management and an awareness of some of the latest research on issues affecting this area.

Meeting convenors Dr Daniel Aras and Dr Peter Wright were delighted with the final outcome and appreciated the contributions of all speakers.

The new Chair of the Tasmanian Regional Committee, Dr Colin Chilvers, thanked Daniel and Peter for their hard work in organising the event and enjoyed the opportunity to network with Tasmanian delegates and interstate anaesthetists. Dr Chilvers said the meeting provided anaesthetists with an interesting professional development opportunity as well as time away with their partner or family in a stunning location.

Planning for next year's meeting has already begun with options for another unique location being considered.

Dr Wright also is convenor of the 2017 Tasmanian Annual Scientific Meeting and encourages everyone to save the dates March 17-19, 2017. Professor Stephen Shafer will be the keynote speaker at the meeting, joining an impressive array of speakers, including Professor Guy Ludbrook and Clinical Associate Professor Marcus Skinner. Workshops, including upper and lower limb regional anaesthesia demonstrated with cadaver specimens, an advanced life support refresher course and an anaphylaxis workshop, will be highlights to the futuristic program.

Social functions include drinks and canapes on the Hobart waterfront on the Friday night, while Frogmore Creek winery will cater for the conference dinner. Registrations are expected to open in mid-October.

Above from left: Peppers Cradle Mountain Lodge; ALS Refresher workshop with Dr Malcolm Anderson (co-facilitator), Dr Brenda Cassidy, Dr Rob Easter, Dr Naoifa Lavin, Dr Sarah Madden and Dr Kylie Wright; Dr George Merridew presenting on "The Crimean War: How Modern Hospitals Began".



Less than 130 years ago, Sir Frederick William Hewitt, a pioneering English anaesthetist soon to become "anaesthetist to the King" (Edward VII), demonstrated that asphyxia was not a necessary component of his practice.

Known for his clinical work on nitrous oxide and his improvements in the design of medical apparatus, Hewitt was able to achieve an effective plane of anaesthesia "without the unhappy concomitant phenomena of stertor, cyanosis and jactitation that were not uncommonly seen (at that time)".

Above: Hobart at night. Photograph by Dr Roger Wong, FANZCA.

How our outlook and expectations have changed, as today we have sugammadex, video laryngoscopes, end tidal control and the iPhone.

Sir Arthur Conan Doyle, creator of the fictional detective Sherlock Holmes, wrote another, lesser-known essay, "Life and death in the blood", in 1883. In this essay he attempted to describe the experiences of an individual who was reduced to less than one one-thousandth of an inch and "while of this microscopic stature, convey himself through the coats of a living artery" to tour throughout the vasculature of the human body².

Now we can perceive the potential development of nanorobots, which can travel in the blood stream and potentially bind and activate or inhibit receptors, such as those for opioids, providing dense analgesia. Nanorobots could activate gamma-aminobutyric acid (GABA) receptors providing loss of consciousness and analgesia or activate receptors at the neuromuscular junction providing muscle relaxation³. Already, for example, a self-propelling "nanocar" has been developed by Tour at Rice University in 2005 measuring three to four nanometers across⁴.

The future of anaesthesia is filled with challenges. How to improve anaesthesia delivery? How to improve patient care? How to reduce the cost of providing anaesthetic services? How to reduce anaesthetic environmental impact? Automation is increasing in our world with the development of driverless cars and robot-staffed hotels (the Henn-na Hotel in Japan). How will these developments affect the future of a specialty that prides itself on being in the vanguard regarding the uptake of new technology?

Futuristic topics will be covered in the combined Tasmanian ANZCA and Australian Society of Anaesthetists scientific meeting being held in Hobart from March 17-19, 2017. Professors including Steven Shafer (Stanford), Guy Ludbrook (Adelaide) and Francis Bowling (Westmead) will discuss topics ranging from new devices, new drugs and new philosophies in the provision of services. Political machinations also may be up for contemplation.

Dr Peter Wright, FANZCA
Dr Peter Unwin, FANZCA
Royal Hobart Hospital, Tas

References:

1. Edwards G, Hewitt, Frederick William (1857-1916), *Ann R Coll Surg Engl.* 1951 Mar; 8(3): pp. 233-245.
2. Arthur Conan Doyle, *Life and death in the blood*, www.arthur-conan-doyle.com/index.php?title=Life_and_Death_in_the_Blood
3. Freitas R. *Pharmacocytes: An ideal vehicle for targeted drug delivery*, *Journal of Nanoscience and Nanotechnology*, Vol.6. 2006; pp. 2769-2775.
4. "Rice scientists build world's first single-molecule car" (2005) www.sciencedaily.com/releases/2005/10/051021021040.htm.

