DECEMBER 2016

ANZCA BULLETIN

Research record: ANZCA allocates $A1.7 million

Firm but fair: Putting on the primary exam

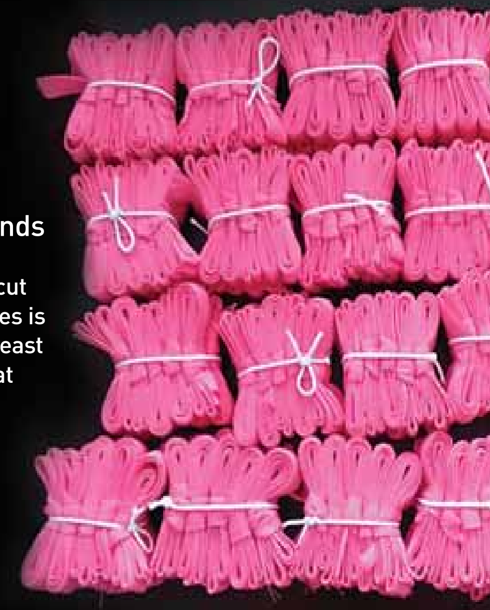
Legalising cannabis: The debate continues

Profile: Michael Cousins, a pain medicine giant

32 **Record research funding**
Associate Professor Jennifer Weller will be the Douglas Joseph Professor in 2017. She is one of several Fellows who shared a record $A1.7 million in research funding from the ANZCA Research Foundation.

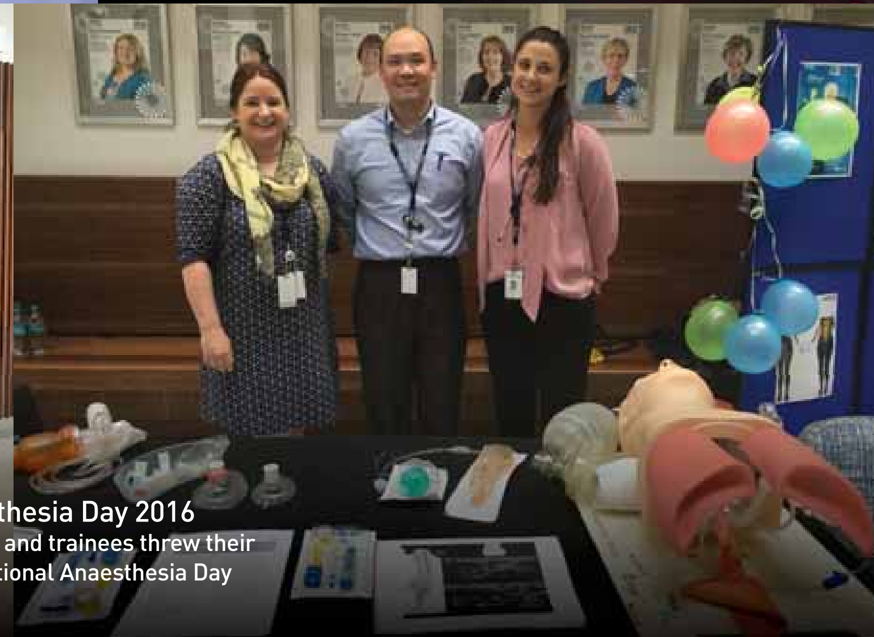
28 **Our CICO position**
ANZCA has clarified its position on can't intubate, can't oxygenate (CICO) front of neck access in response to a statement by the Royal College of Anaesthetists.

80 **Giant of pain medicine retires**
Professor Michael Cousins retired from full-time practice this year. We profile a brilliant career in anaesthesia, but especially in pain medicine.



30 **Ettties raising funds**
One anaesthetist's simple idea for pre-cut endotracheal tube ties is raising money for breast cancer, a disease that means more to him than most.

56 **Explaining the primary exam**
Fellows and College staff work hard to deliver a primary exam that is fair for all trainees who have reached this first milestone in anaesthesia training.



16 **National Anaesthesia Day 2016**
One again, Fellows and trainees threw their support behind National Anaesthesia Day in October.

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: Dr Julia Dubowitz from the Monash Institute Pharmaceutical Sciences in Melbourne, is one of several Fellows to have been awarded nearly $A1.7 million for research projects in 2017.

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 that 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.

Contents

4 President's message
5 Chief executive officer's message
6 Letters to the editor
6 IMGS to become SIMG
7 Awards
10 ANZCA and FPM in the news
12 ANZCA and government: College adds its voice to industry issues
16 National Anaesthesia Day: Anaesthesia 170 years later
18 ANZCA's professional documents: What would you do?
19 Professional documents – update
20 Social media: Join ANZCA in the conversation
23 College improves its accreditation process
25 ANZCA explores a perioperative future
28 Safety and quality: CICO and front of neck access – ANZCA's position
30 Charitable idea improves patient safety
32 Record amount funds anaesthesia and pain research projects
49 ANZCA Clinical Trials Network: ATACAS researchers present final results
50 ANZCA Research Foundation news
54 The importance of feedback in learning
56 Behind the scenes of the primary exam
58 Canadian post brings invaluable experience
61 Training program improvements for 2017
62 Preparing for provisional fellowship
63 Fellows present training research in Barcelona
64 Mentoring: A trainee's perspective
66 Committee provides voice for trainees
67 Successful candidates
73 FPM: Dean's message
74 Evidence supports use of "medicinal" cannabis
78 Pain researcher wins Women of the Future award
80 Honouring a giant in the field of pain medicine
84 Overseas aid: Unrest brings healthcare challenge in PNG
86 Lifelong learning essential to consultant anaesthetists
88 What's new in the library
92 Special Interest Group events
96 New Zealand news
98 Australian news
105 Obituaries
107 Future meetings

President's message

Perioperative medicine – we are not alone

In the specialties of anaesthesia and pain medicine we realise the care we provide for our patients is not done in isolation, nor is it confined to the important intraoperative period.

The need for more comprehensive, planned and integrated care for older and sicker patients was highlighted in the extremely well attended Perioperative Medicine Special Interest Group (SIG) meeting held in Noosa in October.

It was the largest Perioperative Medicine SIG meeting ever, with 350 attendees, almost a third of whom were not anaesthetists! This highlights the willing engagement and interest of other specialties. A strategy workshop was held on the morning preceding the meeting, contributed to by anaesthetists, physicians, surgeons, intensivists and many geriatricians. Anaesthetists are already skilled in perioperative care, but clearly there is a need to extend this practice for many patients, and to develop greater skills in interested clinicians of all specialties.

Our College is leading a collaborative approach to perioperative medicine, based on sound fundamentals in training, strong support for continued learning, and the opportunity for more intense skills and knowledge development. ANZCA Council has recently approved the development of a framework that aims to enable the College to help those interested in higher skills in perioperative medicine to achieve formal credentials. This will be a big and important step forward for our specialty and we intend to ensure it is achieved in a consultative and effective way. See page 25 for an article by the Chair of the Perioperative Medicine Working Group, Dr Sean McManus.

Medicare Benefits Schedule review

The Department of Health in Australia is undertaking a widespread review of Medicare item numbers, which looks at their appropriateness, ease of use, potential for misuse and what changes or additions need to be made. The review committee for anaesthesia has been established, and I met with the Chair of the Medicare Benefits Schedule Review Taskforce, Professor Bruce Robinson, and the head of the Anaesthesia Clinical Committee Associate Professor Jo Sutherland at ANZCA House, along with Associate Professor David M Scott, the President of the Australian Society of Anaesthetists (ASA).

The clinical committees are "balanced" by many non-anaesthetists in their memberships, which aims to avoid conflicts or bias. However, it is important they are well informed. To that end, we discussed the importance of the Relative Value Guide and established that it was well designed in principle and fit for purpose, especially with flag-fall items that were uncoupled from the actual surgical details.

One of the points emphasised by Professor Robinson was that the taskforce considers that the Medicare Benefits Schedule should be structured to encourage and reward good clinical practice, and we explained how, for example, preoperative consultation items do just that.

The College does not see its role in planning fees or item number structures – the ASA has the expertise and imprimatur in those areas. However, schedules such as the Medicare Benefits Schedule should reflect appropriate evidence-based practice backed up by sound clinical judgement because these schedules influence (or guide) clinical behaviour.

It is therefore important that decisions made relating to these matters are well informed and underpinned by College standards, and safety and quality data, which we are keen to provide.

National Anaesthesia Day

Elsewhere in this *ANZCA Bulletin* (page 16) is a full report on the very successful National Anaesthesia Day, which was held on Monday October 17 throughout Australia and New Zealand.

Our theme of "Is regional anaesthesia for you?" enabled some really good and constructive engagement with media and our patients. An ultrasound machine in the hospital lobby certainly creates interest!

Curiously, the World Federation of Societies of Anethesiologists sponsored World Anesthesia Day, promoted on October 16, also was themed on regional anaesthesia – this was a helpful coincidence!

I want to thank all the Fellows who participated for their enthusiastic and creative contributions, and also the terrific College Communications team, who put together all the promotional materials and strategies, and worked so effectively with the media to help get our message out. This was yet another opportunity to advocate for our specialty and improve public understanding of our vital role.

It has been said in the past that we are an "invisible" specialty. This is changing dramatically with preoperative and postoperative engagement by specialist anaesthetists in public and private practice, including acute pain management, and in inter-specialty consultation. Every National Anaesthesia Day provides an opportunity to achieve these goals in a structured way. Every day in practice can be another contribution to the foundations of our specialty.

Professor David A Scott
ANZCA President

Chief executive officer's message

ANZCA's Strategic Plan 2018-2022 – setting our future direction

Our inaugural ANZCA Strategic Plan 2013-2017 has proven to be a positive guide to ANZCA's direction over the past four years. Next year represents the end of the planning period and, of course, it gives us an opportunity to review and develop a new five-year plan looking ahead to 2022.

We should all feel a sense of pride when we look back at what has been achieved since 2013. Through the collective skill, commitment, expertise and experience of Fellows, trainees and staff, the College has met the objectives set out in the strategic plan 2013-2017. A snapshot of these achievements is published on our website under "news" on the home page and includes:

- The revised anaesthesia training curriculum implemented at more than 170 training sites (2013).
- More than $A5 million allocated in research grants (2013-16).
- Rollout of the revised ANZCA Continuing Professional Development (CPD) Program and new online CPD portfolio system (2014).
- Launch of the Faculty of Pain Medicine's revised curriculum and training program (2015).
- Highly successful annual National Anaesthesia Days, which have attracted high levels of Fellow input and attracted extensive media coverage (2013-16).

The strategic plan is an excellent guide to how we work together, what we aspire to achieve, how we collaborate with others, nationally and internationally, and how we determine and shape our preferred future as a dynamic, engaging and world leading medical College.

Early work has begun on developing the new strategic plan 2018-22 with an emphasis on building on our achievements and success over the past four years, maintaining our mission and vision, reviewing our strategic priorities and evolving our objectives.

Developing the 2018-22 strategic plan will seek wide participation and include a variety of approaches to ensure broad consultation with Fellows, trainees, staff, the Faculty of Pain Medicine, New Zealand and other important stakeholders.

Consultation will begin in early 2017 when the first survey will be distributed seeking your ideas about the direction of the College. We also will be conducting workshops with the Australian regional committees, FPM, the New Zealand National Committee and others. We will undertake phone interviews, run focus groups and mini workshops, and will encourage your input at the appropriately themed "Think big" 2017 annual scientific meeting in Brisbane. We are confident there will be plenty of opportunities for you to contribute before the new strategic plan is completed towards the end of next year and launched in 2018.

FPM will also review its current strategic plan using a similar approach to ANZCA. The FPM strategic plan 2018-2022 will be developed focusing on priority areas for the faculty most importantly recognising the continuing work to consolidate the specialty of pain medicine. There will be no conflict between ANZCA and FPM priorities with the plans being broadly aligned.

If you have ideas you would like included in our discussions, please send them to me at ceo@anzca.edu.au.

Foundation supporting research

At its meeting in September, the ANZCA Research Committee awarded a record $A1.7 million through the ANZCA Research Foundation to fund research. This is an increase from $A1.46 million in 2016.

The College's prestigious 2017 quadrennial Douglas Joseph Professorship was awarded to Associate Professor Jennifer Weller, University of Auckland.

The Academic Enhancement Grant was awarded to Professor Eric Visser, University of Notre Dame in Western Australia. Professor Visser was advised he had won the award one day before speaking at a reception celebrating his appointment as the inaugural Churak Chair of Chronic Pain Education and Research at the University. At the function, Professor Visser and Vice Chancellor Celia Hammond both mentioned the Academic Enhancement Grant as an important, independent validation of the work of the new chair, which involves a pain medicine program collaboration between Notre Dame University and Murdoch University's Centre for Research on Chronic Pain and Inflammatory Diseases.

In addition to the Academic Enhancement Grant, two important new honorary research awards have been awarded for 2017 – the inaugural Elaine Lillian Kluver bequest, following the late Dr Kluver's generous bequest of $250,000, and the new Provisional/New Fellow Research Award, made possible through a generous endowment in 2014 from past Dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons (RACS) and former ANZCA Dean of Education, Professor Barry Baker.

Letter of agreement with RACS

ANZCA Council has approved a letter of agreement to be signed with RACS, stating "a shared commitment to providing high quality training and a safe shared working environment to their respective trainees, Fellows and international medical graduates". Our colleges have a shared interest in dealing with discrimination, bullying, and sexual harassment, and we have agreed to collaborate in addressing these issues.

Key points contained in the letter of agreement include that the colleges will:

- Support each other in activities that promote respect, and counter discrimination, bullying and sexual harassment and improve patient safety.
- Share information and resources regarding the education and training available in relation to discrimination, bullying, and sexual harassment.
- Collaborate on the development of programs and processes to deal with discrimination, bullying, and sexual harassment in the health sector.
- Support each other's initiatives to foster greater diversity within each other's specialty and share information and models for flexible training and other models that reduce impediments to a more diverse workforce in training.
- Work together to ensure that supervisors and unit heads have the necessary skills and are supported to provide training, assessment, feedback and support to trainees and IMGSs free of discrimination, bullying and sexual harassment.

I would like to acknowledge the generosity of RACS in their willingness to share their considerable work with us and other medical colleges.

John Ilott
Chief Executive Officer, ANZCA

Letters to the editor

NSW Government defends medicinal cannabis law

I write in response to the article "When advocacy and legislation move ahead of evidence: the 'medicinal' cannabis story" and accompanying editorial, which appeared in the September 2016 *ANZCA Bulletin*.

The article and opinion piece urge caution, while the latter quite rightly argues that anaesthetists "do not have a responsibility to support community advocacy or legislation that is out of step with the evidence".

I assure you this position is entirely consistent with that taken by the NSW Government.

That is why we have invested $9 million in clinical trials to advance our knowledge of what role medical cannabis might play in providing relief to children with drug-resistant epilepsy, end-of-life palliative care patients, and patients who experience chemotherapy-induced nausea and vomiting.

There's already some pre-clinical or clinical evidence that medicinal cannabis may help some patients with these conditions; however, our clinical trials will provide the evidence we need to better understand and evaluate the therapeutic benefit of medicinal cannabis products.

The product to be used in the trial involving palliative care patients is provided by Bedrocan, a licenced producer in the Netherlands. The product being used in the trial involving chemotherapy patients is from Canadian company Tilray and the products to be trialled for children with drug-resistant epilepsy are being produced by GW Pharmaceuticals.

But while this research is continuing, the calls from within the community for some of our most vulnerable – those who are very sick or dying – to be given immediate access to medicinal cannabis grow louder.

I have read hundreds of letters from people suffering from debilitating medical conditions, and their loved ones, who believe cannabis might be their last hope or that their illicit use of cannabis provides them some relief.

The NSW and Commonwealth governments are regulating access to unregistered cannabis-based medicines in the same way they regulate other unapproved therapeutic goods. The *Commonwealth Therapeutic Goods Act* allows for the use of unregistered products in clinical trials, and through the existing Authorised Prescriber and Special Access Schemes. New regulations applying to the prescription of certain unregistered therapeutic products in NSW, including medicinal cannabis products, took effect on August 1 this year. This allows doctors to apply to NSW Health for authority to prescribe cannabis-based products, which also must be approved for supply through the Commonwealth schemes.

This allows doctors to discuss with their patients – in the situation where common treatments are proving ineffective and the potential benefits outweigh potential risks – whether a lawfully produced cannabis-based product might be suitable for them to try.

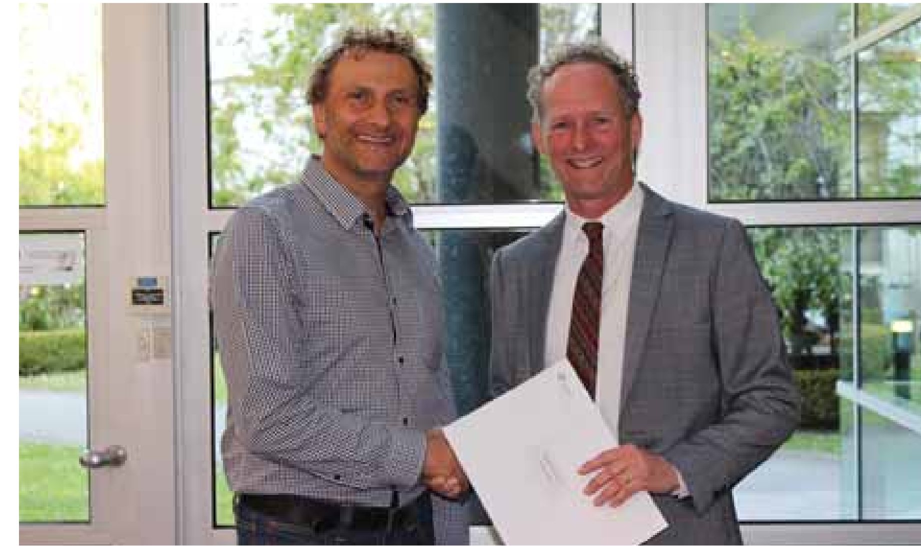
It's expected that a medical professional prescribing a cannabis product would most likely be a specialist in the treatment of the condition for which the product is being requested. Of course it is open to any specialist in these circumstances to reject the patient's request to prescribe a cannabis product and, in the absence of scientific evidence, it would be unsurprising if this did not occur.

I trust this reassures anaesthetists and other clinicians that the NSW Government is pursuing precisely the course of action modern medical science would expect of us. It is not the first time that a plant's medicinal properties will have been converted to clinically appropriate drugs, and it is high time that researchers were able to get on with testing a century of patients' stories in a way that will meet the standards of modern western medicine.

The Honorable Pru Goward, MP
NSW Minister for Mental Health
NSW Minister for Medical Research
NSW Assistant Minister for Health
NSW Minister for Women
NSW Minister for the Prevention of Domestic Violence and Sexual Assault

Professor Laurence Mather presents his view on "medicinal cannabis" on page 74.

Awards



Personal approach wins welfare award

Dr Ian Balson of the Royal Women's Hospital in Melbourne has won the Ray Hader Award for Pastoral Care for his contribution to trainee welfare.

During his training and early years as an anaesthetist, Dr Ian Balson noticed that if a doctor experienced personal issues, or was involved with an adverse event or death, the medical world was not an empathic place to be. Anaesthetists were often left to cope by themselves. So later, once qualified, Dr Balson made a point of contacting registrars and consultants who were exposed to any of these issues, to invite them for a coffee or a chat.

He decided that the public hospital in which he worked the most, the Royal Women's Hospital in Melbourne, would benefit from a more structured program of support for trainees. So he did a post-graduate diploma in psychotherapy and counselling and set up a mentoring program at the hospital in 2013. He also routinely offers a kind ear and support to colleagues.

"They may feel very isolated from the medical community when these events occur and are often very vulnerable, sometimes for the first time in their medical career," Dr Balson said.

Dr Balson is this year's recipient of the Ray Hader Award for Pastoral Care for his work. The award is named after Dr Ray Hader, a Victorian ANZCA trainee who died of an accidental overdose in 1998 after a long struggle with addiction. Dr Hader's friend, Dr Brandon Carp, originally established the award in his memory. Dr Balson, who happens to have known Dr Hader, was recognised for his direct personal support and encouragement of trainees, as well as for the mentoring program and for raising awareness of mental health issues.

Dr Balson was nominated by colleagues at The Women's, led by Associate Professor Alicia Dennis. Since 2013, 98 trainees and Fellows have participated in his mentoring program, Associate Professor Dennis wrote: "The nature of a women's hospital means that traumatic clinical issues arise from time to time. These events include neonatal deaths, stillborn babies, maternal suffering and death, gynaecological cancer in young women, and family and sexual violence issues. Having both formal and informal trainee psychological support built into the department's structure, through Ian's work, means that hopefully no one gets left behind regarding their psychological needs."

Under the mentoring system, Dr Balson receives feedback from both trainees and consultant anaesthetists and confidentially manages issues and concerns, as well as liaising formally with the leadership team when required.

"Ian is very modest and, because of his dedicated passion for the welfare of trainees, has taken on this role in his own time and without consideration for any recognition or acknowledgement," Associate Professor Dennis wrote.

Dr Balson receives $A2000, to be used for training or educational purposes, and a certificate. He will use this to attend a further learning module on loss and trauma and to do a five-year follow-up of the registrars who have been through The Women's training scheme.

Above: Dr Brandon Carp presents Dr Ian Balson with the Ray Hader Award for Pastoral Care.

FPM recognised internationally

The Faculty of Pain Medicine, ANZCA is the recipient of the American Academy of Pain Medicine's (AAPM) Robert G Addison, MD Award.

The award recognises outstanding efforts to foster international co-operation and collaboration on behalf of the specialty of pain medicine. The academy recognises only a few recipients for their outstanding contributions to the field of pain medicine each year.

A Faculty representative will attend the AAPM Annual Meeting in March 2017 in Orlando, Florida to receive the award.

See also the FPM Dean's message on page 73.

Museum wins prestigious award

The Geoffrey Kaye Museum of Anaesthetic History was awarded the 2016 David M Little Jnr media prize under the category of Best Media of 2015 for its online exhibition "Trailblazers and Peacekeepers: Honouring the ANZAC Spirit" at the Anesthesia History Association dinner in Chicago (part of the American Society of Anesthesiologists annual meeting) on October 26.

The exhibition was acknowledged particularly for its clever and creative design.

The "Trailblazers and Peacekeepers" exhibition was judged the best of the five finalists to win the international award. We thank Honorary Curator Dr Christine Ball and Museum Curator Ms Monica Cronin for their hard work, and the many exhibition contributors who allowed us to use their personal stories about working in conflict and emergency relief zones.

Above: Dr Declan Scott, a Wirlomin Noongar man, has won the 2016 Gilbert Troup prize.

Indigenous student wins anaesthesia prize

An Indigenous medical student has won the 2016 Gilbert Troup prize for Western Australia's best performance during the anaesthesia rotation.

Dr Declan Scott, a Wirlomin Noongar man, was presented with the $A500 prize at his graduation ceremony at the University of Western Australia in November.

"It was an immensely proud moment," Dr Scott said.

"I got into medicine through the Aboriginal entry pathway; you do a summer course, and if you do well enough in the exams, you get into medicine.

"So this prize also recognises all the work done by the School of Indigenous Studies, which leads students through high school and then mentors, tutors and supports us through our university courses. All the faith and energy and effort they have put into me over the years has paid off."

The Chair of ANZCA's Indigenous Health Committee, Dr Sean McManus, also saw the win as evidence of the worth of alternative pathways to help Aboriginal students gain access to medicine: "These programs that chip away at disadvantage sometimes get a win, and that particular person can go on and inspire a whole generation of people of Indigenous backgrounds to believe they can do it," Dr McManus said.

Dr Scott would like to become a specialist and is deciding whether to choose anaesthesia or an anaesthesia-related specialty, such as intensive care or emergency department work.

"I change my priority regularly but there's a lot I like about anaesthetics and anaesthetists, so that is currently at the forefront," he said.

New Zealand's Minister of Health Dr Jonathan Coleman presenting ANZCA trainee Dr Mark Fisher with the top prize in the new ideas category of New Zealand's 2016 Clinicians Challenge.

Trainee wins award for surgery "smart" system

An ANZCA trainee has won the top prize in the new ideas category of New Zealand's 2016 Clinicians Challenge, which is held annually to encourage innovative IT solutions to improve healthcare.

Dr Mark Fisher, who will take up a provisional fellowship at Middlemore Hospital in Auckland next year, won against 21 other entries in the new ideas category for his shared preoperative workbench for elective surgery initiative.

Presenting the award on November 2, New Zealand's Minister of Health Dr Jonathan Coleman said: "Winning this year's Clinicians Challenge is a significant achievement given the quality of entries received.

"The competition fosters creative thinking and encourages frontline healthcare professionals to find new ways of using digital health solutions.

"It's great to see clinicians making better use of IT to deliver more timely, quality patient care, as well as improving staff productivity."

Dr Fisher's smart system replaces current paper and Excel spreadsheet systems with an intuitive dashboard view of the patient journey, and their progress in the booking system. It populates worklists for services, with flagged resource dependencies.

He said its aim is to improve efficiency through better handling of patients within the booking system, and more reliable service co-ordination on the day of surgery.

"Auditing of time-stamping at booking, clinics and other events provide easy feedback to any delays in accessing elective surgery. This digital system combines worklists and plans of all services into a common workbench," he said.

Dr Fisher receives $NZ8000 to develop his idea.

The Clinicians Challenge is a joint initiative by the Ministry of Health and Health Informatics New Zealand.

ANZCA and FPM in the news

ANZCA and FPM have been active in the media over the past few months.

Faculty of Pain Medicine Spring Meeting

ANZCA issued five media releases on talks being given at the FPM Spring Meeting in the Adelaide Hills in September. Topics included the safety and efficacy of medicinal cannabis, the dangers of spinal fusion surgery, and the use of acceptance and commitment therapy to treat post-traumatic stress disorder (PTSD) and to manage pain.

Dr Phillip Crowley's critique of the testing of cannabis on children ran first in *The Age* (96,000 readers) and was syndicated to another 95 mastheads across Australia, including the *Sydney Morning Herald* and the *Canberra Times*. He also was interviewed by radio Newstalk ZB in Auckland. Dr Gary Franklin's warning about spinal fusion surgery for patients with lower back pain appeared in the *Herald Sun* (330,000 readers) and was syndicated to the *Courier-Mail* in Brisbane.

Dr Nick Ford's work on acceptance therapy and PTSD was reported in the *Border Watch*, SA. Dean of FPM Dr Chris Hayes spoke to ABC Newcastle, Darwin, ABC Tamworth and radio 2HD in Sydney regarding the dangers of medicinal marijuana. Dr Dilip Kapur's warning that marijuana has not been proved effective in the treatment of pain led to interviews with Newstalk ZB, Auckland, and Radio 3AW, Melbourne, as well the healthtimes website in New Zealand. John Baranoff's paper on acceptance therapy being used for chronic pain ran on scoop.co.nz.

Other media

FPM Dean Dr Chris Hayes sparked a debate in Newcastle, NSW, when he was reported on September 14 urging caution about the "rush" to introduce medicinal cannabis. The *Newcastle Herald* then ran an editorial arguing that Dr Hayes' concerns needed to be addressed by those pushing for the legalisation of cannabis. The debate in the paper continued on September 15 with another news article in which Dr Hayes was requoted amid criticism from cannabis advocates. He then followed up with his own opinion piece on "Medical cannabis: When compassion is not enough", which ran on October 27. The *Newcastle Herald* has 25,735 readers.

Dr Aidan O'Donnell was quoted in a story on women's website Broadly on the question of delirium following pain relief in childbirth on September 21. The same day, ANZCA Fellow Dr Michael Fanshawe was interviewed for 20 minutes on 612 ABC Brisbane on "being an anaesthetist" (audience 19,100). On September 23, Professor Stephan Schug co-authored a 2000-word article in *Australian Doctor* on two new opioids.

Dr Robin Youngson, a New Zealand Fellow and founder of Hearts in Healthcare, was interviewed for a podcast by an American medical website, thedoctorparadox.com, on compassion and physician burnout. He also has a new TedX talk on YouTube called "Perfectly broken and ready to heal".

On October 24, Associate Professor Silvana Marasco was interviewed by the *Herald Sun* on a study done at The Alfred with Professor Paul Myles on the effects of TXA on cardiac surgery patients. The story ran in both the *Herald Sun* in Melbourne (331,715 readers) and the *Hobart Mercury* (31,522).

On October 30, FPM Vice-Dean Dr Meredith Craigie was interviewed for an article on alarms about children being prescribed opioids. It ran in the *Sydney Morning Herald*, the *Sun Herald* and the *Canberra Times*, reaching a total audience of 452,434.

And on November 2, Cecil Gray Prize recipient Dr Adam Mahoney was interviewed on 936 ABC Hobart for five minutes.

Karen Kissane
Media Manager, ANZCA

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

- **15 print reports.**
- **10 radio reports.**
- **Six online reports.**

Please note: This does not include National Anaesthesia Day media coverage. Please see page 16.

Media releases since the previous *Bulletin*:

Thursday September 15:

Sharing prescription opioids with others is risky, patients warned.

Medicinal cannabis a danger to children and teens, expert warns.

Friday September 16:

Buddhist-style 'acceptance' helps PTSD symptoms, research finds.

New psychotherapy helps people deal with chronic pain.

Surgery for lower back pain can cripple, patients warned.

Monday October 24 (joint release with The Alfred):

Drugs cut bleeding after open-heart surgery without triggering stroke: new study.

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

Only ANZCA Fellows can be FANZCAs

FANZCA – recognised worldwide that you are a specialist of the highest professional standing.

All Fellows of ANZCA are entitled to use the FANZCA logo – on stationery, email signatures and slides.
For further information: **www.anzca.edu.au/fellows**

FANZCA Fellow of the Australian and New Zealand College of Anaesthetists

College adds its voice to industry issues

Australia

National medical training survey

The Council of Australian Governments (COAG) Health Council has commissioned an independent National Review of Medical Intern Training. The review is examining the current medical internship model and will consider reforms to support transition into practice, and further training, to ensure the workforce is well trained, fit for purpose and equipped to meet changing health needs. The reviewers note that while the recommendations will focus on internship, postgraduate training is a continuum.

On August 26, a workshop was held in Melbourne to consider the value and applicability of a national training survey across the prevocational and vocational training continuum. The discussion identified that a national medical training survey would be useful in supporting accreditation, monitoring trainee welfare and in continuous quality improvement processes. Participants strongly supported a national training survey in Australia, but identified challenges and issues that would need to be overcome during implementation. Sarah Kleinitz (Manager Policy) and Michelle McKenzie (Curriculum Officer) represented ANZCA at the workshop.

For further information or to view the National Medical Training Survey Background Paper and Final Report, visit www.coaghealthcouncil.gov.au/MedicalInternReview.

Medical Board of Australia: revalidation

On September 6, representatives from the Medical Board of Australia (MBA), including the Chair of the MBA, Dr Joanna Flynn, and the Chair of the Expert Advisory Group on Revalidation, Professor Liz Farmer, visited ANZCA to meet with senior Fellows and staff. The meeting discussed the MBA's proposed options to support medical practitioners to maintain and enhance their professional skills and knowledge and to remain fit to practise medicine. The MBA has adopted the term "revalidation" for this process.

In Australia, a two-by-two approach to revalidation is proposed:

Two parts:

- Strengthened continuing professional development.
- Proactive identification and assessment of "at risk" and poorly performing practitioners.

Two steps:

- Engage and collaborate in 2016.
- Recommend an approach to pilot in 2017.

ANZCA has lodged a feedback submission on revalidation to the MBA.

Further information about the revalidation proposal is available at www.medicalboard.gov.au/News/Current-Consultations.aspx.

Government programs

The Australian Department of Health opened the Specialist Training Program (STP) and Integrated Rural Training Program Expression of Interest (EOI) online portal for the month of November. The EOI portal enabled training sites to register their interest in STP and IRTP-funded posts. Any training sites accepted through this process will be registered on the STP and IRTP reserve list for 2017 and beyond. ANZCA staff undertook end-user testing to support the Department of Health prior to the online portal opening.

The Department of Health has provided the specialist colleges with the STP deed of variation, which will include the Integrated Rural Training Pipeline funding agreements for 2017. ANZCA will provide training sites with their funding agreements as soon as possible.

The STP 2016 engagement strategy culminated in September with a visit by ANZCA staff to the Alice Springs intensive care unit. The unit is funded for a STP College of Intensive Care Medicine trainee.

The post has been funded since 2011 with many past trainees progressing to fellowship.

ANZCA continues engagement with external organisations to ensure the College interests are considered as other government programs are implemented. In November, ANZCA was invited by Aspen Medical to participate on the steering committee for the Rural Locum Assistance Program (Rural LAP). This program provides rural support services to GPs, nurses and allied health professionals and specialists (obstetricians and anaesthetists), in rural and remote Australia. Discussion centred around governance and changes in the program framework.

New Zealand

Stakeholder meetings

In September, the Chair of the NZ National Committee, Dr Gary Hopgood, and ANZCA staff attended the quarterly Council of Medical Colleges meeting. At the meeting, a representative from the Pasifika Medical Association discussed the need for specialist colleges to think about how they can encourage more Pacific people to train as doctors and specialists, and the barriers and demands faced by Pacific medical students and doctors. Ministry of Health representatives discussed progress on the ministry's information technology strategies and work program, and the chair of the Medical Council of New Zealand discussed the council's recent review of its guideline on *Providing care to yourself and those close to you*.

In October, ANZCA Fellows and staff attended the Medical Council of New Zealand's annual Vocational Educational and Advisory Body meeting. Topics discussed included a review of changes to prevocational medical training, including the development of a curriculum framework for postgraduate year one and postgraduate year two, extension of supervision into postgraduate year two, introduction of ePort, and commencement of community-based attachments. Te Ohu Rata o Āotearoa also presented about its project to develop a cultural competency and evidence-based assessment framework, which can be used by medical schools and vocational colleges for training and recertification programs. A panel discussion was held about building a culture of respect. The Royal Australasian College of Surgeons has developed an action plan with emphasis on leadership by Fellows, the need for collaboration among professionals and organisations, and providing a safe environment for staff and patients. Details and publications are available here.

In November, the New Zealand Minister of Health Dr Jonathan Coleman attended the New Zealand National Committee meeting to discuss issues affecting the New Zealand anaesthesia community.

Jo-Anne Chapman,
General Manager, Policy,
Safety and Quality,
ANZCA

ANZCA submissions

Australia

- Queensland Health – Planning framework for Highly Specialised/Complex Services (Part 2).
- Department of Health – Draft finding report from the review of the Specialist Training Program.
- Department of Health – Australian National Guidelines for the Management of Health Care Workers known to be infected with blood borne viruses.
- Australian Commission on Safety and Quality in Health Care – A safety and quality model for colonoscopy.
- Australian Orthopaedic Association Ltd – Revised draft curriculum.
- National Health Practitioner Ombudsman and Privacy Commissioner – Independent review of chaperones to protect patients.

