DECEMBER 2015

ANZCA BULLETIN

$A1.46 million for research: ANZCA funding announced

Obesity and anaesthesia: What you said

20 years of caring: Welfare and what we have learnt

All fired up

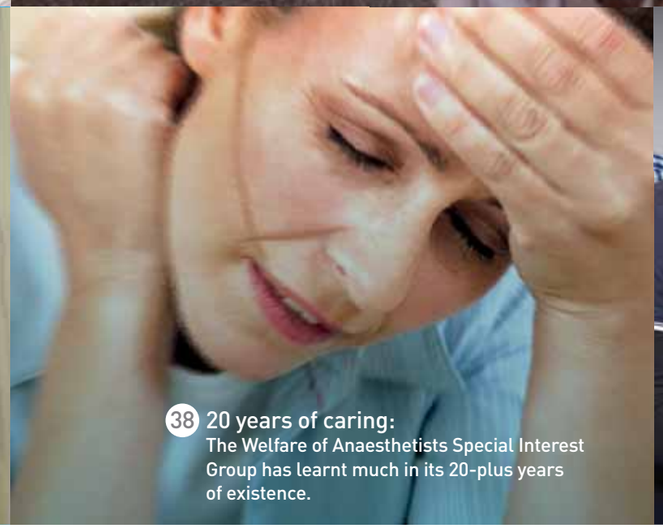
Matthew Chan awarded Harry Daly fellowship

63 **Expert cannabis advice ignored**
A proposed "medicinal cannabis" scheme for Victoria could place specialist pain medicine physicians in an untenable ethical situation.

16 **Researchers awarded $A1.46 million**
The ANZCA Research Committee has announced funding for 23 projects through the Anaesthesia and Pain Medicine Foundation.

44 **Anaesthesia on the frontline**
Liverpool Hospital anaesthetist Kevin Baker recently returned from Yemen where he was part of a Médecins Sans Frontières team working close to the frontline.

30 **Hospitals celebrate National Anaesthesia Day**
National Anaesthesia Day on October 16 attracted widespread media coverage. The day is being supported by an increasing number of Fellows who responded strongly to our obesity survey.



38 **20 years of caring:**
The Welfare of Anaesthetists Special Interest Group has learnt much in its 20-plus years of existence.

34 **Indigenous doctors supported**
ANZCA is building a network of professional mentors for indigenous students to encourage careers in medicine and anaesthesia.

ANZCA Bulletin

The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional medical body in Australia and New Zealand that conducts education, training and continuing professional development of anaesthetists and specialist pain medicine physicians. ANZCA comprises about 5000 Fellows and 2000 trainees across Australia and New Zealand and serves the community by upholding the highest standards of patient safety.

Cover: Professor Matthew Chan's Harry Daly Research Award will investigate re-designing ventilation systems for hospital isolation wards to reduce nosocomial infection.

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

Contents

President's message

As 2015 draws to a close, I have reflected on the many College events and activities that have taken place, as well as other important medico-political events, most of which are ongoing. This year I have travelled to every region in Australia, to New Zealand, Ireland and Canada, and attended the council/board meetings of the Australian Society of Anaesthetists, the Royal Australasian College of Surgeons (RACS), the College of Intensive Care Medicine and the Committee of Presidents of Medical Colleges.

Fellows and trainees will be aware of the serious matters relating to bullying, discrimination and harassment, which have been investigated by RACS. I urge you to read the Expert Advisory Group's final report on the RACS website, and watch president David Watters' courageous and determined apology speech. RACS will soon be launching their action plan, and ANZCA is committed to supporting RACS' position and collaborating with colleagues to ensure there is respectful behaviour in all our workplaces. ANZCA Vice-President Associate Professor David Scott is leading a Bullying, Discrimination and Sexual Harassment Working Group to clearly define ANZCA's strategy, strengthen our processes and support mechanisms to deal with these issues.

In September, the Medical Board of Australia (MBA) released the final report it commissioned from Plymouth University, *The evidence and options for medical revalidation in the Australian context*. Three models have been proposed, models A, B and C. The report is available on the MBA website, and it is important Fellows familiarise themselves with these models and the concepts outlined in the report. The MBA has not yet committed itself to any one of these models, but has commissioned an expert advisory group, a consultative committee and will also perform social research into community expectations of what doctors need to do to demonstrate ongoing competence and fitness to practise. ANZCA representatives will be attending a meeting in December, hosted by The MBA and the Medical Council of New Zealand, to discuss: revalidation, new international medical graduate specialist practice guidelines and the ageing practitioner.

As mandated by the regulatory bodies, ANZCA has to audit 7 per cent of participants in the ANZCA Continuing Professional Development (CPD) Program; the randomly selected participants have been notified and the audit is under way. If Fellows have met the minimum requirements (per their CPD dashboard) and uploaded evidence of participation onto their portfolio, the audit should be painless and require no further effort.

All the medical colleges are participating in the MBS review – two rounds of stakeholder forums have been held and ANZCA has submitted names of Fellows for consideration for appointment on several of the clinical committees. Expertise is sought as content experts, as well as advice about standards of care, safety of practice and evidence-based practice.

In late October, RACS held its 4th Global Health Symposium. This year's theme, based on the Lancet Commission on Global Surgery, was "strengthening safe surgery and anaesthesia in the Asia-Pacific". ANZCA and ASA representatives attended, as both organisations have overseas aid committees and are active in education in anaesthesia, primary trauma care and pain management in the Pacific and south-east Asia. Delegates from 16 countries met to discuss the major barriers and strategies to improve access to safe, affordable surgical and anaesthesia care in our region. The Lancet Commission report, *Global Surgery 2030: evidence and solutions for achieving health, welfare, and economic development*, has set a goal of universal access to safe, affordable surgical and anaesthesia care when needed, with financial protection, by 2030. First steps will be for countries to obtain data on four identified surgical metrics to contribute to a global dataset to measure population access.

ANZCA continues to monitor the workforce situation closely. In early December, the National Medical Training Advisory Network (NMTAN) was due to release its workforce modelling for anaesthesia. New Zealand has recently completed a head of department workforce census (with 100 per cent compliance). The results should be available soon, and it is hoped this census can be repeated across all Australian regions. ANZCA will perform another new Fellow survey in 2016, and possibly also a survey of the most senior cohort of the fellowship, to examine workforce patterns and retirement intention. This is important data to inform workforce planning, which is currently not available; attrition is as important a metric as the number entering the workforce.

Australasian Anaesthesia 2015 (the Blue Book), has been launched and within weeks the long-awaited 4th edition of *Acute Pain Management: Scientific Evidence* and an opioid calculator app for Apple and Android devices will be launched.

I thank all the members of the ANZCA Council, ANZCA Fellows and trainees for their ongoing hard work on ANZCA committees and working groups, the ANZCA supervisors and trainers supporting trainees at the coalface at over 195 training sites in five countries, our cohorts of primary and final examiners, our IMGS assessors, our accreditation teams, our external representatives on a host of government and other bodies and of course the chief executive officer, our directors of professional affairs and all the ANZCA staff throughout Australia and New Zealand. A big thank you as well to all anaesthetists who work selflessly on aid missions throughout Asia and the Pacific, some even further afield, delivering safe, practical anaesthesia, under trying conditions, as well as training for local staff.

Thank you all for your support, professionalism and enthusiasm.

I wish you all a safe and happy holiday season with families and friends.

Dr Genevieve Goulding
ANZCA President

Chief executive officer's message

Like so many organisations, ANZCA has ambitious goals. It is encouraging to see the business plans are followed and the vast majority of goals are, or will be, met by the end of 2015. This can only be achieved by the dedicated efforts and teamwork by Fellows, trainees and staff.

I started at the College in time to experience my first National Anaesthesia Day and I was pleased to see how many Fellows and trainees were involved. More than 40 hospitals told us about their activities for the day and an estimated audience of 1.8 million heard our message via TV, radio, print and online.

Our reach into the community via the media continues to grow and by the end of the year we will have distributed more than 30 media releases promoting many activities including research, scientific meetings and safety issues that will attract more than 460 print, radio, TV and online mentions in 2015.

Substantial input has been provided to Australian and New Zealand governments and health organisations via meetings and at least 100 formal submissions on key issues affecting the health sector, including: transparency of health outcome data; quality and safety initiatives; revalidation; workforce initiatives; "medicinal cannabis" and the re-scheduling of codeine.

We also have commissioned a review of the Specialised Training Program to investigate the value of training in non-traditional settings.

The Pacific region's first Safer Anaesthesia from Education Obstetrics workshop was held with the University of Papua New Guinea, School of Medicine and Health Sciences. Thirty-two delegates attended with 16 delegates trained as future trainers.

The Adelaide annual scientific meeting was a great success and the College also ran seven special interest group meetings, more than 20 scientific meetings and more than 40 trainee courses in Australia and New Zealand. Thousands of Fellows and trainees have benefited from these activities.

The Faculty of Pain Medicine's (FPM) revised curriculum was rolled out, and nine essential topic area eLearning modules have been developed.

Better Pain Management, an online education program for healthcare professionals, is expanding by another six modules and the launch of a free FPM opioid equianalgesic calculator, smart phone app and complementary website to promote consistency in converting combinations of opioids is coming soon (see page 65).

Nearly $A1.5 million in research grants has been awarded through the Anaesthesia and Pain Medicine Foundation, and the perpetual Robin Smallwood Bequest was created, thanks to a generous gift from the family of the late Robin Smallwood, a former dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons.

We have produced two very popular texts for Fellows and trainees, *Australasian Anaesthesia 2015* (the Blue Book) with *Acute Pain Management: Scientific Evidence* (fourth edition) soon to be launched.

A comprehensive library review has been completed and a full-time librarian appointed to further develop the resources and specialised nature of the ANZCA library.

The Geoffrey Kaye Museum of Anaesthetic History was accredited by Museums Australia (Vic) and we had a successful "Trailblazers and Peacekeepers" exhibition and book launch to commemorate 100 years of ANZAC, focusing on the invaluable role played by Australian and New Zealand doctors who administered anaesthesia and attempted to relieve pain during times of conflict.

We also have launched extensive online support resources for ANZCA trainees and ANZCA and FPM supervisors. The availability and accessibility of the ANZCA Educators Program (formerly the Foundation Teacher Course) has increased with the development of five new modules to supplement the existing eight and the formation of a local facilitation model to train facilitators to deliver the course locally.

Six new sample clinical audits have been developed for use by ANZCA continuing professional development (CPD) participants in the practice evaluation activity.

Hospital inspections using the new training site accreditation system were rolled out in 2015. The new system will provide hospitals and visitors with a more streamlined process.

The training portfolio system has been updated to include a greatly improved core unit review process and a more user-friendly process for recognition of prior learning and workplace-based assessments.

Incident reporting through webAIRS has expanded across Australia and New Zealand and into Canada with the Canadian Anesthesiologists' Society signing the canAIRS agreement.

There is much more to come next year, including improvements to the training portfolio system, and we will start work on a new-look, more user-friendly ANZCA website.

Until then, I hope you enjoy a safe and happy Christmas season and I look forward to meeting many more of you in 2016.

Mr John Ilott
Chief Executive Officer, ANZCA

Letters to the editor

Learning labelling lessons

The article "Making a serious drug error shouldn't be so easy (*ANZCA Bulletin*, September 2015) again reminds us of human error in anaesthesia. Sadly, anaesthesia hasn't taken the lessons from our own experience.

Working at Waikato Hospital in the 1980s and 1990s I was very concerned about "drug" errors after several near misses that I undertook to study human factors as a source of human error in the way we administer drugs. At the same time Professor Alan Merry was also studying this in Auckland; focusing on the use of technology.

The question I asked was "What can we do at the operating theatre to reduce errors by focussing attention to human factors?"

I noted that even in one operating suite, the drug trolleys and drug drawers were not the same in each theatre. Why?

This was followed by surveys of anaesthetists to understand what the sequence of administering drugs was and were there any patterns?

The outcome of all of this was:

1. Standardise and colour code the drug drawer in a standard way.
2. Use a disposable plastic tray made in such a way to hold the appropriate syringe sizes, colour coded, to an agreed layout. This was called by the acronym SOFIA (Syringe Organiser for Intravenous Anaesthesia).
3. Use and extend the colour-coded syringe system. Professor Merry's system was superb for this aspect. In addition, these labels were also barcoded, so readily used with Professor Merry's system.

The advantage of the SOFIA system was that it addressed the "syringe swap" component of drug error in an inexpensive way by providing consistent cues to selecting the correct syringe.

Standardisation for routine procedures is the standard for almost every industry, for the reason of safety! (I admit I was a pilot!) Why not standardise the way we handle our drug trolley drawers, and our "on top" syringe layouts?

As we tend to work more in teams, so the adoption of standardisation is even more essential.

Dr Bruce Rudge, FANZCA (long retired)
Nelson, New Zealand

Figure queried

In the September edition of the *ANZCA Bulletin*, the repeated reference to drug errors in one in every 133 anaesthetics in relation to articles on lookalike drug labelling ("Making a serious drug error shouldn't be so easy", *ANZCA Bulletin*, September 2015) is misleading and unfair to the research effort of the Auckland anaesthetists involved.

The source of the figure is Webster et al[1] (with a 72 per cent response rate) and those errors included 15 per cent involved with inhalational agents. The largest category of error among the others was incorrect dose 24/67 (36 per cent); substitution errors were the next most common 20/67 (30 per cent), the other 23 included omission, drug given or repeat dose when not intended, incorrect route and contraindicated drug.

There were 11 labelling problems (table 5), which gives an incidence of 11/7794 (0.14 per cent or one per 709 anaesthetics as reported).

While the authors did suggest the incidence might be higher than one in 133, since they assumed the non-responses were all because of no errors, if that logic is applied then the incidence of labelling problems is 11/10806 or one in 982.

Dr Ray Cook, FANZCA
ACT

Reference:
1. Webster CS, Merry AF, Larsson L, McGrath KA, Weller J. The frequency and nature of drug administration error during anaesthesia. Anaesthesia and Intensive Care 2001 Oct;29(5): 494-500.

Dr David Bramley responds

Dr Cook correctly identifies the reference to the research of Webster et al and makes reasonable comments about the interpretation of their results although I disagree that the comments are unfair to the anaesthetists involved. The "once in every 135 anaesthetics" figure is quoted as the first point of the ANZCA professional document on injectable medicines (PS51). In practice, any number of references could be selected to illustrate the point that drug errors and near misses occur at unacceptable rates despite the well described methodological limitations of the research.

No single figure will accurately represent the complexity of factors contributing to medication errors, but our responsibility to address this very real problem will remain. The "Time for change" report presented to the Therapeutic Goods Administration and discussed in the September *Bulletin* article chronicles adverse events that were almost exclusively due to lookalike labelling with neuromuscular blocking drugs.

Dental anaesthesia

We were interested to read the account of dental anaesthesia by Dr John Williamson ("A short history of dental anaesthesia", *ANZCA Bulletin*, June 2015).

The Epsom Anaesthetic Group, of which we were early members, was founded by Dr Nils Theilman and Dr Derry Lawler in the early 1960s. They purchased approximately 50 Heidbrink and McKesson anaesthetic machines from the Auckland Hospital Board for one pound each. Dr Theilman tested the machines, which were placed in dental surgeries around Auckland. Sometimes we carried our own machines, mostly CIG Midgets.