South Australia and Northern Territory



Continuing medical education

Dr Kingsley Storer, an assistant professor in anaesthesiology from Weill Cornell Medical College, New York, has been on a year-long sabbatical in Adelaide and was guest presenter at the June 2016 SA and NT Continuing Medical Education (CME) meeting, “How systems neuroscience can help explain what we still don’t know about unconsciousness under anaesthesia” held at the South Australian Women’s & Children’s Hospital.

Dr Storer outlined the general field of neuroscience and what neuroscience theories exist around unconsciousness and anaesthesia. The exact mechanisms by which general anaesthetic agents induce unconsciousness remain unclear. In particular, loss of consciousness is poorly understood, reflecting our rudimentary understanding of the phenomena of consciousness.

He provided an historical perspective of anaesthesia, including what has been done in the past and some of the limitations of the old approaches, then introduced methodologies that have emerged in the past 10-15 years and are pushing the field of neuroscience.

Dr Storer summarised the study of differences between induction and emergence, which has suggested ways

in which emergence may be actively managed as effectively as induction is now managed.

The presentation also gave insights into the neurological processes that are being modulated daily. Research in this area has the potential to deliver significant clinical benefits, including better monitoring, cleaner and better drugs and the active management of emergence.

The meeting convenor and member of the SA and NT CME Committee, Dr Bill Wilson, was very pleased with the level of attendance, particularly on a cold winter’s night in Adelaide, and said the topic was of great interest to attendees.

The presentation was professionally recorded and distributed to remote South Australian and Northern Territory anaesthesia departments for training and continuing professional development.

Dr Kingsley Storer moved to Manhattan in 2007 to undertake training in anaesthesiology at New York Presbyterian Hospital-Weill Cornell Medical College and after residency joined the faculty of the Department of Anaesthesiology at Weill Cornell. His clinical practice in New York is predominantly in neuroanaesthesia. His research interests are in the use of computational modelling to study the mechanisms of unconsciousness and amnesia related to the GABA-A potentiating anaesthetics.



CEO visits SA

ANZCA Chief Executive Officer John Ilott visited South Australia recently and met with the Director of Anaesthesia and Chair of the SA and NT Regional Committee Meeting at Flinders Medical Centre, Bedford Park.

Mr Ilott also attended the June meeting of the SA and NT Regional Committee, where re-elected and newly elected committee member positions were confirmed. Mr Ilott updated the committee on council and national matters and had an opportunity to expand discussions on improving collaboration between ANZCA and the Australian Society of Anaesthetists (ASA), with the exiting ASA Chair, Dr Simon Macklin.

Above from left: Dr Roger Capps, Dr Tim Porter and Dr Jason Koerber (CME Committee member); Dr Kingsley Storer from Weill Cornell Medical College, New York; Chair of the SA and NT Regional Committee Dr Perry Fabian, ANZCA Vice-President Dr Rodney Mitchell, ANZCA CEO Mr John Ilott and Deputy Chair of the SA and NT Regional Committee Dr Richard Church.



Part Zero Course welcomes new SA trainees

A free course to welcome new South Australian trainees was held at the ANZCA SA and NT Regional Office on Saturday July 23. The session was convened by Dr Laura Willington and was held for rotational trainees starting their training in August 2016 as part of the South Australia and Northern Territory Rotational Anaesthesia Training Scheme (SANTRATS).

The trainees were welcomed by the Chair of the SA Regional Committee, Dr Perry Fabian, and Dr Sam Willis, a consultant anaesthetist and rotational supervisor (SANTRATS), and were guided through the curriculum and College resources with presentations by Dr Christine Hildyard, Dr Marni Calvert and Dr Munib Kiani.

Dr Agnieszka Szremska presented on the upcoming Part 1 Course and Dr Marion Andrews gave a presentation on welfare.

Dr Mark Sinclair from the Australian Society of Anaesthetists (ASA) discussed the benefits of membership of the ASA and encouraged trainees to join.

The trainees and presenters finished off the day with networking and drinks.