New Zealand

- Minister of Health – briefing for his attendance at the November New Zealand National Committee meeting
- Health Quality and Safety Commission: Atlas of Healthcare Variation: Domain of opioids sector.
- Health Workforce New Zealand – Health of the Health Workforce Report 2016.
- Pharmac – 2016-17 Invitation to Tender.
- Pharmac – Medical devices: possible Pharmac categories.

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

NZ health minister not obsessed with health targets

While the government has set health targets to improve waiting lists, New Zealand's Minister of Health, Dr Jonathan Coleman, told ANZCA's New Zealand National Committee he was not obsessed with meeting those targets at any cost.

Dr Coleman spent about 45 minutes answering questions at the committee's November meeting.

His comments followed an expression of concern that acute cases were not being accepted for surgery because hospitals were reluctant to postpone scheduled elective surgery when they risked failing to meet set targets.

The minister said it was more important to see that "the best care gets to the right people" and he would be concerned if targets were overruling that.

Professor Ted Shipton, speaking as chair of FPM's NZ National Committee, posed the dilemma of how to attract funding for pain medicine training posts when Health Workforce New Zealand had no mandate for funding secondary fellowship training. Dr Coleman said the Faculty needed to make a strong business case to the government, demonstrating how having more pain medicine specialists could reduce the number of people on welfare because of chronic pain conditions.

Other topics included alternative models of care, the Choosing Wisely campaign, the challenges of establishing a single, electronic national health patient record and the provision of sedation for the bowel screening program.

Susan Ewart
Communications Manager,
New Zealand

Above: At the top of the table, ANZCA NZ National Committee Chair Dr Gary Hopgood (left) talking to the Minister of Health, Dr Jonathan Coleman, at the committee's November meeting.

2016 National Anaesthesia Day

Anaesthesia 170 years later

Hospitals across Australia and New Zealand threw their support behind National Anaesthesia Day in October.

Is regional anaesthesia for you? This was the question posed on October 17 as anaesthetists across Australia and New Zealand took on an advocacy role for the profession, which had its beginnings 170 years ago in Boston, Massachusetts.

A new initiative this year was the creation of educational videos for use by Fellows. Combined with a comprehensive media campaign, National Anaesthesia Day was a successful celebration of one of the greatest discoveries of modern medicine.

Fellows again strongly embraced National Anaesthesia Day on October 17, particularly in NZ where all but five public hospitals and two satellite hospitals were involved.

There were many interactive staffed displays involving scanning demonstrations. Hospitals participating were Whangarei, North Shore, Auckland City, Middlemore, Waikato, Rotorua, Gisborne, Palmerston North, Wellington, Hutt and Dunedin Hospitals, Manukau Super Clinic, Waitakere, National Women's, Starship Children's, Whakatane, Kenepuru, Whanganui Hospital, Christchurch, Burwood, Christchurch Women's and Timaru Hospitals, plus at the Elective Surgery Centre (North Shore), Greenlane Surgery Centre (Auckland) and Kapiti Health Centre. Tauranga took the opportunity to launch its new block bay.

In Australia, interactive displays were set up at many hospitals. St Vincent's Hospital, Melbourne, for example, had a week-long window display at the front of the hospital and ran a staffed display in the foyer, which included the College videos. The operating room had cakes and lunchtime celebrations. Other participating Australian hospitals included Wollongong, Dandenong, Nepean, Sir Charles Gairdner, Royal Prince Alfred Hospital, the Royal Brisbane Women's Hospital, Monash Health, Townsville Hospital, Rockingham and John Hunter Hospital.

Royal Prince Alfred in Sydney truly embraced the day. In addition to its interactive display, the team held a "bake-off" complete with perpetual shield; the results were sold off for charity. Special mention also goes to Nepean Hospital, which had cupcakes featuring the National Anaesthesia Day logo.

Social media

The College has increased its social media profile over the past six months and this had a big impact.

Three National Anaesthesia Day videos were produced and uploaded to ANZCA's new YouTube channel and from there, embedded on the website, shared via social media, and supplied to print and broadcast media. Together, these videos have been viewed thousands of times.

ANZCA's first Facebook page was launched eight days before National Anaesthesia Day and this new platform was used very effectively to share the videos (using Facebook's inline video player), media coverage and Fellows' photos.

Twitter also was busy on and around October 17, with 113 tweets mentioning the event hashtag #NAD16. The hashtag was used by 62 people and had a reach of more than 72,500.

Media

ANZCA distributed three media releases for National Anaesthesia Day – one on regional anaesthesia generally, and two on research studies into the effect of regional anaesthesia on, respectively, post-operative delirium and breast cancer recurrence. Each was adapted slightly for the New Zealand audience. The main release also offered media usage of the three videos: "Meet your anaesthetist", "Regional anaesthesia", and "National Anaesthesia Day".

> "National Anaesthesia Day was a successful celebration of one of the greatest discoveries of modern medicine."

In New Zealand, a media alert about hospital displays was issued and 10 individual media releases were provided to community hospitals about the displays available to the public in their areas. In addition, an article was provided for a private hospital staff magazine to be used by three hospitals.

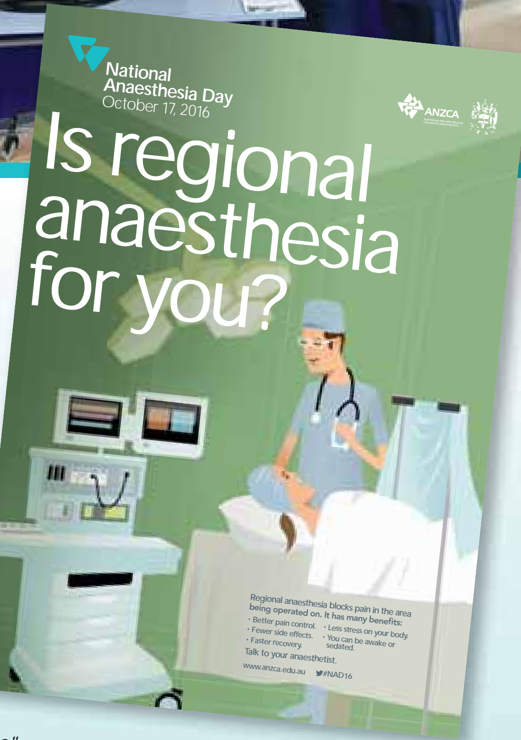
Highlights of coverage this year included ANZCA President David A Scott being interviewed on ABC TV News 24 for five minutes on regional anaesthesia, with our video footage being used as overlay (viewing audience 476,000). Earlier, Dr Rowan Thomas and Professor Scott had been interviewed for 90 minutes on radio 3AW's Talking Health program, reaching an audience of 13,000 listeners.

Associate Professor Alicia Dennis of the Royal Women's Hospital had 14 minutes on ABC radio in Melbourne talking about her study into epidural anaesthesia (audience 40,000). In New Zealand, Dr James Cameron spoke for 15 minutes about regional anaesthesia on Radio New Zealand's national Nine to Noon program.

In addition, in Australia two large regional papers, the *Illawarra Mercury* and the *Newcastle Herald*, wrote stories in which they quoted local anaesthetists, with the *Herald* also running an ANZCA video.

Four other regional papers mentioned the day in briefs and four regional radio stations ran "grabs" from the president in their news bulletins. In New Zealand, substantial news stories ran on the Scoop website and the *NZ Herald* online, as well as in the *Otago Daily Times*, *Gisborne Herald*, *Northland Age* and *Hutt News*. Smaller items ran in five other newspapers. And we scored a 300-word hit on the *Daily Times* website in Pakistan!

Clea Hincks
General Manager, Communications, ANZCA



Above clockwise from top left: St Vincent's Hospital in Melbourne had an information table in the foyer manned by a number of anaesthetists where they invited members of the public to consider regional anaesthesia for any future procedures; Dr Brian Chui, Dr Mathonsi Jila and Sue Nickolai from Lyell McEwin Hospital, SA; Staff at North Shore hospital in Auckland, NZ, demonstrate techniques to the public; Nepean Hospital's National Anaesthesia Day cupcakes; Dr Candy Edwards, Dr Michael Choo and Dr Zoe Keon-Cohen from Box Hill Hospital get into the spirit of day; Rockingham General Hospital's Dr Charles Ho and Dr Kirsty Crocker; Townsville Hospital anaesthetic nurse Liz Keys and Dr Mark Fairley; Royal Prince Alfred in Sydney embraced the day with a "bake off".

What would you do?

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

Reviewing a peer

You are approached by a healthcare facility to perform a review of a specialist as a result of concerns expressed by an anaesthesia nurse and a post-anaesthesia care unit (PACU) nurse to the hospital administration. There is nothing apparently overtly dangerous in the anaesthetist's practice, but the nurses are concerned about performance in theatre, and handovers to PACU, and the hospital is seeking guidance about whether the specialist is practising at the appropriate standard.

The practitioner is a member of an anaesthetic group in a regional area, is a senior anaesthetist and a long-time member of the group, working in both public and private practice. In preliminary discussions it is revealed that they did not fulfil continuing professional development (CPD) requirements in the previous year but on the licencing authority's registration form, ticked that they had. As they intend to practice for several more years, colleagues are concerned and are seeking advice.

There are a number of issues in this case ranging from regulatory breaches, potential clinical underperformance, and behavioural problems. Options for addressing these include any one or combination of approaching the colleague to discuss the issues; informing their mentor if they have one, or a colleague with whom they have a close relationship; escalating to the head of department, or in private escalating to the medical advisory committee/management; notifying the regulatory authorities under mandatory reporting.

What would you do?

Clearly, we have a colleague here in need of help and support. An obvious question is why an experienced senior specialist, who has provided an excellent standard of service for many years, would now behave in this way. Could it indicate the presence of an underlying health issue or cognitive deterioration? What can we do to help?

Under conditions of stress, anaesthetists may turn to their colleagues for help, but may fail to realise they also have access to support from the College. ANZCA acknowledges and seeks to genuinely support its Fellows during difficult times, within its scope of roles, recognising it is not a regulator, nor does it have an industrial mandate. Fellows are encouraged to avail themselves of the resources and experience within the College.

Most Fellows have limited experience in undertaking a comprehensive review of a colleague unless they have been involved in an international medical graduate specialist workplace-based assessment (WBA), which is a similar process.

So in the absence of that experience – (bugle blast) ANZCA "prof docs" to the rescue!

While it is not the remit of this article to provide detailed advice or instructions, it is intended to contextualise the value of the professional documents (see www.anzca.edu.au/resources/professional-documents) in assisting with this process. On the occasions where I have been invited to evaluate alleged concerns there have been two challenges. The first was to develop a clear understanding of the problem(s) and the second was to gauge them against some sort of standard. The terms of reference usually make mention of assessment against clinical standards. Initially, I wasn't sure how to determine a standard and where to look for assistance. It then dawned on me that there is a raft of quality information to which I could refer.

Clinical performance constitutes a multitude of aspects, including knowledge, skills, and behaviour. With regard to expected standards of behaviour, the recently developed resource *Supporting Anaesthetists' Professionalism and Performance: A guide for clinicians* is a very helpful tool.

The Welfare of Anaesthetists Special Interest Group also has a raft of useful resources.

In reference to assessing clinical standards the following may be useful:

- *PS03 Guidelines for the Management of Major Regional Analgesia.*
- *PS06 The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care.*
- *PS07 Guidelines on Pre-Anaesthesia Consultation and Patient Preparation.*
- *PS15 Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery.*
- *PS16 Statement on the Standards of Practice of a Specialist Anaesthetist.*
- *PS18 Guidelines on Monitoring During Anaesthesia.*
- *PS19 Recommendations on Monitored Care by an Anaesthetist.*
- *PS26 Guidelines on Consent for Anaesthesia or Sedation.*
- *PS28 Guidelines on Infection Control in Anaesthesia.*
- *PS29 Statement on Anaesthesia Care of Children in Healthcare Facilities Without Dedicated Paediatric Facilities.*
- *PS31 Guidelines on Checking Anaesthesia Delivery Systems.*
- *PS41 Guidelines on Acute Pain Management.*
- *PS43 Statement on Fatigue and the Anaesthetist.*
- *PS49 Guidelines on Health of Specialists and Trainees.*
- *PS51 Guidelines for the Safe Administration of Injectable Drugs in Anaesthesia.*
- *PS53 Statement on the Handover Responsibilities of the Anaesthetist.*
- *PS57 Statement on Duties of Specialist Anaesthetists.*
- *PS62 Statement on Cultural Competence.*

Armed with all this, it is possible to delve into the interview phase, which involves meeting with the colleague in question followed by multi-source feedback interviews. Along with inspection of documentation and review of continuing professional development activities this represents a fairly robust, consistent and replicable process, especially when considered against set standards. It also can be used for debriefing our colleague, and as the basis for our report.

While we hope the need to review a peer for regulatory reasons is uncommon and declining, a more robust peer review process may become necessary in the future with the introduction of revalidation. Fellows are well placed with respect to revalidation as a result of ANZCA's continuing professional development standard and ANZCA's Continuing Professional Development Program, and the implementation of a modified but similar process to the above may be worth considering when conducting such peer reviews.

"ANZCA acknowledges and seeks to genuinely support its Fellows during difficult times, within its scope of roles."

I wish all Fellows and ANZCA staff all the very best over the holiday season and look forward to an exciting and challenging 2017.

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

Professional documents – update

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

The September 2016, the ANZCA Council approved the development of a professional document on environmental sustainability in anaesthesia practice.

Recent releases

In November, the Safety and Quality Committee approved the following documents and their background papers for promulgation on the ANZCA website.

- ***PS15 Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery (12 month pilot)***
- ***PS58 Guidelines on Quality Assurance in Anaesthesia (12 month pilot)***
- ***PS60 Guidelines on the Perioperative Management of Patients with Suspected or Proven Hypersensitivity to Chlorhexidine (final version)***

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

College improves its accreditation process

Accrediting hospitals to undertake training is a core role of ANZCA.

ANZCA has completed about 60 hospital accreditation visits and inspections since the second half of last year, following an 18-month pause during which the College reviewed and improved its accreditation processes.

Even though nearly all the hospitals visited will receive recommendations for improvement, universally the process found that departments have the best interests of their patients and trainees at heart. About one third of hospitals visited were given only one year's accreditation so the necessary urgent corrective actions could be achieved before the following hospital employment year. So far, all hospitals have complied or are working through significant issues.

Each accreditation visit requires up to four Fellows to act as inspectors; depending on the size of the hospital and its satellites, it takes from half a day to two full days to conduct the visit, plus the travel and report writing. Although it is a lot of work, inspectors enjoy meeting people in their work environments and seeing firsthand the great work being done, often in difficult circumstances. So much so, there is always some aspect of practice that can be pinched to implement back home!

Some of the changes and enhancements made by the College are described here:

Seven to five years

The accreditation cycle has changed from every seven to every five years and brings ANZCA into line with other colleges. More frequent visits provide an opportunity to support the supervisors of training, tutors and heads of department with access to immediate information about increasingly complex training or professional issues. Training Accreditation Committee inspectors are well versed in ANZCA policies and procedures and can discuss and advise about local issues and concerns with the anaesthetists in their workplaces. The feedback received from direct "colleague to colleague" interactions on matters critical to ANZCA and the people on the ground, for example the continuing professional development program, the training portfolio system, workforce, and other emerging issues, is greatly valued.

The training site accreditation system

Any director who has experienced a hospital inspection before the new online system will remember the sinking feeling when faced with the 20-page document that had to be completed prior to the visit.

The training site accreditation system now provides pre-populated relevant information and has greatly reduced the pre-inspection workload for heads of departments. The head of department (or supervisor of training) no longer has to nag trainees to log cases and calculate supervision levels prior to the visit because the information is held in the training portfolio system. No additional work is required.

The only thing trainees need to do is to complete an anonymous, online trainee opinion survey. As a bonus,

supervision reports and workplace-based assessment "run rates" are now available to directors not just at the time of accreditation. The Training Accreditation Committee plans to make these reports available on a regular basis in the future.

Regional committee involvement

The philosophy regarding the membership of the Training Accreditation Committee has changed. Previously, committee membership had geographical representation and others who had an interest in the committee.

The membership now has a formal position called a Training Accreditation Committee officer for each Australian region and New Zealand. These positions are recommended by the regional/national committee and approved by the ANZCA Council. The FPM is also represented on the committee. The Training Accreditation Committee officer has much greater responsibility than before as they know and understand the peculiarities of their state or country, including its geography and travel challenges.

We have around 50 Fellows who are actively involved in accreditation visits and we would welcome more. Training is provided and you will be paired with an experienced inspector before having to lead – a far cry from the traditional "see one, do one, teach one". If you are not already convinced, practice evaluation credits are gained for hospital visits.

If you are interested in becoming an inspector we will be holding a Training Accreditation Committee training session at next year's ANZCA Annual Scientific Meeting in Brisbane on Friday May 12 from 3.30-5pm. If you have any other feedback for the committee, please contact the Training Accreditation team at ANZCA via TAC@anzca.edu.au.

Dr Vanessa Beavis
Chair, Training Accreditation Committee

ANZCA explores a perioperative future

Anaesthetists are rightly proud of the giant strides made by our predecessors, but the law of diminishing returns applies inside the operating theatre with directly related anaesthetic mortality now estimated to be as low as 1:50,000.

In stark contrast, there is strong evidence that patients are at risk in the post-operative period from adverse events that may be preventable or reduced with improved perioperative care.

Worldwide healthcare is moving from an individual to a team-based approach. The best analogy I can think of is the change in aviation in the 1970s. Many pilots were extremely experienced war veterans, but aircraft became too complex for one pilot to fly.

Last year, the then-ANZCA President, Dr Genevieve Goulding, asked me to take on the perioperative medicine portfolio. The ANZCA Council put several names forward, trying to ensure we had a diverse group with respect to location, type of practice and career stage. We knew some Fellows might be disappointed that we didn't seek formal expressions of interest, but the delay caused by an exhaustive selection process seemed unwise when it has been more than 10 years since ANZCA's original perioperative taskforce was established.

Although ANZCA always envisaged the perioperative medicine project would involve collaboration with Royal Australasian College of Physicians and College of Intensive Care Medicine, we decided to focus on aligning within ANZCA and FPM before formally seeking their input.

Once the group gathered, the first question we asked was: "What problem are we trying to solve?" I have been involved in many cases where each individual has done a reasonable job, but fragmentation of care has led to patient harm. I am sure this is familiar to many Fellows.

ANZCA's 2016 Perioperative Working Group

- Dr Sean McManus (Chair) Cairns, Qld.
- Dr Grant Brace (full-time private practice) Melbourne, Vic.
- Dr Matt Brbich (new Fellow) Perth, WA.
- Dr Genevieve Goulding (immediate past president), Brisbane, Qld.
- Dr Suzanne Cartwright (Faculty of Pain Medicine) Tamworth, NSW.
- Associate Professor Jo Sutherland, Coffs Harbor, NSW.
- Dr Conrad Macrokanis, Brisbane, Qld.
- Dr Dick Ongley (Chair, Perioperative Medicine Special Interest Group), Auckland, NZ.
- Dr Peter Roessler (ANZCA Director of Professional Affairs), Melbourne, Vic.
- Dr Joel Symons (Monash Perioperative Medicine Program), Melbourne, Vic.
- Professor David Story (Foundation Chair of Anaesthesia, University of Melbourne), Melbourne, Vic

We see the role of the perioperative doctor similar to that of the navigator/co-pilot – guiding the surgeon while they focus on the technical aspects of surgery with more formalised co-management throughout the patient's perioperative journey.

Simultaneously anaesthetists will apply the systematic thinking that has improved safety and systems inside the operating theatre to the broad perioperative medicine space (yes, we need to come out of the theatre closet into the sunlight).

ANZCA has decided to improve the exposure, teaching and examination of perioperative medicine for all trainees so all ANZCA Fellows will be practitioners of perioperative medicine.

Simultaneously, the College is developing a high-level qualification to support those wanting to become specialists in perioperative medicine. We recognise that all anaesthetists practice perioperative medicine to some extent in their daily practice, but some will seek higher qualifications to support their practice. This also may involve practitioners from other specialties.

The ultimate goal is to enable our patients to benefit from a higher standard of care.

In coming months, we will be encouraging feedback from Fellows, which will help guide us in the direction we need to go. Stay tuned.

Dr Sean McManus
Chair, Perioperative Medicine Working Group

CICO and front of neck access – ANZCA's position

ANZCA has clarified its position on can't intubate, can't oxygenate (CICO) front of neck access in response to a statement by the Royal College of Anaesthetists.

The release of the Royal College of Anaesthetists' (RCoA) statement, "Anaesthetists and surgeons reach agreement on front of neck emergency techniques in life-threatening 'CICO' situations", associated with a BJA editorial "Surgical intervention during a can't intubate can't oxygenate (CICO) event: emergency front of neck airway (FONA)?", has raised a number of questions about ANZCA's current view on the optimal technique for front of neck access. This is in the context of our trainee education and also the Emergency Responses CICO training guidelines.

These articles highlight the importance of oxygenating the patient as the primary priority and then securing a definite airway, which ANZCA strongly supports. The "scalpel-bougie" technique has been advocated because it can be performed at most locations, with readily available equipment, by both surgical and anaesthetic teams. Importantly, it is recognised that other techniques can be used depending on individual experience, training, comfort of use, and case specifics.

ANZCA is aware that expert opinion differs on the preferred management of securing a surgical airway, but recognises the need for clinicians to be familiar with at least one.

The College does not mandate one approach to FONA over the other. Both are part of CICO training, and circumstances are likely to direct a preference for one over the other (including department and individual training, patient factors, and the presence of surgical assistance). This is acknowledged in the RCoA release as well.

"ANZCA has clarified its position on can't intubate, can't oxygenate (CICO) front of neck access."

However, given the limited evidence and lack of consensus among experts, the following important points are noted:

- It is fully accepted that individual situations, skills and environments will differ and a specialist is unquestionably entitled to choose either a "scalpel-first" or a "needle-first" approach.
- All specialists and all trainees should continue to learn both needle and scalpel techniques.
- It is fully accepted that in running courses and teaching both techniques, specialists are entitled to use their personal experience and preferences and this will continue to be encouraged until the evidence is clear.

ANZCA has advocated that institution-specific education sessions are developed to satisfy local needs, incorporating local staff, work environments, non-technical skills and point-of-care equipment and resources.

Based on the current evidence, ANZCA recognises three algorithms as being suitable for the front of neck access performed by anaesthetists. This includes the Royal Perth CICO algorithm with its stepwise progression from needle-based technique to the definitive airway, DAS 2015 Guidelines, and the Canadian Difficult Airway Focus Group 2013 Guidelines.

Specific ANZCA resources relating to airway management and CICO:

- Airway assessment and planning www.anzca.edu.au/documents/pu-airway-assessment-20160916v1.pdf.

- Airway equipment www.anzca.edu.au/documents/ps56bp-2012-guidelines-on-equipment-to-manage-a-di.pdf.
- Cognitive aid www.anzca.edu.au/getattachment/resources/professional-documents/ps61_guideline_airway_cognitive_aid_2016.pdf.
- CICO human factors www.anzca.edu.au/documents/report-from-the-anzca-airway-management-working-gr.pdf.

Professor David A Scott
ANZCA President

webAIRS news

Following a successful year of webAIRS conference workshops and presentations, 2017 will see further webAIRS-themed sessions presented across a spectrum of settings. At the 2017 ANZCA Annual Scientific Meeting in Brisbane, Dr Martin Culwick and members of Australian and New Zealand Anaesthetic Allergy Group (ANZAAG) will be presenting on "improving outcomes in perioperative anaphylaxis". This will explore this significant issue and how the reporting of incidents can improve clinical practice. This presentation expands on previous collaborations between ANZCA and ANZAAG, which resulted in the production of co-badged clinical guidelines titled "Perioperative Anaphylaxis Management Guidelines".

Also included in the program is a webAIRS workshop. Participants will learn about all aspects of the incident-reporting system; from how to register and link to a site, through to using local webAIRS data to facilitate morbidity and mortality meeting discussions. The workshop will provide a perfect introduction for those who are unfamiliar with the system, while offering experienced users an insight into how to make best use of webAIRS' extensive functionality.

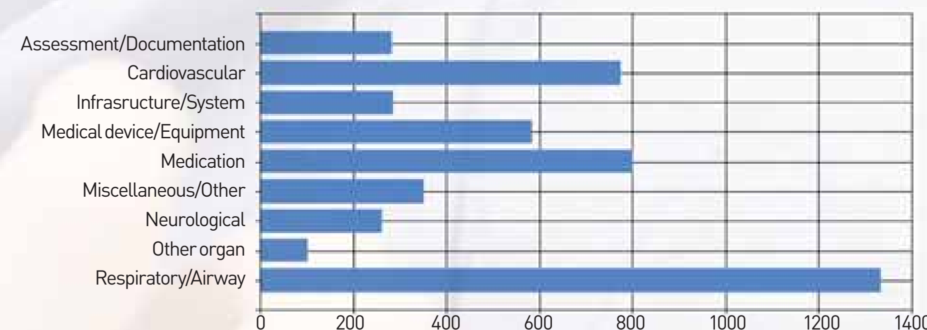


Figure 1. Bi-national incident category breakdown – October 2016

Significantly, webAIRS has now collected more than 4000 incident reports. As well as hundreds of individually registered anaesthetists, many more are linked to the 140 sites registered in the system. The growth in users and data collection has brought about the formation of a publications group. Led by Professor Alan Merry, this group is co-ordinating and publishing a series of articles from data derived from the first 4000 incidents. The analysis will include the four big As: awareness, anaphylaxis, aspiration and airway. Mortality, hypotension and medication error data also will be examined.

December 31 marks the end of the triennium for the ANZCA Continuing Professional Development (CPD) Program. Did you know that reporting incidents in webAIRS earns two credits (per hour) in the practice evaluation category? If you're not already registered and earning CPD points, the process is very straightforward. Follow the links from the webAIRS landing page (www.anztadc.net) and sign up as an individual user or as part of team. All reports make an important contribution to improving safety and quality in anaesthesia.

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

Safety alerts

Recent alerts:

- Inadvertent use of Phenol to spray vocal cords.
- Update: New Zealand Remifentanil shortage update – 2 mg now available.
- Medtronic model 37751 recharger – used with neurostimulators.
- Update: New Zealand Ultiva injections supply delayed.
- GE Avance CS2, Avance and Amingo Anesthesia Devices.
- TGA safety review: Nonsteroidal anti-inflammatory drugs (NSAIDs) and spontaneous abortion.
- Supply disruption to Ultiva for injection (remifentanil hydrochloride) until 2018.
- New Zealand: Temporary supply disruption to Ultiva injections.

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

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

Charitable idea improves patient safety

Below from left: Dr Steven Gubanyi, Kate and baby Jackson; samples of Gubanyi's "etties", endotracheal ties.

A simple idea for pre-cut endotracheal tube ties is raising money for breast cancer research and improving safety in the operating room.

It began with a casual conversation in theatre. A disjointed conversation, in which a nurse was complaining about the tedious work of cutting endotracheal tube ties from rolls of cotton tape, and the anaesthetist, Dr Steven Gubanyi, was wondering how he could contribute to the cause of breast cancer charities.

Dr Gubanyi's wife, Kate, had been diagnosed with breast cancer five years earlier. She now contributes some of the profits from her bridal boutique business to cancer charities, and Dr Gubanyi wanted to do the same. The nurse's complaint led to his Eureka moment: a project he now calls "ettties".

The very next patient in theatre required intubation, but he had a large head and the tie the nurse had cut was not long enough. Precious seconds were wasted while the nurse rustled up another.

Dr Gubanyi knew the endotracheal tube ties are used "everywhere" – theatres, crash trolleys, the intensive care unit, the emergency department – to hold in place the tubes that connect patients to machines that help them breathe. He thought it was a waste of nursing time – and hospital money – for university-trained nurses to have to cut and tie them. And he thought it was unsafe for patients that ties were sometimes too short, causing a delay in securing the airway.

So now: "I import the ETT ties already cut and knotted, dyed pink to represent breast cancer awareness, and sell them to hospitals," Dr Gubanyi says. "One hundred per cent of the profit goes to the McGrath Foundation, which funds breast cancer nurses, or to the National Breast Cancer Foundation, to fund their research. The accounting is open source to anyone who wants to look."

"I import the ETT ties already cut and knotted, dyed pink to represent breast cancer awareness, and sell them to hospitals."

Nominally, his individual ties cost more than big rolls, which are hand-cut. But he argues that this is true only if one fails to take into account the real cost of nurses' labour: "A roll of 500 metres is supposed to cost around 10 cents apiece, but by the time you add in the time it takes nurses to cut the roll up and knot the ties, the real cost is closer to 40 or 50 cents."

Another advantage of his ties is that they are always long enough, which means precious seconds are not wasted in an emergency. And they are never too long, which means there is no wastage.

Dr Gubanyi, who is based on the Gold Coast, is selling to public and private hospitals in several states. If he can get up to 250 hospitals using ettties, he hopes be able to donate $A50,000 a year.

The cause is very close to his heart. His wife, Kate, owes her life to modern breast cancer treatment. Then, after chemotherapy drastically reduced her fertility, the couple's son, Jackson, was an unexpected blessing.

So, the one-man band is committed to continuing to order, import, spruik, pack and mail his ettties. He sees it as a win-win initiative.

"It's an easy way for hospitals to become more charitable while saving money and improving patient safety," he said.

For further information, contact ettties@gmail.com or http://ettties.wixsite.com/website.

Karen Kissane
Media Manager, ANZCA

Record amount funds anaesthesia and pain research projects

Project grant recipient Dr Rebecca Christensen from the Royal Brisbane and Women's Hospital, Qld. *See page 45.*

The ANZCA Research Committee has awarded funding of nearly $A1.7 million through the ANZCA Research Foundation for research projects in 2017. The funding supports the:

- **2017 Douglas Joseph Professorship.**
- **The Academic Enhancement Grant.**
- **22 new project grants.**
- **Eight continuing project grants.**
- **The Simulation/Education Grant.**
- **Three novice investigator grants.**
- **The pilot grant scheme.**

These grants support important research initiatives in leading hospitals and universities in Australia, New Zealand and Hong Kong and are vital to ANZCA's continuing contribution to improvement in the safety and quality of patient care in anaesthesia, intensive care, perioperative medicine and pain medicine through high-quality medical research.

The foundation appreciates the supporters and sponsors who have provided the named research awards – the Cole family, the late Dr Robin Smallwood's family, the late Dr John Boyd Craig's family, Professor Barry Baker, Dr Peter Lowe and Australian Executors Trustees.

Douglas Joseph Professorship

Associate Professor Jennifer Weller

ANZCA congratulates Associate Professor Jennifer Weller for the award of the quadrennial Douglas Joseph Professorship for 2017. This prestigious award is open to Fellows of the College in Australia, New Zealand, Hong Kong, Malaysia or Singapore who are making an outstanding contribution to the advancement of the speciality to pursue scholarship and research in human anaesthesia. The tenure of the professorship is one year and Associate Professor Weller will hold the courtesy title "Douglas Joseph Professor of Anaesthesia".

Associate Professor Jennifer Weller is head of the Centre for Medical and Health Sciences Education at the University of Auckland, and a specialist anaesthetist at Auckland City Hospital. Associate Professor Weller is on the editorial board of the *British Journal of Anaesthesia,* and an editor of the new journal *BMJ Simulation and Technology.*

She is widely published in the areas of simulation-based learning, inter-professional teamwork, and patient safety and assessment, directs a masters program in clinical education, and is involved in inter-professional simulation-based initiatives in the medical and nursing undergraduate programs.

Associate Professor Weller will deliver the Australasian Visitor's Lecture at ANZCA's annual scientific meeting in Sydney in 2018 as part of the professorship.

The Douglas Joseph Professorship emolument will assist Associate Professor Weller in pursuing her study evaluating a national quality improvement initiative for safer surgery.

Evaluating a national quality improvement initiative: multidisciplinary operating room team simulation for safer surgery

Multidisciplinary Operating Room Simulation (MORSim) is a national simulation-based team-training program comprising realistic simulated surgical cases, which present communication challenges to all members of the operating room team. Each simulation is followed by a debrief to enable participants to reflect on the events, expose assumptions and explore issues with communication, as well as to identify behaviours and strategies that improve the performance of the team. From this, participants identify new practices to apply in their workplace. The simulations are supported by presentations, videos and discussions on specific communication strategies.

The primary research aim is to demonstrate that a multidisciplinary simulation-based team training intervention for operating room staff (MORSim) improves outcomes for surgical patients. A second aim is to demonstrate improved processes in the operating room. Finally, the investigator will explore the implementation process itself, to identify factors that facilitate or limit the uptake of patient safety initiatives such as MORSim.

MORSim represents a major quality initiative to improve outcomes for our patients. The stepped rollout of the initiative across all 20 district health boards in New Zealand affords a limited time opportunity to produce evidence of the effectiveness of this innovative team-training initiative and inform implementation of future safety interventions. This anaesthetist-led national initiative is an international first and could lead the world in changing the way teams work together in operating rooms.

Associate Professor Jennifer Weller, University of Auckland, NZ.

$A70,000

Named research awards

Harry Daly Research Award – Professor Andrew Davidson

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

Neurodevelopmental outcome after sevoflurane versus dexmedetomidine/remifentanil anaesthesia in infancy: a randomised controlled trial

There is strong evidence that commonly used general anaesthetics, such as sevoflurane, have a profound effect on the developing brain in the animal model, especially with prolonged exposure. In contrast, there is evidence that dexmedetomidine does not produce these effects. There is also mixed human cohort evidence that surgery in early childhood may be associated with an increased risk of later poorer performance in language and cognition. The role, if any, of anaesthesia in this association is unknown.

In the proposed study, the investigators plan to randomise 440 infants, aged less than one year, having more than two hours of surgery to either a standard general anaesthetic with sevoflurane or a new anaesthetic regimen using dexmedetomidine and remifentanil. Dexmedetomidine and remifentanil have so far appeared to cause little, if any, of the changes that are seen in animals with the other anaesthetic agents.

The trial will be led from Melbourne and will recruit children in Sydney, Perth, the US, Switzerland and Italy. It will be based on the successful network established through the GAS trial. They will then have a battery of standard neuropsychological tests, known as the Bayley-III. This tests their cognitive, language, motor and emotional and behavioural development.

Millions of infants have anaesthetics around the world. In Australia alone, more than 70,000 children under four years of age have an anaesthetic every year. Over 80 per cent of infant anaesthesia administrations are of less than two hours duration. If the dexmedetomidine/remifentanil technique proves to have superior outcomes compared to volatile anaesthesia, this will provide significant opportunities to improve neurodevelopmental outcomes after surgery in infants. It also will provide the strongest evidence to date that neurotoxicity is indeed a significant issue for paediatric anaesthesia, which will prompt clinicians to consider delaying lengthy surgery if safe to do so, and provide further impetus to the development of other less toxic regimens.