The basic techniques developed by Dr Theilman and Dr Lawler consisted of a Goldman vaporiser and Mapleson A (Magill) circuit with a standard mask or a Goldman mask. Anaesthesia was induced by either thiopentone or methohexitone in a semi-recumbent position in the dental chair, bilateral nasopharyngeal airways were inserted and a connection established. The pharynx was then packed with cotton wool gauze. The anaesthetist stood behind the patient and managed the airway.

In the early days, many procedures were for full and partial clearances, removal of wisdom teeth and orthodontic extractions. Endotracheal intubation was only used in prolonged conservative dentistry.

Patients initially recovered in the chair and then transferred to a recovery room where a dental assistant monitored them until discharge. Monitoring was basic – a blood pressure cuff and finger on the carotid.

During the 40 years until the demise of surgery-based dental anaesthesia, members of the group administered an estimated 70,000 general anaesthetics. Two of us administered around 15,000 general anaesthetics for one oral surgeon over 30 years.

During this time there were no deaths or serious complications. Transient tachyarrythmias were occasionally seen during halothane anaesthesia.

Unlike Dr Williamson and his colleagues, we avoided relaxants, partly because of the potentially life-threatening risk of anaphylaxis and also because of the inadequate reversal. Suxamthonium was considered inappropriate because of the high incidence of myalgia in ambulant patients, and the risk of anaphylaxis or prolonged apnoea.

Dr Evan Watts, Dr Glyn Richards and Dr Bill Peskitt
Auckland, New Zealand

Dr Louise Ellard wins Ray Hader Award

ANZCA Fellow Dr Louise Ellard says her role as mentor and tutor developed naturally through her interest in the personal and professional development of the trainees around her and an understanding of the challenges of anaesthesia training.

Her interest led to her developing both structured and informal support at the Austin Hospital in Melbourne to help trainees through their exams, and even family crises.

"Trainees have all sorts of issues to deal with and I was very familiar with that when I began as a staff anaesthetist," Dr Ellard said.

In November, Dr Ellard was named the recipient of the 2015 Dr Ray Hader Award for Pastoral Care for her support of trainees.

The trainees who nominated her are glowing in their assessment of the dedication and time Dr Ellard gives to them, saying she is always available for a friendly chat or assistance as an examination coach.

"I had a lot of support around me when I was a trainee," Dr Ellard said.

"It's often a critical time in someone's personal development. It's a typical age to partner, perhaps get married, have children, and also a time when older relatives might become ill."

As one of only two female staff anaesthetists out of more than 20 at the Austin Hospital in 2012, Dr Ellard was a particular drawcard to female anaesthesia trainees.

"I don't see myself as deliberately being a role model, but as the mother of two young children I did want to emphasise that you could have a family and be an anaesthetist," she said.

"Trainees have all sorts of issues to deal with and if I can help them see through their goals, I'm very happy to be able to offer that kind of support."

The Ray Hader Award for Pastoral Care is awarded to an ANZCA Fellow or trainee who is recognised to have made a significant contribution to the welfare of one or more ANZCA trainees in the area of pastoral care. This may have been directly, in the form of support and encouragement, or indirectly via educational or other strategies.

Ebru Yaman
Media Manager, ANZCA

Dr Louise Ellard with Dr Brandon Carp, who established the award in memory of his friend Dr Ray Hader.

College raises profile with huge rise in media coverage

Look-alike drugs putting patients' lives at risk, too easy to mix up, anaesthetists warn

Some of Australia's leading anaesthetists are warning patients are at risk of serious harm because labels on strong surgical drugs are too easy to mix up.

Dr David Bramley, from the Australian and New Zealand College of Anaesthetists, has written to health authorities urging them to introduce clearer labels.

Senior doctors have sent a report to the Therapeutic Goods Administration detailing a number of serious medication errors involving neuromuscular drugs.

"These medications paralyse patients, leaving them unable to move or breathe, whilst remaining fully conscious, and place them at risk of serious psychological trauma or death if administered accidentally," Dr Bramley said.

He has outlined 12 cases of the wrong surgical drugs being used in Victorian hospitals in 2011, with more than 90 per cent of errors due to look-alike packaging.

In 10 instances, doctors injected a completely different type of drug into patients.

Warning on NSAIDs and sport

Kids struggling with post-surgery pain

A TONSILLECTOMY is an excuse to recover on a diet of ice cream and jelly but evidence shows young patients are being left in excruciating pain by the surgery.

Pain management provided by hospitals is so poor that half the children have to go to their GP for help within a week of having their operation.

Melbourne researchers are trying to get to the bottom of what is causing their agony and come up with better ways to manage it.

Sarah Walker, who had her tonsils removed three years ago, said she would "rather birth a baby than do this" even though her surgeon had prescribed a powerful drug cocktail to help her through the post-surgery period. She is now worried her son may need to have his tonsils out.

Specialist anaesthetist Dr David Bramley said about 20,000 primary school children in Australia and New Zealand have their tonsils removed every year.

In the past the surgery was to manage recurrent tonsillitis infections but now three in four operations are to help control sleep apnoea and snoring in children.

While the surgery may have changed and adapted, the pain felt by children does not appear to have been improved.

Anti-inflammatory drugs risky for runners: expert

TOMMY LIVINGSTON

Anaesthetists warn fat epidemic risking lives: 200kg patients 'not unusual'

'Drugs risky for runners'

Runners who take anti-inflammatory drugs before exercising are putting themselves at risk, a sports health expert says.

Speaking at the Otago University Faculty of Pain Medicine's spring meeting over the weekend, Dr Hamish Osborne said the use of anti-inflammatory drugs while exercising could seriously damage one's kidneys.

"People are generally aware that anti-inflammatories can cause stomach ulcers and cause the stomach lining to bleed, but it is not well known that they can also damage the kidneys," he said.

Osborne said taking a standard dose of an anti-inflammatory, such as Voltaren or Nurofen, 36 hours before a hard 30-minute run triggered a 40 per cent reduction in kidney function.

This condition was not seen in people running with no anti-inflammatories in their system.

While anti-inflammatory drugs had a place in pain treatment, Osborne said he wanted them taken off the pharmacy shelf and put back in the hands of GPs.

"It would save a lot of people getting stomach ulcers and kidney damage."

In 2015 ANZCA and FPM significantly built on its media profile, promoting College initiatives, research, and safety and quality achievements. The Communications unit had distributed more than 30 media releases at the time of printing the December *ANZCA Bulletin*, which has led to print, radio, television and online coverage of a broad range of topics. These have raised the profile of the College and its Fellows.

The work of ANZCA and its Fellows reached an estimated combined cumulative audience of more than 17 million readers, listeners and viewers, according to ANZCA's media monitoring service iSentia. This is an increase of more than six million on the audience reached last year.

While National Anaesthesia Day (see page 30) was the standout media success story in the final quarter of 2015, there was no shortage of stories for media.

The cover story of the September *Bulletin*, "Which is which? Drug labelling under fire", highlighted the vexed issue of lookalike labelling and calls for regulations to ensure different classes of anaesthetic and other drugs are not easily mistaken for each other on a medication trolley. Dr David Bramley was interviewed by ABC national medical correspondent Sophie Scott and made a persuasive case for clearer labelling. The ABC broadcast this story on television, on radio and online and reached an estimated audience of more than 800,000 people.

A media release on behalf of the Faculty of Pain Medicine supported proposals to ban over-the-counter sales of medicines containing codeine and a media release generated after a presentation at the joint Airway Management and Obstetric Anaesthesia Special Interest Groups meeting in October compared the mental pressure anaesthetists experience to that of Olympic athletes and soldiers. This was widely reported across NZ and Australia in print and on radio.

Ebru Yaman
Media Manager, ANZCA

In 2015 ANZCA has featured in:

- **More than 100 print reports.**
- **More than 350 radio reports.**
- **Close to 90 television reports (including syndications).**
- **More than 300 online stories.**

Media releases since the September *Bulletin*:

October 25: What can sport teach medicine?

October 25: General anaesthesia has no adverse effect on infant brain development.

October 16: Hospitals face extra costs for care of obese pregnant patients.

October 15: Obesity complicates anaesthesia.

October 12: World-first study looks at economic cost of maternal obesity – media alert.

October 9: National Anaesthesia Day – NZ media alert.

October 8: Poor drug labelling a recipe for disaster.

October 4: Managing expectations about chronic pain cure.

October 3: Competitors risk serious injury using anti-inflammatories.

October 3: ACC looking beyond direct cost of injury.

October 2: Pain medicine specialists welcome proposed codeine ban.

August 27: Access to anaesthesia and pain relief a human right, health experts say.

August 18: Children who have their tonsils out suffer significant pain.

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

Advocacy in the spotlight

The mission for the College is to promote safety and high-quality patient care in anaesthesia, perioperative medicine and pain medicine. However achieving this mission is complex, as the health landscape is crowded with groups trying to push their agendas. In Australia and New Zealand there are hundreds of non-government organisations engaging in robust public policy discussions about the future of our health systems. These advocacy activities range from grassroots workplace initiatives, to macro health system lobbying of key opinion holders in policy development and government.

The advocacy efforts undertaken by the College evolve every year. This evolution is important, as we must be responsive when practice changes and develops, as health systems and services are rationalised and reformed, as regulatory and legislative frameworks develop and as funding for education and clinical services becomes more complex.

Effective promulgation of our views requires the College to be responsive and proactive to the issues of today through *advocacy*, and being prepared for the issues of tomorrow by *horizon scanning*.

Advocacy

Once the College has an established policy position, it is critical this position is promoted when appropriate. One way is through meeting with key strategic stakeholders. Following are examples of this activity:

- **Paediatric training in WA (Australia)**
  In September, ANZCA representatives met with staff from the Department of Health (WA) to better understand the modelling applied to anaesthesia in the *Medical Workforce 2013/14 Report*, and to discuss emerging issues related to potential training bottlenecks in paediatric anaesthesia for ANZCA trainees. This meeting was followed up with communication with the chief medical officer seeking funding support to expand training opportunities, with the aim of having a workforce that can meet the needs of the Western Australian population.
- **HQSC meeting (NZ)**
  In October Dr Gary Hopgood and NZ staff met with Health Quality and Safety Commission representatives to discuss the framework it is developing for quality improvement and patient safety capability and leadership-building for the health system. ANZCA emphasised that any framework will need to be user-friendly and clearly communicated to engage clinicians. The risk of medication-safety errors related to illegible packaging and labelling of drug ampoules also was reiterated.
- **Assistants to the anaesthetist (NZ)**
  In October, Dr Geoff Long and Dr Nigel Robertson attended a Health Workforce New Zealand-facilitated meeting to discuss anaesthesia assistant education (both for anaesthetic technicians and registered nurse assistants to the anaesthetist), along with a number of other organisations. ANZCA reiterated that it is important anaesthetists can be confident that all assistants meet the minimum level of competence regardless of their training route.
- **Department of Health and Ageing (Australia)**
  ANZCA staff met with department representatives to discuss the future of the Specialist Training Program (STP). This is a $1 billion program that funds over 900 training posts across Australia. The College has argued the current anaesthetic posts should continue and that pain medicine training positions should expand in any future allocation rounds. The College's recent evaluation of the program demonstrates it successfully meets its objectives to enhance specialist training by providing training opportunities in non-traditional environments, such as rural and private practice locations.
- **Nurse endoscopy services (NZ)**
  In October, Dr Nigel Robertson and NZ office staff met with representatives from the New Zealand Society of Gastroenterology, Ministry of Health, and New Zealand Society of Anaesthetists to discuss a nurse endoscopy training program beginning in 2016, being led by the Ministry of Health. The key purpose of this meeting was to discuss how conscious sedation could be delivered safely in a nurse-endoscopist model.

Horizon scanning

Meaningful contributions to public policy require issues to be well analysed. By keeping abreast of emerging issues in the health sector, the College is able to respond in a timely and considered manner when required. A range of issues fall into this category:

- **Revalidation**
  As part of the Medical Board of Australia's ongoing discussion about revalidation they have published a discussion paper which aims to:

  1. Establish the existing evidence base for the validity of revalidation or similar in countries comparable to Australia.
  2. Identify best practice and any gaps in current knowledge surrounding revalidation processes.
  3. Identify the underlying principles for revalidation development and implementation.
  4. Develop three models for consideration, including associated evaluation frameworks.

While there is no formal mechanism at this stage to provide input, it is clear that the College needs to consider this issue fully and be ready to provide input if this initiative is implemented.

- **Medicinal cannabis**
  In Australia, medicinal cannabis is quickly becoming a key public health concern. In response to the recent Victorian Law Reform Commission recommendations in its *Medicinal Cannabis Report*, the Faculty of Pain Medicine has strongly urged that severe chronic non-cancer pain be excluded from the list of conditions and symptoms for which medicinal cannabis could be made available. This issue also gained media attention in New Zealand, and the Dean of the Faculty of Pain Medicine, Professor Ted Shipton, was able to discuss the Faculty's position with the Associate Minister of Health, Mr Peter Dunne. See page 63 for an update by FPM's Director of Professional Affairs Professor Milton Cohen.
- **Revision of Medicines Act**
  In New Zealand, the Ministry of Health is developing a new regulatory regime for therapeutic products that will replace the Medicines Act 1981. As well as medicines, the new regime will include medical devices, cell and tissue therapies, hybrids of all three, and future innovations. The ministry aims to have a draft bill released in mid-2016, and the College will need to consider and respond to the implications of the planned legislation change.
- **Medically assisted dying**
  The Health Select Committee in New Zealand is conducting an inquiry into medically assisted dying. This follows a petition to parliament asking "That the House of Representatives investigate fully public attitudes towards the introduction of legislation, which would permit medically assisted dying in the event of a terminal illness or an irreversible condition, which makes life unbearable". The Health Select Committee will look at the social, legal, medical, cultural, financial, ethical and philosophical implications of medically assisted dying. Public submissions are being sought on the issue, due by February 1, 2016.
- **New Zealand Health Strategy**
  An updated version of the New Zealand Health Strategy was released for public consultation, with responses due by December 4. It is required under the New Zealand Public Health and Disability Act 2000 that the Minister of Health has a strategy to guide the government's direction of the health sector. This document will be important for guiding the development of policy and legislation at a government level, and district health boards will be expected to align their work with the direction of the health strategy.

Submissions

Another way we promote our policy views is through formal submissions. Some recent examples include:

New Zealand

- Medical Council of New Zealand in response to its "Better Data" paper on transparency of information.
- Health Quality and Safety Commission in response to its position paper on transparency of information.
- Nursing Council of New Zealand about the registered nurse prescribing (ophthalmology) schedule.
- Medical Council of New Zealand on its review of good prescribing practice and prescribing drugs of abuse.
- Health Quality and Safety Commission on its draft framework for quality improvement and patient safety capability and leadership building for the New Zealand health system.
- Pharmac on its Invitation to Tender 2015/16.
- Medical Council of New Zealand on its "Vision and principles for recertification for doctors in New Zealand".
- Health Select Committee on the Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill.
- Pharmacy Council of New Zealand on its proposed supplementary wording to clause 6.9 of the Code of Ethics 2011.