Above: Back row from left: Dr David Barlow, Dr James Murtagh, Dr Richard Seglenieks, Dr Matthew Matto and Dr Tim Wonders.

Front row from left: Dr Doris Tang, Dr Rachel Dawson, Dr Laura Willington, Dr Marni Calvert and Dr Munib Kiani.



ANZCA Educators Program

The inaugural ANZCA Educators Program course was held in Adelaide on July 26. The aim of the course was to assist with planning effective teaching and learning in a clinical setting.

The course was presented by Dr Agnieszka Szremska and the session was well received, with participants particularly enjoying the interactive structure.

Above: Dr Cristianne Read, Dr Marni Calvert, Dr Mahdi Panahkhahi, Dr Arpudaswamy Kumar and presenter Dr Agnieszka Szremska.



SA Faculty of Pain Medicine continuing medical education meeting

The SA Faculty of Pain Medicine continuing medical education meeting was held on June 27 on the topic “Irritable bowel syndrome – from research to practical tips for clinicians”. The meeting included presentations from PhD researcher Ecushla Linedale, dietitian Steph Gaskell and clinical psychologist Cathy Martin. It was an informative presentation covering symptoms, diagnosis and management of IBS. Diet options, including low FODMAPs, were discussed, along with the brain-body-gut connection and psychological approaches, such as hypnotherapy and relaxation strategies.

Above: Ecushla Linedale presenting to South Australian members of the Faculty of Pain Medicine.

Victoria



To seek, master and excel

The 37th Annual ANZCA/ASA Combined CME Meeting was held on Saturday July 30 at the Sofitel Melbourne on Collins. The theme was “Trade secrets – to seek, master and excel” and the aims were to cover important and topical peri-operative anaesthetic-related issues.

The first session focussed on updates of current guidelines, including pain, airway and obstetric blood management guidelines. The second and third sessions presented pre-operative and intra-operative issues. The last session was a reflection on our current practice, including opioid management, peri-operative infection control and patient flow improvement with the implementation of ERAS.

Professor Steven Schug was our guest speaker, who flew from Perth specifically to participate in this meeting. We are thankful for his time and interest. The other speakers were selected based on their expertise and different specialities and were drawn from both public and private hospitals. They represented a haematology unit, infection control unit and also a surgical unit. All speakers delivered excellent presentations which were very well received. The overall feedback from the 187 delegates was positive.

Dr Irene Ng, VRC CME Officer



Primary course

This course is run twice per year for candidates intending to sit the primary FANZCA. The most recent course was held from May 30 to June 10. Lecturers generously gave their time and experience and candidates clearly appreciated their academic and clinical gems.

This year we had 62 candidates, a high proportion of whom flew in from inter-state and from overseas; we are now consistently reaching capacity in the auditorium. The final afternoon is a practice viva session, which is an opportunity to start answering primary questions two to three months away from the exam itself. This session was well received by the candidates. Many thanks to the 15 examiners who attended.

Above from left: Guest speaker Professor Stephan Schug (third from left) with session chairs; Delegates enjoying lunch; Dr Peter Howe, lecturer and SOT with trainees; Trainees in the auditorium.

Registrars meeting

The Faculty of Pain Medicine Victorian Regional Committee held its second annual Victorian Registrars Scientific Meeting on August 17 at the College.

This meeting is devoted to the opportunity for those in training and pain medicine to present case studies with a literature review, audit or original research. This is a requirement as part of their training. It also gives an opportunity to fulfil one of the scholar roles another requirement of training.

Four trainees in pain medicine presented over the course of the evening (Dr Gayathri Aravinathan, Dr Bethany White, Dr Chris Woodgate and Dr Jamie Young). The topics were very varied and of high quality. Each presented points for questioning and discussion and were well received.

Our sincere thanks goes to Dr Murray Taverner, who adjudicated on the evening and concluded that Dr Bethany White deserved the prize on the night (pictured above). We were delighted that the President of ANZCA, Professor David A Scott, was in attendance. We will endeavour to hold the registrars scientific presentation at the same time each year. We thank our generous sponsors Seqirus for their support at this meeting.



Dr Diarmuid McCoy
Chair, FPM VRC

Western Australia



Ask the experts in Bunker Bay

The Western Australia Country Meeting will be held from October 21-23 at the Pullman Resort Bunker Bay with a theme of “Ask the experts”. We have invited physician colleagues to discuss some common perioperative problems and how to navigate these patients safely through the perioperative period. These will include cardiologists, respiratory physicians, pain specialists as well as intensivists. We will be running several workshops during the conference, including advanced life support, major haemorrhage and adductor canal blocks.