However, if this study finds little evidence of difference in outcomes the results from this study, along with the GAS trial results, would provide the strongest evidence to date that neurotoxicity seen in the preclinical studies is not likely to be a significant clinical issue for the majority of paediatric cases. This would provide strong evidence that clinicians do not have to change their current standard of practice.

Professor Andrew Davidson, Royal Children's Hospital, Melbourne, Vic; Dr Justin Skowno, The Children's Hospital at Westmead, NSW.

$A66,019

The Russell Cole Memorial ANZCA Research Award – Dr Paul Wrigley

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

The long-term effects of spinal cord stimulation on neural function in chronic low back pain – a pilot study

The Global Burden of Disease study now ranks chronic low back pain as the number one cause of disability in Australasia affecting three million Australians and costing more than $A14 billion a year. Despite extensive efforts, sustained pain relief for people with chronic low back pain has been difficult to achieve using conventional medical treatments.

Spinal cord stimulation (SCS) has been employed for the management of chronic pain for over 50 years. Over this time, SCS has become a well-established mode of treatment for neuropathic pain. Until recently most success with SCS has been obtained with pain involving the limbs with relief of chronic low back pain more difficult to achieve.

Dr Paul Wrigley will lead a study examining the long-term effects of SCS on nerve function. While SCS has been used for many years, the way it works remains poorly understood. Even less is known about the newer forms of stimulation, including the introduction of high frequency SCS (500Hz to 10,000HZ), raising concerns about the potential for effects on spinal cord function over time.

This pilot study will monitor changes in neural function associated with propriety low (<100Hz) and high frequency (10kHz) SCS in 30 people with chronic low back pain over 12 months. The project will inform the development of a full-scale trial.

While no definitive evidence of neural damage has been found to date using physical examination, it is crucial to obtain long-term safety data using more sensitive assessments. This information will better inform patient selection and cost benefit analyses. With this in mind, a one-year follow-up study will be undertaken using sensitive measures of spinal cord nerve function to track patients following spinal cord stimulator implantation.

This research will provide essential information to determine the safety of spinal cord stimulation in the long-term management of chronic low back pain.

Dr Paul Wrigley, Pain Management Research Institute, Royal North Shore Hospital, Sydney, NSW.

$A70,000

The Elaine Lillian Kluver ANZCA Research Award – Professor Eric Visser for his Academic Enhancement Grant

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

Sympathetically maintained pain in complex regional pain syndrome

In 2015, the University of Notre Dame Australia (UNDA) in Fremantle, WA, appointed Professor Eric Visser to the inaugural Churack Chair of Chronic Pain Education and Research in the School of Medicine. This new academic chair was tasked with reducing the impact of chronic pain, one of the biggest unrecognised health problems in the community, by furthering research and the education of medical students in chronic pain management.

Specifically, Professor Visser was charged with developing a pain education curriculum and research program at UNDA, and to establish a strong collaborative pain research program with Murdoch University's Centre for Research on Chronic Pain and Inflammatory Diseases, under the direction of Professor Peter Drummond and Professor Philip Finch. They have collaborated on pain research for many years at Murdoch University, and have published a large number of scientific papers on complex regional pain syndrome and other forms of pain.

The vision is to develop the Churack chair as a co-operative academic organisation (UNDA and Murdoch University) to foster much needed expansion in pain science research.

To achieve this goal, UNDA will establish a "flagship" post-doctoral research position at Murdoch University's pain research centre, known as the Churack Post-Doctoral Pain Research Fellowship. This position will not only contribute to the advanced pain research program at Murdoch University, it will also underpin the new research/education programs of the Churack chair (particularly in basic pain neurosciences), thus laying the groundwork for collaboration between the two universities.

By providing access to technical expertise, research facilities and equipment at Murdoch University, there will be opportunities for medical, health and science graduates and, specifically, ANZCA and Faculty of Pain Medicine trainees and Fellows, to complete a masters or doctor of philosophy in pain research at UNDA/Murdoch University under the direction of staff from both universities.

A major research focus of Murdoch University's pain research centre has been to clarify the involvement of the sympathetic nervous system in complex regional pain syndrome. The specific aim of this application is to build on this research through the use of several complementary approaches: (i) looking for "pain targets" in tissue samples taken from the site of chronic pain; (ii) clarifying the role of these "pain targets" under tightly controlled cell culture conditions in terms of inflammatory processes that might contribute to pain; and (iii) determining whether similar processes can be identified in healthy human participants.

Chronic pain is a major cause of worldwide suffering and for many patients the mechanisms that drive their pain are poorly understood and effective therapies are therefore often lacking. Identifying these mechanisms is crucial for the advancement of pain management and the development of new treatments for certain forms of intractable pain. With the involvement of the Churack chair, these studies will establish a strong base upon which to build a distinctive and clinically relevant research program across the two universities and links with ANZCA and the Faculty of Pain Medicine.

Professor Eric Visser, University of Notre Dame Australia, WA, Professor Peter Drummond, Associate Professor Philip Finch, Murdoch University, WA.

$A99,788

John Boyd Craig Research Award – Professor Britta Regli-von Ungern-Sternberg

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

Palatable and chewable tramadol chocolate-based tablets for effective pain management in young paediatric patients

Medical specialists now have a limited list of approved potent analgesics to prescribe to children undergoing surgery and cancer therapy. Tramadol is used widely in adults and clinical trials have shown it to be effective and safe in children in acute, subacute and chronic pain settings. It provides effective analgesia with low risk compared to other opioids and thus is suited for inpatient use and in the home setting. It is particularly useful for short periods in those experiencing moderate pain following procedures, where nonsteroidal anti-inflammatories (NSAIDS) are insufficient or contraindicated.

However, none of the 82 registered tramadol products in Australia are recommended or appropriate for young children, and caregivers have to perform a multi-step manipulation to transform the tramadol capsule into a liquid for young children. This practice is tedious, potentially risky, and yields a gritty suspension with no mechanism to mask the bitter taste.

A multi-disciplinary study team has designed a tramadol tablet based on a chocolate-flavoured platform. This platform has been successfully applied to midazolam, another bitter drug, and is now in trial at the Princess Margaret Hospital in Perth. The tramadol tablet will be optimised to conform to compendia specifications prior to the conduct of a pilot randomised clinical study in children.

The investigators plan to test the chocolate tramadol tablet against the current broken-open capsule method of delivering tramadol following minor to moderate operations at Princess Margaret Hospital. They aim to determine whether a novel tramadol oral tablet will contribute towards a seamless continuum of care for paediatric patients by providing a palatable, safe and effective product for managing moderate to severe pain. This system will also allow the delivery of a smaller defined dose, not previously available in Australia, which will allow easier and more reliable dosing in smaller children.

The expected outcome is a cost-effective, palatable, safe and effective tramadol oral tablet for managing moderate to severe paediatric pain, and a convenient product to administer in homes and hospitals. The data will confirm the versatility of the chocolate-flavoured delivery platform for the formulation of bitter drugs poorly tolerated by young patients.

Professor Britta Regli-von Ungern-Sternberg, Dr Laurence Cheung, Dr David Sommerfield, Princess Margaret Hospital, Perth, WA; Professor Lee Yong Lim, Dr Sam Salman, University of Western Australia, WA.

$A56,000

The Robin Smallwood Bequest – Associate Professor Philip Peyton

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

Redefining pulmonary uptake of anaesthetic agents

Thorough understanding of the way anaesthetic agents are taken up by the lung is essential to their proper clinical use by anaesthetists to achieve optimal and safe depth of anaesthesia. However, most teaching in this field is simplistic, and sometimes misleading.

Anaesthetic depth is determined most directly by the concentration of the agent in blood to the brain, but this is not readily measurable in routine clinical practice. Instead, concentrations in the gas we breathe are monitored, which are quite different.

This "A-a" difference arises in large part from mismatch of ventilation and blood flow throughout the lungs, which is significant in all patients under anaesthesia. The traditional way this "V/Q" mismatch is conceived and taught is the three-compartment or "Riley" model, which estimates shunt and dead space in the lung using blood gas measurements.

However, this model does not properly explain the way that anaesthetics are taken up by the lung, and the concentrations achieved in blood. This has led to much confusion and misunderstanding over the years about the behaviour of anaesthetic gases in the lung.

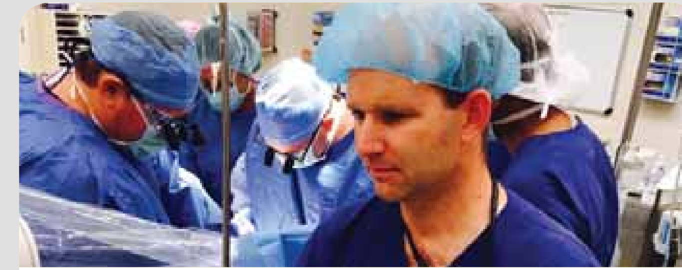
Associate Professor Philip Peyton has previously developed and used sophisticated computer models, which have better explained the way anaesthetic gases are taken up by the lungs, but these are too complex for routine clinical use.

What is needed is a simple model of lung gas exchange during anaesthesia, which still retains accuracy in predicting the behaviour of a range of gases used in anaesthesia. Such a model needs to then be validated using data generated from samples collected from patients under inhalational anaesthesia, and against a state-of-the-art lung model, which incorporates realistic distributions of ventilation and blood flow, as well as lung tissue, blood and alveolar volumes and longitudinal gas diffusion limitation. This will allow it to accurately simulate the behaviour of a range of gas species relevant to inhalational anaesthesia.

The aim is to ultimately provide a more accurate and accessible tool for teaching and research in the field of lung gas exchange physiology and the pharmacokinetics of inhalational anaesthetics.

Associate Professor Philip Peyton, Austin Health, Melbourne, Vic.

$A62,560



Australian Executor Trustees ANZCA Research Award – Dr Thomas Painter

The Australian Executor Trustees ANZCA Research Award was established to encourage excellence in South Australian medical research in the field of anaesthesia, perioperative and pain medicine by supporting a highly ranked project grant from a South Australian ANZCA Fellow anaesthetist or pain medicine specialist.

Do bolus intravenous fluids cause lung injury: Role of TRPV4 channels

Administration of intravenous fluid boluses is one of the most common hospital interventions for patients who are thought to be dehydrated due to illness or after surgery.

However, recent evidence suggests that these large amounts of fluid may, at best, have no effect or, at worst, exacerbate illness possibly increasing the rate of death in some patients. These negative effects are particularly manifest in the lung.

In our preliminary studies, the mechanism by which large doses of intravenous fluids may adversely affect the lung showed the importance of a particular type of channel that is found on the surface of cells lining the circulatory system and which controls the movement of water into and out of the lung, transient receptor potential vanilloid (TRPV4).

These channels also have been associated with other subsequent actions, which control inflammation and the movement of inflammatory immune system cells into the lung. The accumulation of both water and cells in the lung leads to a condition called acute lung injury, or acute respiratory distress syndrome (ARDS). ARDS remains a common problem in intensive care units and retains a 30 per cent mortality rate worldwide.

The aim of this study is to examine further the mechanisms by which administration of large volumes of intravenous fluid can lead to lung injury, by examining the health outcomes and blood of hospital patients.

The investigators will use samples already collected from the REstrictive Versus LIbEral Fluid Therapy in Major Abdominal Surgery (RELIEF) clinical trial whereby patients were randomly assigned to receive either the standard or a restricted amount of fluid after surgery. The effects of each fluid regime on factors in the blood, which either affect the function of TRPV4, or which are affected by the activation of TRPV4, will be determined.

As high-volume bolus fluid resuscitation remains clinically necessary in various cohorts of critically ill patients, this project will extend our knowledge of the involvement of the TRPV4 channel in the patient population and the mechanistic pathway involved in fluid-induced lung injury. Understanding this pathway will assist the development of targeted interventions with potential improved patient safety.

Dr Thomas Painter, Royal Adelaide Hospital, SA; Professor Paul Myles, The Alfred, Melbourne, Vic; Professor Andrew Bersten, Dr Shailesh Bihari, Flinders Medical Centre, SA; Dr Dani-Louise Dixon, Flinders University, SA.

$A65,869

Provisional New Fellow ANZCA Research Award – Dr Matthew Doane

Professor Barry Baker, retired anaesthetist and ANZCA Executive Director of Professional Affairs, and former Nuffield Professor of Anaesthetics, University of Sydney, made a generous donation to the foundation in 2014 to support its ability to provide novice investigator grants. This award is to support a highly ranked novice investigator, who is either a provisional year trainee or a new Fellow within five years of first specialist qualification.

The efficacy of an anaesthetic record in transferring information across hospital settings

In medical practice, communication is an essential component throughout all aspects of patient care. Communication between healthcare providers, when transferring patient information and care, is a varied process.

Over the past 10 years, an extensive amount of work has been published regarding the importance of "handover" in medical care; the act of transferring care and information regarding a patient from one team or team member to another. After handover, when further questions arise, the medical record serves as an essential source of information. However, adverse events related to poor handover of patient information and care is well documented in the perioperative setting. Even with facilitated communication tools, details can be lost in this process.

The aim of this is study is to investigate whether anaesthetic records are regularly reviewed by other medical personnel and, if so, whether they are able to identify clinically pertinent information.

Sample charts will be constructed, each based on a fictitious patient, and anonymously administered to medical staff. The charts will contain an arrangement of paperwork identical to what would be expected for a simple operative hospital stay. A questionnaire will be designed to focus on issues of medical history, allergies, complications, medications, procedures and care that has been delivered during the present hospitalisation. The charts and questionnaires will be validated against a group of anaesthetists prior to commencement.

The data gathered from this study will identify whether changes to the current system of intraoperative record keeping are needed, with the aim of improving the system of transferring pertinent intraoperative information to the ward and other hospital areas.

Dr Matthew Doane, Dr Mark Chemali, Dr Khoi Pham, Royal North Shore Hospital, NSW.

$A18,381

Novice investigator grants

Prehabilitation of frail patients undergoing elective colorectal surgery – a feasibility pilot study

In the context of an increasingly elderly and frail surgical population, ways to optimise and manage patients preoperatively in order to maximise meaningful recovery and prevent complications is a priority both nationally and internationally.

This study aims to assess the feasibility of a randomised controlled trial into prehabilitation; a structured, tailored exercise program with dietary advice, as a treatment to improve outcomes for frail patients undergoing colorectal surgery, including its health economic impact. The treatment proposed is a four-week exercise program, including cardio and resistance-based exercises, tailored to each patient and supervised by exercise scientists. The patients will also receive dietary advice. A comparison group of patients will receive usual care. The primary outcome measure will be six-minute walk distance at the five to six week post-operative clinic visit, as this is a well-validated and easily measurable tool to assess functional capacity.

Frail cancer patients have not before been specifically selected for an exercise intervention. Previous exercise studies in cancer patients as a whole, however, have suggested a benefit. This study will provide important feasibility data to inform further research into improving care for this high-risk patient group. It may reveal a signal towards benefit or harm from the intervention, but the aim is to establish whether this type of intervention can be successfully studied in this population. Prehabilitation is an area of growing interest, but of limited research data. If it can be shown that increasing pre-operative fitness improves outcomes it will inform advice to patients awaiting surgery, and potentially healthcare services and policy in the longer term.

Dr Claire Furyk, Townsville Hospital, Qld.

$A20,000

Nitrous oxide treatment of adolescents with depression (NOTAD): a randomised double-blind placebo controlled pilot study

Major depression affects one in 16 young Australians. For severe depression in young people, the recommended medicinal treatment is the use of a group of medicines called selective serotonin reuptake inhibitors (SSRIs). These medicines work by increasing serotonin in the brain, which reduces depression. Although SSRIs are known to work, they can take up to four to eight weeks before depressive symptoms are reduced. During this period, young people can be at risk of negative side effects due to an increase in activity prior to an improvement in mood.

Nitrous oxide is a safe, inhalational gas, which is commonly used in children and adults in anaesthetic procedures. There is strong biological and clinical evidence that suggests nitrous oxide may have significant acute antidepressant effects in adults with treatment-resistant depression. However, so far no studies using nitrous oxide in adolescents have been conducted.

The aim of this pilot study is to understand whether nitrous oxide will have the same antidepressant effect in adolescents, and whether having a single dose of nitrous oxide together with an SSRI will produce a greater beneficial antidepressant effect, compared to the effect of taking SSRIs alone. The participants will be administered nitrous oxide or placebo for one hour on the day of treatment and will be monitored weekly throughout the entire study, up to 12 weeks after treatment start, in regards to mood and related psychiatric symptoms.

This project has the potential to significantly change the way clinicians treat depressive symptoms in adolescents. If the proposed approach leads to clinical improvements, this in turn can significantly reduce the risk of worsening depressive symptoms in adolescents with depression who are receiving standard pharmacological SSRI-treatment. As a consequence of more effective treatment, adolescents would be able to return to their prior level of functioning earlier, decreasing the overall burden of disease in the community and reducing the length of time these individuals are involved in mental healthcare.

Dr David Sommerfield, Dr Richard Stewart,
Princess Margaret Hospital for Children, Perth, WA.

$19,493

Simulation/Education Grant

Establishing conditions for assessment for learning in the ANZCA training program: what is the role of trust?

The education of health professionals is critical for quality healthcare. Research and innovation in medical education help to ensure future graduates can provide safe, effective and compassionate care to their patients.

The aim of this study is to investigate the extent and determinants of trust between ANZCA trainees and their supervisors and the impact of this on the efficacy of the in-training assessment process.

Workplace-based assessments (WBA) require considerable investment in supervisor time and, if they are performed meaningfully, they can make a very important contribution to trainee learning and decisions on progression through the ANZCA training program.

In higher education, trust is recognised as a vital factor in teaching and learning with great relevance to assessment and feedback interactions. In the medical education context, the effect of the decisions trainees make regarding the extent to which they are willing to trust their supervisors on the implementation of WBAs has not been explored. In identifying the factors that influence a trainee's decisions to trust their supervisor as an assessor and the assessment/feedback process, we will provide information for trainees and supervisors to maximise the value of WBAs and hence the success of the ANZCA curriculum implementation and ultimately the quality of ANZCA Fellows.

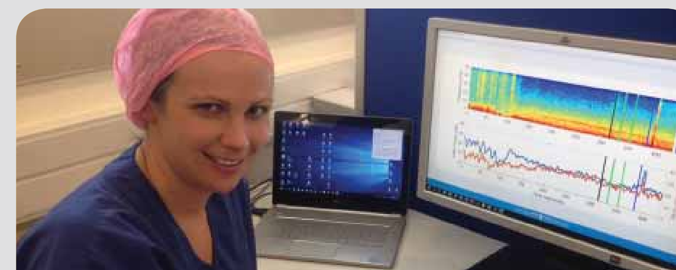
The investigators intend to use a mixed methods approach to answer these questions using a previously valid anonymous survey to gauge the extent of trust trainees have in their supervisors. We will select interviewees with diverse views from the survey respondents and conduct semi-structured interviews to explore further the conditions that afford productive trainee-supervisor assessment interactions.

The investigators expect to discover information on which to base improvements in the use of the ANZCA workplace-based assessment process for trainee learning and in-training assessment. It is anticipated that there will be broad interest in the outcome of the study within the medical education community.

Dr Damian Castanelli, Monash Medical Centre, Vic; Associate Professor Elizabeth Molloy, Associate Professor Margaret Bearman, Monash University, Vic; Associate Professor Jennifer Weller, University of Auckland, NZ.

$A26,384

Project grants



Electroencephalographic markers of behavioural responsiveness during anaesthesia

Awareness during general anaesthesia is a rare but important complication of anaesthesia associated with significant negative psychological sequelae. During anaesthesia, relatively consistent changes occur in the electroencephalogram (EEG) as increasing doses of anaesthetic agents are administered to patients. These changes form the basis of modern depth-of-anaesthesia monitors, which usually analyse recordings taken from across the patient's forehead and output a numerical index value, reflecting the "depth" of anaesthesia.

However, these monitors do not perform well at detecting connected consciousness during anaesthesia, as revealed by simultaneous isolated forearm testing. This is possibly because only changes in the frontal cortex are measured.

Recent studies in healthy volunteers using functional magnetic resonance imaging (fMRI) and multichannel EEG have identified functional changes in other distant regions of the cortex associated with loss of behavioural responsiveness during anaesthesia. In particular, there is growing evidence that a key marker of consciousness or behavioural response is the electroencephalographic connectivity between the frontal and parietal regions of the brain.

This study is unique in that it will test responsiveness during anaesthesia and surgery, using a slow controlled anaesthetic regime, while recording multichannel EEG. The investigators will record the EEG at multiple sites across the scalp, allowing identification of key changes in activity and connectivity in a number of brain regions during transitions between responsive and unresponsive states and vice versa. These recordings will then be analysed to determine which, if any, measures can reliably distinguish between responsive and unresponsive states.

The investigators hope to gain mechanistic insights and achieve reliable measures, which may ultimately contribute to the development of improved depth of anaesthesia monitors. This might assist clinicians in optimising the dose of anaesthetic agents given to patients to minimise complications and side effects, but still ensure that the patient is unaware and unresponsive.

Dr Amy Gaskell, Professor Jamie Sleigh, Waikato Hospital, NZ.

$A54,014 (including scholarship)

Project grants (continued)

PADDI Genomics: An investigation into the genomics of the inflammatory response to surgery and the actions of dexamethasone

The PADDI (Perioperative aDministration of Dexamethasone and Infection) trial is a large multi-centre randomised placebo controlled trial investigating whether the routine intraoperative use of the glucocorticosteroid drug, dexamethasone, is associated with increased or decreased risk of post-operative surgical site infection.

As a sub study of the PADDI trial, PADDI genomics aims to establish a biorepository to support genetic (DNA) and epigenetic (around DNA) investigations into the development of the inflammatory response to surgery and the impact of dexamethasone on that response. An initial analysis using state-of-the-art next generation sequencing technology and multiplex immunoassays will examine the impact of dexamethasone on inflammatory cell gene expression and protein production in patients with severe inflammatory responses. This analysis will provide fundamental preliminary data to begin more detailed explorative genetic, epigenetic, transcriptomic, proteomic and cellular (systems biology) analyses to further define the nature of perioperative inflammation and ultimately define factors that may more precisely predict harmful inflammation and the risk or benefit of intraoperative dexamethasone administration.

The biorepository will be created at 11 collaborating PADDI sites across Australia, New Zealand, Hong Kong and The Netherlands. When complete, it will support complex investigations into the molecular actions of dexamethasone and surgery on the circulating peripheral blood mononucleocytes (PBMC). The research will complement the findings of the PADDI trial by providing evidence, at a genomic level, for how a single dose of dexamethasone modifies innate and adaptive immune function in the surgical setting and how this may be associated with the risk of surgical site infection. The biorepository also will provide tissue to further investigate how dexamethasone may impact on differences in the wide range of other phenotypes monitored during the trial and, importantly, whether there are genomic markers that may predict greater risk or benefit for dexamethasone administration.

In addition, the biorepository can be used to investigate other important perioperative complications such as post-operative nausea and vomiting (PONV), persistent post-operative pain, and blood glucose variation. This project embraces the challenge of generating genomic evidence to support more precise (precision medicine) use of medication in the perioperative period.

Dr Christopher Bain, The Alfred, Melbourne, Vic; Dr Kiymet Bozaoglu, Baker IDI Heart and Diabetes Institute, Melbourne, Vic; Dr Jan Dieleman, University Medical Centre Utrecht, The Netherlands, Professor Tomás Corcoran, Royal Perth Hospital, WA.

$A89,850 (including scholarship)

Myocardial structure in preeclampsia using cardiac magnetic resonance and transthoracic echocardiography

Preeclampsia is a human pregnancy specific hypertensive (high blood pressure) cardiovascular disease, which is a leading cause of global morbidity and mortality. In Australia, preeclampsia affects approximately 20,000 pregnant women each year, is the most common reason to be admitted to an intensive care unit during pregnancy and is responsible for 20 per cent of maternal deaths. Worldwide it affects 6.5 million young women each year and is a leading global cause of maternal mortality. The hypertension and its complications, including renal impairment, acute pulmonary oedema, systolic and diastolic cardiac failure, and intracerebral haemorrhage, are directly related to the cardiovascular system and altered haemodynamics (blood flow).

The proposed unique and innovative study aims to investigate the heart in women with preeclampsia using non-invasive technologies of ultrasound, transthoracic echocardiography (TTE) and cardiovascular magnetic resonance (CMR). Using these safe methods it is anticipated that the study will improve understanding of preeclampsia, lead to better monitoring and the use of different medications to reduce complications in preeclampsia.

Cardiovascular magnetic resonance (CMR) is a relatively new imaging modality for cardiovascular assessment. It is able to provide excellent, high-quality images that can be obtained in any plane and without restriction by body size and morphology. It is non-invasive and does not use radiation, both of which are important considerations in pregnant women.

As it is able to visualise the heart so well, cardiovascular magnetic resonance is an important part of the assessment of cardiovascular structure and function. Cardiovascular magnetic resonance is currently the gold standard for left ventricular volumes and function, and is the only imaging modality currently available that is able to formally quantify right ventricular volumes and function.

By observing women with preeclampsia, this study aims to further determine the differences in cardiac structure in women with preeclampsia, before and after birth. By performing observations in the antenatal period and then at six months post-birth, information will be gathered about initial cardiac changes followed by recovery of cardiac changes.

This information will then assist with understanding of cardiac changes in women with preeclampsia. This in turn may lead to additional or alternative therapeutic or monitoring interventions, such as serial echocardiography to monitor disease progress and resolution, and CMR to assess extent of myocardial oedema or fibrosis and potential for recovery.

It may also lead to consideration of the use of diuretics to reduce tissue oedema and improve cardiac function and the use of cardiac remodelling agents, such as angiotensin converting enzyme inhibitors in women after birth, who demonstrate cardiac structural changes, all of which may reduce short and long-term morbidity from this condition.

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

$A66,591

Can free nicotine replacement therapy (NRT) increase smoking cessation before scheduled surgery? A randomised trial

Each day, 2.5 million people in Australia and New Zealand will smoke tobacco and about 300,000 of these will have elective surgery within the next 12 months. Regardless of whether this surgery is related to a smoking-related condition, many of them will make a quit attempt while on the elective surgical wait-list, and for those who do quit for four weeks or more, the risk of anaesthetic and surgical complications, particularly wound infection, is significantly lower.

Unfortunately, most quit attempts on the wait-list will occur without any behavioural or pharmacological assistance. These are likely to ultimately fail, leaving the majority of smokers arriving for elective surgery having smoked that day. Nicotine replacement therapy (NRT) is recognised as first-line therapy in smoking cessation, at least doubling quitting success compared to unaided quits, yet few perioperative services have an organised approach to ensuring this is offered to all nicotine-dependent smokers.

The investigators propose to study the effects of a systemic offer of a mailed NRT program on the population of nicotine dependent smokers who are awaiting surgery. The uptake, use, acceptability and quit-outcomes of this five-week mailed NRT supply will be quantified in nicotine dependent smokers as they enter the surgical wait-list.

The percentage of patients who quit before surgery when given open access to NRT will be compared to those that were not offered NRT. Confirmation of non-smoker status will be done on the day of surgery by carbon monoxide breath testing. Follow-up of wait-list quitters will be done at three and six months after surgery to determine the proportion of sustained abstinence after surgery in each group.

This study recognises the important position that anaesthetists have to use the perioperative period as an opportunity to improve the health of their patients.

Dr Ashley Webb, Frankston Hospital, Peninsula Health, Vic.

$A70,000

Predicting disability-free survival after surgery in the elderly

People having surgery hope for a speedy recovery, with a return to good health and quality of life.

Unfortunately, it is not uncommon for patients to have complications after surgery, with poor or delayed recovery and, sometimes, persistent disability. This is particularly true for elderly people (70 years of age or older), many of who may never return to their previous level of function after major surgery.

The investigators' previous research revealed that 12 months after surgery one in seven patients had worse health than they did before surgery. The risk of a poor long-term recovery was higher in older people and those with multiple medical problems, with one in three elderly patients having died or been left with significant disability six months after surgery.

The primary objective of this study is to construct and validate a risk score for the prediction of disability-free survival in older patients (aged 70 years of age or older) six months after elective or non-elective surgery in an Australian tertiary referral centre.

The investigators propose to use a large ("big data" style) prospective patient registry to create a scoring system to predict post-operative disability-free survival in older people having elective and non-elective surgery, and will investigate the patient characteristics, medical conditions (including memory impairment), types of surgery and surgical complications (including persistent pain) linked to poor recovery. The identification of these risk factors will help patients and doctors make better decisions about having surgery and plan the level of care patients need before and after surgery.

A scoring system capable of predicting disability-free survival will provide a valuable tool to facilitate patient-clinician risk-benefit discussions prior to surgery and help target high-intensity interventions to at-risk patients. Further, understanding of the epidemiology of post-operative disability will help guide future perioperative research.

Dr Mark Shulman, Professor Paul Myles, Ms Sophie Wallace, The Alfred, Melbourne, Vic.

$A69,747

Project grants (continued)

Fluid status after bowel preparation for colonoscopy: Objective assessment and relationship to hypotension under sedation

Colonoscopy is a common investigation and requires bowel preparation to empty the bowel and allow visualisation of the mucosa.

This study will investigate whether patients are significantly dehydrated after taking bowel preparation solution to undergo colonoscopy. The previous work of our research group has demonstrated that hypotension is common during sedation for endoscopy and it is not prevented by IV fluid administration prior to colonoscopy.

In this study we will combine the Clear Sight® non-invasive cardiac output monitor with a limited transthoracic echocardiography assessment to objectively record the intravascular volume status of the study cohort. Patients' intra-procedure responses to sedation along with post-operative recovery will be determined. Investigation of the fluid status of patients undergoing colonoscopy in this study will allow targeted intervention for the prevention or effective management of hypotension during colonoscopy and ultimately increasing the safety of sedation for endoscopy by anaesthetists.

Dr Megan Allen, Professor Kate Leslie, Royal Melbourne Hospital, Melbourne, Vic.

$A54,938

The Obstructive Sleep Apnoea Study (OSATS): Making tonsillectomies safer

Obstructive sleep apnoea (OSA) is a disorder involving pauses (apnoea) or restrictions in breathing during sleep.

It is caused by the repeated collapse of the upper airways and is characterised by frequent drops in oxygen levels and repeated disruption to sleep. In children OSA has a profound effect on their daily life and development. Surgical removal of the tonsils is the first line treatment for most children suffering from OSA.

However, this airway surgery is associated with a high rate of complications with about 50 per cent of the children suffering from serious breathing problems during and/or after surgery. Disorders such as OSA and other factors, such as young age, are known to increase the risk of these breathing problems, during and after anaesthesia.

These breathing problems often result in an increased need of attention and specialised care.

The "gold standard" test for assessing presence and severity of OSA in children is polysomnography (PSG); however, PSG is a high-cost, labour-intensive test involving a complex overnight sleep study and is associated with long waiting lists. It is therefore rarely used in clinical practice in this population. The abnormally collapsible upper airway in children with OSA is evident during sleep, sedation and anaesthesia. Thus, quantifying collapsibility during anaesthesia could provide an objective tool to predict the likelihood of perioperative respiratory adverse events including post-operative obstruction and asphyxia.

While several methods have been developed for use in sleeping adults, very few studies have been performed in anaesthetised children.

The investigators have adapted one such measurement, the critical closing pressure (Pclose), for use in children in the perioperative environment to assess upper airway collapsibility. Most importantly, the Pclose measurement is non-invasive, quick (20 to 60 seconds per measurement), does not significantly impact theatre times and uses a measurement (pressure) that is highly familiar to anaesthetists.

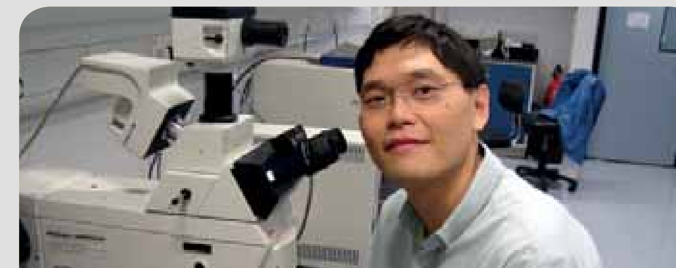
The proposed study is designed to determine the efficacy of Pclose in assessing presence and severity of OSA compared with the gold standard technique of PSG in children undergoing elective tonsillectomy.

The results of this study have the potential to better identify children requiring higher-level care and conversely those who can have same-day discharge. Such measurements also could reduce the occurrence and severity of respiratory adverse events due to better-informed decision-making regarding perioperative management.

The study also may lead to a decrease in the number of unnecessary overnight and intensive care unit admissions.

Professor Britta Regli-von Ungern-Sternberg, Dr Paul Bumbak, Princess Margaret Hospital, Professor Peter Eastwood, West Australian Sleep Disorders Research Institute, Professor David Hillman, Sir Charles Gairdner Hospital, WA.

$A52,726



The role of annexin II in opioid-induced hyperalgesia

Opioids, such as morphine, are commonly prescribed to relieve pain during and after surgery.

Paradoxically, opioid treatment also has been shown to increase sensitivity to painful stimulus and may therefore worsen post-operative pain. The investigators are working on a series of cellular and animal experiments to understand the mechanisms of this phenomenon known as "opioid-induced hyperalgesia".

Attempts to elucidate the underlying mechanisms have suggested the possible involvement of interacting proteins that bind to the membrane μ opioid receptor (MOR). Based on a massive screen of MOR interacting proteins using high-performance liquid chromatography-tandem mass spectrometry, the investigators identified annexin II, a protein that binds to the opioid receptor, as a potential candidate that is important in the development of opioid-induced hyperalgesia.

In a series of cellular and animal experiments, the interactions between annexin II and opioid (remifentanil/fentanyl) treatment on MOR trafficking will be measured. In addition, using an existing biobank of patient DNA samples, the investigators will also conduct a genetic association study to identify the relationship between variants on the annexin II gene and severe pain after a variety of surgical procedures.

The outcomes of this study will help to direct development of preventive and therapeutic strategies for post-operative pain, and will enhance our ability to identify patients at risk of difficult pain management in the perioperative period due to opioid-induced hyperalgesia.

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

$A56,000

Do transthoracic and transoesophageal echocardiography agree in the grading of diastolic dysfunction in cardiac surgery?

Heart failure is well established as a risk factor for adverse perioperative outcomes and has been reported present in almost 50 per cent of patients undergoing cardiac surgery.

Heart failure may reflect either systolic failure, diastolic failure or a combination of the two pathologies, with diastolic dysfunction accounting for approximately half of all new cases of heart failure. Diastolic dysfunction is typically assessed by transthoracic echocardiography (TTE) in clinical practice. The prognostic value of TTE-graded diastolic dysfunction in large numbers of patients across a range of clinical contexts supports the validity of this non-invasive method of assessment.