Australia

- Medical Board of Australia Preliminary consultation paper: Revised registration standard for specialist registration.
- Patient Blood Management Guidelines: Module 6 Neonatal and Paediatrics.
- The Department of Education and Training – Skilled Occupations List (SOL) 2016-17.
- Pharmaceutical Board Advisory Committee query re: fentanyl citrate sublingual (Abstral®).
- Department of Health Review of the Specialist Training Program – October 2015.
- National Safety and Quality Health Service (NSQHS) Standards review.
- Victorian Department of Health regarding the Victorian Law Reform Commission Recommendations about medicinal cannabis for managing chronic non-cancer pain.
- Department of Health regarding medicinal cannabis, with particular reference to its use in the management of patients with chronic non-cancer pain.

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

Jonathon Kruger
General Manager, Policy
ANZCA

What would you do?

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

Conflict between specialists and GP anaesthestists

In this issue I would like to consider conflict in the context of a colleague seeking advice.

You are contacted by a colleague who recently has been appointed to a regional hospital staffed by non-specialist anaesthetists who have provided anaesthesia services to the region for many years. Over recent years, international medical graduate specialists and occasionally Fellows have been appointed, but none has stayed. The colleague is a recent FANZCA whose intention it is to live in the region to provide and expand specialist anaesthesia services to the hospital.

He has a commendable desire to improve standards with a view to attracting more specialists, while also supporting the local general practitioners (GPs). He poses two questions.

The first question is how to achieve this.

The second and equally challenging question is in regard to a concern about one of the GP anaesthetists, who has a strong personality and is highly regarded in the community, but who is antagonistic to suggestions from your colleague. Conflict between the GP and the hospital administration has existed for some time over behavioural issues. Now this conflict has extended to your colleague, who is not sure how to handle it. Your colleague also mentions that the GP often commences anaesthesia in the absence of an anaesthesia assistant.

What would you do?

Local GPs have serviced regional centres for many years and provide anaesthesia services during times of workforce maldistribution.

Specialist presence is desirable and is to be encouraged, although non-specialist services will be required until there are sufficient specialists to meet demand. Part of the challenge to specialists arriving in these areas is to not be perceived as a threat, either clinically or financially.

While it is likely some local practitioners will have preconceived views, the first impression is a major opportunity to alter these. Face-to-face conversations with individuals to canvas their satisfaction and their aspirations opens an avenue for discovering their impressions of both positive and negative aspects of their service to their community. This can become common ground for future discussions and can be presented as a means of facilitating their ambitions. Hopefully it should help to minimise conflict and antagonism.

A good resource that addresses relevant issues is the new booklet *Supporting Anaesthetists' Professionalism and Performance – A guide for Clinicians* at www.anzca.edu.au/resources/professional-documents/pdfs/Supporting Anaesthetists Professionalism and Performance FINAL 20150428.pdf on the ANZCA website. It includes a description of the performance framework for each ANZCA role, the desired pattern of behaviour, and examples of good and poor behaviours.

Of specific relevance are the sections on "collaborator" (pages 10 and 11), "manager" (pages 12 and 13) and "health advocate" (pages 14 and 15).

With regard to standards, many ANZCA professional documents are available to assist including: *PS01Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia; PS02 Statement on Credentialling and Defining the Scope of Clinical Practice in Anaesthesia; PS06 The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care; PS08 Statement on the Assistant for the Anaesthetist; PS54 Statement on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations*. All may be relevant in this case.

While continuing professional development (CPD) is mandated for all Fellows in active practice in Australia and New Zealand, the mandate does not apply to non-Fellows. Nevertheless, it is relevant and practitioners should be encouraged on the basis of item 4.1.1 of the CPD handbook, under Participation Standards.

Despite all best intentions it would be naïve to believe that all parties will respond enthusiastically to change. Clearly some will remain antagonistic and there is a danger that attempts to "convert" these practitioners could become a consuming quest.

It is appropriate to remind ourselves of PS49 *Guidelines on the Health of Specialists and Trainees* in order to optimise our performance in all relevant and applicable ANZCA roles. Of particular note are items 3.3, 3.5 and 3.7 under the "professional" section.

Similarly, the avoidance of fatigue in such settings must be considered and this is addressed in PS43 *Statement on Fatigue and the Anaesthetist*. Enlisting the local team and sharing the load in accordance with the principles of the statement ensures the responsibilities are met.

Your colleague's request above involves consideration of factors at multiple levels, which indeed, may be complex, and raises the issue of having a mentor with whom such issues can be discussed.

While the request appears simple, the issues are complex. It reminds me a little of the request from a surgical colleague wanting to add a patient to the end of the list for a simple lipectomy who was ASA 4 with multiple co-morbidities – simple (surgeon) request associated with complex (anaesthetist) considerations!

Dr Peter Roessler,
Director of Professional Affairs,
Professional Documents

Professional documents – update

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

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

A new professional document, *PS60 Guidelines on the Perioperative Management of Patients with Suspected or Proven Hypersensitivity to Chlorhexidine*, and associated background paper (PS60 BP) have been released for a 12-month pilot period. The purpose of this guideline is to prevent recurrent, inadvertent exposure and subsequent reaction in patients with hypersensitivity to chlorhexidine.

A handy recent development for the professional documents section of the website has been the addition of two new tables showing the grouping of professional documents by either a range of commonly searched topics or the ANZCA roles.

Direct any queries or feedback regarding professional documents to profdocs@anzca.edu.au.

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

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

Safety the focus of **ANZCA research**

The ANZCA Research Committee has awarded funding of $A1,445,821 through the Anaesthesia and Pain Medicine Foundation for research projects in 2016.

The funding supports the 2016 academic enhancement grant, 18 project grants, eight continuing project grants, two simulation/education grants, one novice investigator grant and the pilot grant scheme.

These important research initiatives will be carried out in leading hospitals and universities in Australia, New Zealand and Hong Kong and will continue to advance and maintain a high international standing in safety and quality patient care in anaesthesia, intensive care, perioperative medicine and pain medicine.

The foundation is very appreciative of its supporters and sponsors who have provided the named research awards: the Cole Family, the late Dr Robin Smallwood, the late Dr John Boyd Craig, Pfizer and Perpetual Private, the foundation's new partner and major sponsor.

Dr Jai Darvall was awarded a project grant (see page 24).

Named research awards

Harry Daly Research Award – Professor Matthew Chan

The Harry Daly Research Fellowship 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 awards made by the College provided the project is judged to be of sufficient merit. The award is made each year to the highest ranked grant assessed by the ANZCA research grant process.

Re-designing ventilation system for the hospital isolation ward to reduce nosocomial infection

Healthcare workers are concerned about the risk of acquiring infectious diseases, such as influenza, when caring for patients with severe respiratory infection. The hospital isolation ward is equipped with ventilation systems that aim to remove infectious droplet nuclei dispersed during respiratory interventions. A recent study, using computational fluid dynamic simulations, showed the existing downward ventilation design (from ceiling to floor) performed poorly in removing particles in the isolation ward. In contrast, a novel design of ceiling supply and ceiling exhaust system seemed to improve ventilation performance.

The aim of the present study is to compare the effect ceiling exhaust versus floor exhaust (conventional design) have on the dispersion of exhaled air after application of non-invasive ventilation, jet nebuliser and oxygen delivery using nasal cannula, and to determine the optimal ventilation rate to minimise the risk of nosocomial transmission of potential infectious particles.

With a multi-disciplinary team, including clinicians, aeronautical engineer and architect, a series of experiments will be conducted on a human patient simulator in a full-scale laboratory with exhaust vents installed both in the ceiling and at the floor level. The dispersion of exhaled air from the simulator during non-invasive ventilation, jet nebuliser and oxygen delivery with nasal cannula will be determined using an established laser visualisation method. The ventilation rate of the isolation room will be varied from six to 16 air changes per hour to determine the optimal settings for removal of exhaled air dispersion. This study will evaluate the interactions between the type of ventilation (ceiling versus floor exhausts) and ventilation rate on the spread of potentially infected air after different aerosol-generating procedures.

The study will alert healthcare workers on the risk associated with aerosol-generating procedures and will allow clinicians to develop infection-control strategies to reduce the risk of nosocomial transmission when managing patients with severe respiratory infections. The study will provide important and unique aerodynamic data for a better design of ventilation systems in hospital isolation wards.

Professor Matthew Chan, Chinese University of Hong Kong, Hong Kong.

$A69,940

The Russell Cole Memorial ANZCA Research Award – Dr Philip Finch

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

Central sensitisation and auditory disturbances in complex regional pain syndrome

Complex regional pain syndrome (CRPS) may develop after injury to a nerve or after injuries such as a fracture or a sprain.

Instead of healing progressing normally, pain increases and may spread away from the injured site. In the early stages the affected limb is often abnormally warm and sweaty, and hair, skin and nail growth may change. In addition, muscle weakness, tremor and other movement disturbances may develop. Later, the limb typically becomes cold and is extremely sensitive to light touch and to minor changes in the environment.

Unfortunately, a major stumbling block to greater understanding and treatment of CRPS has been the assumption that most patients exaggerate their symptoms. This view has gained traction because symptoms sometimes appear to be linked with psychological distress. For example, pain increases unpredictably (for example, to loud noises, during changes in the weather or to psychological triggers); failure to use the limb may aggravate muscle weakness and other symptoms; and the pain distribution is often "nonanatomical", in that it doesn't follow the boundaries of peripheral nerves.

The concept to be tested in this project provides a more appealing explanation for these anomalies, namely, that failure of the brain to adequately suppress pain distorts normal sensory processing in CRPS. Consequently, patients may learn to avoid stimuli (for example, stress, arousal and pain itself) that make symptoms worse. Although it might appear from an outsider's perspective that the patient is exaggerating their condition and/or making matters worse, in reality the patient may have few other options for keeping their pain within tolerable limits.

To explore this concept, the association between processing of pain and auditory responses in patients with CRPS using an objective neurophysiological approach will be investigated. The investigators have chosen to use this approach to circumvent difficulties associated with more subjective forms of measurement.

These studies are important as they will be the first to systematically explore interactions between the auditory and pain-processing systems in CRPS. The investigators expect to find an association between central sensitisation and neurophysiological signs of distorted auditory processing, which will help to combat the stigma often associated with CRPS and will encourage new approaches to treatment.

Dr Philip Finch, Professor Peter Drummond and Dr Lechi Vo, Murdoch University, WA.

$A61,797

John Boyd Craig Research Award – Professor Michael Paech

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

Pregabalin for the management of post-dural puncture headache after unintentional dural puncture in obstetric patients: a randomised, double blind, placebo-controlled trial

Epidural pain relief during labour is very popular and used by hundreds of thousands of Australian women each year. However, one of the most common complications of epidural insertion (about one in 100) in obstetric patients is unintentional puncture of a membrane in the spinal column, which results in a leak of spinal fluid, with three to four out of five women likely to get a post-dural puncture headache (PDPH).

This PDPH is almost always worse when a woman stands up. Indeed many women are unable to walk around for more than a couple of minutes and some are unable to lift their head off a pillow when lying down. One of the greatest problems is that the headache is very difficult to prevent or treat. Eventually it will go away, but this is usually well after a week of suffering and occasionally after weeks of symptoms. The many drugs that have been used to try to stop or relieve PDPH have largely proven unsuccessful. This includes strong painkillers such as codeine, oxycodone or tramadol and drugs that relieve migraine headache.

Recent research suggests that a drug now widely used to treat nerve pain and sometimes post-operative pain, pregabalin, may be effective in reducing the severity of PDPH. This drug appears to be effective in non-obstetric patients with headache after spinal anaesthesia, but these patients tend to have less severe headache and the studies so far involved small numbers of patients, so are not very reliable.

Pregabalin has been used by some anaesthetists for pregnant women with PDPH and benefit has been reported, but there has not been a clinical trial to investigate whether this is truly the case. Pregabalin is considered to have a "good" side-effect profile, the most common unwanted effects being drowsiness and dizziness.

Therefore, the first large international multi-centre study will be conducted to evaluate how effective a short course of oral pregabalin is for reducing headache resulting from unintentional dural puncture during insertion of an epidural to relieve the pain of labour and childbirth. The possibility of a breakthrough in reducing the severity of PDPH is exciting, because an effective drug has the potential to relieve the suffering of a very large number of patients, reduce the length of time in hospital for those with PDPH and reduce their need for a much more invasive procedure called an epidural blood patch, which is currently the only therapy that helps.

Professor Michael Paech, King Edward Hospital for Women, WA.

$A37,984

The Robin Smallwood Bequest – Dr Joel Symons

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.

HEpcidin, Reticulocyte haemoglobin and soluble transferrin Receptors in reported OutcomEs in cardiac Surgery (HERROES)

Iron deficiency is very common in patients having many types of major surgery, including cardiac surgery. Iron deficiency is the most common cause of anaemia worldwide, and results in worse outcomes after surgery. This can be partially reversed by giving patients iron through a drip approximately two weeks before surgery, which is a simple, cheap, safe and effective method of restoring a person's iron levels.

However, the haemoglobin level (oxygen carrying component of blood) and blood tests currently used to diagnose iron deficiency may not be the best method to determine whether or not a patient requires iron. These tests also may not be the best to monitor the body's response to the administration of intravenous iron. The reason for this is that many patients who are iron deficient and having surgery are unable to use the supplementary iron given to them. Moreover, it is not known whether the iron being given to them is getting into the red blood cells, which use the iron to make more haemoglobin. Three non-routine blood tests, that is, hepcidin, reticulocyte haemoglobin content and the soluble transferrin receptor level, have shown promise in giving clinicians insight into how iron is used by the body.

This study of 160 patients is a sub-study of a larger study (1000 patients) in which patients who are anaemic and having elective cardiac surgery will be randomised to receive intravenous iron or placebo a few weeks before elective cardiac surgery. In addition to the usual blood investigations and iron studies that are performed before this type of surgery, blood will be taken before and after surgery for hepcidin, reticulocyte haemoglobin content and the soluble transferrin receptor levels in both groups of patients. A bone marrow sample will be taken during surgery from the breast bone for iron staining.

This sub-study is purely observational. It is hoped the results may help shed light on how the iron given to patients who are anaemic is used by the body. This will enable clinicians to better tailor therapies to effectively treat iron deficiency and iron deficiency anaemia.

Dr Joel Symons, Professor Paul Myles, Professor David McGiffin, Alfred Hospital, Melbourne, Vic; Professor Toby Richards, University College London, London, UK; Dr Andrew Klein, Papworth Hospital, Cambridge, UK; Professor Julian Smith, Monash Medical Centre, Melbourne, Vic.

$A49,720

Pfizer ANZCA Research Award – Professor Stephan Schug

Pfizer is a major sponsor of the Anaesthesia and Pain Medicine Foundation. The Pfizer ANZCA Research Award is awarded to a highly ranked pain-related project grant.

Obesity and chronic pain management: piloting a new model of care

This project seeks to address a growing problem in Australia where 70 per cent of males and 56 per cent of females are overweight or obese.

In Western Australia alone, acute hospital costs attributable to excess body mass are approximately $241 million per annum, and a striking 82 per cent of obese patients have been observed to drop out of medical centre treatments.

The investigators are seeking to determine the prevalence and impact of obesity among patients attending the Pain Medicine Centre at Royal Perth Hospital for the treatment of chronic pain. Obese and severely obese adults are twice and four times as likely respectively to report chronic pain, compared to normal weight adults. Very little research has examined the impact of treatment programs that provide intensive support to obese patients with chronic pain. Even slight weight loss impacts positively on clinical outcomes and healthcare costs.