A guest speaker, Dr Peter Schuller, from Cairns, Queensland, will present to the meeting on his recent study on the effects on muscle relaxation on BIS. Registrations are filling up fast and are available via the ANZCA website.

In 2017, the WA Continuing Medical Education Committee will hold a Cable Beach Country Conference from June 9-11, at Cable Beach Club Resort. The conference will follow a similar structure to the country conference usually held in Bunker Bay.

An emergency responses workshop will be held at Rockingham General Hospital on November 26 and will include advanced life support and anaphylaxis components. Spaces are limited. Please visit the ANZCA WA regional events page for further information.

The Foundation Teachers Course was held in WA from July 13-15 and we thank ANZCA Learning and Development Facilitator Mr Maurice Hennessy for facilitating the course. Dr David Law is facilitating the ANZCA Educators Program in the Perth office on various dates from August to October.

The WA Regional Office also hosted the regional primary and final exams in August.

Balendra Wyramuttoo (“Balu”) Rasiah

1930 – 2016



Balu Rasiah (MBBS [Cey]; DA [Eng]; FFARCS [Eng]; FANZCA) was born in Kandy, Sri Lanka (then known as Ceylon while it was under British rule) on July 20, 1930 and died in Palmerston North, New Zealand on June 16.

The eldest son of family GP Dr Arumugam Rasiah and his wife, Matilda, Balu grew up with his sister Saras and brother Lakshman. Their father sacrificed a great deal to send Balu and his siblings to the best schools in the country and in 1938, Balu was a founding student of St Thomas' Preparatory School in Kollupitiya. During the late 1930s, while his father was studying in the UK, Balu, his mother and his siblings spent a year in Jaffna. Balu also attended Trinity College in Kandy after his father returned to take up a post there.

When the effects of World War II reached Sri Lanka, Balu boarded at St Thomas College Gurutalawa, as Colombo was considered unsafe at that time. Following that disruptive period, Balu attended St Thomas College Mt Lavinia, Colombo for his remaining school years.

Balu was widely read, very informed about world events and a quiet achiever. He was very interested in sports, especially cricket, and was a keen wicket keeper and bowler.

A preferred pursuit would have been history, but Balu went on to study medicine at the University of Ceylon in 1950. He qualified as a doctor in 1956, and married Grace in 1958. Balu completed his internship at Batticaloa, and then commenced his training in anaesthesia at Colombo General Hospital where he passed the primary fellowship exams in anaesthetics in 1961.

Winning a government scholarship enabled Balu to go to Hammersmith Hospital, London, to specialise further in anaesthetics and gain his fellowship of the Faculty of Anaesthetists Royal College of Surgeons (FFARCS). He returned to Sri Lanka in 1963 where he was posted to Jaffna Hospital as a consultant anaesthetist. Balu also worked at Colombo South Hospital and in the neuro-surgical unit in Colombo General Hospital. He was a founding member of the College of Anaesthesiologists and Intensivists of Sri Lanka and much sought after by colleagues for their families and friends. Balu worked for 10 years in Sri Lanka after returning from the UK before leaving to work in New Zealand.

In 1973, Balu saw advertisements in the *British Medical Journal* for consultant anaesthetists at Rotorua, Tauranga and Palmerston North hospitals in New Zealand. He applied for all three vacancies and one day received three cables offering him all three posts. At the time, there was no New Zealand high commission or honorary consulate to advise him on a city, so he and Grace chose Palmerston North, arriving on November 22, 1973, for Balu to take up his post as a consultant anaesthetist.

Colleagues describe Balu as a dedicated anaesthetist, very caring towards his patients and inspiring others by his service. Most of the time he assumed a quiet role in the background, but was known for his very high integrity and calibre and was well respected by his surgical colleagues.

Balu expected the same high standards of work from others and he didn't shy away from making that clear. He was a good teacher and trained many doctors over the years who are now consultants or directors in various hospitals. ICU as an entity was set up in Palmerston North Hospital during Balu's time and, as one of the few full-time anaesthetists on staff, Balu played a role in that process. He retired in 1995.

Balu had a deep interest in jazz. His musical discernment was keen and he enjoyed a good dance to the Sri Lankan Baila.