Intraoperative transesophageal echocardiography (iTOE) is routinely used for diagnosis and monitoring in the majority of cardiac surgeries with expert opinion suggesting that perioperative haemodynamic strategies should be varied according to the identified grade of diastolic dysfunction. However, despite widespread use of TOE for the intraoperative evaluation of diastolic dysfunction in cardiac surgery its validity and role in this context and for this purpose remains poorly defined.

The primary objective of this study is to measure the agreement between preoperative transthoracic echocardiography (preTTE) and intraoperative transoesophageal echocardiography (iTOE), performed prior to surgical incision, for the evaluation and grading of diastolic dysfunction in adult patients undergoing cardiac surgery.

Demonstrated agreement between these two measurements for the grading of diastolic dysfunction would provide important but as yet unavailable evidence supporting the validity of iTOE for this purpose. Importantly, it would also provide the rationale and justification for larger studies to evaluate the utility of TOE for monitoring acute changes to diastolic function through the perioperative period, with potential significance for perioperative care processes including novel, targeted and dynamic approaches to goal-directed haemodynamic optimisation.

In contrast, lack of agreement would provide important justification for a large study comparing the prognostic utility of diastolic dysfunction graded by preoperative TTE and post-induction iTOE to clarify whether such disagreement reflected a meaningful change in diastolic function detected by iTOE or important misclassification by iTOE.

Dr David McIlroy, Dr Enjarn Lin, Dr Jessica Kasza, The Alfred, Melbourne, Vic.

$A56,000

Project grants (continued)

Cyanotic congenital heart disease – the role of nitrogen species in adaptation to hypoxaemia

Many babies born with congenital heart disease remain cyanosed from birth until interventional therapies correct anatomical defects.

Despite this relative lack of oxygen supply for their tissues, the majority of these babies survive and remain relatively well in their early life. These babies can continue to grow and develop for variable periods of time while corrective surgeries are planned.

It is clear these babies adapt to hypoxaemia in ways that still allow the tissues to receive sufficient oxygen for survival and growth. The specific ways in which these babies have adapted are not fully understood. Some well-established mechanisms include an increased red blood cell mass (haemoglobin level) and an increase in cardiac output. Both achieve an increase in the amount of oxygen delivered to tissues but with negative impacts on myocardial work and efficiency.

Recent evidence has emerged that blue babies also have alterations in their peripheral circulation.

Changes in the microcirculation fundamentally affect oxygen delivery and may represent a primary compensatory mechanism in chronic hypoxaemia. However, the exact mechanism by which the microcirculatory changes occur is largely unknown. Studies in adults who have adapted to living at high altitudes suggest that an alteration in the way the body deals with nitrogen species is at the centre of peripheral microcirculatory regulation.

This study will explore the mechanism by which blue babies have adapted to low oxygen levels by measuring nitrogen species and the degree of vasodilation in babies who are awaiting corrective surgery. The study will therefore examine the relationship between nitrogen species, specifically nitrites and nitrates and nitrosyl-haemoglobin and the severity of chronic hypoxaemia. Darkfield microscopy will be used as an objective measure of microvascular flow and will allow correlations between nitrogen species and flow to be explored.

An improved understanding of the altered physiology of cyanotic heart disease will benefit all children with this condition. Careful delineation of the mechanisms by which infants and babies adapt to abnormal blood oxygen saturations creates the potential to manipulate or intervene in ways that improve long-term patient outcomes.

The proposed study will provide valuable information on the basic biology of nitrogen species in paediatric populations and on important physiological mechanisms that underpin the adaptation of neonates and infants to chronic hypoxaemia.

Dr Jonathan De Lima, Dr Marino Festa, Mr Killian O'Shaughnessy, Dr Justin Skowno, Dr Neil Street, Professor David Winlaw, Dr Harry Wark, Children's Hospital at Westmead, NSW; Professor Paul Witting, University of Sydney, NSW.

$A41,099

Altering perceived readiness to engage in advance care planning prior to cancer surgery: a randomised control trial

Advance care planning (ACP) is a process that enables patients to plan their own healthcare for the future. It involves the patient appointing a surrogate decision-maker and then discussing their values and beliefs with that person so that if they are no longer able to communicate their wishes their right to self-determination is protected.

Despite there being widespread acknowledgement at a state, national and international level that ACP is a universal health priority, there is generally low uptake at a hospital level. Given the potential benefits to healthcare workers and patients alike, there have been several initiatives globally which attempt to increase the uptake of advance care planning. However, little research has been conducted around the most effective way to achieve this. Furthermore, there is even less research around how best to introduce the concept of ACP to patients in the perioperative period.

Most patients undergoing major surgery will attend a pre-anaesthetic clinic (PAC) where they will discuss their surgery, medical problems and anaesthetic with an anaesthetist. An important aim of this clinic is to use multidisciplinary teams to holistically prepare patients optimally for surgery. Part of this process is to ensure patients and their families have accurate understandings of the risks and benefits of their upcoming surgery. ACP has an important role in preparing patients for surgery so that in the event of complications that render a patient unable to express their wishes, their medical team will still be able to provide treatment in keeping with the patient's wishes.

This randomised control trial will examine the effect of selected interventions on patients' readiness to engage in ACP as indicated by a specific readiness to engage in ACP score. The interventions examined will include both a passive intervention, being a standardised conversation about ACP, and an active intervention, being an individualised risk discussion based on a patient's calculated American College of Surgeons National Surgical Quality Improvement Project (NSQIP) score.

The results of this study will help guide one of the first evidence-based ACP programs. Primarily it will demonstrate whether targeting patients' readiness to engage in ACP in the pre-anaesthetic clinic context is likely to be productive. Secondarily, information regarding the types of patient populations who might respond better to either active or passive interventions could assist in producing easy-to-use tools that would allow the right interventions to be directed at the right individuals in order to maximise their readiness to engage in ACP. Ultimately, the aim is to improve the delivery of patient-centred cancer care by supporting a patient's right to determine their own care.

Dr Debra Leung, Associate Professor Bernhard Riedel, Dr Hilmy Ismail, Peter MacCallum Cancer Centre, Melbourne, Vic; Dr Karen Detering, Austin Hospital, Melbourne, Vic.

$A27,495 (including scholarship)

Does cefazolin prophylaxis during elective bariatric surgery achieve therapeutic concentration in plasma and interstitial fluid?

Obesity is a risk factor for surgical site infection (SSI) and prophylactic cefazolin has been demonstrated to decrease the incidence of SSI in bariatric surgery compared to placebo and other agents. However, the evidence for optimal dosing of antibiotics in this population group is sparse and conflicting and dose adjustment for body mass index or weight is not recommended. Current Australian guidelines recommend two grams of cefazolin for all bariatric surgery patients, regardless of weight.

This study will measure the antibiotic concentrations in the blood and subcutaneous abdominal interstitial fluid in patients after a routine dose of cefazolin for bariatric surgery and a pharmacokinetic profile will be developed.

This will examine if cefazolin concentrations are sufficient to reach the minimal inhibitory concentration of common pathogens and hence prevent infections. If current doses are sub-therapeutic, the appropriate dose will be calculated. This may assist clinicians to develop guidelines for optimal dosing of prophylactic cefazolin for this increasingly common clinical scenario.

Dr Rochelle Ryan, Dr Rebecca Christensen, Dr Dwane Jackson, Professor Jason Roberts, Royal Brisbane and Women's Hospital, Queensland

$A30,963

Does cefazolin prophylaxis during elective bariatric caesarean section achieve therapeutic concentration in plasma and interstitial fluid?

In caesarean section, prophylactic antibiotics are routinely given to women before surgery. These have been shown to significantly reduce the incidence of wound infections, endometritis and serious infectious complications.

However, the dose of antibiotics recommended for adults is the same regardless of their weight. In overweight women this dose may be too small and may result in a reduced concentration of antibiotics in the tissue where infections occur. Overweight women have an increased risk of infection in their surgical wounds and this may be in part due to reduced antibiotic concentrations.

Evidence for dosing of antibiotics in this population is sparse and conflicting. An absence of data to guide antibiotic dosing may result in antibiotic doses for surgical prophylaxis being ineffective, thus putting the mother, foetus and neonate at risk of morbidity and mortality in the event of surgical site infection. It follows that urgent pharmacokinetic data is required to guide clinicians in this increasingly common clinical scenario.

The purpose of this study is to determine optimal dosing of cefazolin prophylaxis in the obese obstetric patient (with a body mass index greater than 35) undergoing caesarean section. The investigators will measure antibiotic concentrations in the blood and in abdominal tissue after a routine dose of antibiotics. If the antibiotic concentration is insufficient, pharmacokinetic modelling will be used to calculate the dose that may be adequate.

Data generated from this study will be used to develop a pharmacokinetic model for cefazolin, which can be used to develop dosing recommendations to optimise therapeutic activity to reduce the rate of infections in the surgical wound of women having caesarean section in this patient population.

Dr Rebecca Christensen, Dr Victoria Eley, Dr Rochelle Ryan, Dr Dwane Jackson, Professor Jason Roberts, Professor Jeffrey Lipman, Royal Brisbane and Women's Hospital, Qld.

$A30,963

These projects will describe the pharmacokinetics of prophylactic cefazolin levels in the pregnant and non-pregnant bariatric surgical patient.

Project grants (continued)

Understanding the impact of anaesthetic technique and neural-inflammatory signalling on cancer recurrence and metastasis

Cancer continues to be one of the top five disease burdens among Australians and, with a rapidly changing landscape, the impact of cancer diagnosis is expected to continue to rise exponentially. In fact, one in two patients are expected to have a cancer diagnosis by the age of 85 years.

Surgery remains the most common treatment used in the treatment of cancer, ahead of chemotherapy, radiotherapy and immunotherapy. With surgical removal of cancer indicated in over 60 per cent of patients presenting with solid tumours and up to 85 per cent of cancer patients exposed to anaesthesia as part of their treatment, it is critical to understand the impact of the perioperative period and anaesthetic agents on long-term surgical outcomes.

The aim of this research project is twofold. Firstly, we will investigate the impact of anaesthetic agents in cancer recurrence and spread in an experimental model of human breast cancer. Secondly, the investigators will explore the mechanisms driving these effects. The research will help to define optimal strategies for perioperative intervention to help guide clinical research and establish standards for anaesthetic care of the cancer patient.

This research will be performed in collaboration with the Monash Institute of Pharmaceutical Science and the Department of Anaesthesia at the Peter MacCallum Cancer Centre, bringing together clinicians and researchers at the forefront of cancer research in Australia and ensuring rapid translation of scientific research into meaningful application in the clinical setting.

The potential impact of this research is to identify anaesthetic and perioperative strategies that provide the best possible long-term cancer outcomes for patients. Novel use of existing anaesthetic agents means that findings from our research will be rapidly and easily translated into impactful changes in clinical practice. As surgery, and as such anaesthesia, continues to be a major part of cancer treatment, research into this field is vital.

Dr Julia Dubowitz, Dr Erica Sloan, Monash Institute of Pharmaceutical Sciences, Melbourne, Vic; Professor Bernhard Riedel, Peter MacCallum Cancer Centre, Melbourne, Vic.

$A50,654 (including scholarship)

Validation of a simplified method for assessing perioperative and OSA risk

Obstructive sleep apnoea (OSA) is a common condition characterised by repetitive episodes of complete or partial airway collapse during sleep and associated with an increased risk of adverse health outcomes. Among these, individuals with OSA are at increased risk of cardiopulmonary complications in the recovery period following surgery resulting in increased admissions to high-care environments and longer hospital stays.

While these risks exist, OSA is often poorly characterised prior to surgery or not recognised at all. Further, given limited resources, high acuity care is not available for every patient in whom the possibility of having OSA has been raised.

To address these problems we propose to measure airway-closing pressure (Pclose) on patients prior to emergence from anaesthesia as a simple means of objectively identifying and quantifying vulnerability to upper airway obstruction when unconscious. The degree of collapsibility determined by this measure will be a guide to airway behaviour during subsequent sleep and sedation. As such, it may be useful in stratifying risk, identifying those most vulnerable to obstruction.

If so, it may be valuable in informing perioperative management decisions including required intensity of post-operative monitoring. The ability to easily and accurately stratify patients to appropriate level care would facilitate effective and cost effective use of resources and ultimately reduce the burden on tight healthcare budgets. It is also possible that the measure of Pclose in the perioperative period may be useful for identifying those with OSA for subsequent sleep management.

The immediate post-operative period offers an opportunity to assess airway function in unconscious subjects and thereby quantify the tendency for OSA in a large, at risk, but largely undiagnosed population. New, streamlined methods for evaluating OSA are warranted as it is a very common condition with substantial economic cost to the Australian community.

Professor David Hillman, Dr Brad Lawther, Sir Charles Gairdner Hospital, WA; Professor Peter Eastwood, Dr Jennifer Walsh, Dr Kathleen Maddison, West Australian Sleep Disorders Research Institute, WA.

$A33,850

Post-discharge opioid use following acute surgical care: a multi-centre study

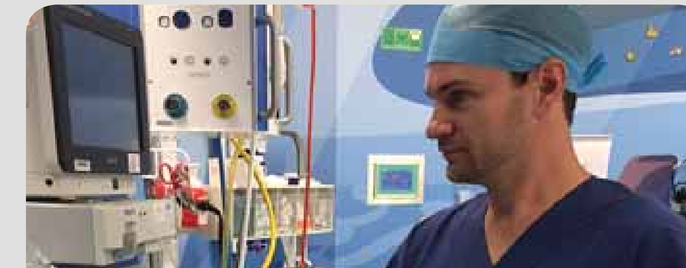
As opioid prescription has increased, so too has concern about diversion, overdose, dependence and unintentional poisoning. The contribution to the community opioid pool by opioids dispensed from hospital following surgical care in Australia is unknown.

This study involves four hospitals, each servicing distinct surgical populations. We will follow the surgical cohort across these institutions. At two weeks after hospital discharge patients will be contacted to determine their pain control, adequacy or excess of discharge opioid analgesia and storage or disposal methods for any excess.

Obtaining a snapshot of the handling of prescription opioids post-surgery in Australia will reveal whether excess supply at hospital discharge is a material problem. Defining the problem is a vital first step in designing an intervention to better target opioid prescription to offer good pain relief and reduce the potential for a pool of prescription opioids in the community.

Dr Megan Allen, Dr Charles Kim, Royal Melbourne Hospital, Melbourne, Vic; Dr Tim Hucker, Peter MacCallum Cancer Centre, Melbourne, Vic.

$A34,459



The effect of dexmedetomidine given as a premedication or intraoperatively on post-hospitalisation behavioural change in children: a randomised controlled trial

Post-operative negative behaviour, such as sleep and eating disorders, nightmares and tantrums, is a significant problem related to childhood surgery and anaesthesia with an incidence of over 50 per cent reported in various studies. It may also persist for up to a year in a small percentage of children. It is a significant problem as it may have long-term effects on a child's compliance with future medical therapy and it has been suggested that distress surrounding medical procedures in children leads to an increase in pain and anxiety surrounding medical events as adults. A recent meta-analysis of alpha-2 agonists, including dexmedetomidine, found that they effectively reduce the incidence of emergence delirium but none of the studies looked at longer-term outcomes, such as negative behaviours after discharge from hospital.

The aim of this study is to measure the incidence of negative behaviour change in three groups of children. Two to seven year-old children requiring general anaesthesia for common day-case procedures will be randomly assigned to: a dexmedetomidine pre-medication group, an intraoperative dexmedetomidine group and a control group. Baseline anxiety levels of the parent will be recorded and the anxiety of the child during induction of anaesthesia also will be recorded using validated tools. The primary outcome will be negative behaviours after hospitalisation and these will be measured using the Post Hospitalisation Behaviour Questionnaire for ambulatory surgery (PHBQ-AS) and the Strengths and Difficulties Questionnaire (SDQ).

Improving the perioperative experience for children and their families is of vital importance. Dexmedetomidine may reduce the incidence of negative behaviour change after surgery and anaesthesia, which would improve the recovery of the child, improve overall child and parental satisfaction with the perioperative period, reduce parental absence from work and reduce additional visits to the doctor. It may also have longer-term benefits by reducing stress and anxiety surrounding future episodes of healthcare.

Dr Paul Lee-Archer, Lady Cilento Children's Hospital, South Brisbane, Qld.

$A28,792

Grant review process

Thank you to all reviewers listed below who reviewed a grant, and in some cases two, for your invaluable contribution to the grant process. The ANZCA Research Committee is extremely grateful for your assistance. Each year ANZCA Research Committee members read and review the grants, select two additional reviewers for each grant on the basis of their expertise and relevance to the project, read the reviews, collate the information and act as overall spokesperson for each grant, and make the final recommendations.

The grant review process is rigorous and transparent. Conflicts of interest are recorded and members of the committee are excluded from consideration of any grants for which they have a conflict. The presence of Dr Angela Watt, our community representative, adds an extra safeguard in this regard.

ANZCA Research Committee members:

Professor Alan Merry, Chair
Professor David A Scott, Deputy Chair
Professor Matthew Chan
Dr Andrew Klein
Professor Kate Leslie, AO
Associate Professor Simon Mitchell
Professor Paul Myles
Professor Tony Quail
Professor Britta Regli-Von Ungern-Sternberg
Professor Stephan Schug
Associate Professor Tim Short
Professor Andrew Somogyi
Professor David Story
Professor André van Zundert
Professor Bala Venkatesh
Dr Angela Watt, community representative
Associate Professor Jennifer Weller

Grant reviewers for the 2017 grant round

Dr Megan Allen
Professor Brian Anderson*
Associate Professor David Baines
Dr Paul Baker
Associate Professor Michael Barrington*
Dr Pierre Bradley
Associate Professor Charles Brooker
Associate Professor Wendy Brown
Professor Thomas Bruessel
Dr Andrew Buettner
Professor Donal Buggy
Dr Michael Bujor
Dr Douglas Campbell*
Dr George Chalkiadis
Professor Allen Cheng
Dr David Costi
Dr Brian Cowie
Dr Meredith Craigie*
Dr Martin Culwick
Dr Allan Cyna
Professor Andrew Davidson
Associate Professor Alicia Dennis
Dr George Djaiani
Dr Glenn Downey
Dr Patrick Farrell
Associate Professor Philip Finch
Associate Professor Craig French*
Dr Neville Gibbs
Associate Professor Roger Goucke*
Associate Professor Kathleen Gray
Dr Keith Greenland
Dr Genevieve Goulding
Associate Professor Michael Harrison
Dr Andrew Heard
Clinical Associate Professor Peter Hebbard
Dr Elizabeth Hessian
Dr Jonathan Hiller
Clinical Professor David Hillman*
Dr Malcolm Hogg
Associate Professor Alex Holmes
Dr Christine Huxtable
Dr Erik Jensen
Professor Peter Kam
Professor David Kennaway
Associate Professor Ross Kennedy
Dr Zoe Keon-Cohen
Dr Ross Kerridge
Dr Roman Kluger
Dr Alex Konstantatos
Dr Peter Kruger
Associate Professor John Loadsman*
Dr Nuala Lucas
Associate Professor Ross MacPherson
Associate Professor Silvana Marasco
Dr Stuart Marshall
Dr Daniel Martin
Dr Peter McCall
Clinical Associate Professor Nolan McDonnell
Professor Paul Myles
Dr Irene Ng
Professor Michael Nicholas
Dr Fergal O'Donoghue
Dr Michael O'Leary
Dr Edmond O'Loughlin*
Professor Michael Paech*
Dr Tom Painter
Dr Neil Paterson
Associate Professor Philip Peyton*
Dr Tuong Phan*
Dr Philip Popham
Professor Bernhard Riedel
Associate Professor Richard Riley
Dr Lindy Roberts
Professor Franklin Rosenfeldt
Dr Andrew Ross
Professor Colin Royse
Associate Professor Andreas Schibler
Professor Stephan Schug*
Associate Professor Ian Seppelt*
Professor Philip Siddall
Dr Craig Sims
Dr Justin Skowno
Dr Ben Slater
Professor Jamie Sleigh
Dr Barry Snow
Dr Joel Symons
Dr Jane Thomas
Dr Rowan Thomas*
Dr Craig Walker
Dr William Weightman
Professor Daryl Williams
Dr Niall Wilton
Associate Professor Sunny Wong
Associate Professor William Wu
Dr James Yeates

*Reviewed two grants

ATACAS researchers present final results

The final results of the Aspirin and Tranexamic Acid for Coronary Artery Surgery (ATACAS) trial were showcased before a large audience of anaesthetists from around the world at the American Society of Anesthesiologist's (ASA) 2016 annual meeting in Chicago by principal investigator Professor Paul Myles on October 23.

The trial received $A4.5 million from the National Health and Medical Research Council, and from ANZCA. The trial was run out of The Alfred and Monash University, in Melbourne. The aspirin arm of the trial was published in the *New England Journal of Medicine* earlier this year (N Engl J Med 2016;374:728-37).

ATACAS has been running for more than 10 years at 31 cardiac hospitals across seven countries. Now the ATACAS-tranexamic acid results have been published in the *New England Journal of Medicine*.

This study provided definitive results that tranexamic acid can be safely used to reduce the bleeding complications in patients undergoing cardiac surgery without increasing the risk of thrombosis after cardiac surgery.

The results build on the evidence-base in anaesthesia, pain and perioperative medicine needed to improve patient outcomes.

About the trial

Patients undergoing cardiac surgery are commonly administered tranexamic acid to reduce the complications of bleeding, however, it is unclear whether it increases the risk of heart attack or stroke.

ATACAS was designed as a multi-centre, double-blinded, randomised two-by-two factorial trial, in which 4631 high-risk patients undergoing coronary artery surgery where randomly assigned to receive tranexamic acid or placebo.

The primary outcome was a composite of death and thrombotic complications (non-fatal myocardial infarction, stroke, pulmonary embolism, renal failure and bowel infarction) within 30 days of surgery. Secondary endpoints included blood transfusion, re-operation, respiratory failure, and hospital length-of-stay.

Of the 4631 patients who consented to participate in the trial, 2311 were randomly assigned to receive tranexamic acid (50-100mg/kg) and 2310 received a matched placebo. The primary outcome occurred in 386 (16.7 per cent) patients assigned to the tranexamic group and 420 (18.1 per cent) patients in the placebo group (relative risk, 0.92; 95 per cent confidence interval, 0.81 to 1.05; P=0.22).

Major haemorrhage or tamponade requiring re-operation occurred in 1.4 per cent and 2.9 per cent of patients (P=0.001), any blood transfusion within 24 hours of surgery was used in 31 per cent and 49 per cent of patients (P<0.001), seizures occurred in 0.7 per cent and 0.1 per cent of patients (P=0.002) in the tranexamic acid and placebo groups respectively.

In patients having coronary artery surgery, pre-operative tranexamic acid reduced bleeding complications without increasing the risk of death and thrombotic complications within 30 days of surgery. Tranexamic acid was associated with a small increase risk of post-operative seizures. Tranexamic acid can be safely used for coronary artery surgery.

Professor Paul Myles, FANZCA
Principal investigator
On behalf of the ATACAS trial investigators and the ANZCA Clinical Trials Network

New name, same goals as foundation supports research into anaesthesia and pain medicine

New name for the foundation

The ANZCA Research Foundation is the new name of the College's research and education fundraising and grant program management body.

The new name follows extensive consultation with FPM, the foundation committee and its chair, Dr Genevieve Goulding, ANZCA President Professor David A Scott, the foundation's Board of Governors, the general managers of ANZCA's Communications and Fellowship Affairs units, ANZCA Chief Executive Officer John Ilott, and consultants RobeJohn & Associates.

Dr Goulding presented recommendations to ANZCA Council at its meeting on September 23 and the following was approved:

Name: A change of name from the "Anaesthesia and Pain Medicine Foundation" to the "ANZCA Research Foundation".

Mission statement: "To support medical research and education that saves lives, helps people to optimise their health, and works to make life as pain-free as possible."

Vision statement: "To be a leader in funding high-quality research and education in anaesthesia, perioperative and pain medicine."

Unifying emotional proposition: "Saving lives, improving life".

The changes build on the work done by those who developed the foundation's previous name and will improve the foundation's ability to communicate its purpose and focus concisely and with impact. It will continue to support ANZCA's overseas aid and indigenous health programs.

Australian Executor Trustees

After a Board of Governors lunch in late 2015, the foundation secured a $A35,000 grant from Australian Executor Trustees for a South Australian researcher.

In September 2016, the project "Do Bolus intravenous fluids cause Lung Injury: Role of TRPV4 channels" (Dr Thomas Painter, Royal Adelaide Hospital), was ranked highly by the ANZCA Research Committee and ANZCA will contribute additional funding, as per the grant agreement, to allow the project to proceed in 2017.

Elaine Lillian Kluver ANZCA Research Award

Dr Elaine Kluver from Southport in Queensland, passed away in May 2016, leaving a very generous bequest to the foundation for research to advance anaesthesia, analgesia and pain medicine.

The Elaine Lillian Kluver ANZCA Research Award has been created and the inaugural award has been granted to Professor Eric Visser, of the University of Notre Dame, WA, who in September received ANZCA's Academic Enhancement Grant for 2017 for his project "Sympathetically maintained pain in complex regional pain syndrome" (see page 35). Dr Kluver's obituary can be found on page 106.

Academic Enhancement Grant to Churack Chair

After a gift of $A1 million to the University of Notre Dame in Perth from Mr Geoff and Mrs Moira Churack, and further fundraising, the University of Notre Dame has created the new Churack Chair of Chronic Pain Education and Research, collaborating with Murdoch University's Pain Medicine Research Centre.

Professor Visser, who received the Elaine Kluver award, has been appointed inaugural chair. The College and the foundation received positive acknowledgement from both Professor Visser and the university's Vice-Chancellor Celia Hammond at the recent announcement of Professor Visser's appointment.

Provisional/New Fellow ANZCA Research Award

Following Professor Barry Baker's generous endowment to the foundation in 2014, the ANZCA Research Committee has allocated the inaugural Provisional/New Fellow ANZCA Research Award for 2017 to Dr Matthew Doane from Royal North Shore Hospital, Sydney.

This wonderful contribution is part of ANZCA's strategic objective of supporting new researchers.

Automatic giving

The foundation now offers patrons and other regular donors the option of automatic donation from their Visa and MasterCard. A donor may cancel their automatic donations at any time. To establish automatic donations, please contact the foundation.

Making a bequest

Any Fellow interested in creating a foundation bequest in their will should contact Rob Packer at the foundation on +61 3 8517 5306 or rpacker@anzca.edu.au.

With deep appreciation to all of the foundation's generous donors.

Rob Packer
General Manager, ANZCA Research Foundation

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

The importance of feedback in learning

Feedback is widely believed to be an essential component of effective learning. Feedback conversations have the potential to enhance learning and improve performance.

In this overview we revisit the concept of feedback, reframing it as a collaborative learning conversation rather than a one-way transfer of information from "expert" to learner.

We also introduce the new Fundamentals of Feedback modules, developed to support ANZCA and FPM Fellows and trainees when having feedback conversations in clinical and simulation-based settings.

What is feedback?

Traditionally feedback has been considered as something we "give" to someone, often at a "formal" meeting at the end of a period of learning, for example, at the end of a list. We might present our views on strengths as well as areas for development.

However in these types of interactions individuals tend to adopt specific roles with the person "giving the feedback" seen as the "expert diagnostician" and the learner as the "attentive listener"[1]. Although there are situations in which this may be appropriate, and possibly effective, there are several reasons why we should broaden our concept of feedback to consider this as a reflective conversation. We will focus on two reasons here.

Firstly, conceptualising feedback as something we "give" to someone places the emphasis on the views imparted by the "expert" and de-emphasises the importance of the many and varied sources of information that occur throughout the day in our interactions with learners. A raised eyebrow, nods of agreement, a clarifying question or a corrective gesture are all sources of information that provide feedback about how we are performing. This information can go unrecognised by learners as "feedback" if we maintain the perception that feedback only occurs when undertaken "formally".

Secondly, if we dive in and present our views on what we think should be done to improve, we run the risk of misunderstanding what led the learner to act as they did. For example, if we assume that a learner's failure to check the presence of working suction prior to rapid sequence induction was due to a lack of knowledge, our suggestions for improvement will be based on the learner's need to improve their knowledge.

If, on the other hand, the learner in fact didn't check the suction because they were distracted, we will have missed an opportunity to have an altogether different type of learning conversation. The learner may nod politely and thank you for your feedback but the net result is likely to be no observed change in performance.

If we explore the learner's thinking, why they did what they did, we have a better chance of understanding the nature of any gaps in performance and thus, a better chance of discussing strategies for improvement that are actually relevant to the learner's needs. In the example above, the conversational strategies for improvement would focus on how we might manage distractions at a critical time as opposed to giving the learner a mini-lecture on the components of rapid sequence induction.

So, what is feedback?

Many definitions have been proposed and in 2008 van de Ridder et al[2] proposed a consensus statement describing feedback, in an educational setting, as sharing "specific information about the comparison between a trainee's observed performance and a standard, given with the intent to improve the learner's performance".

In this definition, feedback is conceptualised as information to be transmitted with the learner as the focus. We prefer the term "feedback conversation" because we are focusing on more than just the transmission of information. In short, a feedback conversation is a collaborative conversation that is intended to improve performance.

How are feedback and debriefing related?

The terms "feedback" and "debriefing" are sometimes used interchangeably and in many ways they have more similarities than differences. We generally conceptualise debriefing, in an educational sense, as a facilitated reflective conversation that takes place after a simulated event and feedback as a conversation that takes place in the workplace.

Both feedback and debriefing have been conceptualised as feedback conversations for the purposes of this project as they share the common goal of improving performance and there are many conversational techniques that are effective in both settings.

What is effective feedback?

Having defined a feedback conversation as a collaborative learning conversation with the goal of improving performance, perhaps the ultimate measure of effective feedback is the degree to which performance is improved over time. However, when it comes to feedback, it is possible to "do everything right" and yet not see the expected change in behaviour.

Like most interactions involving people, the success or otherwise depends on a complex set of social and other factors, for example the nature of the relationship between those involved and the credibility of the person providing feedback[3].

If we take this into account it becomes obvious that "effective feedback" relies on considerably more than just the skills of the feedback "provider" and that sometimes, despite our best intentions and our best efforts at facilitating a feedback conversation, there will not be any resulting change in behaviour. Therefore, just like anaesthesia, we need to consider process as well as outcome measures when it comes to defining high quality feedback.

Key characteristics of high quality feedback conversations include timely provision of specific information, based on personal observation that is relevant to the learner[4], and provided by a source perceived by the learner as credible[3]. The conversation should occur in the presence of psychological safety and include a learner action plan for improvement.

In addition, for feedback to be effective the learner needs to want to improve (and ideally should be regularly actively seeking feedback) and to have interpreted the intended message accurately.

How do we do it?

There are several approaches that can be utilised to engage learners in feedback conversations. In the Fundamentals of Feedback we have chosen to focus on three techniques that are well described in the literature and, increasingly, widely recognised in healthcare.

1. Utilising learner self-assessment
Encouraging self-assessment promotes reflection. "How did I do? What could I do differently next time?"

2. Provision of directive feedback
Directive feedback is the provision of specific comments based on was observed and is useful for development of procedural skills. "Next time try this..."

3. Pairing of advocacy and inquiry
"Advocacy-inquiry" refers to the pairing of an advocacy statement ("I saw this...and I thought this...") with an inquiry ("I wonder how you see that?") to share and explore each person's perspective. It is used to what happened and why so we don't miss learning opportunities[5].

Useful resources
Eppich and Cheng[6] have developed a framework for debriefing in the simulated setting called "Promoting Excellence and Reflective Learning in Simulation" (PEARLS) which is highly applicable to feedback conversations in the workplace. This framework incorporates the same techniques used in Fundamentals of Feedback and we recommend this resource to all.

Final thoughts

We can think of no better way to sum up our approach to feedback conversations than the four suggestions by Glenda Eoyang[7] below.

- Turn judgment into curiosity.
- Turn disagreement into shared exploration.
- Turn defensiveness into reflection.
- Turn assumptions into questions.

Dr Cate McIntosh
Chair, Fundamentals of Feedback Project Group

Maurice Hennessy
Learning and development facilitator, ANZCA

ANZCA is extremely grateful to the project group, the staff of the Hunter New England Simulation Centre, and the many volunteers from the Department of Anaesthesia at John Hunter Hospital for their contribution to the development of these resources, which will help ANZCA and FPM Fellows and trainees have more effective feedback conversations.

Psychological safety

For a learner to feel comfortable discussing their performance it is important they feel safe to do so. In feedback conversations an ounce of prevention is worth a pound of cure. That is, it is much better to create a safe space for learning, or psychological safety, at the outset rather than try to "rescue" a situation in which the learner has become defensive and the conversation has become "difficult". If there is "psychological safety" the learner will feel comfortable sharing their thinking with you so together you can think and discuss things critically.

About the Fundamentals of Feedback modules

There are seven modules applicable to situations arising in the workplace and in simulation-based settings.

Targeting all levels of expertise and experience in feedback conversations, the modules are highly interactive with videos and activities to practice and refine skills. The modules have been tailored for those wishing to work through the program individually but ideally people will work in pairs or small groups.

Where to find the modules

The seven modules are available on Networks from December 16 and are easily accessed with your College ID and password.

References:

1. Molloy E, Clarke D. The positioning of physiotherapy students and clinical supervisors in feedback sessions. Focus on Health Professional Education. 2005;7(1):79-90.
2. Van De Ridder JM, Stokking KM, McGaghie WC, Ten Cate OT. What is feedback in clinical education? Med Educ. 2008;42(2):189–97.
3. Watling C, Driessen E, van der Vleuten CPM, Lingard L. Learning culture and feedback: an international study of medical athletes and musicians. Med Educ. 2014;48(7):713–23.
4. Eva KW, Armson H, Holmboe E, Lockyer J, Loney E, Mann K, et al. Factors influencing responsiveness to feedback: On the interplay between fear, confidence, and reasoning processes. Adv Heal Sci Educ. 2012;17(1):15–26.
5. Rudolph JW, Simon R, Rivard P, Dufresne RL, Raemer DB. Debriefing with good judgment: combining rigorous feedback with genuine inquiry. Anesthesiol Clin. 2007;25(2):361–76.
6. Eppich W, Cheng A. Promoting Excellence and Reflective Learning in Simulation (PEARLS): Development and Rationale for a Blended Approach to Healthcare Simulation Debriefing. 2015, 10(2):106-115.
7. Eoyang, G. Uncertainty in healing and learning: Finding the simple in the complex. Paper presented at AMEE Conference; 2016 Aug 27-31; Barcelona, Spain.

Behind the scenes of the primary exam

Fellows and College staff work hard to deliver a firm but fair primary examination, the first big milestone in anaesthesia training.