This project seeks to advance understanding of the clinical and economic impacts of obesity on chronic pain treatment outcomes, and enable improved clinical outcomes for overweight and obese patients seeking treatment for chronic pain by facilitating online access to cost-effective and evidence-based treatment for pain and obesity.

The project brings a psychological focus to weight loss among chronic pain patients, and seeks to strengthen existing treatment models for obesity by assisting patients with the psychological aspects of lifestyle change.

The investigators intend to pilot the feasibility and effectiveness of a new, interactive internet-based weight-loss treatment program tailored for overweight patients with chronic pain. For the first time, this program will give overweight chronic-pain patients free access to treatment from home, helping to overcome the challenges faced by many Western Australian patients associated with travelling vast distances for specialist treatment in Perth.

The multi-disciplinary research team anticipates the findings will have far-reaching implications for improving existing models of care and treatment outcomes for chronic-pain patients across Australia, who also are battling obesity.

Professor Stephan Schug, Dr Allyson Brown, Professor Elizabeth Geelhoed, University of Western Australia; Professor Sebely Pal, Curtin University of Technology, WA.

$A44,806

Perpetual ANZCA Emerging Researcher Award – Dr Nicole Tan

Perpetual is a major sponsor of the Anaesthesia and Pain Medicine Foundation. The Perpetual ANZCA Emerging Researcher Award is awarded to a highly ranked novice investigator grant.

Does the addition of LIA to a multimodal systemic analgesic regimen improve recovery after anterior THR?

Major joint replacement surgery plays an important role in improving the quality of life of many people.

As Australia's population grows and ages, joint replacement surgery will be performed more often. However, surgery to replace a major weight-bearing joint is a painful procedure, involving trauma to bone, muscle and soft tissue.

Part of the anaesthetist's role as a perioperative physician is to provide patients with effective analgesia, enabling a rapid recovery and return to an appropriate level of function. The widely used technique of infiltrating local anaesthetic into the hip joint during surgery is simple, with seemingly few side-effects when used in conjunction with multimodal oral analgesia.

However, recent studies have questioned its effectiveness at reducing pain in the traditional surgical approach to hip replacement. To date, no study has examined its effectiveness in the setting of less invasive surgery (anterior hip replacement).

The aim of this study is to determine whether the addition of local anaesthetic infiltration (LIA) to multimodal oral analgesia will improve recovery after anterior total hip replacement (THR). Participants will be randomly allocated to receive infiltration of local anaesthetic or saline placebo during surgery with recovery measured by quality of recovery score on day two following surgery.

This trial will be the first to specifically examine the efficacy of LIA in anterior THR. An improvement in general wellbeing and mobility, or a reduction in post-operative pain, will have a positive impact on a large post-surgical population. A negative result will provide evidence that LIA should no longer be used as an analgesic technique for anterior THR.

Improved post-operative and longer-term mobility and comfort provides benefits not just for an individual, but also for the whole community.

Dr Nicole Tan, Epworth Hospital, Melbourne, Vic.

$A19,370

Academic enhancement grant

Emerging projects for the Anaesthesia, Perioperative and Pain Medicine Unit (APPMU) at the University of Melbourne

Professor David Story was appointed the foundation Chair of Anaesthesia at the University of Melbourne in 2012. Since his appointment, Professor Story has established the Anaesthesia, Perioperative and Pain Medicine Unit (APPMU) within the Melbourne Medical School. APPMU aims to promote research, teaching and engagement in the areas of anaesthesia, perioperative and pain medicine among the 14 hospitals affiliated with the Melbourne Medical School.

This academic enhancement grant will enhance the research program of APPMU by expanding the role of the research manager. With an increasing suite of projects, the role of the research manager is integral to the successful functioning and development of APPMU. The research manager will co-ordinate ongoing and emerging research projects, support higher degree students and develop and oversee a large multi-centre study: Colorectal cancer, anaemia and iron management: a large, multi-centre, stepped-wedge, cluster-randomised, controlled trial (C-CaFe).

C-CaFe is the largest of a suite of studies to be undertaken by APPMU. These studies will not only address important research questions through the conduct of quality multi-centre trials, but will enhance the research capability of the University of Melbourne-affiliated hospitals and the broader ANZCA research community

The APPMU research program promotes collaboration between hospitals, medical and allied health professionals, as well as departments within and beyond the university. With greater research experience, University of Melbourne-affiliated hospitals will play a more significant role in ANZCA research, particularly with the ANZCA Clinical Trials Network.

Professor David Story, University of Melbourne, Vic.

$A90,610

Novice investigator grant

Influence of anaesthetic choice on Prospective Outcomes after Creation of Arteriovenous Fistula (POCAF)

End stage kidney disease (ESKD) affects many people in Australia and New Zealand and represents a considerable health burden. The incidence of patients requiring treatment is projected to increase, largely due to our ageing population.

About half the patients diagnosed with ESKD will require vascular access to allow for renal replacement therapy by haemodialysis. The optimal surgical technique for vascular access is the formation of an arteriovenous fistula (AVF).

Where local anaesthesia infiltration is inadequate, an upper-limb brachial plexus block to provide regional anaesthesia to the upper limb or general anaesthesia may be used. Compared to general anaesthesia, an upper-limb brachial plexus block may be particularly beneficial in patients with ESKD by avoiding hypotension; it also may provide optimal surgical conditions by enabling superior dilation of the blood vessels and veins.

These factors may be important in preserving AVF patency. However, regional anaesthesia also may be associated with an increased risk of peripheral neural dysfunction. To date, there have only been small retrospective studies investigating the impact of anaesthesia on medium-term post-operative outcomes (including AVF function and peripheral neural dysfunction) after the creation of an AVF.

This pilot study will be a multi-centre prospective observational study investigating the six-week outcomes of patients having their initial AVF created in relation to the type of anaesthesia they have had (regional anaesthesia versus general anaesthesia). Six-week outcomes are clinically important as a decision to reintervene or abandon the fistula is typically made within this time frame. This pilot work will provide important foundations for the development of a multi-centre randomised controlled trial investigating the impact of regional and general anaesthesia on medium-term morbidity after the creation of an AVF.

Evaluating the impact of anaesthesia technique on AVF outcomes has the potential to alter anaesthetic practice significantly. Any demonstration of an improved outcome based on choice of anaesthetic technique will benefit a large cohort of patients with ESKD who may require haemodialysis. Minimising complications associated with AVF will have significant personal, social and economic benefits.

Dr Raymond Hu, Austin Health, Melbourne, Vic.

$A17,404

Project grants

Developing a pain modulation index in people with chronic pain: a pilot project

Pain modulation describes the pathways and chemicals within the brain and spinal cord system that act to enhance or reduce the intensity of pain. As such, it is a major determinant of the severity of pain.

Given the importance of pain modulation, a large number of investigators around the world have developed physiological methods of assessing the pathways involved. Despite this intensive effort and the development of several physiological techniques that assess pain modulation, the expense, complexity, time and expertise required for physiological testing means that application is mainly limited to the research setting.

As a result, although it would be hugely helpful in assessing pain, there is still no simple, non-invasive tool that can quickly assess pain modulation in the clinical setting.

The investigators aim to develop and validate a new, inexpensive and easy-to-use assessment tool that evaluates symptoms and signs associated with changes with internal pain modulation. This will be done using a short patient questionnaire administered to a sample of people with various chronic pain conditions and a group of people without pain.

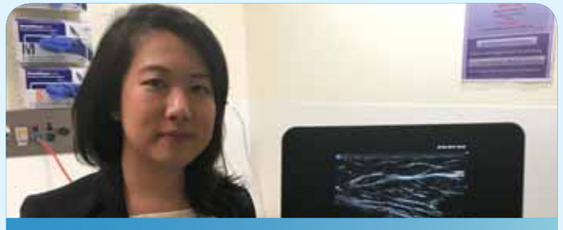
Each person also will undergo physiological testing that is now used to assess pain modulation and the results used to validate the scores and individual items of the questionnaire. From this pilot study, an initial “pain modulation index” will be developed, which can be further validated in a larger sample and across other pain conditions.

Persistent pain is a major health problem with many studies showing approximately one-fifth of the Australian population suffers ongoing pain with a significant impact on peoples’ lives. Much of our uncertainty in diagnosis and variability in outcomes is due to our limited ability to identify simply and accurately the physiological contributors to pain, particularly those in the central nervous system, which we know are enormously influential in modulating the experience of pain.

The ability to quickly and reliably assess the contribution of pain modulation using a simple, quick and inexpensive pain modulation index would be a major step forward for clinical practice. It will allow more widespread assessment of this important contributor to pain, which has been largely confined to the experimental setting, and improve clinicians’ potential to manage pain effectively by indicating the selection of treatments most appropriate to the underlying physiological processes. This also will provide better understanding of the integration of psychological and physiological processes.

Professor Philip Siddall, Greenwich Hospital, NSW; Dr Paul Wrigley, Professor Ali Asghari, Pain Management Research Institute, Sydney, NSW.

$A49,458



Do pectoral nerve blocks improve patient quality of recovery following breast surgery?

Acute post-operative pain following surgery for breast cancer is problematic and is associated with persistent post-surgical pain.

Ultrasound-guided block of the medial and lateral pectoral nerves (between pectoralis major and minor) combined with blockade of the intercostal nerves (deep to pectoralis minor) has been recently described with much interest and is known as the pectoralis II (pecs II) block.

This regional technique for post-operative analgesia has been developed as a “less technical” and less invasive alternative for breast surgery. The sonographic landmarks and needle trajectory are straightforward and reproducible. The pecs II block has been shown to reduce post-operative pain scores following breast surgery in one recent non-placebo-controlled randomised controlled trial. Further study is required to improve the robustness of the evidence for this procedure and to improve generalisability.

The objective of this study is to compare the effect of the pecs II block versus placebo (alongside routine local anaesthetic infiltration by surgeons) on quality of recovery by performing a prospective, placebo-controlled randomised controlled trial. This study will evaluate pain-related physical and emotional dysfunction and opioid consumption in early and late post-operative periods. The results of this study may influence perioperative management of patients scheduled for breast cancer surgery.

Dr Gloria Seah, Associate Professor Michael Barrington, St Vincent’s Hospital, Melbourne, Vic.

$A26,172

Use of the six-minute walk test to predict recovery and complications in morbidly obese patients undergoing elective surgery

The aim of this study is to assess the ability of the six-minute walk test (6MWT) to predict post-operative functional recovery and medical complications in morbidly obese patients in Wollongong Hospital who attend a pre-admission assessment clinic.

Local data show that at least 13 per cent of patients undergoing elective surgery at Wollongong Hospital each year are morbidly obese. Most of the literature suggests morbidly obese patients have higher rates of clinical complications in the post-operative period than the non-obese, although this finding has not been universally reported. Assessment of risk in obese patients cannot be accurately based on the presence of obesity alone.

Measurement of functional capacity preoperatively is considered essential for useful risk stratification and prediction of post-operative outcomes. Cardiopulmonary exercise testing (CPET) is the gold standard for assessing cardio-respiratory fitness. However, CPET is expensive, resource-intensive, and requires a dedicated specialist laboratory and trained technicians.

In contrast, the 6MWT is a simple and cheap test for evaluation of cardio-respiratory function, which has compared well to cardiopulmonary exercise tests in previous studies. It may be ideal for assessing functional capacity in morbidly obese patients as it can be performed by existing staff in a pre-operative assessment area and has been shown to be safe for morbidly obese patients in multiple papers.

There are currently no published data on the use of the 6MWT as a screening tool to predict high risk in obese patients undergoing surgery. A subset of ANZCA's current METS trial involves the 6MWT in the general surgical population.

Accurate identification of risks in this subset of patients in the preoperative period allows anaesthetists and surgeons to further investigate, optimise, and plan to minimise risks as much as possible. Such measures may include reconsidering the benefits of surgery, preoperative optimisation measures, additional more invasive preoperative investigations, transfer to a specialist tertiary centre, altered monitoring and anaesthesia techniques intra-operatively, and efficient post-operative planning, such as the need for an intensive care unit bed.

A reliable and efficient method to accurately stratify risk preoperatively in this patient group may make it possible to decrease morbidity and mortality and the associated healthcare costs to the community.

Dr Natalie Smith, The Wollongong Hospital, NSW; Dr Mark Shulman, The Alfred, Melbourne, Vic; Dr Stephen Asha, St George Hospital, NSW.

$A39,936

> "The outcomes of this study will pave the way for the scaled up manufacture of chocolate-based midazolam tablets for use in Western Australian paediatric wards, and the adaptation of the chocolate base for the formulation of other bitter drugs, such as, antibiotics."
>
> – Professor Britta Regli-von Ungern-Sternberg

A pilot randomised open-label taste-testing study to evaluate the acceptability of chocolate-based midazolam in children

Children reject medicines due mainly to poor taste and, for children less than six years of age, there is an inability to swallow solid medicines, such as tablets and capsules.

Until recently, taste has not been an evaluated parameter for paediatric drug formulations, despite its importance in influencing therapeutic compliance in children.

One drug that causes significant grief for clinicians is midazolam, a short-acting benzodiazepine with sedative, amnesic and anti-anxiety effects. Midazolam is commonly prescribed to children for premedication prior to the induction of anaesthesia. Rejection of the existing midazolam products administered orally at the Princess Margaret hospital is poorly tolerated by conscious patients and has presented difficulties in children who are very anxious or unco-operative in the preoperative setting.

Not surprisingly, midazolam administration becomes distressing for patients and their caregivers, who are already stressed by the impending surgery, and safety and efficacy are compromised when some of the medicine is spat out or the child refuses to take any more of the medicine. This also can lead to poor post-operative compliance in taking oral analgesia and/or antibiotics.

To provide safer and more palatable substitutes, the investigators have developed a prototype chocolate mini-tablet, which masks the bitter taste of midazolam.

This project aims to bring the development of the mini-tablets to the next level, and provide samples for preclinical and clinical evaluation to evaluate their efficacy and acceptance by clinicians, caregivers, and most importantly, the target, paediatric patients.

The outcomes of this study will pave the way for the scaled up manufacture of chocolate-based midazolam tablets for use in Western Australian paediatric wards, and the adaptation of the chocolate base for the formulation of other bitter drugs, such as, antibiotics.

Pharmaceutically, the chocolate tablets, which are prepared without water, will provide more stable products for labile drugs than liquid mixtures. They are more convenient and cheaper to store and transport than bulky liquid formulations.

Professor Britta Regli-von Ungern-Sternberg, Princess Margaret Hospital for Children, WA.

$A56,000

A prospective study of perioperative variation in creatinine production rate in adults undergoing cardiac surgery

Acute kidney injury (AKI) after cardiac surgery represents a major healthcare burden, occurring in approximately 25 per cent of all patients with no preventive or therapeutic intervention yet proven effective.

One suggested factor contributing to this lack of success has been an inability to accurately detect renal injury in a timely manner. Although serum creatinine (SCr) is the current diagnostic standard for AKI, it is widely held to be an inadequate diagnostic tool in large part due to a markedly delayed response to injury. As a result, intensive resources are being invested in identifying and developing novel diagnostic tools to enable earlier recognition of renal injury.

Sophisticated computer modelling suggests approximately 12 hours is required for SCr to increase sufficiently to identify AKI after an acute 30-40 per cent reduction in kidney function and this is likely to be longer in the context of cardiac surgery, where the obligatory fluid load significantly dilutes and attenuates any rise in serum creatinine.