He was also interested in DXing – a hobby where he listened to radio stations from faraway places such as Uganda, Croatia, Ukraine, Sweden, Tanzania, Ecuador, The Netherlands and Cuba. After listening to these transmissions, he would write detailed reception reports back to those stations, acknowledging he had heard them on his shortwave radio. The radio stations would then write back to Balu as a means of validating his report, often in awe that their transmission had reached around the globe to Palmerston North.

His wife, Grace; children Indira, Ajit and Ishani; and eight grandchildren survive him.

Ajit Rasiah (son)

Alistair John Gray

1965 – 2016



Better known to his family and friends as “Ali G”, Alistair John Gray was born at Wellington Hospital on August 27, 1965, the proud and only son of John and Marjorie Gray. He was the youngest of his family with three older sisters.

His first home was the Makara Radio Station Village, his father being a radio technician with the then NZ Post Office. By the time he started school, Alistair's family had moved to Karori, Wellington, and he attended Karori Normal School before moving on to Wellington College from 1979-1983.

Alistair excelled academically, gaining a junior scholarship, and showed prowess at music and sporting activities. He won events at national level for cross-country running and was a member of the Wellington Youth Orchestra at that time. This was a talent he kept well hidden – many in our department were unaware Alistair even played the violin! His adaptability was well developed by then, he learned to play the trombone just so he could join the jazz orchestra on tour.

Alistair's first occupational choice was as a pilot and he enrolled for training at Ohakea (a NZ Air Force base). He found this did not suit his temperament, however, and he gained entrance to Otago Medical School in 1984. As well as his medical studies, Alistair maintained his interest in music by playing bass in a band named Abdominal Pain.

He transferred to the Wellington Clinical School in 1987, marrying Lorna Searle the same year. Between 1989 and 1991 Alistair began his love affair with travel and new places, working in Edinburgh and Brisbane during this time. In 1992, he returned to New Zealand to begin anaesthesia training at Palmerston North. Gemma was born during this year.

In 1995, Alistair's training brought him to Wellington, where he trained at both Wellington and Hutt hospitals. Jayden was born in 1996. It was during this time that Alistair's warmth and generosity were expressed by being involved with fostering a number of children; Kelly has remained in close contact with the family to this day.

Alistair completed his training in 1997 and moved back to Palmerston North to take up his first consultant position.

The next few years were a time of difficulty both for Alistair personally, and his family relationships. He came through it and met Cath in 2003.

After holding consultant posts in Palmerston North and Hutt hospitals, Alistair took up a consultant position at Wellington Hospital in 2007. Since that time, he has created many friendships, while holding dear the relationships he had formed in Palmerston North.

He was very much an everyman in the anaesthesia world, applying his skills to virtually anything put before him. He was well liked by all and maintained very good relationships with trainees and anaesthesia technicians. One of our trainees described him as “the sort of anaesthetist I want to become”. Who could ask for a better epitaph?

Professionally, Alistair was someone you could rely on, always willing to help out or come to the rescue. His technical ability, handed down from his dad, made him an ideal liaison for all things practical around our department. As a result of this work, he had close relationships with many company reps.

Personally, Alistair lived life to the full. He travelled widely and had the privilege of diving in many of the world's most interesting places, including the Galapagos Islands, Vanuatu, the Great Barrier Reef and our own Deep Cove. He was always planning the next trip and had some marvellous fishing trips with his mates from Palmerston North – photos of the spoils of those trips still adorn our department's walls. He was a keen golfer and, although never reaching his own expectations, had managed a hole-in-one. Perhaps his greatest love was his motorbike, which he would ride to work when on call.

Alistair's happy and inclusive demeanour hid a trouble that he had battled with for much of his adult life. When he recognised the recurrence of his depression, he volunteered that he “thought he had beaten it”. We hoped that this was a reflection of his current contentment in his personal and professional lives.

Sadly, Alistair wasn't able to lift himself out of his last bout of depression and died on Friday April 15. His partner, Cath Haley, children Gemma and Jayden, and stepdaughter Hayley, survive him.

Paradoxically, Ali G was a person who would make you feel good about yourself and had the knack of making you feel comfortable in his presence. He had an ability to connect with everyone he worked with and is seriously missed by his colleagues and friends.

Dr Derek Snelling, FANZCA
Director, Department of Anaesthesia and Pain Management,
Wellington Hospital, NZ

For help or information, visit beyondblue.org.au or spinz.org.nz or call Lifeline (Australia) on 13 11 14 or Lifeline (New Zealand) on 0800 543 354.