The two members of the Court of Examiners confer quietly in their cubicle. Dr Nic Randall and Dr Tony Keeble order their papers and confirm which questions each will ask in this viva: four topics, two each. Dr Keeble has a chart and graph for the candidates to analyse.

"The topics have already been picked," Dr Keeble said. "We do our best to find out what the candidates actually do know. If they know nothing, we just move on to another topic."

The first bell of the day rings and someone calls, "OK, they're coming in." Dr Keeble grins: "Order in the court." Dr Randall grins back and bangs his pen on the table like a gavel. Then they adopt blank faces and a formal air. Their first candidate has arrived and is studying the first question, which is pinned to the outside wall of the cubicle, and scrambling to gather thoughts about injured blood vessels.

A second bell rings. The candidate strides in to face her judges and drops into her chair. Dr Keeble hits the timer. It's on.

The primary examination – known as the "1000-hour exam" because of the amount of study required to pass it – and associated vivas are the first big milestones in anaesthesia training. It's tough and the pressure is intense, as candidates have had to juggle work, work-based assessments and study time in order to prepare for it. And the pass rate for the primary exam, which focuses on scientific basics, is often about 60 per cent, as opposed to about 80 per cent for the final exam, which is more focused on clinical anaesthesia.

For candidates on the day, nerves stretched to breaking point have been known to result in tears, tantrums and even, occasionally, fainting. One candidate, determined not to throw away all her hard work despite the all-too-imminent arrival of her baby, insisted on sitting her exam while she was in labour.

But an enormous amount of work also has gone into exam preparation on the other side of the equation: by the examiners and the ANZCA staff who support them, particularly Moira Besterwitch, ANZCA's Team Leader, Primary Examinations.

While the College ensures there are enough administrative staff to carry out the detailed administrative work required behind the scenes – the tasks of managing registration and candidate numbers, payments, venue bookings, and the transportation and security of exam papers, for example – the College must rely on Fellows to volunteer as examiners. Each primary viva exam needs at least 24 examiners from a panel of about 40 (five have just retired), and the final exam requires 60 examiners from a panel of around 90 (12 have just retired).

Dr Emma Giles, the Deputy Chair of the Primary Examinations Sub-Committee, says the Court of Examiners is always on the lookout for new talent.

"There are lots of anaesthetists who would be great examiners, but the ones who apply tend to be just from the big-city hospitals," Dr Giles said.

"Often people don't apply because they worry about imposter syndrome; they think it needs to be professors or people in research positions. But we want anaesthetists from all different backgrounds. I think there are people out there who don't realise they could be an examiner. But you don't have to be working in a teaching hospital, you can be in a smaller hospital. You are just required to be a competent anaesthetist with an inquiring mind."

What's in it for them? "It's a thing we enjoy doing. It's intellectually stimulating. You learn a lot and it attracts continuing professional development credits. And it's a chance to give back; a sense of repaying the debt to the system that nurtured us."

Queensland anaesthetist Dr James Derrick, who works in private practice, has been an examiner since 2007. He was invited to join because he had previously set up a primary teaching program in Hong Kong.

"The reason why I took on part one tutorials is because no one else was doing it. I am glad I did it now. I do find pharmacology and equipment interesting. The people you examine with are very bright, talking to them is valuable and you certainly learn things while you are there. All of these things affect your clinical practice."

Are you interested in becoming an examiner?

ANZCA examiners are Fellows of the College with a minimum of three years' post-fellowship experience for the primary examination and five for final examination. Examiners are appointed by the Primary Examination Sub-Committee or Final Examination Sub-Committee and are given training about processes and expectations.

Appointment of examiners takes into account factors such as willingness to commit, knowledge of the relevant ANZCA vocational training program curriculum, ability to recognise and manage potential bias and conflicts of interest, and communication skills.

Further information can be found at:

- http://anzca.edu.au/Fellows/Benefits-of-fellowship/Contributing-to-your-college (under primary and final examiner)
- http://anzca.edu.au/Fellows/Benefits-of-fellowship/Duties-of-a-primary-examiner
- Page 187/188 of the ANZCA handbook http://anzca.edu.au/Documents/training-accreditation-handbook.pdf

Fellows wishing to apply should contact either primaryexam@anzca.edu.au or finalexam@anzca.edu.au. A current curriculum vitae and three referees (one of whom should be a past or present examiner) are also required. Please include a letter of support from your head of department if he or she is not a referee.

Examiners commit to 12 years in the role, although can take a year off if required.

"There are five days a year where you come to Melbourne and spend Monday to Wednesday examining. There is another 20 to 40 hours of doing things like marking, or thinking up questions," Dr Giles said.

"When we are marking, we have a group of us and we get together and we talk about what we think is a good marking grid (regarding the content of the answers). Once the candidates do the questions, maybe a lot of them will see a different interpretation we haven't thought of, and we will adjust to make it fair.

"Exam papers are set at the previous exam. This year we did it on Saturday before the September primary exam, which was on a Monday. Fifteen of us came together at the weekend and debated. We decided the balance of the questions and then chose the questions themselves, both the multiple choice and the short-answer questions.

"We look carefully at every question over several months to ensure there is no ambiguity, and then we write the marking grids. There are 15 questions, and I might mark question one only, about 200 times, and someone else will mark question 15. It makes it really fair, because each candidate is marked by the same person."

> "The primary examination – known as the "1000-hour exam" because of the amount of study required to pass it – and associated vivas are the first big milestones in anaesthesia training."

A lot of effort goes into designing the papers and the processes to maximise fairness. The examiners sit the exams and then scrutinise the range of marks, to ensure the questions are neither too hard nor too easy. Examiners conducting vivas are forbidden to lead the candidates but are told to be encouraging.

"You want to know what they know, not what they can manage to tell you through a cloud of sheer, abject terror," Dr Giles said.

Examiners themselves undergo continuous assessment by examiner assessors, who sit through vivas and give marks on whether the questions were fair and were worded appropriately, and whether candidates were given appropriate guidance. Candidates see three pairs of assessors, and a "pathway" has been worked out for each candidate so that they do not face any repeated questions.

And lastly, examiners marking the short-answer questions can use a Mac-based app written by Dr Derrick to warn if they are developing a bias over time when they are marking – "For example, if you are getting tired and your marks are therefore getting lower," Dr Giles said.

All the fairness in the world cannot ensure everyone gets over the line. No one finds out their actual mark; four weeks after they sit, candidates learn if their result is pass or fail.

"We do get tearful calls after the exams, but the marks have been checked multiple times," Ms Besterwitch said. "The outcome is final. A lot of primary candidates take it really badly if they fail the exam. It is probably the first time they have failed any exam."

Those who struggle with exams are referred back to their training hospitals, which may recommend they see a sports psychologist to help with performance anxiety. Candidates used to be able to sit exams as often as they wished but now there are limits: five times for the primary and seven times for the final.

Dr Giles said: "If they have failed three times, either the chair or the deputy chair will take part in a remediation interview, with the supervisor of training, education officer and senior exam representative. We talk about how the candidate has prepared for the exam, trying to offer them support. Sometimes I feel like I have been of help; sometimes I don't."

For one high-achieving candidate, however, the result will mean glory, with the Renton Prize for the trainee who wins the highest mark.

Karen Kissane,
ANZCA Media Manager

Above from left: The primary exam was held in the Clarendon Room of the Melbourne Exhibition and Convention Centre in August; examiners were Dr Abhijeet Tandel from Gosford, NSW and Dr Annette Turley, from Rockhampton, Queensland.

Canadian post brings invaluable experience

"By throwing myself into total uncertainty, I gained perspective into who I was and who I wanted to become for the rest of my career."

Trainee anaesthetists learn life-changing lessons during a provisional fellowship year in Toronto.

Trepidation... anxiety... we stood metaphorically on the edge of a platform, one step away from the vast unknown of our fellowship in Toronto, Canada. Our preconception of what lay ahead was formed through limited reading and unbelieving discussions with those who had gone before.

It was close to midnight as we waited nervously at Sydney's Kingsford Smith international airport, the clock had ticked long past our scheduled departure time. Finally an apologetic announcement overhead: "We are sorry to inform you that your flight to Toronto via Hong Kong has been cancelled because the plane was struck by lightning..."

My husband and I looked at each other in astonishment. What a great start to our year in Canada!

When we left Sydney for Toronto over a year ago we knew little about overseas fellowships. However, once we landed, we were surprised to find ourselves surrounded by Australian Fellows. By writing this piece I hope to inform other anaesthesia trainees about these wonderful opportunities, to inspire them to take a leap of faith, and help them avoid preventable pitfalls.

The journey to becoming a qualified doctor is lengthy and arduous, and most people choose to not take an exploratory detour, understandably so. I am grateful that ANZCA gives trainees flexibility in their provisional fellowship year to pursue something different because the most rewarding aspect of venturing to Canada was personal growth. By throwing myself into total uncertainty, I gained perspective into who I was and who I wanted to become for the rest of my career.

Canada is a hub for international Fellows, especially Australians, in anaesthesia, surgery, internal medicine and radiology. It has an auspicious combination of well-established fellowship programs in world-class medical institutions without pre-requisite exams or language barriers (except French in Quebec, which still perplexes me), and lifestyle-wise, it is practically Australia!

Toronto General Hospital is a quarter of the University Health Network, an amalgamation of four sub-speciality hospitals in downtown Toronto. The hospital is home to the famous Peter Munk Cardiac Centre, the largest multi-organ transplant program in Canada and also specialises in major surgical oncology.

I completed a 12-month clinical fellowship in cardiac anaesthesia and perioperative echocardiography, with four months lung transplant call, while my husband did hepato-biliary and liver transplant.

The cardiac surgery division of Peter Munk Cardiac Centre performs approximately 1800 open-heart surgeries per year. It is Canada's leading cardiac valve, thoracic aorta/arch repair, ventricular assist device and heart transplant centre. It is also central Canada's centre for adult congenital cardiac surgery. Moreover, it is home to David's Procedure (valve sparing aortic root replacement) and the Simplici-T® System for mitral and tricuspid annuloplasty.

Their multi-organ transplant service performs more than 500 organ transplants each year and has the largest lung, kidney, liver and pancreas transplant program in Canada. During my four months on the lung transplant roster, sharing the burden and pleasure with two other Fellows, I anaesthetised for 18 lung transplants. For another extremely lucky (or unlucky) Fellow, his first lung transplant also was the world's first combined liver, pancreas and lung transplant!

The clinical exposure was mind-boggling. After four weeks of pre-entry assessment, Fellows were supervised with one-to-two-cover (one staff anaesthetist supervised two operating theatres) and we were given substantial autonomy. Over the course of the fellowship, I had more than 150 on-pump cardiac cases, 22 TAVIs and four heart transplants under my belt. There were no anaesthesia nurses, which, although painful at the time, provided excellent training in self-sufficiency. I very quickly learnt the intricacies of fluid-giving sets, infusion pumps and rapid infusers.

Two other invaluable features of the fellowship experience were obtaining American NBE TEE accreditation and developing a growing interest in research. The perioperative echocardiography program was intense. Each cardiac anaesthesia Fellow performed and reported more than 200 TOE studies in 12 months and TOE teaching occurred twice a week. No wonder the success rate in NBE Advanced PTEeXAM at Toronto General Hospital has been 100 per cent!

One could argue that a drawback of Australian anaesthesia training is lack of infrastructure for research. In contrast, the University of Toronto is a research machine, the best in Canada and among the best in the world. There were five full-time research assistants, a librarian, a statistician, countless research students and an animal laboratory, and that was just for the anaesthesia department in one hospital. As well as living and breathing ice hockey, the medical facility also breathed research. It was easy for Fellows to get involved in research and although it still meant hard work, one wasn't alone slogging away at the office on a weekend or after work (and, yes, there were offices for Fellows!).

(continued next page)

Provisional fellowships in Canada – practical pointers

- Start researching and talking to people who completed a fellowship; personal recommendations are invaluable.
- Apply early; most fellowships fill up 12 to 18 months in advance.
- The most coveted fellowships in Toronto are:
  - Toronto General Hospital: Cardiac anaesthesia, thoracic anaesthesia and hepatobiliary anaesthesia.
  - Toronto Western Hospital: Neuro-anaesthesia and regional anaesthesia.
  - Mount Sinai Hospital: Obstetric anaesthesia.
  - The Sick Kids Hospital: Paediatric anaesthesia.
- Once accepted into a program, start the mountain of paperwork immediately.
- Save up; one would want to enjoy the year without worrying too much about finances.
- Maintain your professional network in Australia.
- Useful Canadian fellowship websites:
  - http://cas.ca/English/ACUDA-Fellowships
  - Most popular are: University of Toronto, University of British Columbia, University of Ottawa, McGill University
  - www.anesthesia.utoronto.ca/fellowships-offered

Above from left: Winter colours of Toronto; Dr Lei Lei winning best oral presentation at the University Health Network Shield's Day; Lung transplant equipment; Toronto General Hospital employs about 20 clinical Fellows from all over the world, in our cohort there were Canadians, Spaniards, British, Irish, Singaporean, Columbians, Brazilians, Japanese, a New Zealander and four Australians; The Peter Munk Cardiac Centre/ CN Tower.

Canadian post brings invaluable experience (continued)

Mentorship is so important to young aspiring careers. When I first arrived at Toronto General Hospital, I was star struck. Every day, I found myself talking to the author of latest coagulation guidelines (Karkouti), ACC/AHA perioperative guidelines (Wijeysundera), world-renowned thoracic anaesthesia guru (Slinger), creator of UHN PIE Virtual TEE website (Vegas/Menerie), author of adult congenital heart disease textbooks (Heggie) or airway extraordinaire (Cooper), to name a few. One could almost feel neurons synapsing and buzzing in the air creating new ideas and pushing boundaries. Even more humbling, these experts were keen to teach and to get to know me, a nobody, who was enthusiastic to learn and pocket pearls of their wisdom.

The anaesthesia department at Toronto General Hospital was incredibly multicultural with consultant anaesthetists from all over Canada and the world. It was fascinating to get to know them and learn how they became the specialists they are, realising that behind every success lies hard work triumphing over many failures.

While the experience was remarkable, obtaining gainful employment in Australia at the end of the fellowship is probably the foremost concern of trainees going overseas. It wasn't easy, but after a combination of cold emailing, many job applications, 1am phone interviews, flying back to Australia, brushing off rejections and, most importantly, staying in touch, I am thankful my efforts paid off.

There is potential to stay on in Canada and some Australians extend their fellowships but most eventually return to Australia. The 23-hour flight to visit family and friends can be soul destroying and it is hard to give up the amazing Australian weather, good food and great coffee (Tim Horton's is an insult to coffee!)

Furthermore, working overseas helped me to appreciate that medical care in Australia is world class, and there is an opportunity to do a whole lot more.

With limited knowledge and a desire to explore something different, it was a case of the blind leading the blind, where my husband and I led one another to Toronto General Hospital and one of the best years of my life.

Dr Lei Lei (Emma)
Staff specialist, Westmead Hospital, Sydney, NSW
VMO anaesthetist, Canberra Hospital, ACT

Training program improvements for 2017

Improvements to ANZCA's anaesthesia training program will be implemented for the 2017 hospital employment year, including changes to scholar role activity requirements and changes to volume of practice targets.

Streamlined scholar role activity requirements

From the start of the 2017 hospital employment year, the scholar role requirements are:

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 departmental scholar role tutors or their nominee.
5. Complete an audit and provide a written report.

The audit activity will be completed under the supervision of scholar role tutors only.

There is no recognition of prior learning or exemption process for completion of the audit activity. All trainees must complete this activity and the audit scope and process has been redefined to be more achievable and aligned with the continuing professional development standards for audit. 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 need to be submitted for assessment.

During the 2017 hospital employment 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 tutor will make this decision.

For trainees who have begun the training program, transition arrangements are available to assist with meeting the scholar activity requirements. Further information is available on the scholar role training webpage (www.anzca.edu.au/training/2013-training-program/scholar-role-training).

Enhanced evaluation forms

The evaluation forms for the five core scholar role activities will be improved to include detailed information and consistent rating scales for each evaluation criteria item to help trainees to satisfactorily address the assessment requirements. The updated forms are available on the scholar role training webpage.

Reduced volume of practice requirements

To focus trainee engagement on achieving the required learning outcomes rather than meeting minimum assessment targets, the volume of practice requirements are reduced for specific skills in the ANZCA Clinical Fundamentals and specialised study units. These reduced targets were communicated directly via email in early September. A table of the volume of practice amendments is available on the 2013 training program webpage (www.anzca.edu.au/training/2013-training-program).

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.

Reduced volume of practice targets apply for Australian and New Zealand trainees from December 5, and are available within the training portfolio system.

Dr Ian Graham
Dean of Education, ANZCA

Preparing for provisional fellowship

The provisional fellowship year gives trainee specialists an opportunity to build skills and confidence during supervised, independent practice.

The ultimate goal of anaesthesia training is to produce a consultant who undertakes sound independent practice.

How is the transition from trainee with supervised practice to consultant undertaking independent practice achieved? Clearly it's the summation of the entire training program.

The 2013 ANZCA curriculum is designed to facilitate this change with the provisional fellowship year. At the end of advanced training, a trainee has acquired considerable skill and experience. The provisional fellowship year provides an opportunity to use those skills in supervised independent practice to further enhance competence and confidence.

It also provides an opportunity to get more intense experience in a particular area of anaesthesia, for example cardiac or paediatric anaesthesia; in other health systems by travelling abroad; or across roles such as research, teaching and management. Many options are approved for provisional fellowship training with the common theme of supervised, independent practice.

One of the great challenges of a provisional fellowship is to get the balance of supervision just right. Too little supervision with no coaching may entrench bad practice, while too much may stifle a trainee's ability to solve problems for themselves, especially if the "correct" answer is always provided.

Ideally a trainee has enough independence to see through their own clinical decisions with enough support to guide them back on track, with no bad outcomes for patients or trainees. The College recognises this independence and includes provisional Fellows in the staffing profile of anaesthetic departments, which are detailed in *PS42 Statement on Staffing of Accredited Departments of Anaesthesia*.

Provisional fellowship positions are approved by ANZCA's Provisional Fellowship Program Sub-Committee. The challenge for the committee is to determine whether an application meets the goals of the provisional fellowship year. In order to make the correct decisions, the committee needs a thorough description of the position, the expectations of the department, and the goals for the year.

Provisional fellowship position applications may be departmental (pre-defined), or for an individualised position not already accredited for provisional fellowship training. Individualised applications are commonly for positions overseas, or in a rural area.

Departmental approvals are valid for five years. During this time trainees are surveyed about their experiences and their opinions on how the position met their training goals and, most importantly, how the year facilitated transition to independent specialist practice.

There are guidelines on the College website under "2013 training program/Provisional fellowship training" to assist departments and trainees to achieve a successful accreditation. These guidelines contain all the things to consider when applying for accreditation.

Importantly, you must provide a session planner clearly describing the range of experience a provisional Fellow will be exposed to. In addition, you should describe accurately how the trainee will spend their minimum 10 per cent clinical support time, an important part of transitioning to consultant-level work. Finally, consider how the role will change throughout the year as the trainee becomes more independent and prepares for specialist practice.

A well-planned provisional fellowship year is a crucial component of the ANZCA training progam, consolidating both clinical and non-clinical skills with the aim of producing confident and competent anaesthetists.

Dr Patrick Farrell and **Dr Emily Wilcox**
ANZCA Provisional Fellowship Program Sub-Committee

Fellows present training research in Barcelona

Two ANZCA Fellows have presented research on the ANZCA Training Program at an international medical education conference.

More than 3500 people from around the world attended a conference of the Association for Medical Education in Europe held in Barcelona, Spain, at which ANZCA Fellows Associate Professor Jennifer Weller and Dr Damian Castanelli presented results from their collaborative research into the ANZCA Training Program.

Associate Professor Weller's presentation, "Combining entrustment scales and standard setting in workplace assessments", was selected as one of the three best abstracts in the First World Summit on Competency-Based Education, held during the conference.

"While ANZCA Fellows and trainees are familiar with our mini clinical evaluation exercise (mini-CEx) and the assessment scale we use, which is anchored by the amount of supervision required, it is still novel to many in the broader medical education community," said Associate Professor Weller, who heads the Centre for Medical and Health Sciences Education at the University of Auckland.

"In our research, we have shown that where consultants made judgments based on the level of trainee independence with the case, the reliability of mini-CEX scores is high. This confirms the results of our previous research in volunteers have been preserved with the implementation of the mini-CEx right across the ANZCA training region.

The researchers also compared the scores to estimates of expected independence based on training level, and case complexity, and this allowed them to identify a cohort of trainees performing below expectations.

"While occasional scores below those expected would represent valuable learning opportunities for trainees, consistent scores below those expected probably indicate a trainee who needs more support in their training," Associate Professor Weller said.

Dr Castanelli, from Monash University, presented findings based on interviews conducted with ANZCA supervisors of training and trainees, which explored their experience with the mini-CEx.

"The reports of the real-world experience of trainees and supervisors using workplace-based assessment are diverse. While often it is used to promote trainee learning, sometimes people are more concerned with 'ticking a box' and getting the assessment done," Dr Castanelli said.

"It's important that the focus is on trainee learning, that trainees challenge themselves when they select cases, and that consultants provide specific, detailed, and honest feedback. Then trainees can use the feedback to plan how they can do better in future."

Associate Professor Weller and Dr Castanelli said the studies were examples of ANZCA Fellows making a contribution to the evidence-base in medical education. Selection for presentation at a major meeting, such as this, shows that others in the medical education community are interested in learning from ANZCA's experience.

"The ANZCA Research Foundation supported both these studies with a Simulation/Education Grant, and continues to support our further research into other aspects of ANZCA training," Dr Castanelli said.

Dr Castanelli and Associate Professor Weller are members of ANZCA's Education, Training and Assessment Development Committee. The College's education committees will use their findings in planning further development in workplace-based assessment as well as ongoing training for Fellows, trainees and supervisors of training.

Dr Damian Castanelli and **Associate Professor Jennifer Weller**
ANZCA Education, Training and Assessment Development Committee

Mentoring: A trainee's perspective

Increasingly, mentoring in medicine is being recognised as a key component in training and career advancement.

The concept of a mentor originates from the Greek legend of Odysseus, in which Odysseus entrusted the care of his son to Mentor, a trusted friend and counsellor.

Dr Solmaz Bezyan, a final-year trainee (right), offers her opinion on the existing mentoring program at Westmead Hospital, Sydney.

Q: What qualities make a good mentor?

A: A good mentor should be a fine role model, empathetic to the experiences of their mentee, approachable, non-judgmental and a good listener. Mentors should be available and willing to share their experiences in an open and honest manner with their mentees.

Q: How can the mentee make the most of their mentor-mentee partnership?

A: Get in touch with your mentor early on. Arrange a meeting to discuss your goals and expectations. Bear in mind that your needs can evolve over time, as can the dynamics in the mentor/mentee relationship. This should not be seen as a bad thing and in some instances you may need to seek a new mentor.

Q: What are key features in making a relationship between a mentor and mentee function effectively?

A: Ideally a good "fit" should exist in the personality and communication style of both parties. Some people choose mentors from a similar demographic background, though I do not think this is necessary. The most important aspect of an effective mentor-mentee relationship is being approachable and creating a non-judgmental environment where the mentee feels safe to discuss issues.

Q: How has having a mentor impacted on your training in general terms?

A: Having a mentor has been a very positive experience for me. My mentor has provided me with advice on how to deal with work and exam challenges, in addition to planning my training and future vocational goals.

Q: How has your relationship changed as you have proceeded in your training?

A: I have become more comfortable interacting with my mentors. I feel that I am able to discuss a wide variety of issues with them and approach them as I need to.

Q: Do you think it is important for all trainees to have a mentor?

A: I believe most trainees will find having a mentor very helpful. However as with anything in life, one size does not fit all. For some trainees, mentoring may not suit their personal needs. I think a formal mentoring program should be available for all trainees, but engaging with the program should be optional.

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

What is mentoring?

There are many definitions of mentoring. A more traditional definition of mentoring consists of a senior person (the mentor), providing advice and wisdom to a more junior person (the mentee).

Modern mentoring is defined as a dynamic, bi-directional learning relationship in which an experienced, "highly regarded, empathetic person (the mentor) guides another individual (the mentee) in the development and re-examination of their own ideas, learning, personal and professional development." It is a learning relationship in which the mentee takes charge of their own development, releases their potential and achieves results that they value. This leads to development not only in the mentee, but the mentor as well.

Common misconceptions

The mentor always has the answers

The mentor's role is in supporting the mentee as they review a problem, assess the situation and initiating and undertake an action plan to accomplish the mentee's goals. The mentor provides a framework to guide both the mentee and mentor through their discussion and facilitates the mentee's exploration of the problem through the use of active listening skills. This assists the mentee in challenging their ideas, developing a wider perspective and initiating an action plan.

The mentor is the teacher and the mentee is the pupil

It is not unusual for mentors to offer suggestions and share their experiences, however, in the mentoring relationship, it is the mentee who determines the solution and the best course of action. Success in achieving goals occurs when the mentee uncovers solutions for themselves, rather than those solutions offered by others. In this way, the mentor is the facilitator and not the teacher instructing the pupil in what to do.

Mentoring is about offering advice

Mentoring is ultimately about assisting the mentee in developing effective skills in identifying and managing problems and consequently helping the mentee to better help themselves. Mentoring embraces the concepts of self-development, reflection, exploration of strengths and weaknesses, being non-judgmental, trust, challenging assumptions, appreciating different perspectives, motivating, empowering, encouraging and nurturing.

Benefits of mentoring

For the mentee

It instils a sense of value, decreases stress, encourages collaboration, facilitates networking, provides perspective, inspiration and motivation, furthers knowledge and skills, enhances maturity and career progression.

For the mentor

It develops a new skill set, stimulates self-reflection, provides revitalisation and rejuvenation and increases job satisfaction.

For the hospital

It increases cohesion, propagates organisational culture, increases job satisfaction and facilitates retention of staff.

Given the potential benefits of mentoring, access to mentoring is in the interests of mentors, mentees and hospitals. At present, access to mentoring across NSW training hospitals is highly variable.

Dr Monika Kenig
Provisional Fellow
Children's Hospital at Westmead
NSW Trainee Committee

Dr Tim Sullivan
Royal North Shore Hospital
Co-Chair NSW Trainee Committee

Mentoring – more reading

- Welfare of Anaesthetists Special Interest Group (WOA SIG), Anaesthesia Continuing Education Coordinating Committee (ACECC) (2011). Mentoring and peer support programs (resource document RD 08). Melbourne, Australia and New Zealand College of Anaesthetists (ANZCA).
- Redfern, N. What is mentoring?
- Flexman A & Gelb A (2011). Mentorship in anaesthesia. Current opinion in Anaesthesiology. 24(6): pp 676-681.
- French, G (2007). Editorial: Mentoring for self-development. Bulletin (Royal College of Anaesthetists). London, Royal College of Anaesthetists.
- Standing Committee on Postgraduate Medical and Dental Education (SCOPME). Supporting doctors and dentists at work – an enquiry into mentoring (1998). London, SCOPME.
- Sambunjak D, Straus S, & Marusic A (2006). Mentoring in academic medicine: a systematic review. Journal of the American Medical Association. 296(9): pp 1103-1115.
- Howe, P (2007). The mentor case: a proposed model for mentoring in anaesthesia departments. Australian Anaesthesia
- Taherian K & Shekarchian M (2008). Mentoring for doctors. Do its benefits outweigh its disadvantages? Medical Teacher. 30: pp e95-e99.
- Connor M & Pokora J (2012). Coaching and mentoring at work: developing effective practice (2nd Ed.). Berkshire: Open University Press, McGraw-Hill.

Committee provides voice for trainees

Reviewing and developing mentoring programs, designing and running the Part Zero course, and collecting and analysing the data from the ANZCA Trainee Survey were the main projects for the NSW Trainee Committee this year.

The committee's role is to provide a voice for trainees, where pertinent educational and training matters are discussed, fed back to the relevant bodies and actioned. Issues can be national or specific to NSW. For example, NSW has a mixture of independent positions as well as rotational scheme positions. Trainees in independent jobs confront a range of issues regarding future job aspects, clinical exposure and after-hours rostering.

The committee members come from a variety of tertiary and peripheral, metropolitan and regional hospitals. Designated positions are reserved for a first year trainee, an independent trainee, and a Group of Australian Society of Anaesthetists Clinical Trainees (GASACT) representative.

This year, the committee is co-chaired by Dr Monique McLeod, Dr Tim Sullivan and Dr Christine Velayuthen, who is also the co-chair of the ANZCA Trainee Committee. Members who have continued their service include Dr Shanthi Pathirana (deputy chair), Dr Dave Zalcberg and Dr George Zhong.

The committee had also welcomed new members Dr Monika Kenig, Dr Kanan Shah, Dr Aylin Seven, Dr Clement Lee, Dr Faith Wang, Dr Andrew Emanuel (GASACT), Dr Brenton Sanderson (GASACT), Dr Nicholas Barton (co-opted independent trainee) and Dr Katherine Gough (co-opted first year trainee). Dr Michelle Moyle is the education officer for NSW and is also a regular attendee of our meetings. Tina Lyroid has played an indispensable role in co-ordinating all the meetings and handling administrative issues.

The mentoring program continues to be an item on the agenda for the committee after last year's survey results. The committee felt, in collaboration with the Welfare of Anaesthetists Special Interest Group, that established mentor programs would be a beneficial way to begin to address this issue.

Dr Kenig and Dr Sullivan extensively investigated existing mentoring programs local and abroad. We have worked to make mentoring a topic of discussion at various levels, including with supervisors of training and at the Combined Special Interest Group in Manly. We are now looking into the interest generated by the program and the utility of a resource package compiled to help initiate a mentoring program or offer resources to help existing programs.

The committee has also been heavily involved in running the Part Zero Course, an annual event hosted by the NSW Committee aimed at orientating introductory trainees and also available as an introduction to anaesthesia for prospective trainees. It is based at Royal Prince Alfred Hospital in Sydney. The upcoming one is to be held on Saturday March 4 2017.

Dr Sullivan, Dr Gough and Dr Zhong have headed the sub-committee for co-ordinating and promoting the Part Zero Course, reviewing feedback from previous years, inviting favourite speakers and finding new and interesting talks relevant to new trainees. We hope to develop an exciting program beneficial to both prospective and current trainees with separate streams organised on the day to address their different areas of interest.

The committee strives to help trainees prepare for the challenging training program and provide prospective trainees a reliable resource via this informative and fun one-day course.

Earlier in the year, the committee compiled and analysed the results collected from the formal ANZCA Trainee Survey 2015 and presented those findings. Those issues have been discussed within the committee and actioned. The survey provides important trainee insight into training and welfare issues. With other trainee committees the questions for the 2016 survey in August/September were revised. We are also reviewing the new data and the current issues that arise.

In addition, the NSW Trainee Committee had also made representation at various external relations functions such as the AMA careers day, as well as highlighting and addressing other trainee concerns such as teaching time, rostering, and training portfolio system changes and usability.

The committee endeavours to continue working through trainee issues aiming to improve various aspects of the challenging yet rewarding anaesthetic training journey.

Dr Monique McLeod
John Hunter Hospital
Co-Chair NSW Trainee Committee

Dr Faith Wang
Wollongong Hospital
NSW Trainee Committee

Successful candidates

Above: Primary fellowship examination court of examiners.

Primary fellowship examination

August/September 2016

The Primary Fellowship Examination was successfully completed by 117 candidates.

AUSTRALIA

Australian Capital Territory
John Vincent Robillard

New South Wales
Ian Bollam
Antony William Brown
Dr Yisha Cao
Supriya Chowdhury
Prateek Dhingra
Emily Louise Fokkes
Katherine Jean Romney Gough
Adrian David Holmewood
Sara Letafat
Holly Ann Manley
Luke McConnell
Nadia Pervez Mian
Nicholas Mundell
Tessa Alexandra Nall
Graham Collin O'Connor
Jessica Monica Heather Paton
Fiona Elizabeth Pearce
Georgina Natalie Prassas
Nathan So
Paul Sochor
Matthew James Spencer
Amanda Jane Taylor
Roumel Jnr Valentin
Allison Joyce Wong
Tony Ka Kei Wong

Queensland
Elayne Louise Anderson
Stephanie Ann Cruice
Steven Glen Durrant
Jonathan Andrew Francis
Jessica Anne Hegedus
Rhyon Troy Johnson
Michael David Kerr
Steven J Klupfel
Jacqueline Maree Laws
Juan Sebastian Lopera Alvarez
Thar Nyan Lwin
Luke Patrick Matthews
Joel Robert Matthews
Simon Timothy Porter
Courtney Maree Roche
Helen Maria Skerman
Robert Leslie Gordon Smith

South Australia
Sophie Jane Bradshaw
Richella-Lea Falland
Joshi Kedar Santosh
Elise Maree Kingston
Daniel Robert Andrew Morcombe
Clara Yale Murphy
David Brian Reid

Tasmania
Hamish Charles Bradley
Victor Tsz Chung Hui
Emily Kate Munday
Bronwyn Rose Posselt

Victoria
Maysana Allaf
Michael Angsuwat
Myat Thant Aung
Jessica Frances Davies
Tabara Dione
Jeremy Liam Duke
Olivia Rebecca Dyer
Nathan Lindsay Fifer
Jessica Christine Fusella
Oliver Thomas Gouldthorpe
Patrick Joseph Hamilton
Emma Beth Hewitt
Alexander Kugel
Daniel Ka Yue Lau
Sophie Ann Lee
David MacGarty
Harry Idris Marsh
Vaughan Edward McCulloch
Andrew Melville
Haran Nath Nathan
Chad Oughton
Aaron Anthony Paul
Inamul Rahiman
Priya Teresa Rao
Michael Peter Shun
Andrew Leslie Simons
Michelle Nicole Stewart
Joshua Lino Telles
Yiying Tsang
Irfan Ul Hassan
Eamon Callaghan Upperton
Kiara Maree Van Mourik
Sam Zachary Walsh
Bernadette Mary Wilks

Western Australia
Mansi Khanna
Paul Jason Schaper
Archana Chandrashekar Shrivathsa

(continued next page)

Successful candidates (continued)

NEW ZEALAND

Lisa Marion Barneto
Charlotte Sarah Brace
John Andrew Forbes Burnett
Hyun-Min Choi
Nicholas John Harrison Cochand
Julius Leslie Mansfield Dale-Gandar
Joel Stuart Daubney
Nicholas Charles William Eaddy
Jennifer Yvonne Fife
Julius William Eruera Glasson
Narguess Jahangiri
Marcus Wei Lerk Lee
Victoria Anne Lyon
Aoi Moniwa
Andrew Robert Nairn
Michael Hugh Ng
Michael Robert Nottingham
Thomas Gavin O'Sullivan
Hye Won Park
Samuel Paul Perrin
Charlotte Louise Smith
Sarah Louise Katharine Thompson
Amy Shan-Mei Tseng
Andrew Marshall Wilson
Andrew Stephen Keith Woodhead
Swarna Lakshimi Baskar Sharma

Renton Prize

The Court of Examiners recommended that the Renton Prize for the half year ended December 31 be awarded to:

Dr Andrew Peter Melville, Victoria

Dr Andrew Melville studied medicine at Monash University in Victoria, and is undergoing anaesthesia training via the Eastern Training Scheme, based at The Alfred. Before this, he spent two years in clinical and research anaesthesia roles at Peter MacCallum Cancer Centre, Melbourne. In 2015, he also completed a master of bioethics, pursuing an interest in clinical ethics. He is grateful for the ongoing support of colleagues, family and friends.