Such modelling, however, assumes the rate of creatinine production by the body is constant and this may not be correct. Recent data from a large cohort of patients undergoing cardiac surgery suggests creatinine may provide an important renal-injury signal within just three hours of surgery.

However, while previous studies have not been designed to identify a mechanism behind such an early creatinine-based signal of renal injury, a mechanistic understanding of such a signal is a pivotal step toward optimal use of the potential benefits of this finding.

A study in patients undergoing cardiac surgery will be conducted to determine whether the rate of creatinine production by the body increases during the intraoperative and very early post-operative period. This will be achieved by precise sequential measurement of body weight, urine volume and the concentration of creatinine in both blood and urine before, during and shortly after surgery.

Importantly, it also will be determined whether an early post-operative creatinine-base renal injury signal is associated with changes in creatinine production rate.

The findings of the proposed study will provide important guidance for future research into early recognition of cardiac surgery associated AKI.

Dr David McIlroy, The Alfred, Melbourne, Vic.

$A62,800

Chewing gum for the treatment of post-operative nausea and vomiting – a pilot trial

The aim of this pilot trial is to determine the efficacy and safety of chewing gum compared with ondansetron (a commonly used anti-emetic drug) in treating post-operative nausea or vomiting (PONV) in the post anaesthesia care unit (PACU).

PONV is a significant complication of general anaesthesia. In addition to patient discomfort resulting from PONV, the cost burdens of anti-emetic rescue therapy and delayed discharge from the PACU are considerable.

Chewing gum has been evaluated in the healthcare setting and has shown initial promise as a means to hasten return of bowel function after major abdominal surgery, but its efficacy as a treatment for PONV has to date not been assessed. A prospective cohort study conducted by this research team on the use of chewing gum in the PACU confirmed its safety and acceptability to patients and staff.

As PONV rates are significantly higher in female patients, 100 females aged 18 years and over undergoing laparoscopic or breast surgery will be included, with participants experiencing PONV after their operation randomised to either ondansetron or chewing gum.

The results of this pilot study will guide a future large randomised controlled trial assessing the efficacy of this comparative simple therapy, of negligible cost. This study has the potential to significantly improve patient and health service outcomes after general anaesthesia.

Dr Jai Darvall, Professor Kate Leslie, Royal Melbourne Hospital, Melbourne, Vic.

$A34,050

Safety and team cultures in the operating room: using WHOBARS to understand clinician attitudes to participation in the Surgical Safety Checklist

The safety of patients in the operating room is paramount. The World Health Organization has established guidelines and tools for enhancing patient safety. One such tool is the Surgical Safety Checklist used in the operating room as a communication tool to promote sharing of important clinical information and more effective teamwork.

Large studies have produced convincing evidence of its effectiveness in reducing patient morbidity and mortality. However, variability in its administration is widely reported and incomplete administration has been linked to adverse patient events.

This study will investigate why there is variable engagement with the checklist by anaesthetists and their operating room colleagues. The investigators will explore self-perceived quality of checklist administration, accuracy of self-perceptions and the reasons for variability in use of the checklist.

Sixty operating room teams from three locations in Auckland will be randomly selected with self-ratings collected for the quality of checklist implementation from the teams involved. An independent observer will rate the cases using a tool previously developed and validated for this purpose – the World Health Organization behaviourally anchored rating scale (WHOBARS).

A subset of participants will be interviewed to explore reasons for their responses to WHOBARS and attitudes towards teamwork and communication as this relates to participation in the checklist.

This will help the investigators understand more about how members of operating room teams feel, and what contributes to their practices in relation to the checklist. The investigators also will be able to compare WHOBARS ratings from different professional groups and determine if operating room teams can accurately determine their own WHOBARS scores for checklist administration. With this information, the investigators plan to design ways to improve the use of the checklist.

Associate Professor Jenny Weller, Professor Alan Merry, Dr Tanisha Jowsey, Associate Professor Simon Mitchell, University of Auckland, NZ.

$A23,082

Mechanisms of analgesia: using ketamine-ester analogues as probes

Despite its widespread use, the fundamental mechanisms of ketamine sedation and analgesia remain to be fully elucidated.

Clinical use is limited due to unpleasant hallucinogenic phenomena experienced across the entire dose spectrum. The investigators have recently synthesised a number of ketamine-ester analogues that demonstrate a spectrum of different clinical effects. One (R1) shows strong sedation effects and weaker analgesic effects, whereas another (R5) shows strong analgesic effects even after any sedation has disappeared.

The unique spectrum of behavioural effects displayed by R1 and R5 administration in animal models, suggests that separation of the hypnotic, analgesic and psychomimetic effects of the parent ketamine may be possible. The differences in structure and activity between ketamine, R1 and R5, will be explored with a view to further understanding the fundamental mechanisms of these properties.

In particular, the research team will investigate what regions of the brain are activated or inactivated with ketamine analgesia and why R5 analgesia persists after the drug has disappeared from the plasma.

The goal of this research is to develop a non-opioid, strong analgesic with minimal psychomimetic side effects. The findings will additionally provide a basis for further understanding of the mechanistic actions of ketamine, which will be of great benefit to anaesthesia and pain management.

Professor Jamie Sleigh, Dr Logan Voss, Dr Martyn Harvey, Waikato District Health Board, NZ.

$A38,400

REACT: Reducing anaesthetic complications in children undergoing tonsillectomies

Despite being a common procedure, tonsillectomy surgery is still associated with significant complications, particularly in children.

Despite the development of anaesthesia management guidelines, perioperative respiratory adverse events (PRAE) remain a major cause of morbidity and mortality during paediatric anaesthesia. It is known that the rate of PRAE is approximately two times higher in children undergoing tonsillectomy procedures compared to adults and that the rate of complications is inversely proportional to age.

This study aims to reduce the incidence of perioperative respiratory adverse events (PRAE) in young children undergoing tonsillectomies. In order to improve the outcome of these high-risk children, the investigators will undertake research targeted at developing optimised anaesthetic management strategies.

One of the prevention strategies consists of a premedication with inhaled salbutamol prior to surgery. Salbutamol is a commonly used drug in the treatment of asthma, which is available as an over-the-counter medication in Australia. Secondary objectives of this study are to reduce the delays in theatre and the time spent in the post-operative care unit due to PRAE, the number of unplanned admissions, prolonged hospital stays and delays in the waiting lists due to sequelae following PRAE.

Should this study confirm that children receiving a premedication of inhaled salbutamol suffer from significantly less PRAE compared with children who did not receive salbutamol, the premedication of children undergoing these surgeries can be easily adopted. This will lead to significantly improved health outcomes and potential improvements in the efficiencies of paediatric theatres and can be easily implemented into the standard anaesthesia management protocols at Princess Margaret Hospital and other hospitals worldwide in which paediatric ear, nose and throat surgery is being performed.

Professor Britta Regli-von Ungern-Sternberg, Princess Margaret Hospital for Children, WA.

$A42,000

ROTEM Platelet in pre-eclamptic obstetric patients: A prospective observational study on labour ward inpatients

Rotational thromboelastometry (ROTEM®) is a point-of-care diagnostic device recently introduced to the Royal Brisbane and Women's Hospital (RBWH) in order to provide rapid and specific coagulation assessment.

The use of ROTEM® is well established in liver and cardiac surgery, but not as yet in the obstetric setting. Previous small-scale studies have reported ROTEM® values in non-pregnant women, normal pregnancies, post-partum and in active labour, but not in obstetric patients with pre-eclampsia, pregnancy-induced complications, liver disease, blood-clotting disorders or other diseases.

Pre-eclampsia is a pregnancy-specific syndrome associated with a low platelet count and platelet dysfunction. ROTEM® Platelet is a new module for platelet function testing, which will be available at RBWH in 2016. The aim of this study is to measure platelet function in pre-eclamptic patients.

Epidurals and spinal anaesthetics are commonly used in obstetric anaesthesia, but are withheld in women with a low platelet count to avoid haematomas, which could potentially lead to devastating and permanent nerve damage. This study will assist in assessing the value of ROTEM® Platelet in the assessment of clotting in the pre-eclamptic patient.

Standard coagulation profiles will be taken for these patients to allow for correlation with ROTEM® values. These patients routinely have a full blood count performed upon presentation to the labour ward, which would include a platelet count. These platelet count results will be retrieved from the laboratory database to also correlate with the ROTEM® Platelet results.

This prospective observational study will provide further understanding of coagulation changes in pre-eclamptic women and enable improved blood transfusion management in these patients. This is an interdisciplinary project in collaboration with the departments of obstetrics and haematology at the RBWH.

Dr Julie Lee, Associate Professor Rebecca Kimble, Dr John Rowell, Royal Brisbane and Women's Hospital, Qld; Dr Paul Gray, Princess Alexandra Hospital, Qld.

$A52,913

Comparison of upper airway properties during dexmedetomidine and propofol sedation

Dexmedetomidine is increasingly used for procedural and intensive care unit sedation.

This growing popularity is based on the belief that it has relatively little impact on both ventilatory drive and upper airway collapsibility, in contrast to benzodiazepines and propofol, which are known to depress ventilation and predispose to upper airway obstruction.

However, the investigators have preliminary data, which demonstrates that at similar levels of sedation the degree of upper airway collapsibility observed with dexmedetomidine is similar to that with propofol. Formal evaluation is now required.

This study will compare the effects of dexmedetomidine and propofol on upper airway function in healthy people and people with known susceptibility to airway collapse (people with obstructive sleep apnoea). Information gained from this study will improve our understanding of the effects of dexmedetomidine and its safe use for procedural and intensive care unit sedation.

Clinical Professor David Hillman, Dr Brad Lawther, Sir Charles Gairdner Hospital, WA; Professor Peter Eastwood, Dr Jennifer Walsh, West Australian Sleep Disorders Research Institute, WA; Dr Åse Danielson, Professor Lars Eriksson, Associate Professor Malin Jonsson Fagerlund, Karolinska University Hospital, Sweden.

$A68,335

A randomised controlled trial of low tidal volume ventilation in major surgery

It is estimated that 783,000 patients undergo general anaesthesia per year in Victoria, which extrapolates to close to four million annually in Australia.

In this setting, mechanical ventilation is often mandatory to support respiratory function. Despite its necessity, mechanical ventilation has potentially detrimental effects on lung tissue. Two mechanical ventilation-associated variables that anaesthetists must set during mechanical ventilation in surgery are tidal volume and the positive end expiratory pressure (PEEP). However, despite the frequency of intraoperative ventilation, the ideal ventilator settings with regard to tidal volume and PEEP are unknown.

Whether short exposure to potentially injurious mechanical ventilation in patients with healthy lungs is sufficient to initiate lung damage is a subject of controversy. Currently, the optimal management of intra-operative mechanical ventilation is not known.

The benefits of a low tidal volume mechanical ventilation strategy first became apparent in studies of critically ill patients with acute respiratory distress syndrome (ARDS). A lung protective strategy resulted in reduced mortality and is now considered standard of care in these patients. However, studies of a tidal volume strategy in patients without lung injury on mechanical ventilation under anaesthesia have yielded inconsistent results. In particular, uncertainty exists with regard to the optimal tidal volume and the need for and the optimal value of PEEP.

The investigators will perform a single centre randomised trial to compare low tidal volume ventilation with PEEP to standard volume ventilation with PEEP. The study will establish the feasibility, safety and preliminary efficacy evidence base for the design of a large interventional multi-centre trial to inform clinicians looking after major surgery patients as to whether a low tidal volume intraoperative ventilation strategy is beneficial to patient outcomes.

Dr Dharshi Karalapillai, Austin Health, Vic.

$A16,030

Regulation of breast cancer gene expression by perioperative beta-blockade: a phase II randomised study

Recurrence of cancer remains a daunting possibility for many cancer sufferers.

Increasing evidence points to an influence of chronic stress and sympathetic nervous system activity on the behaviour of breast cancer cells. Preclinical studies have shown that sympathetic nervous system stimulation changes the breast cancer progression to increase metastasis. Understanding and managing sympathetic nervous system up-regulation during the acute stress of the perioperative period may improve long-term survival after breast cancer surgery.

The harmful changes associated with stress may be offset by anti-hypertensive medication belonging to the class of drugs called "beta-blockers". In animals, beta-blockers can prevent breast cancer metastasis, and in human breast cancer studies, better outcomes are associated with patients who are simultaneously treated for hypertension with beta-blockers. The beta-blocker associated with the most consistent benefit for patients with cancer is propranolol, a drug currently used to treat mild hypertension and anxiety.

This trial seeks to investigate whether the benefits of propranolol seen in preclinical studies of breast cancer are also seen perioperatively in women with breast cancer. The study also will help anaesthetists learn whether propranolol effectively manages preoperative anxiety and whether propranolol limits the body's stress response to surgery.

Patients will be randomised to receive either a placebo or an escalating dose of propranolol for seven days preoperatively. In addition to home blood pressure and heart-rate monitoring, patients will be contacted every two days to ensure compliance and tolerance of side effects.

In their analysis, the researchers will evaluate the effects of beta-blockers on markers of tumour progression and inflammation in tumour samples obtained before and after treatment.

The investigators will examine the levels of inflammatory cytokines in the blood and the presence of anti-cancer immune cells in tumour tissue. This trial unites anaesthetists, surgeons, physicians, pathologists and cancer researchers to translate cancer research into perioperative clinical practice.

The trial's results seek to guide a larger study that will examine the role of propranolol in all patients receiving cancer surgery or in those patients where breast cancer has already spread.

Dr Jonathan Hiller, Associate Professor Bernhard Riedel, Peter MacCallum Cancer Centre, Melbourne, Vic; Dr Erica Sloan, Monash University, Melbourne, Vic; Professor Paul Myles, The Alfred, Melbourne, Vic.

$A40,744

Simulation/education grants

Using workplace-based assessments to make decisions on trainee progression through the ANZCA Training Program

In 2013, ANZCA introduced compulsory workplace-based assessments using a combination of mini-clinical evaluation exercise (mini-CEX), direct observation of procedural skills (DOPS), case-based discussion (CbD) and multi-source feedback (MSF).

These assessments collectively provide a portfolio that records a trainee's performance in the workplace and this information is available to inform the decisions of supervisors of training on trainee progression to the next level of training.

While using a combination of assessments is becoming more common in postgraduate medical training, most of the research has focused on using one type of assessment at a time, not on the use of a combination of assessments to assess different aspects of performance. Assessment methods need to be reliable to be useful. Given the high stakes of the decision the supervisors of training have to make, we need to provide as much evidence as possible and ensure the evidence is reliable.

In this project, the investigators plan to calculate the reliability of the assessment methods, both individually and when combined, in the large population of trainees enrolled in the anaesthesia training program. To do this, information from the ANZCA database of completed workplace-based assessments will be used.

The investigators also will undertake a series of interviews with supervisors of training to explore how they use the information in the portfolio of workplace-based assessments in their decision-making and what factors they perceive help or hinder them in using the information. The results of these interviews and the reliability calculations will inform future developments in workplace-based assessment in the ANZCA Training Program.

Knowledge of current practice and the factors that encourage or inhibit the use of this evidence will facilitate the development of systematic, transparent decision-making on trainee progression by supervisors of training in the future. Ultimately, it will provide information on which to base improvements in the ANZCA workplace-based assessments and the training assessment system.