More information, including access to Welfare of Anaesthetists Special Interest Group resources, can be found at www.anzca.edu.au/resources/doctors-welfare

Francois Georges Domaingue

1920 – 2016



Francois Georges Domaingue died peacefully after a prolonged period of poor health. His was a long journey, full of achievements, despite humble beginnings and a modest end.

He was born in Mauritius and grew up there as part of a large family. His father, Samuel, had lost most of his assets during the Great Depression and life was not easy. Shoes were a luxury only worn on special occasions.

Georges excelled in his last year at college and won a scholarship to study overseas. With World War II looming, he travelled to England to become a doctor. There he met Hilda Elizabeth (Betty) Haynes, a nurse, and they married in 1946.

In 1947, they had their first child, Charles, and the three returned to Mauritius the same year. Georges worked at the Port Louis hospital for two years to satisfy the conditions of his scholarship. Three daughters, Diana, Irene and Margaret were to follow.

In 1949, the family returned to England for Georges to pursue further studies. He undertook anaesthetic training at Oxford under the tutelage of Sir Robert Reynolds McIntosh, and learnt the new skills of endotracheal anaesthesia. Georges became a Fellow of the Royal College of Anaesthetists (UK) and obtained a diploma in tropical medicine prior to returning to Mauritius in 1947.

In Mauritius, Georges worked for many years as a general practitioner, obstetrician and anaesthetist, and was highly regarded. He even managed a case of tetanus in a young boy. The patient had to be paralysed and ventilated for many days. With no ventilator or any monitoring available, he used his anaesthetic machine to hand-ventilate the patient. He taught the head nun of the clinic how to use the machine, and this allowed him to take an occasional nap. The boy made a full recovery.

Georges Domaingue was a founding member and the first president of the Mauritius Medical Association. This organisation was responsible for the eventual formation of the Medical Council of Mauritius, the equivalent of the medical board.

Working as a solo practitioner was sometimes overwhelming, and he took up sailing to escape the constant demands on his time. If he was at sea, nobody could call.

In 1966, the family migrated to Australia after Georges was offered the position of director of anaesthesia at the Royal Victorian Eye and Ear Hospital. He worked there until 1981. He formed a close relationship with Ralph Clark, the director of Anaesthesia at St Vincent's hospital. Ralph Clark was responsible for Georges being conferred an honorary Fellow of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons (FFARACS).

Despite being across the road from each other, St Vincent's and the Eye and Ear hospitals had no links. Ralph and Georges changed that, gradually increasing the bonds between the two hospitals. The Eye and Ear benefited greatly by obtaining intensive care and resuscitation support from St Vincent's.

Eventually, a tunnel was constructed between the hospitals, and many facilities were shared. Georges came to St Vincent's for a urology list once a week, and in exchange, an anaesthetic registrar from St Vincent's visited the Eye and Ear.

Georges had the dubious honour of anaesthetising for Sir Edward "Weary" Dunlop fortnightly. Dunlop would invariably turn up at 5pm for a 2pm list, and an oesophagoscopy would become an oesophagectomy. Georges would be lucky to get home by midnight, with all the anxieties of leaving a critical patient in a basic ENT ward.

In 1973, Georges helped found the Victorian branch of the Society for the Aid of Children Inoperable in Mauritius. For many years prior, he and his wife, Betty, had been doing the society's work on their own. It included organising the transfer of children from Mauritius, looking after them at home, making the necessary hospital arrangements, and sorting out legal and financial requirements.

Francois Georges Domaingue reluctantly adapted to old age. He developed his computer skills to the point that he managed his affairs online. At the age of 92, he progressed to an iPad. His world now consisted of apps and the cloud. He held online subscriptions to *The Age*, *The Guardian* and *Le Monde*, and downloaded countless books.

Georges had many interests. He read widely and enjoyed classical music, in particular Elgar. He also played bridge, and kept on playing until last year. He was aware of the loss of his faculties due to poor health, and this made him very frustrated.

The last few years were a struggle. For many years, Georges cared for Betty, who was wheelchair bound. She died in a care facility in 2008.

Francois Georges Domaingue is survived by his four children, 12 of his 13 grandchildren, and 10 great-grandchildren.

Dr Charles Domaingue, FANZCA,
Melbourne, Vic