The Court of Examiners recommended that the Renton Prize for the half year ended June 30 be awarded to:

Dr John Anthony Newland, New Zealand

Dr John Newland studied medicine at the University of Auckland, and is undertaking anaesthesia training at Waikato Hospital, New Zealand. His interests include teaching, medical ultrasound and research. He acknowledges his partner, Jess, and anaesthetic colleagues at Waikato Hospital, who have supported him throughout.

Final fellowship examination

August/October 2016

The Final Fellowship Examination was successfully completed by 107 candidates.

AUSTRALIA

Australian Capital Territory

Trent Steven Evens
Andy Chih-Wei Ho
Anneliese Renee McBride

New South Wales

Claire Elizabeth Armstrong
Malcolm Ronald Bannerman
Johanna Therese Barrett
Simon Andrew Campbell
Joshua Wesley Campbell
Alison Louise Clark
Leonard Richard Conrad
William Lindsey Dey
Richard Christopher Hall
Melissa Jamcotchian
Katherine Jane Jeffrey
Kim Leng Khoo
Jessica Shao-Yeung Lim
Jacqueline Mary McCallum
Nicholas John Roberts
Christine Sarita Velayuthen
Sanjeev Vijayan
Priya Virdi
Lorna Ann Workman

Queensland

Sheridan Brooke Bell
Samuel Michael Bongers
Boon Tsien Chang
Lucas Dugdale Edwards
Simone Lauren Fagan
James Mackenzie Forbes
Agustina Frankel
Louis Frederick Guy
Daniel John Haenke
Kavindri Rashmi Jayatileka
Adam Lindsay Bacchi Keys
Amy Louisa Krepska
Mitchell James Lawrence
Adrian Fung Lim
David Liu
Jed Ross Mangano
Denise Helen McCool
Timothy David Rance
Angela Rachel Tognolini

South Australia

Timothy Aaron Donaldson
Divahar Sudhandhira Kumar
Kian-Chiat Lim
Martin John O'Reilly
Katharine Ingham Sporne

Tasmania

Adam John Mahoney
Subramanian Parameswaran

Victoria

Verna M Aykanat
Tom Callahan
Patricia Margaret Carroll
Colleen Chew
Sarah Ann Donovan
Emma Ruth Ford
Nathlie Mei Gomes
Auday Abdel Jabbar Hasan
Kathryn Lee Hersbach
Kelvin Gar-Hoo Lam
Mark Simon Lycett
Janette Isabelle Moss
Hosim Prasai Thapa
Roshan Reginald
Faraz Rashid Syed

Western Australia

Anna Jane Carter
Grace Sze-Yee Chieng
Steven Michael De Luca
Gary Robert Devine
Paris Alexandra Dove
Samuel James Fitzpatrick
David Forbes Hamilton
Grace Yee-Hua Ho
Woon-Lai Lim
Christopher McGrath
Thomas James Ryan

NEW ZEALAND

Caroline Mary Ariaens
Oliver Francis Brett
Emily Charlotte Buddicom
Raymond Patrick Casey
Stephanie Laura Clark
Kaveh Djamali Dogaheh
Elizabeth Rose Dunn
Adam John Hollingworth
Connor Patrick Hughes
Martin Guy Hurst
Matthew Stephen Kirk-Jones
Hsi-Yu Ku
Everard Christopher Lee
Emily Elizabeth Morton
Ashvini Maduka Nanayakkara Kahawatta
Nik Ahmad Mazani Nik Mohamad
Jonathan Ashley Panckhurst
Lora Borislavova Pencheva
Richard Paul Renew
George Samuel Rowell
David Michael Sainsbury
Annu Priya Shanmuganathan
David Poh-Kim Tan
Courtney Rose Thomas
Cara Thomson
Petra Maria Van Der Linden-Ross
Samuel Poriana Wall
Anna Louise Waylen
Andy Hoi-Kei Wong

HONG KONG

Chi Yeung Henry Mak

IMGS examination

Three candidates successfully completed the International Medical Graduate Specialist Exam.

AUSTRALIA

Queensland

Kavitha Erinjippurath
Gladness Dakalo Nethathe

Western Australia

Bassam Aref

Cecil Gray Prize

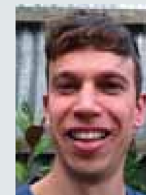
The Court of Examiners recommended that the Cecil Gray Prize for the half year ended December 31 be awarded to:

Dr Adam John Mahoney, Tasmania

Dr Adam Mahoney studied medicine at the University of NSW and moved to Tasmania to begin his internship. Since joining the Tasmanian Anaesthetic Training Program, he has worked at both the North West Regional Hospital and Royal Hobart Hospital. Dr Mahoney is a medical officer in the Australian Regular Army and hopes to pursue a career in military anaesthesia and intensive care. His interests include medical education and trauma anaesthesia.

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

Dr Christopher Raoul Clemens, Victoria



Dr Christopher Clemens completed his undergraduate medical studies at the University of Melbourne in 2008, also graduating with a diploma of modern languages (French). He is undertaking anaesthesia training with the Northwestern Rotational Training Scheme in Victoria. His interests include paediatric anaesthesia, ENT and perioperative medicine. Outside work he finds true happiness in the kitchen, cooking up a storm for friends and family.

Merit certificates

Merit certificates were awarded to:

Jonathan Ashley Panckhurst, New Zealand
Nicholas John Roberts, NSW
Steven Michael De Luca, WA

Faculty of Pain Medicine

Dean's message

Cannabis remains highly newsworthy. Media reports following presentations by Dr Dilip Kapur and others at the Faculty's Adelaide Hills Spring Meeting have drawn animated responses, as has my article "Medicinal cannabis: Where is the evidence?" published in the September *ANZCA Bulletin*. In this issue we have had responses from Professor Laurie Mather (page 74) and the Honourable Pru Goward MP, NSW Parliament (page 6).

Community advocacy continues to call for compassionate access to medicinal cannabis for people suffering chronic non-cancer pain. The call is based largely on anecdotal reports of benefit. Clearly it is time to closely examine the quality of available scientific evidence. The Neuropathic Pain Special Interest Group of the International Association for the Study of Pain published the most definitive meta-analysis in 2015[1].

They examined nine trials (1310 patients in total), eight using Sativex, a mixture of tetrahydrocannabinol and cannabidiol, and one using dronabinol, a synthetic cannabinoid. Three of the trials addressed pain associated with multiple sclerosis (429 patients), three mixed nociceptive/neuropathic pain (443 patients) and three neuropathic pain (including spinal cord injury and painful diabetic neuropathy; 438 patients).

All trials involved the use of an inert placebo. This lack of masking brought an inherent risk of bias in favour of the active agent. Three trials (involving 215 patients) showed a positive result. These trials were smaller and of shorter duration. The remaining six trials, predominantly larger and of longer duration (1095 patients), were negative.

The authors of the meta-analysis made a weak recommendation against cannabinoid use for chronic neuropathic or mixed pain due to "negative results, potential misuse, diversion and long-term health risks of cannabis particularly in susceptible individuals".

Noting that evidence does not support cannabinoid prescription in chronic non-cancer pain there are several clinical trials now under way in Australia to study cannabinoids in settings of greater promise.

These are refractory paediatric epilepsy, chemotherapy-induced nausea, vomiting and loss of appetite and distress in end-of-life settings. These trials might identify situations in which benefit outweighs harm. On the other hand, they might show that cannabinoids are ineffective in these settings also.

If good quality clinical trials do not show benefit, we need to be courageous and speak out against making cannabis medically available.

Otherwise we risk destabilising our society with higher rates of disability and ever more taxes required for the healthcare of chronic conditions.

International award

On a less controversial note I have pleasure in reporting that the Faculty has received a commendation from the American Academy of Pain Medicine (AAPM) in the form of the Robert G Addison, MD, Award. This award is given to an individual or organisation in recognition of outstanding efforts to foster international co-operation and collaboration on behalf of the specialty of pain medicine. I plan to travel to Orlando, Florida in March to attend the AAPM annual scientific meeting and receive the award on behalf of the Faculty. This award is a tribute to the hard work of many of our Fellows. I believe the development of our revised curriculum and training program, publication of *Acute Pain Management: Scientific Evidence* and the electronic Persistent Pain Outcomes Collaboration (ePPOC) are key achievements of international relevance.

Thinking further of matters of international impact, I note the retirement from full-time practice this year of Professor Michael Cousins, foundation dean of FPM and a past president of ANZCA. Professor Cousins' enormous contribution to pain medicine and anesthesia is marked by Professor Ted Shipton and Professor Peter Kam in an article on page 80.

As 2016 draws to a close there is much FPM Board discussion about strategic planning. There is a desire for 2017 to be a year of refining direction as we build to the next five-year FPM/ANZCA Strategic Plan (2018-22). In terms of our training program, we would like to explore in greater detail the specific training requirements of paediatric pain medicine.

Interventional pain management is also being discussed with a recognised need to collaborate with other key stakeholders, including the New Zealand and Australian pain societies, the Neuromodulation Society of Australia and New Zealand and the Royal Australasian College of Surgeons. Development of a Faculty position statement on interventional pain management is in the early stages.

The question arises as to whether we can move to formalise training and volume of practice requirements in interventional practice and also endorse appropriate outcome measurement, potentially involving a pain device implant registry and ePPOC. Additional issues for strategic consideration include indigenous health, the possibility of developing a policy on assisted suicide and euthanasia, and the potential of a six or 12-month diploma in pain medicine suitable general practitioners or other specialist groups.

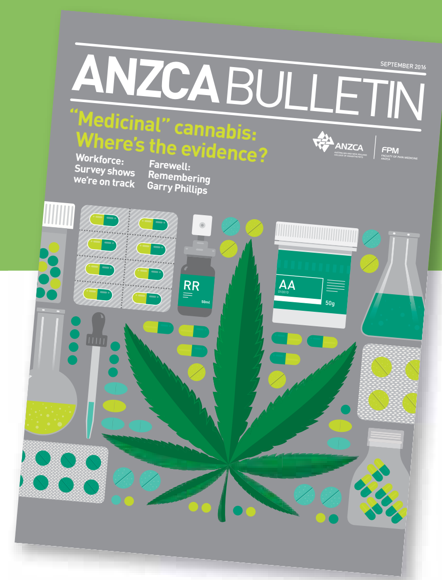
Fellows are most welcome to contribute to the development of our strategic plans by participating in the Faculty's various committees and working groups or by writing to me directly.

Dr Chris Hayes
Dean, Faculty of Pain Medicine

Reference:

1. Finnerup NB, Attal N, Haroutounian S et al. Pharmacotherapy for neuropathic pain in adults: a systematic review and meta-analysis. Lancet Neurol 2015; published online Jan 7. http://dx.doi.org/10.1016/S1474-4422(14)70251-0.

Evidence supports use of "medicinal" cannabis



Professor Laurence Mather gives an alternative view to that presented by Dr Chris Hayes in "Medicinal cannabis: Where's the evidence" in the September *ANZCA Bulletin.*

Dr Chris Hayes (*ANZCA Bulletin*, September 2016) writes that advocacy and legalisation are moving ahead of the evidence about medicinal cannabis, and that medical specialists should consider the un-encouraging scientific evidence of efficacy, substantial evidence of harm, and lessons from the "opioid story". Additionally, FPM professional document *PM10: Statement on "Medicinal Cannabis"* argues, rather bleakly, that there is no need for such a medicine, anyway.

From participating in the NSW Premier's working party in 2000 examining the case for permitting the medicinal use of cannabis in NSW, and various political inquiries since then, my continual appraisal of the literature convinces me that cannabis should be available to patients in need, along with continued research to determine its best uses[1,2].

With widespread media coverage, cannabis presents a difficult topic for health professionals. In Australia, cannabis is essentially regarded as an illegal psychogenic substance, clinical studies are difficult to perform for reasons more legalistic and bureaucratic than medical, and there is still no dependable prescribing guide, nor an approved prescribable cannabis preparation, except through cumbersome processes. Any medical specialist wishing to be informed thus needs to digest the ever-increasing medical and scientific literature.

Like other plants, cannabis is a veritable chemical fruit salad. Its nearest botanical relative is hops, a constituent of popular beverages. "Medicinal" cannabis, in contrast to home-grown or black market cannabis, denotes a botanical product harvested from genetically identical plant clones of known provenance, having reproducible active principle composition, quality of batch consistency, and freedom from harmful contaminants[3]. A reasonable analogy is papaveretum (Omnopon™), a well-known opium extract. Whether cannabis will remain a botanical preparation, a resource for isolated active principles, or a lead to novel cannabinoids, remains the subject of intensive research[4]. Particular cannabinoids have preferred uses and different preparations are being tailored accordingly, for example, from the Dutch Ministry of Health[5].

It is true that anecdotal evidence about cannabis abounds. Cannabis has, arguably, been undergoing the world's largest uncontrolled clinical trial over decades.

As for any drug, the evidence on "medicinal" cannabis is required to show that, when used for a specific approved purpose, its benefits outweigh its risks — not its superiority over other treatments. Clinical research on cannabis has long been hampered by legal and research funding restrictions. However, research about harms from recreational cannabis has been generously funded, leading to "publication bias", and the result, although very powerful, is of tenuous applicability to cannabis pharmacotherapy in medical patients. Moreover, the standard randomised placebo-controlled clinical trial has been found to be a rather blunt instrument for assessing cannabis pharmacotherapy and, indeed, for many other drug treatments for pain management[6,7]. Such trials are based on the grouping of patients with the expectation of homogeneity, but with the finding of "responder-nonresponder" dichotomy[8,9]. It is thus not unexpected to find that no single cannabis preparation or dose suits all patients[10,11].

Original evidence about cannabis has been the subject of innumerable published commentaries, with the ever-present risk that pre-filtered evidence is preferentially selected to support one or another viewpoint. Of the few citations given by Dr Hayes and in PM10, one major review by (medicinal cannabis expert physicians) Grotenhermen and Müller-Vahl, also cited in PM10, is mentioned here. This review found a preponderance of favourable controlled trials for treatment of a range of conditions, including spasticity resulting from disseminated sclerosis (nine favourable to three unfavourable), chemotherapy-induced nausea and vomiting (40 to one), HIV/AIDS-related cachexia (seven to zero), cancer-related cachexia (three to one), chronic neuropathic pain (12 to two) and other chronic pain (11 to two)[12]. On the other hand, PM10 also cites the review by (drug abuse-policy experts) Farrell, Buchbinder and Hall, and their negative conclusions, such as "...the effectiveness of cannabinoids... is unclear and any benefit is likely to be modest, while mild to moderate adverse events are common..."[13] (and without noting the published criticisms of the article). Countering this, a review by (anaesthetist-pain specialist) Notcutt argues that "...cannabinoids may be effective in treating a wide range of different disorders and intractable symptoms unmanaged by established treatment options"[14]. When experts fail to agree, readers need to examine the evidence for themselves.

Sometimes experts do agree – but the results can be equally disobliging, for example, a recent expert panel review of pharmacotherapy of neuropathic pain stated, "there was generally no evidence for efficacy of particular drugs in specific conditions"[15]. Clearly, we still have much to learn about pain pharmacotherapy.

Any prescriber or dispenser of any medicine needs to know its associated health risks, and cannabis is no exception. Pharmacological studies in animals permit insight into drug actions in humans. Insofar as laboratory animal research provides a guide, Δ^9-tetrahydrocannabinol (THC), the principal psychomimetic cannabinoid, is of relatively low toxicity, with respective median lethal doses (LD50) after intravenous and intragastric administration of 28.8 and 668 mg/kg in rats, and 42.5, and 482 mg/kg in mice[16]. Scaled to humans, these values indicate an acute toxicity of THC on the scale of grams, compared to pharmacotherapeutic doses on the scale of milligrams – and similar to drugs such as tramadol and ketamine.

"My continual appraisal of the literature convinces me that cannabis should be available to patients in need, along with continued research to determine its best uses."

Whereas many pain management studies involve defined cannabis preparations, for example, nabiximols (Sativex®), the cited POINT study indicated widespread community use of undefined "cannabis"[17]. With such heterogeneity between reports, it is inevitable that various beneficial and side effect issues become extrapolated from the particular conditions (agent, dose, route, etc.) to the general, thereby generating uncertainty in any drawn conclusions. Nonetheless, evidence derived from nabiximols helps to answer questions about chronic use by patients. The side effects were modest with 10 per cent of patients choosing to discontinue treatment, and with a greater incidence over placebo treatment for disorientation (4 per cent versus 0.5 per cent), attention disturbance (3.7 per cent versus 0.1 per cent), feeling drunk (2.9 per cent versus 0.4 per cent), euphoric mood (2.2 per cent versus 0.9 per cent), depression (1.9 per cent versus 0.8 per cent), memory impairment (1.4 per cent versus 0.1 per cent) and dissociation (1.7 per cent versus 0.1 per cent); tolerance did not develop, and the author concluded that abuse or dependence "is likely to occur in only a very small proportion of recipients"[18]. Longer-term studies have not indicated new safety concerns after several years of chronic administration[19,20].

The pre-1980s "tight-fisted analgesia" paradigm that led to extended-duration opioid dosage forms for assisting patients to avoid the swings from analgesia to agony also led, regrettably, to over-enthusiastic commercial promotion of such preparations, resulting in over-enthusiastic prescribing, occasionally with lethal effects from the drugs used. Experienced prescribers indicate that patients prefer to titrate dose to effect, especially when using dosing strategies such as vaporisation[21]. Although a variety of adverse effects of cannabis are recognised[22], direct cannabis-caused lethality is not one of them.

Clearly, there is still much to learn about cannabis pharmacotherapy at many levels[23]. Nevertheless, we should remember the warning of Sir Austin Bradford-Hill: "All scientific work is incomplete – whether it be observational or experimental. All scientific work is liable to be upset or modified by advancing knowledge. That does not confer upon us a freedom to ignore the knowledge we already have, or to postpone the action that it appears to demand at a given time."[24]

Regarding "medicinal" cannabis, I believe that legislation and advocacy are not moving ahead of the evidence.

Professor Laurence E Mather, FANZCA, FRCA
Emeritus Professor of Anaesthesia
The University of Sydney
Sydney, NSW

References:

1. Mather LE, Rauwendaal E, Moxham-Hall V, et al. (Re-)introducing medicinal cannabis. Med J Aust 2013; 199: 789-791.
2. Mather LE, Rauwendaal E, Moxham-Hall V, et al. The issue of medicinal cannabis in contemporary Australia. Griffith J Law Human Dignity 2015; 3(2): 287-311.
3. Hazekamp A, Fischedick JT. Cannabis-from cultivar to chemovar. Drug Test Anal 2012; 4(7-8): 660-667.
4. Russo EB. Taming THC: potential cannabis synergy and phytocannabinoid-terpenoid entourage effects. Brit J Pharmacol 2011; 163(7): 1344-1364.
5. CIBG Ministerie van Volksgezondheid, Welzijn en Sport Informatieclip: The Office of Medicinal Cannabis. BMC English. Available at http://youtu.be/hE6oil2pI_k.
6. Moore RA, Moore OA, Derry S, et al. Numbers needed to treat calculated from responder rates give a better indication of efficacy in osteoarthritis trials than mean pain scores. Arthritis Res Ther 2008; 10(2): R39.
7. Moore RA, Cai N, Skljarevski V, et al. Duloxetine use in chronic painful conditions--individual patient data responder analysis. Eur J Pain 2014; 18(1): 67-75.
8. Zajicek JP, Hobart JC, Slade A, et al. Multiple sclerosis and extract of cannabis: results of the MUSEC trial. J Neurol Neurosur Ps 2012; 83(11): 1125-1132.
9. Saccà F, Pane C, Carotenuto A, et al. The use of medical-grade cannabis in patients non-responders to Nabiximols. J Neurol Sci 2016; 368: 349-351.
10. Ware MA, Wang T, Shapiro S, et al. Cannabis for the management of pain: Assessment of safety study (COMPASS). J Pain 2015; 16(12):1233-1242.
11. Penington DG. Medical cannabis: time for clear thinking. Med J Aust 2015; 202: 74-75.
12. Grotenhermen F, Müller-Vahl K. The therapeutic potential of cannabis and cannabinoids. Dtsch Arztebl Int 2012; 109: 495-501.
13. Farrell M, Buchbinder R, Hall W. Should doctors prescribe cannabinoids? Brit Med J 2014; 348, g2737.
14. Notcutt W, Clarke E. Cannabinoids in clinical practice: A UK perspective. In, Handbook of Cannabis, Pertwee RG (ed), Oxford University Press, Oxford 2014; pp 415-432.
15. Finnerup NB, Attal N, Haroutounian S, et al. Pharmacotherapy for neuropathic pain in adults: a systematic review and meta-analysis. Lancet Neurology 2015;14(2):162-73.
16. Forney RB. Toxicology of marihuana. Pharmacol Rev 23(4):279-284.
17. Degenhardt L, Lintzeris N, Campbell G, et al. Experience of adjunctive cannabis use for chronic non-cancer pain: Findings from the Pain and Opioids IN Treatment (POINT) study. Drug Alcohol Depen 2015; 147: 144-150.
18. Robson P. Abuse potential and psychoactive effects of d-9-tetrahydrocannabinol and cannabidiol oromucosal spray (Sativex), a new cannabinoid medicine. Expert Opin Drug Saf 2011; 10: 675-685.
19. Notcutt W, Langford R , Davies P, et al. A placebo-controlled, parallel-group, randomized withdrawal study of subjects with symptoms of spasticity due to multiple sclerosis who are receiving long-term Sativex® (nabiximols). Mult Scler 2012: 18: 219-238.
20. Serpell MG, Notcutt W, Collin C. Sativex long-term use: an open-label trial in patients with spasticity due to multiple sclerosis. J Neurol 2013; 260: 285-295.
21. Aggarwal SK, Blinderman CD. Cannabis for symptom control # 279. J Palliat Med 2014; 17(5): 612-614.
22. Volkow ND, Baler RD, Compton WM, et al. Adverse health effects of marijuana use. New Engl J Med 2014; 370: 2219-2227.
23. Pertwee RG. Targeting the endocannabinoid system with cannabinoid receptor agonists: pharmacological strategies and therapeutic possibilities. Phil Trans R Soc B 2012; 367: 3353-3363.
24. Bradford Hill A. The environment and disease: Association or causation? Proc Roy Soc Med 1965; 58: 295-300.

Faculty of Pain Medicine (continued)

FPM 2016 Spring Meeting

The FPM 2016 Spring Meeting "Managing pain in the workplace" was held in Hahndorf, SA from September 16-18.

After the wettest day recorded in September in Adelaide and widespread storms and flooding, the sun shone on the start of the annual spring meeting.

The meeting was extremely successful with 105 registered delegates, who enjoyed the stunning scenery of the Adelaide Hills and the quaint setting of historic Hahndorf.

The meeting offered a diverse and thought-provoking scientific program, which examined the complex issues accompanying pain management and rehabilitation in the setting of occupational injury.

International speaker Dr Gary Franklin gave informative presentations on opioids and work injury and the outcomes of spinal surgery in the workers' compensation setting. These presentations are available for viewing on the FPM website and YouTube channel. A range of talented Australasian experts complemented these presentations on issues such as the current debate around medical marijuana; pain, mental health and work; and back and upper limb pain in the workplace.

The meeting generated a great deal of media interest, with articles in *The Age* and *The Herald Sun* discussing the appropriateness of spinal fusion operations and controversial cannabis trials on children. The meeting's convenor, Dr Dilip Kapur, was interviewed by Melbourne radio station 3AW on medical marijuana as an ineffective and irresponsible treatment plan for pain relief. His concerns are supported by FPM's policy on cannabis, *PM10: Statement on "Medicinal Cannabis"* with particular reference to its use in the management of patients with chronic non-cancer pain – 2015, which does not support the use of cannabinoids in chronic, non-cancer pain "until such time as a clear therapeutic role for them is identified in the scientific literature".

The Faculty is pleased to advise that the 2017 Spring Meeting will be held from September 22-24 at the RACV Resort in Torquay, Victoria with the theme "Transcending pain: ride the next wave".

News

Admission to fellowship of FPM

By examination:

Dr Willem Volschenk, FANZCA, NSW.

Dr Alister Ramachandran, FCARCSI, NSW.

By election:

Dr John Alchin, FAFOM(RACP), NZ.

This takes the total number of Fellows admitted to 438.

Training unit accreditation

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

- Hunter Integrated Pain Service, NSW.
- Prince of Wales, NSW.
- Sir Charles Gairdner Hospital, WA.
- Sunshine Coast Persistent Pain Management Service, Qld.

Foundations of Pain Medicine examination

On November 4, 25 candidates sat the Foundations of Pain Medicine examination. Twenty-three candidates were successful in this examination.

The written section of the fellowship examination was held in 10 venues on November 4 with the clinical section held at the Australian Medical Council National Test Centre, Melbourne on November 26, 2016. Sixteen of the 24 candidates were successful.

Merit awards were presented to Dr Anthony Carrie (NZ), Dr Megan Eddy (Vic), Dr Irina Hollington (SA) and Dr Alan Nazha (NSW). The Barbara Walker Prize was not awarded in 2016.

Successful candidates

The 16 candidates who successfully completed the fellowship examination are listed below:

Australian Capital Territory
Roopa Gawarikar
Alan Nazha

New South Wales
Raj Vinod Anand
Jane Standen

New Zealand
Anthony Carrie
Yvonne Murray

Queensland
Mazyar Danesh
Gunjeet Minhas

South Australia
Irina Hollington
Sharon Keripin

Tasmania
Michael Thomas

Victoria
Megan Eddy
Babak Farr
Christopher Woodgate
Jamie Young

Western Australia
Duane Anderson

Pain researcher wins Women of the Future award

Chronic pain researcher Georgia Richards was this year's Judges' Choice Winner at the *Australian Women's Weekly* and Qantas Women of the Future Awards. The award honours young Australian women who are pursuing a dream to help others and was announced on August 31 at an event in Sydney.

Ms Richards, 22, conducted a study for her bachelor of science honours research project at the University of Queensland to examine the role of long-term opioid therapy in people with chronic low back pain. She measured the differences in pain-related psychosocial variables, insomnia, cognitive performance and plasma cytokine concentrations. Her supervisors included FPM Fellows Associate Professor Brendan Moore and Dr James O'Callaghan.

Ms Richards found patients receiving opioid therapy had more reductions in attention, and significantly lower self-efficacy beliefs, than patients who did not take opioids. But she found no significant differences in other cognitive and pain-related measures, which she attributed to the independent contribution of pain to the results for both groups, and the development of opioid tolerance in those receiving long-term opioid therapy.

Her research was selected as a poster presentation at the IASP 16th World Congress on Pain in Yokohama, Japan and has been submitted for publication in the journal *Pain Medicine*.

The $A20,000 award helped fund Ms Richards's attendance at the congress in Yokohama and will be used to travel to the University of Oxford, UK, to meet world leaders in evidence-based medicine.

Honouring a giant in the field of pain medicine

Opposite page clockwise from top left: Professor Cousins on ABC's 7.30 program; past presidents and deans of ANZCA, FPM and intensive care medicine with retiring CEO Joan Sheales and President Professor Cousins (second from the right in the bottom row); article on Professor Cousins being appointed an Officer in the Order of Australia in 2014; He was granted an audience with Pope John Paul II in 1987; early days of the Pain Management and Research Centre with Professor Cousins, Laurie Mather (Royal North Shore) and Professor Lorne Elthrington (Stanford).

This page from left: In 2010 Professor Cousins chaired the Steering Committee which developed Australia's first National Pain Summit at Parliament House, Canberra; first Diploma of Pain Medicine graduands and teachers from the University of Sydney .

A pain medicine perspective

This year Professor Michael Cousins retired from full-time practice, winding down a remarkable career in anaesthesia and pain medicine. The immediate past dean of the Faculty of Pain Medicine, Professor Ted Shipton, profiles Professor Cousins from an Faculty perspective, and Professor Peter Kam from an ANZCA perspective.

The last letter I wrote as dean of the Faculty of Pain Medicine was on the evening of Sunday, May 1. It was to Michael Cousins, on his imminent retirement, to express our gratitude to him for his enormous contribution to the Faculty.

I first met Michael early in 1991 in Johannesburg, where he was a guest of the College of Medicine of South Africa. I was keen to start an acute pain service and had recently acquired 20 ambulatory patient-controlled analgesic machines. I invited Michael to visit our hospital in the suburb of Hillbrow. His advice proved most helpful and we started the first acute pain service in South Africa at Hillbrow Hospital in May 1991. A year later, I was appointed editor-in-chief of the South African *Journal of Anaesthesiology and Analgesia*. When looking for members for our international editorial board, I approached Michael, and he readily agreed to join the board.

Michael Cousins has worked in the field of persistent pain for more than 40 years as a clinician, researcher, educator, administrator and community advocate. In 1997, he took over from John Gibbs as chair of ANZCA's Joint Advisory Committee in Pain Medicine, which had been tasked by the ANZCA Council to examine training requirements for a certificate in pain management"[1]. On October 3, 1998, regulations were approved to establish the inaugural board of the Faculty of Pain Medicine[2]. Michael was given this task. On February 4, 1999, the Faculty held its first face-to-face board meeting in Melbourne[3] and Michael was elected the foundation dean, serving from 1999 to 2002. The Faculty owes him a great deal for his inspired foresight and determination as foundation dean, overseeing the birth of the Faculty.

Michael played a key role in gaining Australian government recognition of pain medicine as an independent medical specialty, and in obtaining universities' recognition of pain medicine as an academic discipline. The Faculty has established the Michael Cousins Lecture, a plenary lecture at the ANZCA annual scientific meeting in his name.

Michael Cousins was born and educated in Sydney. He received a postgraduate fellowship to carry out research on acute pain management with a pioneer in this field, Professor Philip Bromage, at McGill University in Montreal. From 1970 to 1974, he was assistant professor of anaesthesia at Stanford University in California. While at McGill and Stanford universities, Michael networked with three of the pioneers in pain medicine, Ronald Melzack and Patrick Wall (of the Gate Control Theory of Pain), and John Bonica, who became the founding father of the multidisciplinary approach to pain managements. In 1975, he was appointed the foundation professor of anaesthesia and intensive care at Flinders University, SA. In 1979, he served as the founding president of the Australian Pain Society. Since 1990, and until recently, he has been the foundation chair of anaesthesia and pain management at the Royal North Shore Hospital and the University of Sydney. There he established and became director of the Pain Management and Research Centre (now named the Michael Cousins Pain Management and Research Centre), which has received many nationally and internationally competitive research grants.

Michael drove the development of the University of Sydney's diploma and masters course in pain management. With its web-based education program, the course enrols students from around the world. From 1995-99, he chaired the National Health and Medical Research Council (NHMRC) working party that developed Australia's first evidence-based medicine guideline on the management of acute pain. Michael's basic and translational clinical research has resulted in more than 350 peer-reviewed publications, numerous chapters and three books.

On the international front, he was a long-serving councillor of the International Association for the Study of Pain (IASP). Michael is the only Australian, and first anaesthetist after its founder, John Bonica, to serve as president of the IASP from 1987-90. In 1999 he was made an honorary member.

He also served as president of the Australian and New Zealand College of Anaesthetists (2004-06), and was first chair of the ANZCA Foundation (now the ANZCA Research Foundation). He established the ANZCA Clinical Trials Group (2005); served as chair of the Committee of Presidents of Medical Colleges (2006-08), as a councillor of the Australian Medical Council (2006-09), and on the NHMRC.

Michael chaired the steering group for the Australian National Pain Strategy, which set out to improve quality of life for people with pain and their families, and to minimise the burden of pain on individuals and the community. On March 11, 2010, 200 health professionals, consumers, industry representatives and funders met at the National Pain Summit at Parliament House in Canberra, and unanimously adopted the National Pain Strategy. This strategy now guides national pain strategies in the US, Canada, UK and some European countries.

In August 2010, he chaired the first international pain summit in conjunction with the IASP's World Congress on Pain in Montreal, Canada. An important outcome of this summit was the "declaration of Montreal", which called for "Access to pain management as a fundamental human right".

In 2012, Michael became the first head of the new academic discipline of pain medicine at the University of Sydney. In 2014 was appointed an Officer in the Order of Australia (AO). He spearheaded the formation of Painaustralia, a network of healthcare, consumer and other organisations formed to facilitate the implementation of the National Pain Strategy, and remains a clinical representative on their board.

Michael has retired from the university, but will continue his neuromodulation research at the Northern Private Pain Centre on the North Shore.

In recognition of his work for the university the title emeritus professor was bestowed on Michael in November.

Michael Cousins has been one of the great world leaders in pain management. He has mentored many clinicians and researchers across the world. In the dean's office at ANZCA House, his portrait will remind every new dean of his great vision. As a Faculty we pay tribute to him not only for his service, but also for what he has achieved for pain medicine internationally, and particularly for what he has achieved for pain medicine in Australia and New Zealand.

Throughout his career, Michael has been ably supported by his wife, Michele. We wish them both a well-deserved retirement.

Professor Ted Shipton
Immediate past dean, FPM

References:
1. Shipton EA, Moore B, Cousins MJ, Atkinson RL. The Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists - History and Strategic Plan. Pain Medicine 2014;15(12):1992-5.
2. Minutes of ANZCA Council, October 2-3, 1998.
3. Minutes of the Meeting of the Board of the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists, Council Room, at College Headquarters, Melbourne, February 4, 1999.

No pain proves a gain

PALM BEACH PROFESSOR'S AO

Honouring a giant in the field of pain medicine (continued)

An anaesthesia perspective

Michael Cousins may be best known for his achievements in pain medicine, but he also had a big impact on anaesthesia and on ANZCA itself.

It is a great privilege to write about the contributions of Professor Michael J Cousins to anaesthesia and ANZCA. Michael is an astute clinician, teacher, mentor, administrator, collaborator and an innovative researcher, and is recognised for these skills throughout Australia and overseas.

On completion of his specialist training in anaesthesia at the Royal North Shore Hospital in 1968, Michael was awarded the Cecil Gray Prize as the top candidate in the then FFARACS (now FANZCA) examination.

Michael was subsequently awarded a University of Sydney postgraduate fellowship (1969-70) to work with Professor Philip Bromage at McGill University in Montreal, Canada.