Dr Damian Castanelli, Monash Medical Centre, Melbourne, Vic; Associate Professor Jennifer Weller, University of Auckland, NZ; Professor Brian Jolly, The University of Newcastle, NSW.

$A37,948

Comparison of learning focused cardiac ultrasound between self-directed/simulator and instructor/live model teaching

The use of focused cardiac ultrasound (FCU) to aid clinical examination in the perioperative period and in critical care to guide patient management is increasing due to improved availability and affordability of portable ultrasound devices and evidence that it alters the diagnosis and management in approximately 50 per cent of patients at increased cardiac risk.

Inclusion of FCU into the training curriculum of critical care will increase the already large gap in supply and demand for FCU training in Australia.

Traditional teaching methods simply cannot cope with this demand as they rely on close supervision from trainers and patients with pathology, which is difficult to fit into an overstretched training or continuing professional development program.

Ultrasound simulators allow learning in a private room away from distractions of clinical practice and family life. They also provide a wide range of pathology. Although equivalent to traditional methods, simulators have been reported only as an adjunct to traditional methods, relying on motivated instructors.

The named investigators from the University of Melbourne have developed and tested a self-directed learning course (FCU TTE) using a simulator, which removes the time pressure and need for instructors and patients, increasing availability and reducing the expense of FCU training.

This course is fully scalable (capable of training tens of thousands or more doctors) and can be set up at any institution in the world with a Vimedix ultrasound simulator, requiring only a brief, three-hour workshop orientation to the simulator. The rest of the learning is provided by eLearning and by the simulator.

The funded project aims to test whether the self-directed simulator course is as effective as the current standard teaching model (iHeartScan™) in imparting FCU interpretation of pathology and imaging skills.

A health economic analysis also will be performed to determine whether the new simulator course is as cost-effective as the traditional course. If the new course is as cost-effective, then the simulator course may become the new method for teaching bedside ultrasound, as it is scalable.

This would result in significant health benefits to a very large number of patients worldwide.

Dr David Canty, Professor Colin Royse, Professor Alistair Royse, University of Melbourne, Vic; Professor Andrew Palmer, Menzies Research Institute, Tas.

$A32,000

Hospitals embrace **National Anaesthesia Day**

Anaesthetists run awareness activities to highlight the risks of obesity.

Fellows and trainees again embraced National Anaesthesia Day in hospitals throughout Australia and New Zealand.

Celebrated on October 16, the 169th anniversary of the day in 1846 that ether anaesthetic was first demonstrated in Boston, Massachusetts, National Anaesthesia Day aims to raise awareness of the role anaesthetists play in patients' preparation for surgery, their wellbeing during surgery and their recovery.

This year's theme, "Obesity complicates anaesthesia", aimed to highlight the risks caused by obesity and advise patients what they can do, such as talking to their medical team, including their anaesthetist.

National Anaesthesia Day promotions appeared in ANZCA publications in the lead-up to the day and heads of departments (or their nominated "champions") were sent kits containing:

- "Obesity complicates anaesthesia" posters.
- National Anaesthesia Day balloons.
- "Obesity and anaesthesia" factsheet (available for download from website).
- "Who is your anaesthetist?" poster (available for download from website).

More than 40 hospitals contacted the Communications unit about their activities, up from 30 the previous year (other hospitals participated without advising Communications). Anaesthetists, trainees and medical students also acknowledged National Anaesthesia Day at Port Moresby General Hospital in Papua New Guinea, where ANZCA's Overseas Aid Committee was running a course.

In Australia, hospitals and private practices across the nation marked the day with displays in their foyers and departments. At Western Health (Sunshine Hospital) in Melbourne, a booth with patient information, balloons as well as an anaesthetic machine, airway and an epidural trainer attracted more than 80 people over four hours.

At Fiona Stanley Hospital in Perth, anaesthetists and other staff set up a stand with posters, anaesthetic equipment and a simulation mannequin, while a video played showing anaesthetists discussing obesity.

Tamworth Base Hospital in NSW had posters all over the hospital and registrars and consultants at the main entrance, where an airway station was set up. Latrobe Regional Hospital held an "Ether Breather" conference to celebrate the day.

In Australia, Communications heard from Nepean Hospital, Tamworth Hospital, Wollongong Hospital, Seventh Day Adventist Hospital in Wahroonga, Canterbury Hospital, Western Health, St Vincent's, Dandenong Hospital, Latrobe Regional Hospital, Mildura Base Hospital, Royal Women's Hospital, Maroondah Hospital, Royal Darwin Hospital, Fiona Stanley Hospital, St John of God Hospital, Sir Charles Gairdner Hospital, Swan District Hospital, Hollywood Private Hospital, Royal Brisbane & Women's Hospital, The Prince Charles Hospital, The Townsville Hospital, Mackay Base Hospital, Toowoomba Hospital, Redland Hospital, the Friendly Society Private Hospital in Bundaberg, Bundaberg Base Hospital, Princess Alexandra Hospital, Northwest Regional Hospital and the Royal Hobart Hospital.

In New Zealand, more than 50 per cent of hospitals participated in National Anaesthesia Day with some using the opportunity to create extensive interactive displays. Auckland City Hospital, for example, co-ordinated a display in the main foyer, featuring simulator training equipment, an anaesthetic machine with full monitoring equipment and an ultrasound machine with targets. The display included a historical section with equipment nearly 100 years old. They developed some excellent resources, aided by funding from ANZCA, and made these available to other New Zealand departments, some of which incorporated them into their own displays.

Other New Zealand hospitals participating, many booking foyer space for displays, included Chelsea Hospital, Gisborne Hospital, Palmerston North Hospital, Wellington Hospital, Hutt Hospital, Wanganui Hospital, Dunedin Hospital, Middlemore Hospital, Tauranga Hospital, Rotorua Hospital, Whangarei Hospital and Taranaki Base Hospital.

Wanganui Hospital's clinical director of anaesthesia, Dr Marco Meijer, used the day to launch his hospital board's new "Fit for Surgery" strategy and, as well as displaying it publicly on the day, Dr Sven Karmann used the National Anaesthesia Day material to support his presentation on bariatric anaesthesia to the Whangarei Hospital department in early November.

Media

Print, radio and television media outlets enthusiastically covered the National Anaesthesia Day theme "Obesity complicates anaesthesia", reaching a combined audience of 1.8 million via more than 30 individual news reports (plus dozens of syndications) across all media platforms.

Early results of the MUMSIZE study, which received seed funding from ANZCA, were released to coincide with National Anaesthesia Day, and this resulted in a strong media release and widespread media coverage.

The data, collected by seven Victorian hospital maternity units, found hospitals experienced an average increased anaesthesia time of between of eight to 18 minutes or 10 to 25 per cent for obese or very obese patients having a caesarean. This amounted to extra costs of $25 per minute for hospitals.

For obese women with a body mass index (BMI) of 35-45, there was a 10 per cent increase on the 72-minute average and for very obese (BMI of 45 and over), there was a 25 per cent increase in time. These two groups made up 28 per cent of all the women in the study.

Melbourne University's Professor David Story, who led the MUMSIZE study, gave a number of interviews. ANZCA also was represented by ANZCA President Dr Genevieve Goulding, who spoke about the ways obesity complicates a person's anaesthesia and recovery, and Dr Nico Terblanche from Tasmania was interviewed about his research into ultrasound-guided epidurals and airway management.

ANZCA issued two media alerts, two media releases and radio "grabs" pre-recorded by the ANZCA president. Using a distribution service for radio in Australia, these resulted in more than 270 downloads, including 2GB and 2SM in Sydney, 3AW in Melbourne, 5AA in Adelaide, 2CC in Canberra and 6PR in Perth, who interviewed the ANZCA president separately.

Other highlights of the news coverage included a prominent page-three lead in the *Herald Sun*, in Melbourne as well stories in *The Age* and other Fairfax publications and News Corp publications including the *Courier Mail, Adelaide Advertiser* and *Canberra Times*.

There also was excellent coverage in NZ media including the front-page lead story in *The Dominion Post* and an item on TV One's 6pm news hour filmed at Auckland and Hutt hospitals and presented by ANZCA Media Award winner, Lorelei Mason. There were two stories in the *Wanganui Chronicle* and other coverage in community newspapers. A media alert about the plans for activity in NZ hospitals resulted in useful publicity before the day alerting the public to those displays.

Clea Hincks
General Manager, Communications

Clockwise from top left: Dr Nigel Robertson and Dr Helen Lindsay at Auckland City Hospital, NZ; Dr Charlie Ho (in white) and team at Fiona Stanley Hospital, WA; Dr Natalie Smith and Ms Nicole Sheppard at Wollongong Hospital, NSW; National Anaesthesia Day 2015 poster; Dr Kerstin Wyssusek (fourth from left) and anaesthesia staff at Princess Alexandra Hospital, Qld; Sir Charles Gairdner Hospital anaesthesia staff with their display, WA.

Fellows call for action on obesity

"Obese patients are getting bigger, more frequent, they are harder to anaesthetise and they take a lot of the joy out of this job."

ANZCA Fellow in survey response.

"For BMI, 40 is the new 30!"

This sentiment from one Fellow seemed to sum up the views of many in the inaugural National Anaesthesia Day survey distributed on October 16.

The survey was sent to nearly 5300 practising ANZCA Fellows and more than 800 responded, a 15 per cent response rate. Of these, 31 Fellows were based outside Australia and New Zealand.

Most of those surveyed (64 per cent) believed obesity to be the most common preoperative co-morbid condition. Only 15 per cent disagreed or strongly disagreed.

Table 1: In my practice, obesity is the most common preoperative co-morbid condition

	No. of anaesthetists	Percentage
Strongly disagree	27	3%
Disagree	101	12%
Neutral	155	19%
Agree	347	42%
Strongly agree	199	24%

In the free text section, there were 342 responses including 271 from Australian and New Zealand anaesthetists.

Many Fellows said treating obese patients made their work harder.

"Obese patients are getting bigger, more frequent, they are harder to anaesthetise and they take a lot of the joy out of this job," said one Fellow whose feelings reflected those of many others.

A strong theme was the lack of awareness by patients of their obesity and how this affected their health, and the difficulties anaesthetists sometimes had in discussing the issue.

"Obese is the new 'norm'. I feel 'politically incorrect' if I have to discuss with patients their extreme weight/fatness and for the main, most obese are oblivious to their condition and the anaesthetic/post-surgical problems it can cause'," one respondent said.

Respondents were strongly of the opinion that obesity was increasing and many said they could not see the situation improving.

"When I started a career in our specialty 38 years ago I looked forward to the time that having had so much experience that it would be so easy," an experienced Fellow said. "Behold obesity has made the previously simplest procedures difficult in the cause of safety."

Another said: "We used to identify our morbidly obese patients on the surgical OR list using initial 'MO' to alert staff so we could be better prepared. We might as well stop doing this as more than 60 per cent of our patients fit this category."

There were several passionate calls for action from Fellows who advocated taxes on unhealthy food and other methods of addressing obesity in the community.

"We can't just keep on building bigger, wider ambulances, operating tables, ward beds, hoists, air mattresses, doorways, airline seats, coffins and funeral plots," one Fellow said. "Someone has to draw the line and say: 'NO MORE: the nation has to get thinner'.

"This is a health crisis for our society and the government and health professionals must act; tax on soda drinks; mandatory intervention for obese school children including counselling their parents; portion control especially for takeaway foods. Look at photos of Australian crowds in the Hawke era or before – we were a slim nation! Now we are a nation of fatties!"

Another called for more effort to be made in preventing obesity.

"Many patients attend public and private hospitals requiring treatment for obesity-related disease, including diabetes, cardiovascular disease and surgeries such as joint arthroplasty," the Fellow said. "However, ironically, they cannot access weight-reduction surgery. Public health campaigns will fail, as has been proven in the US.

"Would the health dollar not be better spent treating the obesity and not fighting the multiple fires that obesity creates?"

A similar thought from another Fellow was: "As a specialty, we should take a stand and say that this is an unacceptable pre-op risk. Patients need to have demonstrated attempts to improve their condition prior to elective surgery."

The first two questions in the survey related to anaesthetics given "yesterday". When the data was narrowed to work completed in Australia or New Zealand hospitals on weekdays, most Fellows (36 per cent) anaesthetised four to six patients the day before while 23 per cent anaesthetised one to three patients (table 2).

In tallying the numbers of obese patients, 23 per cent reported they had one patient who was obese and 41 per cent had two to four obese patients (table 3).

Table 2: Number of patients anaesthetised in Australia and New Zealand on a weekday

Patients anaesthetised	No. of anaesthetists	Percentage
0	103	15%
1-3	155	23%
4-6	244	36%
7-9	102	15%
10+	72	11%

Nearly 65 per cent of anaesthetists had one to four patients who were obese on their list the previous day, although 29 per cent had none (table 3).

Table 3: Number of patients anaesthetised who were obese (weekday lists in Australian and New Zealand only)*

Patients anaesthetised	No. of anaesthetists	Percentage
0	194	29%
1	158	23%
2-4	276	41%
5-9	35	5%
10+	2	0% (0.2%)

*11 provided no answer

Unsurprisingly, most respondents agreed that obesity increased perioperative risks with 70 per cent strongly agreeing and 25 per cent agreeing. Interestingly, 3 per cent strongly disagreed (table 4).

Table 4: How strongly do you agree that obesity increases perioperative risks?

	No. of anaesthetists	Percentage
Strongly disagree	29	3%
Disagree	0	0%
Neutral	12	1%
Agree	204	25%
Strongly agree	585	70%

In answer to the question "How strongly do you agree that obesity increases lifetime risks?" 95 per cent of respondents strongly agreed (80 per cent) or agreed (15 per cent). Four per cent strongly disagreed (table 5).

Table 5: How strongly do you agree that obesity increases lifetime risks?

	No. of anaesthetists	Percentage
Strongly disagree	31	4%
Disagree	2	0%
Neutral	6	1%
Agree	128	15%
Strongly agree	660	80%

As a result of the survey, the College is looking at developing resources for Fellows treating obese patients and will continue to address the issue in future editions of the *ANZCA Bulletin*. Fellows may be interested to know there are a number of groups both locally and internationally who are committed to improving safety and quality in the peri-operative care of obese patients.

These include the International Society for Peri-operative Care of Obese Patients, the Obesity Surgery Society of Australia and New Zealand and the Society for Obesity and Bariatric Anaesthesia. The latter group is UK-based and, in conjunction with the Association of Anaesthetists of Great Britain and Ireland, have recently published guidelines for peri-operative management of obese surgical patients. (Nightingale et al Anaesthesia 2015).

Clea Hincks
General Manager, Communications

What Fellows said

- It's a massively out-of-control problem that will haunt healthcare providers for the length of their professional careers.
- Adds an enormous stress to every anaesthestist's working day.
- Greatly increases my anxiety levels, impacts greatly on theatre lists due to extra time being required to safely anaesthetise.
- Obesity is increasingly being normalised in society, which makes discussion of its concomitant risks with patients more awkward.
- Serious and increasing problem. We are not vocal enough about it. I would like to see BMI limits for non-cancer, elective operations (joints, hernia etc).
- The future is looking very scary.
- It is getting worse every year. Comparing the patients I had a decade ago and now, the obesity rate and BMI are much higher now and still going up.
- Consumes disproportionate amount of resources.
- The ignorance of these patients regarding the impact of obesity on anaesthesia is extremely concerning.
- It's here to stay; we have to get good at managing it.
- Single main issue that confronts anaesthetists and no evidence that it will improve in my lifetime.
- Patients are frequently unaware of their obesity – either denial or altered perception of the norm.
- Gross obesity used to be once a month or less, now often a daily occurrence.
- The most significant challenge to our practice.
- Diminishes my enjoyment of my job, let alone the patient risks.
- Profoundly affects every element of anaesthesia: pathophysiology, pharmacology, vascular access, airway management, regional anaesthesia, positioning.
- Experience is required to manage obese patients well. They often come to harm when managed by non-anaesthetists or inexperienced anaesthetists.
- Patients have no understanding of enormous risk implications re. BMI's over 40. Standard response is "I've never had a problem before!"
- Makes every aspect of anaesthesia more difficult and or risky.
- Worse than smoking. Worse than IHD. Worse than DM. Worse than anaesthetising a colleague or a barrister.

ANZCA supports indigenous doctors

The College is building a network of professional contacts and mentors for Indigenous students to encourage careers in medicine and anaesthesia.

After 15 years working as a nurse, including 10 years in intensive care, Darren Hartnett, a Kamilaroi man formerly from southern Goulburn in NSW, committed to studying medicine. Now at the end of his second year of medicine at the University of Newcastle, he is dedicated to training as an anaesthetist after finishing his studies.

"Working under pressure is something I enjoy," Mr Hartnett said. "When I look at medicine, everyone has a role, but in anaesthetics you have the opportunity to branch out."

Mr Hartnett was among three medical students and one graduate of medicine sponsored by ANZCA to attend the ANZCA annual scientific meeting (ASM) in Adelaide in May.

"Meeting anaesthetists and other people interested in the field was great encouragement for me," Mr Hartnett said. "I got to see what makes a great anaesthetist and a better idea of the research and the amount of time they put in to improving themselves and anaesthetics as a whole."

At the Australian Indigenous Doctors' Association (AIDA) conference in September, ANZCA held a workshop for Indigenous medical students and doctors to encourage interest in the specialty of anaesthesia.

ANZCA Fellow Dr Rod Mitchell and Aboriginal anaesthesia trainee Dr Dasha Newington helped lead the workshop, which focused on simple airway management, emergency airway management, intravenous fluid management and defribillation.

"We wanted to provide practical displays of what our profession entails," Dr Mitchell said. "Part of the reason for the workshop was to try to nurture any enthusiasm for anaesthesia but also to provide useful contacts."

Building this network of professional contacts and mentors for Indigenous medical students is an important platform of ANZCA's commitment to encouraging and nurturing Indigenous Australians and New Zealanders into the medical profession in general, and also into anaesthesia.

"The workshops we held this year aimed to demonstrate what the profession was about in a culturally safe space," Dr Newington said.

"Some indigenous medical students got into their course on alternative entry schemes and it's easy to feel like you don't belong there, or that you've taken someone else's place, as a student. That can make it hard to ask questions.

"It's a bit easier when you graduate because you've had to pass the requirements, but that insecurity can make it easier for indigenous students to ask questions in a culturally safe space."

In Australia, ANZCA works to encourage an indigenous medical workforce that is on par with the indigenous representation in the community.

"Ideally we are looking for parity," Dr Newington said.

"Aboriginal and Torres Strait Islanders make up 2.5-3 per cent of the Australian population but only 0.2 per cent of medical doctors."

At the 2016 ANZCA ASM, being held in Auckland from April 30 to May 4, the College will again sponsor the attendance of medical students and junior doctors to encourage careers in anaesthesia and pain medicine.

These scholarships will be open to Maori, Pacific Islanders, Aboriginal and Torres Strait Islanders and are made possible by the generous donations of ANZCA Fellows to the Anaesthesia and Pain Medicine Foundation.

Mr Hartnett encourages anyone who is interested to apply so they can see from a closer perspective what a career in anaesthesia entails.

"My own interest in anaesthesia comes from my time in intensive care units," he said.

"There is a lot of flexibility and it is a specialisation that can send you in so many different directions – from transplant cases to emergencies and paediatrics, it's such wide variety.

"You can be in a clinical setting one day and in retrieval the next – anaesthesia allows you to perform across all different types of surgery."

Ebru Yaman
Media Manager, ANZCA

Clockwise from top left: Dr Dasha Newington, Dr Bodie Rodman and Dr Janelle Trees; attendees at an ANZCA skills workshop; Dr Joel Wright and Dr Richard Browning; Harmione Wong and Ryan Peters watch as Dr Rod Mitchell demonstrates equipment; L-R: Dr Tammy Kimpton, Dr Dasha Newington and Dr Richard Browning; visitors at the ANZCA booth; an ANZCA skills workshop in progress; delegates are encouraged to ask questions.

NICHEportal launched

An updated Network for Indigenous Cultural and Health Education portal (www.nicheportal.org) was launched at the Royal Australasian College of Surgeons in Melbourne on Friday October 23 with a special smoking ceremony by an elder of the Wurundjeri Tribal Council.

ANZCA was heavily involved in developing the portal, represented on the steering committee by Dr Michele Poppinghaus and contributing a number of educational resources for specialists. (www.anzca.edu.au/fellows/community-development/indigenous-health.html)

Associate Professor Kelvin Kong opened proceedings, and invited an elder from the Wurundjeri Tribal Council to perform the Welcome to Country recognition.

"The NICHEportal will be an important tool for the specialist medical colleges as they endeavour to encourage more Aboriginal and Torres Strait Islander doctors to undertake specialist training," Associate Professor Kong said.

"The portal will be part of a suite of initiatives to prepare for a future with a greater emphasis on indigenous health with improved cultural awareness and understanding."

The aim of the current stage of the project was to build a new NICHEportal that included:

- Search engine optimisation.
- Responsiveness to mobile and other devices.
- Improved navigation.
- Additional resources from specialist medical colleges.

The Australian Government Rural Health Continuing Education (RHCE) Program funded the first two phases of the NICHEportal project, which resulted in the development of the NICHEportal website.

Paul Cargill,
Policy Adviser, ANZCA

Maori specialist shifts focus to the Earth

Auckland anaesthetist Stuart Walker says respect for the land is part of his Maori heritage. But he believes everyone needs to take responsibility because we are all indigenous to planet Earth.

Stuart Walker is from the Whakatohea tribe, which traces its *whakapapa*, or genealogy, to the Bay of Plenty where his ancestors arrived via the Mātaatua, one of the great voyaging canoes in which Maori migrated to New Zealand some 800 years ago.

Professor Alan Merry felt this *whakapapa* would be of benefit to the Auckland University School of Medicine, which he heads, integrating the principles of the Treaty of Waitangi into the curriculum for medical students learning about the cultural context of surgery and anaesthesia.

"Alan Merry was one of my mentors," Dr Walker said. "I wanted to help him as much as he'd helped me as a junior doctor; as a Maori, one has an obligation to tribal elders and in a way he was an elder to me."

He was also happy to oblige when asked in 2013 to join the Indigenous Health Committee of ANZCA, where Professor Merry is a councillor.

Dr Walker is an anaesthetist at Middlemore Hospital in Auckland South, which has many Maori and patients of immigrant, ethnic minorities, whose health status is below the rest of the New Zealand population.

Economic deprivation, poor housing, poor diet, tobacco and alcohol use are key factors impacting on the health of the Maori in New Zealand and have led to problems such as obesity, diabetes, metabolic disorders and cancer.

"There are cultural issues too," Dr Walker said. "Some may try alternative care before seeing the doctor. Some also still live in small, rural communities and don't have the economic means to get an early diagnosis through screening programs available in the bigger centres.

"Maori may also be less assertive and demanding when it comes to healthcare and this can lead to different levels of care between Maori and non-Maori."

Indigenous doctors may be more attuned to the needs of patients from their own culture, Dr Walker said.

"If you have a withdrawn, uncommunicative patient who doesn't front up to appointments and isn't friendly, doesn't say thank you – if you're not on the same cultural wavelength, the patient may get a different level of attention," he said.

While the health of the Maori population is worse than the rest of the New Zealand population, Dr Walker believes the relative health of indigenous Australians is worse still. He believes this may relate to an imbalance in the number of indigenous doctors in each country.

According to ANZCA data collected this year, of the 4224 (58 per cent) Fellows and trainees who responded to a question about whether they identify as indigenous, in Australia (population 23.9 million) six identified as Aboriginal and one as a Torres Strait Islander. In New Zealand (population 4.6 million), 24 identified as Maori and nine as being Pacific Islander.

There are about 600,000 Maori in New Zealand and a similar number of Aboriginal and Torres Strait Island people in Australia. There are about 300,000 Pacific Island people in New Zealand.

Dr Walker says better Maori representation among doctors is due largely to the long-standing Maori and Pacific Admissions Scheme (MAPAS), which encourages Maori and Pacific students to study health sciences, including medicine, to address ethnic disparities in the health workforce.

He recommends those with an interest in the demographics of ethnicity and health should read a paper by Nobel laureate Angus Deaton[1], cited by Nobel laureate Paul Krugman in a *New York Times* column[2], which demonstrates that mortality and morbidity rates are increasing for middle-aged white Americans. One possible factor to which he attributes this, is the broadening gap between the extremely wealthy and the rest of the population. Another factor is the epidemic of chronic pain in that community and the consequent epidemic usage of prescription and non-prescription opioids.

"The same thing could potentially happen in New Zealand and Australia – we're subject to the same economic and political forces where 1 per cent of the population is collaring more and more of the resources and this could start showing up in health outcomes," Dr Walker said.

"We in the western world not unnaturally look to America for leadership, ideas and trends.

"As a community and as healthcare professionals – and not just anaesthetists – we have to understand the direction in which the healthcare system is travelling."

Local healthcare issues are only part of the picture for Dr Walker, who believes Earth's growing population, rising carbon dioxide levels and global warming are already having an impact through the increasing spread of tropical diseases, mass human migration and major climatic events.

"These are significant medical human problems that aren't going to go away, they are going to increase. Sea levels are rising and there is increasing ocean acidity. They're going to seriously affect our children and grandchildren," he says.

Dr Walker's Maori heritage means he has a strong sense of *katiakitanga*, or "guardianship" of the land.

"Some may try alternative care before seeing the doctor. Some also still live in small, rural communities and don't have the economic means to get an early diagnosis through screening programs available in the bigger centres."

"The Maori concept of land tenure is not one of 'ownership' but 'guardianship'," Dr Walker says.

"I think that's a concept the Maori can bring to the world. I'm not talking about individual land titles, I'm not talking about buying and selling land – I'm talking about collective guardianship, or collective care of the planet; how we look after it all.

"We're all indigenous to the planet."

He believes "all of us are going to have to think about what our personal contributions are going to be".

"I now consciously limit my air travel and am resigning myself to a vegetarian/insectivorian diet in the future.

"I am delighted that the ORA (a New Zealand Maori doctors' organisation) has recently endorsed a document calling for increased commitment to combating climate change[3].

New Zealand Society of Anaesthetists (NZSA) and the Royal Australasian College of Physicians also have endorsed the document.

"We must not fail to adequately address the issues contained within that document."

Clea Hincks,
ANZCA General Manager, Communications

References:

1. Anne Case and Angus Deaton. Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century. Proceedings of the National Academy of Sciences. (Published online before print in November 2015).
2. Despair, American style. Paul Krugman, op-ed, New York Times, November 9, 2015.
3. Climate Change and Health, Health Professionals Joint Call for Action, October 2015. www.orataiao.org.nz/joint_nz_health_professional_s_call_for_action_on_climate_change_and_health

Caring for anaesthetists for more than 20 years

The Welfare of Anaesthetists' Special Interest Group started more than 20 years ago, initially called "Onions" after the restaurant in which we had our first meeting, in 1994. For a while afterwards, our perception was that the attitude of the founders of the group was that we were "a couple of crazy old women" – we weren't even that old!

But with the support of several enlightened men and women, we have progressed to the present, and doctors' health has become an important, universally recognised, and mainstream topic.

An enormous help in achieving this was the addition of welfare questions in the ANZCA final examination. Welfare issues are now embedded in the ANZCA curriculum in the professional role.

Our group soon became one of the first special interest groups with the support of ANZCA, the Australian Society of Anaesthetists and New Zealand Society of Anaesthetists. Known as WOA SIG, we now have more than 500 members. The 15 members of the SIG executive meet regularly, usually via teleconference, to discuss matters related to the group's area of interest.

Today the WOA SIG aims to provide education to anaesthetists and trainees in the care of their personal and psychological health, and that of their colleagues and peers. Anaesthesia can be a challenging and stressful profession and the WOA SIG seeks to foster a culture of care, openness and support for each other as a community.

What does the WOA SIG do?

Welfare input begins at the start of training, with members giving presentations about the importance of self-care, life balance and social networks at the Part Zero courses. While the focus of Part Zero attendees is understandably on ANZCA regulations and examinations, trainees need to be aware of the importance of looking after themselves and each other in the potentially stressful early years of training, and of the pitfalls they may encounter. Under stress, trainees can lose perspective; the support and care of their peer group is pivotal in helping avoid this.

The WOA SIG conducts sessions at all national anaesthesia meetings in Australia and New Zealand; presentations are always given at the combined SIG annual meetings and WOA SIG has convened several of these. Invited speakers, such as national leaders in mental wellbeing and experts from medical defence organisations, share data, wisdom and informed advice.

The combined SIG conferences traditionally are held in a restful non-metropolitan location, with a focus on practical skills to develop a culture of wellbeing in anaesthetists, both for ourselves and on behalf of our patients.

Workshops include mindfulness, mentoring toolbox and guidance on management of difficult conversations and situations.

The WOA SIG has a dedicated webpage (www.anzca.edu.au/fellows/special-interest-groups/welfare-of-anaesthetists/introduction.html) with quick links to resource documents, articles, podcasts and links to regional and national doctors' health services, as well as activities, a biannual newsletter and news of upcoming events (ANZCA and ACECC websites).

Members of the WOA SIG executive are often called for advice in a variety of situations and, with their experience and the information in the resource documents, they are in a good position to help the person access appropriate support and resources.

The role of the WOA SIG is non-therapeutic and it is important that members only listen, discuss and give advice, and not take on a "duty of care" to the callers: a duty of care can be assumed if any member says: "I would do ..." rather than "You could do..."

Calls occasionally will be from doctors experiencing difficulties themselves, but usually they are from concerned colleagues. Support may soon be available closer to home for many anaesthetists with the establishment of welfare advocates in many departments, including private practice.

We often hear about the tragedy of suicides, accidental intravenous drug deaths and misuse of drugs; sadly in the latter, recommendations in resource document 20 have not always been followed. Early intervention, immediate treatment and a long period of rehabilitation and monitoring may prevent suicide and relapse.

Where to from here?

There is wide acceptance by professional bodies and health administrations of the importance of welfare issues for all doctors, including anaesthetists.

The topic came to the fore recently with the publication of a beyondblue national mental health survey of doctors and medical students highlighting important issues in doctors' health. It is worth reading (www.beyondblue.org.au/docs).

In response to this report, the WOA SIG has proposed a mental healthcare model, which is now under discussion. The model would examine what evidence-based components of care anaesthesia groups and departments should have. Training in resilience and self-management of stress are becoming available using techniques such as positive psychology, mindfulness, meditation and process communication skillsets.