McGill University – 1968-1970

In his early research, Michael, while collaborating with Professor Bromage, demonstrated that epidural anaesthesia both provided effective pain relief and this was associated with the improvement in blood flow through the surgical vascular graft.

His interests in the renal effects of anaesthesia and surgery began at this time as a result of discussions with Professor Gutelius, a professor of surgery at McGill University, who introduced Michael to background studies in this area.

Standford University – 1970-74

During his tenure at Stanford University in California, Michael collaborated with Professor Richard Mazze in studies on the metabolism and renal toxicity of methoxyflurane and isoflurane. These were pivotal studies and led to the development of new safer inhalational agents. In 1975, Michael was awarded a doctorate in medicine from the University of Sydney for this work.

While at McGill and Stanford universities, Michael developed his interest in acute and chronic pain management as a result of interactions with John Bonica, Ronald Melzack and Patrick Wall, pioneers in pain medicine.

In 1973, he returned to the Royal North Shore Hospital in Sydney as the director of the pain clinic and senior staff specialist anaesthetist.

Flinders University – 1975-89

In 1975, Michael was appointed as the foundation professor of anaesthesia and intensive care at Flinders University, SA. Together with Professor Garry Phillips, Professor Laurie Mather and other scientists, he began research with a major focus on basic science and clinical anaesthesia, and in pain medicine. He continued his research into the toxicity of inhalational agents and developed an animal model of halothane hepatotoxicity. This enabled a better understanding of the pharmacogenetics and metabolism of halothane.

In collaboration with Professor Mather, Michael conducted basic science studies on neuraxial local anaesthetics and opioids. This resulted in improvements in the use of regional anaesthesia. It also produced the first report of the use of epidural opioids in humans, published in *The Lancet* in 1979. A 1984 review by Michael and Laurie on "Intrathecal and epidural opioids" in *Anesthesiology* has been the most cited article in the anaesthesia literature (more than 1300 citations) and many millions of patients have benefited from the use of neuraxial opioids for post-operative pain, labour analgesia and cancer pain. Michael and Laurie continued many studies on the pharmacokinetics of analgesic agents in patient-controlled analgesia, which have improved the efficacy and safety of the technique.

During this period, he edited the internationally recognised textbook *Neural Blockade and Pain Management*, a key reference for regional anaesthesia and pain management. In recognition of his work in anaesthesia, Michael was elected to the Royal College of Anaesthetists of Great Britain in 1988.

Royal North Shore Hospital and the University of Sydney – 1990 onwards

In 1990, Michael moved to Sydney on his appointment to the University of Sydney as the foundation professor and head of anaesthesia and pain management at the Royal North Shore Hospital, within the discipline of anaesthesia. Professor Mather also returned to Sydney and together they continued their research on local anaesthetic toxicity, safer intravenous anaesthetic drugs and novel methods of delivering analgesic agents.

Michael established the large, multidisciplinary Pain Management Research Institute and, in 1998, this was recognised as one of eight "Centres of Clinical Excellence in Hospital-based Research" by the National Health and Medical Research Council.

He was awarded the DSc by the University of Sydney in 2006 and DSc (Hon) by McMaster University (Canada) in 2011.

Contributions to ANZCA

Michael has been a major contributor to training in anaesthesia and pain medicine through his involvement in ANZCA. He has served as chair of the Primary Examination Committee (1979-85) and as chair of the Research Committee (1995-2002).

He was elected to the ANZCA Council in 1995 and was the president from 2004-06. During his term as president, he helped to develop ANZCA into a recognised professional organisation and initiated the ANZCA Anaesthesia Foundation. These enhanced the education and training functions as well as research activities of the College. In his capacity as chair of the Committee of Presidents of Medical Colleges, he raised the profile of Australian anaesthesia nationally and internationally.

Michael's success can be attributed to a number of exceptional traits possessed by very few in our profession. Firstly, he has an ability to overcome resistance to change that is so prevalent in medicine. Michael is persuasive and is able to prevail upon the medical profession when needed. He exudes enthusiasm and confidence.

In conclusion, Michael has inspired a generation of anaesthetists and pain medicine specialists. He has established enduring relationships and networks of research and clinical collaboration between colleagues in anaesthesia and pain medicine in Australia and overseas. He will be remembered as a pioneer and leader in Australian anaesthesia and pain medicine.

Michael will continue consulting in pain medicine and we wish him well for the future.

Professor Peter C A Kam
Nuffield Professor of Anaesthetics,
Sydney Medical School,
Royal Prince Alfred Hospital

"Michael is persuasive and is able to prevail upon the medical profession when needed. He always appeared to me to exude enthusiasm and confidence."

Michael Cousins - national and international awards and eponymous lectures

- John Mitchell Crouch Research Award, Royal Australian College of Surgeons (first non-surgeon) – 1982.
- Mushin Medal, Welsh National University (first Australian) – 1986.
- Royal College of Physicians and Surgeons of Canada, Royal College Lecture – 1985.
- Inaugural JJ Bonica Distinguished Lecturer on Pain Therapy, American Society of Regional Anaesthesia (in memory of the "father" of the field of pain medicine) – 1988.
- Ralph Waters Lecture, Illinois Society of Anesthesiologists (in honour of one of the pioneers of Anesthesiology, first and only Australian – 1994.
- Western Canada Distinguished Professor – 1994.
- Sir Arthur Sims Professorship, Royal College of Surgeons and Physicians of UK, Canada & South Africa (first anaesthetist) – 1994-95.
- Sir Ivan McGill Lecture, Chelsea and Westminster Hospital UK – 1995.
- JJ Bonica Lecture, Eastern Pain Society, New York, US (first and only Australian – 1995.
- Member of the Order of Australia (AM) – 1995.
- Gaston Labat Medal of the American Society of Regional Anesthesia (commemorates the acknowledged key pioneer in the field of regional anaesthesia for surgery, first Australian – 1996.
- Inaugural Kester Brown Lecture, Australian Society of Anaesthetists – 1997.
- EA Rovenstine Memorial Lecture, American Society of Anesthesiologists (the prime eponymous lecture of the ASA, first and only Australian – 1997.
- Rotary Award for Vocational Excellence in Anaesthesia and Pain Medicine – 1999.
- Honoured as the Australian Neuroscience Society Eccles Lecturer (in memory of Nobel Laureat, Sir John Eccles) – 2001.
- Carl Koller Gold Medal, European Society of Regional Anesthesia (commemorates the discovery of local anaesthesia, first Australian) – 2002.
- Michael Cousins "foundation lecturer" Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (in recognition of his founding of the Faculty of Pain Medicine) – 2003.
- Elected to fellowship of Chapter of Palliative Medicine, Royal Australasian College of Physicians – 2005.
- Royal College of Anaesthetists Chloroform Sesquicentenary Lecture, Edinburgh.
- The Seldon Award International Anesthesia Research Society (first Australian) – 2005.
- William Russ Pugh Research Award of the Australian Society of Anaesthetists (the first Australian and second recipient) – 2007.
- Robert Orton Medal, Australian and New Zealand College of Anaesthetists (ANZCA's highest award) – 2008.
- Distinguished Member Award, Australian Pain Society – 2008.
- American Academy of Pain Medicine, Founders Award (first award outside the US) – 2008.
- International Pain Educator of the Year Award – 2009.
- McMaster University, Ontario Canada DSc(Hon Causa) and address to graduands on occasion of the 500th convocation and 125th anniversary of the university – 2012.
- Honorary Fellow of the Faculty of Pain Medicine, College of Anaesthetists of Ireland – 2013.
- Inaugural Lifetime Achievement Award, International Neuromodulation Society, Australian and New Zealand Neuromodulation Society – 2013.
- Officer in the Order of Australia (AO) – 2014.
- Numerous other eponymous lectures at universities in the US, Canada, Europe and the UK.
- Keynote international lectures to 23 different disciplines at various times (anaesthesia, intensive care, medicine [physicians], surgery, spinal surgery, neurosurgery, oral surgery, neurology, psychiatry, clinical psychology, gastroenterology, hepatology, nephrology, cardiology, oncology, pain medicine, palliative care, pharmacology, dentistry, rehabilitation medicine, physiotherapy, nursing, history of medicine).

Unrest brings healthcare challenge in PNG

When Australian anaesthetists Dr Chris Acott and Dr Yasmin Endlich flew to Papua New Guinea in July, they landed in the middle of a political storm. The unrest changed the tone of the overseas aid visit and highlighted the impact of ongoing instability on the delivery of healthcare in PNG.

Arriving in Port Moresby, a city of about 410,000 inhabitants, we discovered the immediate political crisis meant treatment at Port Moresby General Hospital (PMGH) was provided only in emergencies. Most patients we planned to treat for cleft palate repair or an oral cancer were either bluntly sent home or asked to stay until the political unrest ceased.

Making the best of our time, we conducted workshops and delivered lectures to the senior anaesthetists, the anaesthetic registrars and the nursing staff.

The workshops concentrated on the management of the difficult airway in the PNG setting, fibreoptic intubation (for the Port Moresby registrars) using the Dexter model developed by Dr Colin Marsland from New Zealand – Colin had generously donated a Dexter to PNG last year – basic life support and advanced life support in adults, paediatric patients and neonates.

The use of ultrasound, donated by Sonosite, for regional anaesthesia and airway assessment was examined, and various simulation scenarios were attempted using the iSimulate donated to Port Moresby General Hospital by Dr Anthony Lewis in 2015. The lecture program concentrated on "can't intubate, can't oxygenate" (CICO), oxygen therapy, the use of apnoeic oxygenation, nasal intubation, the safe use of laryngeal masks, airway blocks for awake intubation, airway assessment and the management of obstetric emergencies. As always, the local medical staff were eager to learn and a great pleasure to work with.

During our stay in Port Moresby, we also supported local anaesthetists in the care of the first ever thoracoscopy, performed in Papua New Guinea. Double lumen endotracheal tubes, an arterial line and confirmation of position with the fiberoptic scope were crucial to this patient's successful surgery and anaesthesia.

On a side note, we are happy to report that the threat of civil unrest became "something nothing", to use a Pidgin phrase.

Our visits to Nonga Base Hospital, in Rabaul, and Alotau General Hospital, in Milne Bay, revealed another problem that can be traced back to the political situation in PNG. In both hospitals we found an acute and critical shortage of drugs and equipment. Neither hospital had received sufficient funding from the National Department of Health for more than six months prior to our arrival; any drugs that were available were either out-of-date or expired, and were sourced from India or China.

To make matters worse, most ampoules had unidentifiable labelling and were not labelled in English. The anaesthetists at these hospitals, including Port Moresby General Hospital, reported that the Indian manufactured propofol had caused unusual anaphylactic reactions in some patients, causing at least one fatality in both Alotau and Port Moresby.

A lack of suitable vasoconstrictors prompted the use of out-of-date adrenaline or dobutamine to manage hypotension during spinal anaesthesia for caesarean sections. Oxygen, a major expense for hospitals in PNG, also was in short supply, causing clinicians to only use it in patients younger than 60 years old.

Thanks to some good fortune in Milne Bay, we met Wendy Stein, the driving force behind "Spacim Pikinini" – a Rotary-sponsored contraceptive implant program. Most of the year she lives on her boat and tours islands of the region; she has already provided more than 50,000 contraceptive implants to women in PNG. Not only did she have fascinating stories to tell, but access to several oxygen concentrators, which she willingly donated.

We set up three oxygen concentrators in the recovery unit of Alotau General Hospital and are setting up more in the intensive care unit. In the meantime, Rotary, through Wendy, has taken this one step further and will donate oxygen concentrators to each hospital in PNG provided the hospitals pay transport costs from Port Moresby. We demonstrated how to use these to the anaesthetists and nursing staff and conducted workshops on how to use them at the PNG Medical Symposium in September in the hope other hospitals would be interested in obtaining them.

Alotau hospital is the "jewel in the crown" in provincial PNG hospitals and it was disappointing to see it slip backwards due to a lack of government support. The doctors, nurses and administrative staff do their utmost to treat the community and to run the hospital but short-term help with equipment and drugs is desperately needed.

Companies that donated

- Cook Medical
- DAK Foundation
- Laerdel Global Health
- Lifebox
- Rotary Australia World Community Service
- Smiths Medical
- SonoSite
- STORZ

Rabaul was completely buried in volcanic ash in 1994 and only parts of the township have been dug out. Nonga Base Hospital was nearly destroyed and, in the 20 years since, has been allowed to deteriorate. Fortunately, the PNG government, with AusAid support, has finally decided to restore the hospital. As those who have worked in PNG prior to 1994 will know, Rabaul was a "paradise on earth", particularly Nonga hospital. Situated near the beach, it was a clean, well-run, tropical hospital, which hopefully will be restored to its former glory. However, during our visit this year we could see it was lacking essential equipment, similar to Alotau General Hospital.

Prior to leaving both Nonga and Alotau, we were given wish lists of urgently needed equipment. Endotracheal tubes, breathing circulation filters and consumables are among the things urgently needed – things we take for granted in our hospitals in Australia. When we returned to Australia, we contacted medical companies to see donations and hospitals for unused equipment. These companies (see table) and various hospitals provided us with more than 200 kilograms of equipment, which we took with us in September to the medical symposium. Qantas generously waived the cost of air transport and, to our pleasant surprise, AirNiugini waived the excess luggage cost to Milne Bay as well.

We would like to thank Karl Storz Australia for its generous and ongoing support of anaesthesia in PNG and our efforts to improve the level of safe anesthesia and patient wellbeing in this beautiful country.

Dr Yasmin Endlich, FANZCA
Royal Adelaide Hospital, Women's and Children's Hospital, SA

Adelaide anaesthetists attend PNG medical symposium

In September, a group of Australian anaesthetists travelled to PNG to attend the 50th annual Medical Symposium of Papua New Guinea at Alotau, the capital of Milne Bay Province.

Nearly all PNG' medical officers and personnel – between 800 and 1000 delegates – gather at this meeting to learn and discuss issues related to healthcare. The symposium is split into two parts: the first three days are a general forum, while the last three days are devoted to the various medical specialties.

At the anaesthesia meeting, audits are presented on the work done in each hospital and registrars sitting their final exams present projects on various topics, which are discussed by a panel.

An anaesthetic team from Adelaide, consisting of Dr Chris Acott, Dr Yasmin Endlich, Dr Kirstie Morandel, Dr Kris Usher, Dr Richard Walsh and Dr Donna Willmot, attended the anaesthesia specialty meeting this year and gave lectures and ran specialised workshops relevant to the complications PNG medical professionals face in their provincial hospitals. These workshops have been held at this forum for the past 10 years. Initially, workshops concentrated mainly on airway issues and management relative to PNG, but they have expanded in the past five years and now address FOB intubation, paediatric laryngoscopy, adult paediatric and neonatal BLS and advanced life support, ultrasound regional anaesthesia concentrating on upper and lower limb blocks, PNG-tailored "can't intubate, can't oxygenate" algorithm, emergency tracheostomy care, oxygen concentrators and LMA insertion. ANZCA and medical device company Karl Storz Australia have helped to further expand the workshops, which were previously organised and funded privately. SonoSite has provided ultrasound systems for these workshops since 2014.

The DAK Foundation generously donated an ultrasound machine to the anaesthetic department of the Alotau hospital. We used the machine during the workshops and then handed it over to Dr Lucas Samof and his anaesthetic team. Dr Acott donated a textbook about ultrasound-guided regional to a local anaesthetic trainee, Dr Joel Silari.

For the second year in a row, Karl Storz Australia provided a prize for the best-presented senior registrar project.

"At the anaesthesia meeting, audits are presented on the work done in each hospital and registrars sitting their final exams present projects on various topics, which are discussed by a panel."

The prize consists of registration, airfares and accommodation for the 2017 ANZCA Annual Scientific Meeting in Brisbane. The team judged the papers on presentation, content and relevance to anaesthesia in PNG. This year, Dr Melanie Werror achieved the highest results for her paper on a comparison of morphine and pethidine intravenous infusions for post-operative pain relief. She indicated that pethidine is preferred because of the "feared side effect" of respiratory depression associated with morphine. This shows that myths about morphine need to be dispelled before EPM (Essential Pain Management) courses are successful, and a drug commonly used in western settings can be successfully used in perioperative care in PNG.

It rained continuously while we were in Alotau, which was consistent with previous visits, and it made us appreciate the conditions in which the Australian troops fought during the Battle of Milne Bay in 1942. This battle was the first in which the Japanese were defeated on land and was as significant to the defence of Australia as the Kokoda campaign. There were three airfields at Milne Bay and if the Japanese had been successful they would have been able to bomb the east coast of Australia at will. Two of our group had relatives who had fought there; Kris Usher's great uncle was killed, while Chris Acott's father went on to fight in other New Guinean campaigns.

Since returning from these adventures, we have shipped more than 20 boxes of medical supplies and 26 wheelchairs, thanks to Rotary in Adelaide, and have two trips planned to PNG in the upcoming year. Thank you to those who support us. We encourage everyone to join this rewarding team effort to help PNG and other developing countries.

Dr Yasmin Endlich, FANZCA
Royal Adelaide Hospital, Women's and Children's Hospital, SA

Lifelong learning essential to consultant anaesthetists

Introduction

Fellows need to manage their own learning once their ANZCA training is behind them. How do we support trainees to become self-directed lifelong learners?

We know from literature[1] that successful lifelong learners:

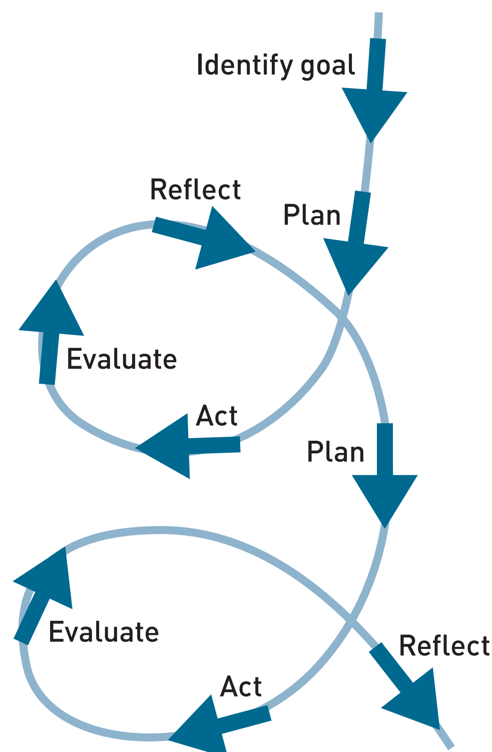
- Continuously strive to grow and improve.
- Remain curious, asking questions and challenging assumptions.
- Are prepared to take risks and learn from mistakes.
- Are mindful of how they learn.
- Evaluate their own performance.
- Reflect on their learning.

The essence of lifelong learning is to take control and responsibility for your own learning and development. This involves identifying learning needs, developing learning goals, and creating active plans to meet these goals. It is essential then to judge if the learning activities have met the learning goals. This requires evaluating your own performance, and reflection, to develop a continuous cycle of learning.

This framework for self-directed learning is described in Figure 1.

We will follow Monash Children's Hospital anaesthetist, Dr Richard Barnes, as he learns a new skill to highlight the steps in the framework.

Figure 1: Learning framework

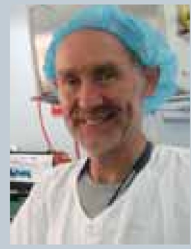


Identifying learning need(s)

We can identify learning needs in multiple ways. As a trainee, the curriculum outlines what ANZCA thinks we need to know and be able to do. As a Fellow, it is up to you to do this for yourself, so trainees, and especially provisional Fellows, should practise moving from curriculum goals to their own learning goals.

Sometimes there is an aspect of care you would like to be able to provide your patients that you haven't learnt before, maybe because your workload changes or the standard of care advances and you need to keep up. Other times, in listening to feedback from your colleagues or reflecting on your own performance, you can identify something you could do better.

Dr Richard Barnes on his learning need:
"I have never been comfortable with the internal jugular approach in small children, finding the vein easy to transfix but often difficult to cannulate... our 'lines audit' began to show that internal jugular lines in infants rarely last longer than seven days. So I was on the lookout for something better."



Setting goals

It is vital to set goals, beginning with the end in mind. When learners set their own goals they achieve more, are more motivated and more efficient than when others set the goals[2]. Once you finish training, this is up to you.

Dr Barnes sets his goal:
"In 2011, a paper was published describing a novel approach to central venous cannulation in young children: an ultrasound-guided, supraclavicular approach to the brachiocephalic vein[3]. The technique immediately interested me, as it involved an in-plane ultrasound approach, which I find to be accurate and reliable. I was eager to try the technique myself."

BJA
REGIONAL ANAESTHESIA
Consecutive, prospective case series of a new method for ultrasound-guided supraclavicular approach to the brachiocephalic vein in children
C. Breschan, M. Platzer, R. Jost, H. Stettner, A.-S. Beyer, G. Feigl and R. Likar

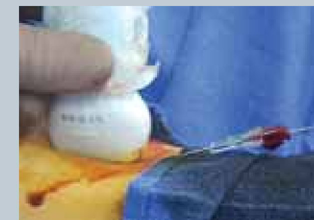
Planning

Consider what learning resources you will need to achieve your identified learning goals. This may include human and material resources. Work out what steps you need to take on the way to your goals, balancing your needs and your learning opportunities. You have already learnt many anaesthetic skills and have used many different ways to improve – which of these strategies do you think will help you in this situation?

You can take account of your own learning preferences when planning your learning activities. Some of us like courses with certificates, others like shadowing a colleague and don't need the external confirmation of our learning.

Whatever plan you make, you need to act on it! Actively engage with the plan you create. Learning requires active involvement and energy. Be prepared to adapt your plan as you learn. Make the most of the diversity within anaesthesia and value the opportunity to be exposed to multiple different approaches to what appear to be similar situations. Learn from mistakes you might make.

From Dr Barnes' plan:
"I took the opportunity on a number of anaesthetised children to practise identifying the relevant ultrasound anatomy... I had a copy of the description in my briefcase."



Evaluating

It is important to assess what you accomplish in your learning against what you set out to achieve. This requires evaluative judgment, which is recognised as a difficult skill. Like anything else we need to learn, it comes with practice and improving takes work. Seeking feedback from others and measuring yourself against external indicators of performance, where possible, are ways to support and improve the quality of your self-assessment once you are responsible for your own learning.

In training, be honest with yourself and invite honesty from those supervising you so you get realistic feedback to compare with your own judgment of your performance, so your own self-assessment can improve. Asking "how does this feedback fit in with what I think?"[4] will help you develop your own evaluative judgment.

Dr Barnes on evaluating:
"I decided to keep an audit... Soon I had my only two 'failures' until the present; both were valuable learning experiences."

Reflect

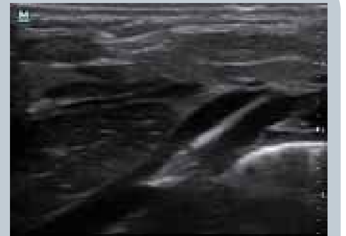
"Reflection is an important human activity in which people recapture their experience, think about it, mull over and evaluate it. It is this working with experience that is important in learning"[5].

Questions you might like to ask yourself to stimulate reflection include: What worked well? What could you have done differently? Which of the learning strategies you used were successful? How will you continue to improve your performance in this area? What will you take from this that will help you learn in the future? Always consider why this is so for each question.

The object in reflecting is to revise your previous plans and generate new ones, and the cycle continues.

Dr Barnes reflects:
"The skills required for handling the needle with one hand while maintaining a good long axis view with the other were indeed skills I already possessed."

"I have now performed the technique another 50 times, with no further failures. To my delight, our 'lines audit' shows that lines placed by this approach routinely last two weeks and often three weeks."



Conclusion

Fellows need to be lifelong learners and ANZCA training needs to prepare trainees for this, just as it does all the other important aspects of performance as a consultant anaesthetist. We need to support our trainees in developing their abilities as self-directed learners so they can assume responsibility for their own learning once their training is complete.

Dr Damian Castanelli
Supervisor of Training, Monash Medical Centre, and Education Officer, Vic

Maurice Hennessy
Learning and Development Facilitator, ANZCA

Acknowledgment
The authors acknowledge the valuable assistance of ANZCA Fellow Dr Richard Barnes in preparing this paper and, in particular, being willing to share his reflections.

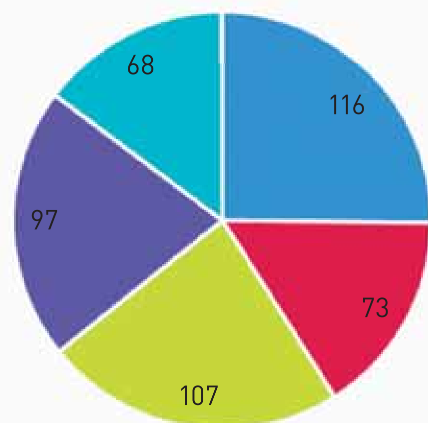
References:
1. Deakin Crick R, Broadfoot P, Claxton G. Developing an Effective Lifelong Learning Inventory: the ELLI Project. Assess Educ Princ Policy Pract. 2004;11(3):247–72. DOI: 10.1080/0969594042000304582.
2. Developing, monitoring and reporting on personal learning goals [Internet]. Learning Policies Branch, Student Learning Division, Office of Learning and Teaching, Victoria. 2006. Available from www.education.vic.gov.au/studentlearning/studentreports/
3. Breschan C et al, Consecutive, prospective case series of a new method for ultrasound-guided supraclavicular approach to the brachiocephalic vein in children, BJA 106(5):732-7, 2011.
4. Boud D, Keogh R & Walker D p 43. Reflection: turning experience into learning. Kogan Page, London. (1985).
5. Heen S. How to use others' feedback to learn and grow. 2015. Available from: www.youtube.com/watch?v=FQNbaKkYk_Q5.

What's new in the library

Literature search requests reach 100!

The library recently completed its 100th literature search request for the year and has already exceeded the previous annual record of 107 requests in 2014.

Number of literature searches



2016 YTD | 2015 | 2014 | 2013 | 2012

Fellows and trainees are often required to perform a literature search to provide evidence for patient care, research, presentations, and many other purposes.

ANZCA library provides a literature search service that is available to all Fellows and trainees. The service involves a comprehensive search of published literature to identify good-quality citations relevant to a topic, and may include books and articles, and other sources of information, such as reports and government websites.

The final citation/abstract list is provided in MS Word and EndNote format.

Recent literature searches have been conducted on such topics as:

- Environmental impact and waste management in anaesthesia.
- 3D printing for anaesthesia.
- Barriers in participation in research by doctors.
- Opioid addiction after surgery.

Submit a literature search request at: www.anzca.edu.au/resources/library/request-a-literature-search.

Spotlight on: Apps

Library Guides

The Apps Library Guide highlights apps of interest to anaesthetists and pain specialists. The library subscribes to and regularly trials a number of different apps to help increase the flexibility with which our users can access our online resources. Some apps allow customised or personalised delivery of content and alerts, which can be accessed directly from your device. The guide also collates apps in use in the wider medical community, including an app produced by ANZCA's Faculty of Pain Medicine. The guide is regularly updated with the latest information, including:

- Read by QxMD aims to provide a single place to keep up with new medical and scientific research. It is user-friendly and displays content in the style of a personalised digital journal. Simply select "Australian and New Zealand College of Anaesthetists" from the list of institutions to link to ANZCA Library full-text articles.
- FPM Opioid Calculator. The Faculty of Pain Medicine has developed a smart phone app designed to calculate dose equivalence of opioid analgesic medications.

Access this library guide at: http://libguides.anzca.edu.au/library/apps.

New books for loan

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

Abdominal and pelvic pain: From definition to best practice
Messelink, Bert [ed]; Baranowski, Andrew [ed]; Hughes, John [ed]. -- Philadelphia, PA: Wolters Kluwer; IASP Press, 2015.

Advances in neuroscience in anesthesia and critical care
Kofke, W. Andrew [ed]; Fleisher, Lee A [ed]. -- Philadelphia: Elsevier, 2016.

Coaching and mentoring at work: Developing effective practice
Connor, Mary; Pokora, Julia. -- 2nd ed -- Maidenhead, England: McGraw-Hill/Open University Press, 2012.

Medical ethics: A very short introduction
Hope, Tony. -- Oxford, United Kingdom: Oxford University Press, 2004.

Medical law: A very short introduction
Foster, Charles. -- Oxford, United Kingdom: Oxford University Press, 2013.

Monuments to the discoverers of anaesthesia: A traveller's guide
Gibbs, Neville. -- Perth, 2016. *Kindly donated to the Geoffrey Kaye Museum by the author, Dr Neville Gibbs.*

Therapeutic guidelines: Antibiotic: Antibiotic Expert Group
Therapeutic Guidelines Limited. -- Version 15 -- West Melbourne: Victoria Therapeutic Guidelines Limited, 2014.

Follow the #ANZCALibrary on Twitter

Want to stay up to date with the latest news and resources from the ANZCA Library? Follow **@ANZCA** on Twitter and you will see weekly updates from the library using the **#ANZCALibrary** tag. The library highlights the resource of the month, as well as any new books and articles of interest as soon as they hit the collection.

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

Oxford higher specialty training: Advanced training in anaesthesia
Prout, Jeremy [ed]; Jones, Tanya [ed]; Martin, Daniel [ed]. -- Oxford University Press: Oxford, United Kingdom, 2014. *Purchased thanks to a financial donation from Dr Mark Adams.*

Atlas of pain management injection techniques
Waldman, Steven D. -- 4th ed -- St. Louis, Missouri: Elsevier, 2017.

Basic physiology for anaesthetists
Chambers, David; Huang, Christopher; Matthews, Gareth. -- Cambridge, United Kingdom: Cambridge University Press, 2015.

Essential echocardiography: Transesophageal echocardiography for non-cardiac anesthesiologists
Maus, Timothy M [ed]; Nhieu, Sonia [ed]; Herway, Seth T [ed]. -- Switzerland: Springer, 2016.

Features and management of the pelvic cancer pain
Cascella, Marco; Cuomo, Arturo; Viscardi, Daniela. -- Switzerland: Springer International Publishing, 2016.

Handbook of critical and intensive care medicine
Varon, Joseph. -- 3rd ed --New York: Springer International Publishing, 2016.

Interventional critical care: A manual for advanced care practitioners
Taylor, Dennis A [ed]; Sherry, Scott P [ed]; Sing, Ronald F [ed]. -- Switzerland: Springer International Publishing, 2016.

Nunn's applied respiratory physiology: Applied respiratory physiology
Lumb, Andrew B. -- 8th ed -- Edinburgh: Elsevier, 2017.

Surgical intensive care medicine
O'Donnell, John Merritt [ed]; Nacul, Flavio Eduardo [ed]. -- 3rd ed -- New York: Springer International Publishing, 2016.

Topical issues in anesthesia and intensive care
Chiumello, Davide [ed]. --Switzerland: Springer International Publishing, 2016.

Teaching professional attitudes and basic clinical skills to medical students: A practical guide
Benbassat, Jochanan. -- Switzerland: Springer International Publishing, 2015.

Ganong's review of medical physiology
Barrett, Kim E; Barman, Susan M; Boitano, Scott; Brooks, Heddwen L. -- 25th ed -- New York: McGraw-Hill Education, 2016.

Special Interest Group events

Combined Communication, Education, Welfare, and Leadership and Management special interest groups meeting

"Building resilience - reflections, culture and changing minds"

The combined special interest groups (SIGS) annual meeting was held in Sydney from October 7-9. Now in its 13th year, the conference, was held at the Novotel in Manly and attracted more than 120 delegates from around Australia and New Zealand.

As always the meeting provided an excellent opportunity for an educational update, networking and also this year, a chance to see the sights of Sydney.

The meeting was entitled "Building resilience - reflections, culture and changing minds". We were privileged to have as our international keynote speaker Professor Mark Jensen, a professor and Vice-Chair for Research of the Department of Rehabilitation Medicine, University of Washington. An internationally recognised clinician and researcher and the editor of Pain, Mark provided tremendous insights into cognitive-behavioural, hypnotic and motivational approaches to pain management, and interpersonal communication more generally. His two half-day interactive workshops on motivational interviewing were a particular highlight with his engaging style and obvious expertise.

Along the same theme of exploring different approaches to communication, Dr Allan Cyna Communication in Anaesthesia SIG Chair again opened the eyes of attendees to his workshops on the use of suggestion and the practical use of hypnosis for the busy anaesthetist, while ANZCA's Maurice Hennessy challenged us on the important issue of providing feedback.

There was a further highlight with the presentations from the Vice-President of the Royal Australasian College of Surgeons, Mr Graeme Campbell, and ANZCA President Associate Professor David A Scott on the response of the colleges to high-profile coverage of bullying and what is being done to promote professionalism. In addition, Professor William Runciman provided a valuable link between past and present with his reflections on the evolution of incident reporting and ASA President Associate Professor David M Scott gave a thought-provoking presentation on his personal reflections of working in challenging and hostile environments.

The social program included a night cruise for dinner on the harbour and the venue was generally acknowledged as outstanding, being a short stroll from the beach and the numerous restaurants and cafes of Manly.

The meeting was a great success and I acknowledge the assistance from all the chairs of the SIGs, Dr Allan Cyna, Professor Guy Ludbrook, Dr Marion Andrew and Associate Professor Jenny Weller for helping put the program together, as well as the invaluable work done by Kirsty O'Connor and Alexis Marsh of the ANZCA Events team, without whom the meeting would not have happened.

Associate Professor Scott Simmons
Convenor

Above clockwise from left: "Becoming a compassionate presence – mindfulness and compassion in action" workshop; Welfare of Anaesthetists SIG session with ANZCA President Professor David A Scott, former RACS Vice President Mr Graeme Campbell and Human Factors Specialist Werner Naef; Meeting convenor Associate Professor Scott Simmons and ASA President Associate Professor David M Scott; Delegates enjoying dinner on the Captain Cook III cruise vessel.

Perioperative Medicine Special Interest Group meeting

"The elderly surgical patient"

Held in the tranquil and stunning Peppers Resort in Noosa, Qld, the 2016 Perioperative Medicine Special Interest Group (SIG) meeting was run in association with the Australian and New Zealand Society of Geriatric Medicine. Given our ageing population, the topic of "The elderly surgical patient" was chosen and proved to be very popular with the meeting sold out 10 weeks' before the event, which attracted 350 delegates.

More than 50 stakeholders in perioperative medicine were invited to a strategic meeting before the start of the conference, including surgeons, geriatricians, ICU, physicians, health fund representatives, anaesthetists and palliative care specialists. The goal was to describe the problems and critical issues in perioperative medicine and discuss solutions and recommendations. A summary document is being prepared.

The heart of our meeting was collaboration and teamwork. I would like to thank the geriatricians who came out in force to support this meeting and represented a third of the delegates. Our international speakers were from the UK. Dr Richard Griffiths, a consultant anaesthetist at Peterborough and Stamford, and Dr Jugdeep Dhesi, a consultant geriatrician at Guys and St Thomas. Both were outstanding, Richard for his ability to mix European history and humour with evidence surrounding ortho-geriatric anaesthesia, and Jugdeep for showing us how her Perioperative Older Care Service developed and the lessons she has learnt along the way.

Our local speakers also were amazing. Geriatrician Associate Professor Ruth Hubbard gave us an insight into frailty and practical ways to approach frailty assessments. One of the most powerful quotes from her was: "Women manage frailty beautifully. Men die". Ruth will speak at next year's annual scientific meeting in Brisbane if you'd like to hear more. Mr Steve Smith, a colorectal surgeon from Newcastle, NSW, spoke about colorectal surgery in the elderly patient and covered risk stratification, techniques that can be used to optimise them and post-operative management. Orthopaedic surgeon Mr David Morgan was very entertaining as he unpacked perioperative medicine from his point of view.

We also had a number of high quality problem-based learning discussions, discussion groups and small lectures. Thank you again to all who contributed. The formal meeting was finished by acknowledging Dr Dick Ongley for his contribution to the Perioperative Medicine SIG as chair.

Transport to the conference dinner was by sunset river ferry to Ricky's River Bar and Restaurant, a beautiful venue. Our ANZCA event organiser, Alexis Marsh, presented her adventures with direct-action ocean conservation organisation the Sea Shepherd earlier this year. She finished her presentation by explaining her resignation from ANZCA to take up further seaward adventures with Sea Shepherd. Alexis, you will be sorely missed and we wish you many safe journeys.

Next year we've had to move venue to the Novotel in Manly, Sydney as we've outgrown Noosa. The theme is "Cancer surgery and perioperative medicine: prehab to rehab". We are pleased to be running the meeting in association with the Royal Australasian College of Surgeons and can see this being another very successful educational event.

Dr Jeremy Fernando
Chair of the Perioperative Medicine Special Interest Group
Anaesthetist-intensivist,
Rockhampton Hospital, Queensland

Above clockwise from left: Delegates at the strategic meeting; International keynote speaker Dr Richard Griffiths delivers the plenary; Former ANZCA President Dr Leona Wilson (second from right) with attendees from Wellington, NZ.

Special Interest Group events (continued)

Welfare SIG satellite meeting

On Friday September 16, the Welfare of Anaesthetists Special Interest Group convened a satellite meeting to the 75th Australian Society of Anaesthetists National Scientific Congress in the heart of Melbourne.

All enjoyed the view from the Melbourne Convention and Exhibition Centre as 63 anaesthetists and trainees gathered to reflect on the concept of working at one's personal best.

We were treated to a stimulating discourse during the morning plenary sessions. Former Victorian premier turned mental health campaigner Jeff Kennett, an inspiring and emphatic speaker, challenged the medical profession to consider ways it can act to improve the mental health of doctors. In "rebuttal" we received wise words and advice from Dr Kym Jenkins, medical director of Victorian Doctors' Health Program, with strategies for thriving rather than just surviving our practice. Finally Nick Arvanitis, of beyondblue, explained the concept of, and need for, mentally healthy workplaces.

The afternoon saw the group divide to attend a series of workshops: Process Communication Model; diet, exercise and a fascinating exploration of the microbiome and its importance; a practical and evidence-based expose of mindfulness; and, finally, an exploration of the need for and some techniques to support our colleagues. The workshops were well received, tinged with laughter, but rich with learning. All who attended left with a broader perspective and useful and practical tips to improve the quality of our health and that of our patients.

Dr Kushlani Stevenson and **Dr Antoinette Brennan**
Co-convenors

Above from left:
Co-convenors of the meeting, Dr Kushlani Stevenson and Dr Antoinette Brennan; Dr Marion Andrews, Chair of the Welfare of Anaesthetists SIG; former Victorian premier turned mental health campaigner Jeff Kennett.

WELFARE SIG ARTICLE SERIES

Bereaved by suicide

A recent article in the *Medical Journal of Australia*[1] quantified the rate of suicide among health professionals and found female health professionals and male nurses and midwives had suicide rates higher than those in other occupations.

Sadly, the suicide of relative, friend or colleague will affect most of us at some time in our lives and will no longer be a statistic one reads about in medical journals. In such times, we can be left with feelings of guilt and helplessness. The stigma surrounding suicide can make it harder to talk to someone who is bereaved.

If you have been personally affected by the loss of someone close there is always someone to talk to, 24 hours a day via the Suicide Call Back Service (www.suicidecallbackservice.org.au), which offers free phone, video and online counselling for anyone affected by suicide.

For guidance on how to support someone bereaved by suicide, please visit:

www.headsup.org.au/supporting-others-in-the-workplace/suicide-prevention-and-awareness/supporting-someone-bereaved-by-suicide

www.conversationsmatter.com.au/resources-community/those-bereaved-by-suicide

Reference:
1. Milner AJ, Maheen H, Bismark MM, Spittal MJ. Suicide by health professionals: a retrospective mortality study in Australia, 2001-2012. Med J Aust. 2016;205(6):260-5

New Zealand news

Quality assurance network getting under way

New Zealand's anaesthesia departments are enthusiastic about the establishment of a network for their quality assurance co-ordinators – an ANZCA NZ National Committee initiative being led by committee member Dr Rob Fry.

Under *PS58 Guidelines on Quality Assurance in Anaesthesia*, all anaesthetists and trainees are expected to take part in quality assurance activities and ANZCA recommends that each anaesthesia department appoints a quality assurance co-ordinator.

Dr Fry says aspects of the co-ordinator role can be challenging and the network will support those who are endeavouring to guide their department's quality initiatives and enable them to share ideas, initiatives, activities and, possibly, data.

The network will launch with a one-day national meeting in Wellington in February. That departments would have liked to send more than the one person each there is space for, indicates the high level of interest.

There is likely to be a follow-up meeting later in the year to consolidate the nature of the network, framework and direction. An annual, possibly themed, meeting is envisaged with most business managed using email and an internet forum between meetings.

Central rotation hospitals host CEO

ANZCA CEO John Ilott met anaesthetists and trainees at Wellington Hospital in November as he continued his visits to the main hospitals in each of New Zealand's training rotations – visits timed to coincide with meetings of the New Zealand National Committee (NZNC).

Wellington Hospital is part of New Zealand's central rotation and the Capital & Coast District Health Board. Mr Ilott was accompanied by NZNC Chair Dr Gary Hopgood and ANZCA's NZ General Manager Heather Ann Moodie.

Their visit included meetings with the district health board CEO Debbie Chin, the supervisors of training, rotational supervisors, trainees and others involved in delivering the ANZCA training program, and the department's executive team, led by director Dr Derek Snelling.

The afternoon concluded with drinks and an informal discussion with trainees, Fellows and other anaesthetists.

Mr Ilott and Dr Hopgood also visited the nearby Hutt Hospital anaesthesia department with Mrs Moodie and Dr Leona Wilson, where they discussed continuing professional development, the ANZCA Library and the training program with the Director of Anaesthesia, Dr James Cameron, supervisor of training Dr Phil Eames, Fellows and provisional Fellows.

Mr Ilott said he found the opportunity to talk to people in their workplaces very valuable.

"They are more inclined to talk about how they are involved in the work of the College, their expectations of the College, how well its services are being used and how easy they are to use, as well as to make suggestions," he said.

NZ Anaesthesia ASM 2017 – Rotorua calling

Planning is well under way for the NZ Anaesthesia Annual Scientific Meeting being held in Rotorua November 8-11, 2017 with the theme "Fear and excitement".

A committee from Waikato Hospital, convened by Dr Kevin Arthur, is organising the meeting, which is hosted jointly by the NZNC and the NZ Society of Anaesthetists

Many of the speakers have been locked in, the industry prospectus released and the social program is being finalised.

Topics will include surviving the coroner, preadmission, ethical dilemmas in anaesthesia, airway dilemmas, dangers in everyday practice, and more. Workshops enabling participants to meet their continuing professional development requirements will be held on the Saturday.

For more information and to register interest in attending, see www.nzanaesthesia.com.

Regional symposium success continues

About 30 anaesthetists and trainees from Palmerston North, Hawke's Bay Regional and Whanganui hospitals attended the fourth regional symposium utilising NZ Anaesthesia visiting lecturers on November 3 at Whanganui Hospital. This year, they heard from Dr Matt Jenks (Dunedin) and Dr Ben Griffiths (Auckland City).

In what was described as "an 'eye-opening' presentation", Dr Jenks presented on "Operating theatre waste, climate change and the anaesthetist". Utilising his own experiences at Tauranga and Dunedin hospitals together with an up-to-date review of the literature, Dr Jenks gave practical guidance about how to make anaesthesia practice more environmentally sustainable.

Dr Griffiths gave an "outstanding presentation with a wealth of thought-provoking data" on the topic "Emergency Laparotomy perioperative outcome and quality improvement pathways: A United Kingdom and NZ perspective". The talk encompassed the extremely topical issue of poor perioperative outcome within the UK for this "forgotten group" and the recent steps taken aiming for improvement. It also reflected current data from the wider Auckland area, including possible explanations for outcome differences.

Symposium organisers Dr Nigel Waters (Palmerston North) and Dr Marco Meijer (Whanganui) said that once again, the symposium provided an ideal opportunity to network and support regional collaboration.

"It is also a cost-efficient way for multiple secondary level hospitals to simultaneously get exposure to experts in their field," they said.

Opposite page, from top left: Dr Rob Fry; ANZCA CEO John Ilott (left) talking with Wellington Hospital anaesthetists and ANZCA Fellows, Dr Geoff Carden and Dr Alan McKenzie; John Ilott (left) talking to Dr James Cameron, along with Dr Leona Wilson and Dr Gary Hopgood.

This page above from left: Whanganui host Dr Marco Meijer introducing Dr Matt Jenks (left); Dr Leona Wilson leads a discussion on bullying with members of New Zealand's Education Sub-Committee at their annual workshop. NZ Education Officer Dr Brent Waldron is at left.

Catching up on training developments

New Zealand's supervisors of training and rotational supervisors gathered in the ANZCA office in Wellington in October for their annual workshop and the Education Sub-Committee face-to-face meeting.

They appreciated the opportunity to discuss developments in the training program and the training portfolio system with ANZCA General Manager, Education Olly Jones. He also updated them on new educational resources and future developments, while Dr Jennifer Woods presented on the amended scholar role requirements.

Executive Director of Professional Affairs Dr Leona Wilson led a discussion on bullying and resources the College is developing in this area, and NZ Trainee Committee Chair Dr Lizi Edmonds presented on the results of last year's trainee survey.

New members welcomed to NZNC meeting

Several new members were welcomed to the November meeting of ANZCA's NZ National Committee, including elected members Dr Michal Kluger (North Shore) and Dr Chris Harrison (Christchurch); appointed members Dr Tom Fernandez (Auckland City) and Dr Hamish Gray (Christchurch); and New Fellows representative Dr Richard More (Southland) – all pictured from left.

The meeting began with a 45-minute discussion with New Zealand's Minister of Health, Dr Jonathan Coleman (see page 13). Other topics on the agenda included updates from Mr Ilott and immediate past president Dr Genevieve Goulding.

A suggestion that the committee look at developing a strategy for sustainability will be considered later in light of an ANZCA Council decision to develop a professional document on environmental sustainability in anaesthesia practice.

Australian news

Australian Capital Territory

Art of anaesthesia

With occasionally tenuous links to the movie, the "Back to the Future" edition of the Art of Anaesthesia meeting moved back to spring and the Floriade festival over the weekend of October 15-16. A wide range of speakers did us great service in celebrating this return with the overall theme perhaps being more rightly the application of knowledge at the appropriate time in a disciplined manner, whether it be for pulmonary embolus, peri-arrest Caesar, Ebola, Parkinsons, peripartum headache or the patient with a penchant for illicit drugs. Other speakers gave us a framework for looking at how the job gets done, from accreditation, through the department of health to the Australian Commission on Safety and Quality in Healthcare or, at the bedside, with point of care coagulation testing, and cerebral oximetry. With finally, some possibilities for the future discussed. There was much to ponder during the breaks and the convenors wish to thank all the speakers for their generosity and knowhow.

More than 80 delegates attended the Saturday lecture series at the John Curtin School of Medical Research, a renowned scientific institution situated on the Australian National University (ANU) campus, in Canberra. Dr Ramsy D'Souza, of Sydney's St Vincent's Hospital, opened the program with an excellent presentation on the management of pulmonary embolism. Throughout the day delegates were presented with insightful presentations by both local and interstate speakers, concluding with Dr Chris Van Leuvan who gave a thought provoking presentation on future technologies.

Three workshops were held on the Sunday, including two emergency response workshops. The can't intubate can't oxygenate (CICO) workshop held at Calvary Hospital was convened by Dr Andrew Watson with assistance from Dr Andrew Hehir, Dr Ed Coxon, Dr Carmel McInerney and Dr Ashwini Tambe. The anaphylaxis workshop, the first of its kind to be held in Canberra, was convened by Dr Melinda Ford with Dr Freya Aaskov, Dr Jennifer Myers, Dr Jill van Acker, Dr Candida Marane and Dr Nathan Oates assisting with the facilitation. In the afternoon, Dr Scott Parkes of Launceston General Hospital, conducted a fibreoptic intubation workshop with assistance from Dr Andrew Deacon and representatives of Karl Storz. All three workshops were fully subscribed and provided an opportunity for delegates to refresh their knowledge on these important topics whilst also providing a means for completing their emergency response requirements under the ANZCA Continuing Professional Development (CPD) Program. The feedback provided on each of the workshops was excellent with delegates praising both the facilitators and the content covered in each workshop.

The Art of Anaesthesia meeting was held during the annual Floriade flower festival in Canberra, giving interstate and local guests the perfect opportunity to experience Canberra at its best. After a few weeks of rainy grey weather the nation's capital turned on a spectacular weekend for the meeting and we hope all the delegates were able to get out and about and enjoy Canberra.

Thank you to the conference convenors, Dr Carmel McInerney and Dr Girish Palnitkar for their tireless efforts in bringing together a wonderful meeting.

Above clockwise from top left: ACT Health Director-General Ms Nicole Feely gave a presentation on the "Future of healthcare in the ACT"; Delegates enjoying morning tea; Conference convenor Dr Carmel McInerney and guest speaker Dr Geoff Herkes; Guest speaker Dr Martin Wakefield and ACT Regional Committee Chair Dr Andrew Hehir; ACT Trainee Committee Chair Dr Jennifer Hartley, guest speaker Dr Jennifer Bath and workshop facilitator Dr Candida Marane.

Western Australia

Asking the experts in Bunker Bay

The WA ANZCA/ASA Country Conference was held from October 21-23 at the Pullman Resort Bunker Bay and the theme of the conference "Ask the experts". The keynote speaker, Dr Peter Schuller from Cairns Hospital, delivered an excellent and thought provoking lecture on "BIS in the awake but paralysed anaesthetist" which was the highlight of the weekend. It was a full weekend of lectures and social events as well as major haemorrhage workshops by Dr Simon Zidar, sub sartorial block workshops by Dr Brian Hue and the pig leg and also a few cardiac arrest workshops that spanned over the entire weekend by the hardworking Dr Jude Penney and team. Dr Nick Martin provided an excellent "first aid" session for the children, which helped them refresh their first aid skills and gave the parents a well needed break!

The conference was well sponsored including major sponsorships from Avant Insurance, Smiths Medical, Medtronic and Seqirus, a CSL Company. The WA CME Committee thanks the anaesthetists who had a role in making this conference a success as well as Dr Merlin Nicholas, the convenor from Joondalup Hospital.

In 2017 the WA CME Committee will be holding a Cable Beach Country Conference from June 16-18 at Cable Beach Club Resort. It is titled "Comfortably numb: Updates in regional anaesthesia" and is convened by the CME Committee. This conference will follow a similar structure to the country conference that is usually held in Bunker Bay.

Thank you to the chairs and members of the West Australian Regional Committee, the Education Officer and Supervisor of Training Committee, the Continuing Medical Education Committee, the Faculty of Pain Committee and the Trainee Committee for their dedication to attending the meetings and their efforts in supporting the College for 2016.

Above clockwise from left: stunning Bunker Bay; Cardiac arrest workshop; Sub-sartorial block workshop; Keynote speaker Dr Peter Schuller from Cairns Hospital.

Australian news (continued)

New South Wales

NSW Anatomy Meeting

The NSW Anaesthetic Continuing Education Committee presented another full day of demonstrations in the Anatomy department at The University of Sydney on November 26. Specimens which have been especially dissected for anaesthetists allow examination of the anatomy relevant to nerve blocks. The event was fully subscribed and once again we thank the presenters: Dr Andrew Armstrong, Dr Paul Bertolino, Dr Luke Bromilow, Dr Graham Bruce, Dr Rob Crocket, Dr John McCarty, Dr Elizabeth O'Hare, Dr Kevin Russell and Dr Gurdial Singh for giving up their valuable time to present once again.

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: nswcourses@anzca.edu.au

New South Wales

Primary Refresher Course in Anaesthesia

The course is a full-time revision course, run on a lecture/tutorial basis and is suitable for candidates presenting for their Primary Examination in the second part of 2017.

Date: Monday May 1 – Friday May 12, 2017
Venue: Large Conference Room, Kerry Packer Education Centre Royal Prince Alfred Hospital Missenden Road Camperdown, NSW
Fee: $1078 (including GST)

In addition, a comprehensive set of supplementary notes, lectures notes and USB will be given to each participant at the commencement of the course.

Applications close on Monday April 10, 2017 (if not filled prior). The number of participants for the course will be limited. Late applications will be considered only if vacancies exist

For further information: Annette Strauss, ANZCA New South Wales Regional Committee, nswcourses@anzca.edu.au, or phone +61 2 9966 9085.

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: Annette Strauss

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

Victoria

Registrars' Scientific Meeting

The Victorian Registrars' Scientific Meeting was held at ANZCA House on Friday November 18.

The adjudicators, Associate Professor Phil Peyton, Dr Forbes McGain, Dr Ashley Webb and Dr Georgina Imberger each presented their research and were very well received.

The trainees presented a total of 12 motivating projects, each highly researched and clinically significant. The presentations were divided into clinical/scientific research and audits/miscellaneous papers. The recipient of the prize for the first category was Dr Julia Dubowitz and Dr Harry Sivakumar for the second category. Both will soon be receiving a commemoration plaque and a book voucher.

The event was very well attended by the trainees; best ever yet, as well as many of their supervisors, the VRC Chair, and ANZCA President.

Quality assurance meeting

The last quality assurance meeting of the year was held on Saturday October 26 at ANZCA House. The theme of the day was "Mishaps and tribulations outside OR." The presenters were Dr Brett Pearce, Dr Nicole Sheridan, Dr Duncan Bunning, and Dr Shiva Malekzadeh.

The morbidity and mortality session was slightly reformatted. The ongoing issue of patients transferred to other facilities or hospitals was recurrent.

The sessions were well received and attended, as indicated by universal participation, as well as passion and enthusiasm on display.

We look forward to the 2017 quality assurance sessions.

Queensland

Elizabeth Maycock wins citation

Queensland anaesthetist Dr Elizabeth "Buff" Maycock has been presented with a prestigious ANZCA Council citation to recognise her efforts in anaesthesia anaphylaxis, preoperative assessment and communication interpersonal skills training.

Dr Maycock, who got her medical degree in Liverpool, England, became a Fellow in 1981 in New Zealand where she worked for 16 years at both the Wellington and Christchurch Hospitals.

She came to Brisbane in 1992 and set up an anaesthetic skin testing clinic at the Princess Alexandra Hospital. She was also an obstetric anaesthetist at the Mater Mother's Hospital. In 2003 she joined the Cognitive Institute and became a facilitator teaching communication skills to doctors. In 2005 she became the medical co-ordinator of the preadmission clinic at the Princess Alexandra Hospital.

In 2010 she was part of the inaugural group of anaesthetists and immunologists that formed the Australia and New Zealand Anaesthetic Allergy Group (ANZAAG). This group has produced the first Australasian guidelines for the "Management of anaphylaxis during Anaesthesia", now in its second edition, as well as guidelines for the investigation of anaphylaxis during anaesthesia.

Dr Maycock has also published and presented widely on anaphylaxis.

The ANZCA Council citation is an award made at the discretion of the council of the College in recognition of significant contributions to particular activities of the College.

Remembering Chris Bassett

ANZCA was saddened by the sudden passing of Chris Bassett, the regional manager of the College's Queensland office, on Thursday November 17.

Chris was appointed as regional manager for Queensland in July 2013 and quickly rose to the challenge, endearing himself to Fellows, trainees and staff in ANZCA's Queensland office.

He was dedicated, committed and a very loyal and supportive leader and friend. He will be remembered as both a highly professional colleague and a gentle, amusing and charming family man.

A number of staff and Fellows were in attendance at Chris' funeral. The most common themes in all the conversations after the service revolved around Chris' charm, the respectful way he operated and his terrific sense of humour.

A life cut too short, but well lived.

Above from left: Associate Professor Phillip Peyton (right), and winner of the second category, Dr Harry Sivakumar; Trainees who attended the Victorian Registrars' Scientific Meeting; Dr James Hosking presents Dr Elizabeth Maycock with a prestigious ANZCA Council citation to recognise her efforts in anaesthesia anaphylaxis, preoperative assessment and communication interpersonal skills training; the late Chris Bassett, regional manager of the College's Queensland office.

Australian news (continued)

Tasmania

Annual Scientific Meeting

We live in an ever-changing landscape due to evolving technology, changing demographics of patients and a political and economic environment that is under increased scrutiny with conflicting demands and priorities.

How is this all impacting on anaesthesia and what does it mean for future practice?

These are topics that will be examined and discussed at Tasmania's upcoming 2017 combined Annual Scientific Meeting to be held in Hobart on the weekend of March 17-19, 2017.

The one-and-a-half day meeting will again be held at the modern Medical Science Precinct, University of Tasmania, in Hobart. This state-of-the-art venue was highly rated by delegates in 2015 and 2016 as it provides open space for attendees to network and mingle freely in a light, spacious and relaxed environment while providing world-class facilities for a scientific conference.

An impressive array of speakers is again a key feature of the ASM with internationally renowned Professor Steven Shafer from Stanford University travelling from San Francisco to share his insight in this area. Steven's wife Professor Pamela Flood is also attending and discussing pregnancy-related analgesia. Other notable speakers include Professor Guy Ludbrook (Adelaide) and Professor Francis Bowling (Westmead), who will be discussing topics ranging from new devices, drugs and philosophies in the provision of anaesthetic services. Political machinations in the provision of healthcare will also be contemplated.

In response to feedback from previous meetings the meeting convenor, Dr Peter Wright, has announced a change to the structure of the meeting. Peter explained that to ensure delegates don't miss a moment with these impressive speakers an array of workshops on offer will be held separately on the Saturday afternoon. Speaker presentations will occur on Saturday and Sunday morning.

These workshops include both upper and lower limb regional ultrasound with the use of fresh cadavers and live models. There will also be two emergency response cardiac arrest workshops for delegates to hone their resuscitation skills (and gain important CPD points), as well as two anaphylaxis workshops. Added to the mix are two workshops focusing on education and a small group discussion on mentoring.

For those not attending workshop sessions, a fascinating 90-minute "Hobart history and the medical profession" walking tour focusing on the historical heritage of Hobart is an option. Delegates will have the opportunity to visit significant medical sites including the original colonial tent hospital and the location of the "new" 1820s general hospital. The tour will also dwell on some of the less savoury aspects of Van Diemen's Land history such as the doctor turned politician with a penchant for body snatching and the museum curator with a collection of morgue souvenirs.

Social functions will again be a highlight with canapes and drinks overlooking the Hobart waterfront as the sun sets on the Friday night. On the Saturday night, a bus ride will transport attendees via the famous Coal Valley vineyards to Frogmore Creek winery. This multi award-winning restaurant has won restaurant of the year in 2015 and 2016 from the Tasmanian Hospitality Association Awards and "Restaurant of the Year, Regional Australia" for the past two years from the Australian Hotels Association. The stunning views combined with great cuisine will ensure a memorable night for delegates.

A "Trainee Day" held on the Friday before the ASM has become an important part of the "tradition" of the ASM. This is a day purely for trainees and provides them with the opportunity to meet and hear from some of the key note speakers who are attending the ASM in a small, intimate environment that has been designed especially around their needs and wants. The organiser of this meeting, Dr Rob Easther, is also chair of the Tasmanian Trainee Committee. He is confident that a dynamic and interesting day will be on offer which provides an opportunity for trainees from all over Australia and New Zealand to learn together and network in a fairly unique setting.

These meetings have grown considerably over the last few years and each year the planning committee works hard to provide a stimulating and educative meeting combined with opportunities to relax and socialise with colleagues.

Registrations have opened and we encourage you to book your place as soon as possible.

South Australia and Northern Territory

Assessing cognitive change following surgery and anaesthesia

Professor Stanton Newman, Professor of Health Psychology and Dean School of Health Sciences and Pro Vice Chancellor (International), City University London visited Adelaide on his recent trip to Australia to present at the SA and NT Annual Dinner Meeting, held at the Lion Hotel, North Adelaide.

Professor Newman's talk outlined that approximately 250 million major surgeries are conducted annually. A not insignificant number of these patients will show some form of cognitive disturbance post-surgery. For many, this will be transient and for a smaller percentage, this may be long lasting. The importance to distinguish between delirium, short-term cognitive disturbance, long-term cognitive deficits and a patient's perspective of their cognitive change post-surgery was summarised. Patient cognition from before and after surgery provides a sensitive measure of the surgery and anaesthesia process and can be used as a tool to improve surgical performance and patient anaesthesia.

He discussed the different forms of assessment of cognitive function and the purpose of the assessments. These range from brief bedside assessments through to a full cognitive assessment for patients with suspected brain damage. The practical constraints of assessing patients who have surgery requires a careful choice of assessment tools to be used and the need for these to be aligned with the purposes of the assessment. The evaluation of the results of the assessments was also addressed.

The presentation also illustrated the assessments that can be performed by non-specialists within the time constraints of surgery.

Dr Nathan Davis, SA NT CME Committee Chair and convenor of the meeting, was very pleased with the event and said that the topic was of great interest to attendees.

The presentation was professionally recorded and distributed to remote South Australian and Northern Territory anaesthesia hospital departments for their training and CPD purposes.

Above clockwise from top left: Dr Jonathan Clarke and Dr Scott Ma; Dr Bill Wilson and Dr Robin Limb; Professor Stanton Newman with Dr Nathan Davis; Dr Min-Qi Lee, Dr Piers Robertson and Dr Charlotte Taylor; Dr Laura Willington, Dr Sophie Bradshaw and Dr Michelle Harris.

Adrian Soroszczuk Selwyn, FANZCA 1936-2016

Adrian Selwyn was born in Czernowitz, Bukowina Duchy, then in Romania (now, Western Ukraine) on November 1, 1936 and died on his eightieth birthday.

Following the Russian invasion in 1940, the family, including a baby, abandoned everything except what they could carry to escape. They settled in Poland, but were moved on after two years, spending the next eight years in Germany.

As conditions in post-war Germany remained extremely difficult, Adrian's indomitable mother decided they should begin life again somewhere else.

After stringent checks, the family, now eight people, was accepted as immigrants to Australia, arriving in August 1950.

Rail transfer to Bonegilla Migrant Camp (MC) followed disembarkation at Melbourne. Adrian's family was broken up. His father was sent to a job in Sydney, his older brother sent to Marulan, while the others were sent to Uranquinty MC.

Adrian would catch the bus to school, while his mother would pedal to work at Dunlop, in Wagga Wagga. She quickly deposited five pounds on a block of land, repaying the residue by instalment.

Accustomed to hard work and hardship, the family cleared the land, built a garage and then a house. Materials came on credit. Adrian, the oldest boy at home, contributed greatly. Three months later, passing three of eight subjects at school in a new language, he took the opportunity given by his headmaster to advance a class rather than repeat.

He always found jobs (giving the earnings to his mother to help the family), participated fully in the school, becoming a cadet under officer, and performed as the major general, in his matriculation class production of "Pirates of Penzance".

He achieved straight As for his leaving certificate and was in the top four in the Riverina, winning a Commonwealth scholarship four years after arrival.

Enrolling in medicine at Sydney University, he was fully involved as a resident student at St Johns College. As the scholarship only covered fees, he drove a taxi for funds.

Graduating in 1965, he served residency years at Parramatta District Hospital in 1965-6. Then he did a year in general practice followed by two years as an anaesthesia registrar at Prince Alfred Hospital, Sydney from 1968-9.

During that period, he and Marian Kolos met briefly on a ski lift then again 18 months later. Married five months afterwards, they left for England. He held jobs in anaesthesia for two years at Hammersmith, firstly as a senior house officer, gaining the FFARCS, then as a senior registrar, concurrently an instructor at the Royal Postgraduate Medical School. A period followed as locum chief in anaesthesia at Vaxjo, Sweden.

After this, they spent a year in Florida, where Adrian worked at the University of Miami School of Medicine as a visiting assistant professor.

In 1973 the family moved again to Adrian's next position as instructor at Harvard. Then, he accepted the invitation of Professor Michael Stanton Hicks to become his first faculty member, as an associate professor at the new University of Massachusetts Medical School.

In 1977, Adrian returned as an anaesthetist to Royal Prince Alfred Hospital in the cardio-thoracic unit, serving there until 1989, before leaving to work extensively in private practice.

He was respected throughout his working life for his reassuring and supportive attitude, his competence, efficiency, knowledge, skill, dedication and integrity.

He and Marian had 11 children, considering each child a great blessing from God, and were extremely proud of them and their grandchildren, loving them all very much. They lived in Lindfield, where they were active members of their local congregation. Adrian was a devout Catholic, always true to himself and his Lord. He returned to playing squash, and tennis, adding golf, and he was deeply involved with the Tangara School community.

His family, many friends and colleagues from Australia and overseas found Adrian humorous, egalitarian, honest ("telling it like it was"), a consultor and a teacher.

He was a devoted husband and father, a sincere, courteously outspoken and impactful gentleman, who had zero tolerance for bullying.

He was a determined and competitive player of tennis, squash and chess, and this co-existed with his compassionate and humane nature. He was always interested in present company, and was joyful, humble, fair, firm and friendly.

He was loving, passionate about all aspects of life, grateful for small things and into mastering something new, be it a language, flying an aeroplane, playing a musical instrument or singing.

Adrian knew the inevitability of his illness but like all of us pleaded for more time. His aim was to to live to be present at one of his children's weddings; he lived three years from diagnosis to be present at three more weddings.

He attended daily mass and one could see the growing progression of pain and suffering as the weeks passed. He was recently offered major rescue surgery but sensibly refused. With Marian at his side he maintained his dignity to the very end.

He was a uniquely outstanding and unforgettable man who led an extraordinary life. To overcome all the barriers, including his childhood participation in the family's tribulations through war-torn eastern Europe, and then raise a very large family was indeed a great achievement.

Despite his obviously constrained life, he never complained, never said "why me" but asked in prayer that he would face his end bravely. He was always cheerful, and enjoyed debating and conversing about "the old days", his faith, family and current political and sporting news, so that it was never burdensome, always a pleasure, indeed inspirational, to visit him.

How proud were his children who carried the casket out of the church and were then present at the graveside when his remains were gently laid to rest with the sound of his long-time friend Frank Cheok playing the harmonica to the joy of all present. "He was a beautiful and deserving person, all who knew him benefited."

RIP, dear Adrian.

More than a score of people, including family, friends, colleagues and a former professor, too many to acknowledge individually, have contributed greatly to this obituary, summarised by Dr Paul Bellhouse, FANZCA.

Elaine Kluver, FANZCA 1944-2016

Elaine Lillian Kluver had two passions in life: she loved anaesthesia and she loved world travel.

Elaine died on May 27 on the Gold Coast, Qld, from an overwhelming malignancy. She had retired at 70, just 18 months before her death, and had planned other world travelling adventures.

The eldest of four children, Elaine was born in Brisbane on August 20, 1944. Her father, Harry, died from malaria contracted during the war. At the time Elaine was 11 years old and her youngest sibling just six months old. Her mother, Lillian, raised her four children under very difficult financial circumstances but ensured they all had a good education.

Elaine had an interesting journey into anaesthesia. After finishing her secondary education at Lourdes Hill College, Brisbane she enrolled in the then Australian Institute of Radiography program at the Mater Hospital. Soon after completing her diploma she travelled to Canada and worked in Vancouver and in Montreal for seven years as a radiographer and in nuclear imaging.

On her return to Brisbane in 1974, Elaine began a medical degree at Queensland University graduating in 1979, 16 years after finishing secondary school. After her residency at Princess Alexander and the Mater hospitals, Elaine joined the Southside Anaesthetic Training Program at Princess Alexander Hospital in 1982, obtaining her fellowship in June 1986. She spent several years as a staff specialist at QE 11 in Brisbane.

I first met Elaine in 1983 during her second year of training at Princess Alexandra Hospital. At the time I was a visiting anaesthetist. Our paths crossed again in 1990 at the late Dr John O'Donnell's retirement gathering at the Irish Club. John, to whom many of us owe so much, was the foundation director of anaesthesia and ICW at Princess Alexander Hospital.

Elaine commented that she would like a change and we were very fortunate that she accepted our invitation to join the Southport Anaesthetists group in December 1990.

At that time she was the first female anaesthetist in Southport. She was a trail blazer. It was not easy for her, as anaesthesia and surgery was an all-male domain on the Gold Coast at that time. Now, of course, there are many women in anaesthesia on the Gold Coast.

Elaine loved anaesthesia and was well suited to the speciality. She thought scientifically, she was determined, focused and extremely careful and safe. She didn't tolerate foolishness or shenanigans from theatre staff, medical or non-medical. Thus she was very highly regarded and respected by all staff.

As well as anaesthesia, Elaine loved and lived for travel. She was able to combine many of her overseas trips with anaesthetic conferences and this love of travel and adventure took her to all parts of the globe.

Elaine was a very skilled photographer. Using this skill she took photos of all the exotic places she visited. After each trip she incorporated these photos with commentary into wonderful large albums, which were put on display in the operating theatre suite. She became the natural "travel consultant to operating theatre staff".

As I mentioned, she loved anaesthesia and its camaraderie. She attended many conferences, interstate and overseas, and kept up an association with the College by joining the retired anaesthetists division.

In her will, Elaine made a very generous gift to the ANZCA Research Foundation for the advancement of anaesthesia, analgesia and pain management. The gift will be a perpetual gift for the further development of knowledge in the specialities and towards the continuous improvement of outcomes for patients.

The foundation has established a research award in her name in honour of the gift to be known as the Elaine Lillian Kluver Award. Elaine told me that by naming it as such, she, her mother and the Kluver family would be remembered well into the future.

Elaine's sisters, Bernice and Marion, and her brother, John, survive her.

It was a privilege knowing and working with Elaine over so many years.

Dr Michael Power, FANZCA
Southport, Queensland