What have we learnt?

Over the years, the WOA SIG has learnt a great deal, including:

- Even with all attempts to help those suffering from depression, it is not always possible to prevent a lethal outcome – suicide. It's a potentially lethal disease.
  - The effect of a colleague's suicide is devastating and those who have had this experience must find support for themselves and avoid any guilt.
- Keeping de-identified notes on contacts and on drug/suicide deaths is confidential; however they have been useful activities.
- Doctors report substantially higher levels of psychological stress and attempted suicide compared to the Australian population and other Australian professionals.
- Anaesthetists rank second among the medical specialties for suicide ideation, harmful levels of alcohol consumption, and third for depression.
- Anaesthetists who fall into substance misuse can become manipulative and extremely clever in hiding their addictions.
  - Psychiatrists are not always aware of the cunning behaviour of intravenous substance misusers: ANZCA and the Royal Australian and New Zealand College of Psychiatrists have formed a working group to address this. WOA SIG members have had a letter published in *Australian Psychiatry*.
  - A handful of those misusing anaesthetic drugs, usually propofol, have obtained a mainstream medical diagnosis to account for their aberrant behaviour.
  - There are many excuses for observed behaviour, for example, shaving off all body hair before hair is required for drug testing or having an injury that needs a bandage (to cover up an indwelling cannula) etc.
  - Sadly, relapse is not uncommon and can result in death.
  - Propofol is supplanting opiates as the favoured drug of abuse; Sevoflurane has been used in a few cases (RA Fry, LE Fry, DJ Castanelli. A retrospective survey of substance abuse in anaesthetists in Australia and New Zealand from 2004 to 2014 Anaesth & Int Care 2015 Jan; 43 [1]:111-117).
  - The Australian Doctors in Recovery organisation is willing to assist (www.idaa.org/sites/adr/).
- Although alcohol may be far more common as a drug of abuse, mostly WOA SIG does not hear about these doctors. It's a slow burn, not a catastrophic incident, although just as dangerous for patients.
  - The Australian Doctors in Recovery organisation is willing to assist (www.idaa.org/sites/adr/).
- Examinations, examination failure and relationship breakups are some of the triggers for doctors getting into difficulties. Immediate and ongoing support should be available and offered at these times.
- More doctors have their own general practitioner than 20 years ago. A telephone conversation can assist colleagues to take appropriate steps in an issue (Sexton, R: Doctors need a doctor, MIGA Bulletin Aug 2012).
- The messages about self-care do not change. Anaesthetists, like other doctors, use denial, self-diagnosis and self-prescribing to avoid taking time off, or being perceived as weak or unreliable. This requires a culture change in addition to self-care prioritisation.

Beyondblue highlights the relevance of attitudes and actions in the workplace. In line with the recent initiative in the beyondblue "Heads Up" project, the WOA SIG will play an active role in leading the development of mentally healthy workplace practices to support anaesthetists, their families and, ultimately, our patients.

The WOA SIG has welcomed a recent Royal Australasian College of Surgeons' Expert Advisory Group report on discrimination, bullying and sexual harassment: (www.surgeons.org/media/22086656/EAG-Report-to-RACS-FINAL-28-September-2015-.pdf).

ANZCA Vice-President Associate Professor David A Scott will chair a College working group to outline ANZCA's strategies in these important areas. Anaesthetists and trainees will be assisted and educated in approaches aimed at minimising bullying, discrimination and harassment, to ensure safe workplaces and promote cultural change; ideally all such approaches should be interdisciplinary.

In a positive initiative, the Medical Board of Australia will fund the development of a program similar to the Victorian Doctors' Health Program in all regions of Australia.

The WOA SIG has come a long way since the early days. We don't have all the answers, but we learn daily and use best evidence to proactively support mental wellbeing.

Dr Diana Khursandi, FANZCA
Dr Marion Andrew, FANZCA
Welfare of Anaesthetists Special Interest Group

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

Further information

Welfare of Anaesthetists Special Interest Group, including resource documents: www.anzca.edu.au/fellows/special-interest-groups/welfare-of-anaesthetists/introduction.html

Doctors welfare resources: www.anzca.edu.au/resources/doctors-welfare

beyondblue National mental health survey of doctors and medical students: https://www.beyondblue.org.au/about-us/programs/workplace-and-workforce-program/programs-resources-and-tools/about-the-doctors-mental-health-program/doctors-mental-health-program

Australian Doctors in Recovery at International Doctors in AA (IDAA) website: www.idaa.org/sites/adr/

Welfare advocates – should every department have one?

I have just returned from another great combined Communication, Education Management and Welfare Special Interest Group (SIG) meeting, at Peppers in Noosa, Queensland. This year we hosted our first welfare advocate lunch, which coincided with the ratification this year of the Welfare SIG resource document RD26 The Welfare Advocate by the SIG parent bodies, the Australian Society of Anaesthetists, the New Zealand Society of Anaesthetists and ANZCA.

Welfare advocates have been active in some Australian states and non-existent in others and New Zealand. I took up the welfare advocate cause in Queensland and realised there was a need for networking within states, and between states and countries.

The welfare advocate lunch provided an opportunity for welfare advocates and those interested in what we do to chat and raise points for discussion in an informal lunchtime setting. There was an excellent attendance with almost 50 participants. We started by introducing RD26 and what it covers in broad terms; some background, how to appoint a suitable person, the duties of a welfare advocate, aspects of the role of the welfare advocate and resources available. We then took 20 minutes to chat and come up with points for discussion over a rather delicious buffet lunch.

The resulting discussion was fruitful and varied. We were very fortunate to have several experienced Welfare SIG committee members present, which meant authoritative answers were available for most of the questions that arose.

Examples of topics raised included:

- The provision of support to those in private practice, especially those practising alone or in rural practices.
  - It was acknowledged that this is a problem and needs to be addressed, although how is the big question.
- How to make welfare a more mainstream subject in anaesthesia.
  - Ideas included having a welfare topic included in a formal teaching program for registrars. This would enable the teaching of welfare issues as part of final FANZCA exam preparation, while introducing ideas about how to maintain good mental health throughout one's career.
- Training for welfare advocates.

We hope to provide a welfare advocate workshop at a future ANZCA annual scientific meeting or Australian Society of Anaesthetists national scientific congress. This would be tailored for welfare advocates and those interested in welfare in their groups or departments.

- Some fundamentals for any welfare advocate.
  - Only provide support and advice but not treatment.
  - Maintenance of confidentiality and documentation.
- The difference between welfare advocates and mentors.
  - When issues arise, welfare advocate are there to provide support, advice and knowledge of where to get formal help.
  - Mentor/mentee relationships provide longer-term guidance and career support whether or not there are concerns about the mental health or performance of the mentee.
  - In the longer term, a welfare advocate may provide education on welfare issues, but at a departmental rather than an individual level. Mentors may suggest a colleague/trainee talk to the welfare advocate, but equally the welfare advocate may suggest a colleague talks to, or acquires, a mentor.
- How active does a welfare advocate have to be?
  - It was agreed this would depend on the individual. A proactive approach would be good, but only in the form of education and prevention, not in the form of checking that every member of the department is OK all of the time. A reactive approach is probably the main work of the welfare advocate, offering support and guidance when a problem arises.
- Resources and support for welfare advocates.
  - Suzi Nou from Melbourne has set up a Dropbox full of useful resources, which can be accessed by welfare advocates and anyone else who is interested. Request access via the ANZCA website at www.anzca.edu.au/fellows/special-interest-groups/welfare-of-anaesthetists or by emailing events@anzca.edu.au or contact Suzi directly at suzi.nou@nh.org.au
  - Welfare advocates are encouraged to help each other. The benefits of discussion and support for each other cannot be underestimated. We also discussed whether we should list welfare advocates on the ANZCA website. This is available in Queensland on ANZCA Networks, but it takes some effort to find. It was agreed this would be worthwhile pursuing and making more user friendly.
  - The existence of the Australian Doctors in Recovery organisation was highlighted for our information. It is a useful resource and their members are willing to visit any doctor who has been suspended from work due to substance abuse.

So, back to the title question: "Should every department have one?"

When I started my drive to establish a welfare advocate role in every ANZCA-accredited department in Queensland I thought the answer was yes. I now realise that a welfare advocate who is not really interested may be worse than having none at all. It may be that if a problem arises in a department where no one has volunteered to take on the welfare advocate role, then the department director, supervisor of training or any department member could seek advice from a welfare advocate in another department. This would be another benefit of having a list of relevant people on the ANZCA website.

In summary, the inaugural welfare advocate lunch at the combined SIG meeting in Noosa was full of lively and profitable debate and mutual support. I extend many thanks to Di Khursandi, Prani Shrivastava and Suzi Nou for their input. Everyone agreed it was a worthwhile exercise and should be repeated. Hopefully we will make it an annual event at the combined SIG meeting.

If any of you are welfare advocates already, interested in being a welfare advocate in your department/practice or are interested in collegial welfare, please come along next year, October 7-9 at the Novotel, Manly, NSW.

Dr Anna Hallett,
Queensland Welfare Advocate Co-ordinator
anna.hallett@health.qld.gov.au

A compassionate festive season

The festive season is upon us. A time to reflect on what has been, plan for the new year and hopefully a time to spend with family and friends.

There is never a great time to be in hospital, but this time of year can be particularly difficult for our patients. With this in mind, I wonder whether we are providing the best care that is humanly possible? By that, I mean compassionate care, that shows we are human and understand the humanity of our patients. Or are we just too burnt out?

Robin Youngson is an anaesthetist from New Zealand who is behind the movement for human-centred healthcare. For many more resources or even better, to join the movement, please visit his website: http://heartsinhealthcare.com and visit the resources page (http://heartsinhealthcare.com/learn/resources/) to purchase a copy of his book – great for that last minute Christmas present. (We don't receive any commissions!)

If you have any recommendations for future articles of the month, please contact Alexis Marsh (amarsh@anzca.edu.au) or Dr Suzi Nou (Suzi.Nou@nh.org.au)

Peer-review groups add value in the Hunter

In 2013, at the Combined SIG Meeting, psychiatrist Dr Shirley Prager described an approach to continuing professional development now strongly encouraged for psychiatrists in Australia and Ireland.

Peer-review groups are small groups of doctors who meet on a regular basis to discuss cases confidentially, both clinical and non-clinical aspects, and to give and receive open feedback[1]. In both the Australian and Irish colleges of psychiatry, individuals and their groups register with their college, and receive continuing professional development (CPD) points for participation. In the same year, an article was published in the Australian Society of Anaesthetists magazine, proposing peer-review groups as an additional option for CPD in anaesthesia[2].

Following this meeting, the first peer-review groups were established in NSW, based at the Department of Anaesthesia at the John Hunter Hospital in Newcastle. A pilot meeting was held in October 2013 and the first peer-review group met in November 2013. This article describes the supporting framework developed and the ways in which the various groups function.

Our aim was to create an inclusive peer-review group program open to all anaesthetists in the Hunter region, starting with specialists and potentially expanding to include GP anaesthetists. All specialist anaesthetists and provisional Fellows in the Hunter were invited to participate in the program, including those working full-time or part-time in public or private practice and those on extended maternity or sick leave.

To establish a transparent process for creating or joining a group, a peer-review group co-ordinator was identified, whose role is to document membership, to store records of meetings, and to hold lists of anaesthetists seeking to join a group and to link them with groups seeking members. There are currently six active groups with a total of 52 participants representing more than 50 per cent of specialists and provisional Fellows (n=98) in the Hunter. The minimum meeting documentation required is attendance by name, meeting duration and broad topics discussed.

A survey was conducted to inform this paper. Of the people who responded to the survey (n=42), all people who joined a peer-review group remain members. Half of the groups have been functioning for more than 12 months. While they range in membership from six to 12, most meetings are attended by five to eight people and occur anywhere from monthly to quarterly, with some scheduling meetings randomly. The meetings are held in a variety of venues including members' homes and restaurants (private rooms recommended) and work-related spaces.

The perceived benefits were:

- Learning from others.
- CPD points.
- Opportunity for feedback.
- Safe forum for discussion.
- Opportunity to socialise.
- Cross-generational reflections.

The only negative aspects about peer-review groups were:

- Difficulty achieving a quorum.
- Potential breaches of trust.

Suggestions for improvement include flexibility in meeting times. With most peer-review groups meeting in the evenings, those with small children sometimes missed out. While some groups are happy to proceed with a minimum of three or four people, others would like more regular participants.

Some of the solutions to these issues have included:

- Increasing the membership to 12-14 to ensure a regular quorum.
- Rotating the day of the meeting.
- Allowing each member to nominate a date.

Peer-review groups continue to be popular, with more than 30 meetings held over the past 18 months. The Newcastle experience has been universally positive with members finding peer-review groups are not only informative and supportive, but also very enjoyable.

Dr Jennifer Reilly, Dr Tracey Tay, Dr Allysan Armstrong-Brown
John Hunter Hospital, Newcastle

References:

1. Balla M, Knothe B, Lancaster J, Prager S, Beatson J. Group peer review in psychiatry: the relationship to quality improvement and quality care. Aust NZ J Psychiatry 1996; 30 (5) 653-659.
2. Shrivastava P, Tay T. Peer Review Groups in Practice. The Magazine of the ASA 2013; April 28-29.

Anaesthesia on the frontline

Liverpool Hospital anaesthetist Dr Kevin Baker recently returned from Yemen where he was part of a Médecins Sans Frontières team setting up emergency surgical programs in two hospitals not far from the frontline.

Above: Displaced from the heavy fighting in Haradh bordertown and Sa'bah governorate are seen in Al Manjoorah temporary settlement at the outskirts of Beni Hassan, in Hajjah province, northwest of Yemen. Photographer: Narciso Contreras.

Opposite: Dr Kevin Baker in the field.

"Our uniqueness is defined by our determined neutrality, our ability to talk with all parties, and our refusal to be embedded with any military."

From his base in Ibb Governate, Yemen, Dr Kevin Baker writes about his experiences with Médecins Sans Frontières.

In 1997 I moved into humanitarian work and came to work for the medical aid organisation Médecins Sans Frontières. Although I had been aware of the organisation's formation after the Biafran War, I came to it late due to the inevitable responsibilities of life. Médecins Sans Frontières became my *raison d'etre*, providing a rare honour to bear witness and share the suffering of countless humans, the voiceless, the "rejected and acquainted with grief".

I am now beginning my 14th assignment – a return to Yemen. My missions have been predominantly in the Middle East in acute war contexts. I have many roles: establishing the operating theatre and emergency room; training medical staff; performing resuscitation; helping in the out-patient department and – of course – being the anaesthetist.

In addition to the war wounded, there are abrupt caesarean sections and 15 per cent paediatric operating theatre cases.

The positives include sharing unique experiences with diverse, innately good people. It is often punishing work, but there is a strange resolve among this professional group of doctors, nurses and logisticians. Our uniqueness is defined by our determined neutrality, our ability to talk with all parties, and our refusal to be embedded with any military.

What are the qualities required to do this work? 1. To have respect for the human condition. 2. To resist paternalism. 3. To have the ability as a leader to remain calm under duress and, often, chaos. 4. To retain a sense of humour. 5. To persistently teach/train/mentor the team. 6. To maintain awareness of a changing security situation.

There have been countless memorable experiences.

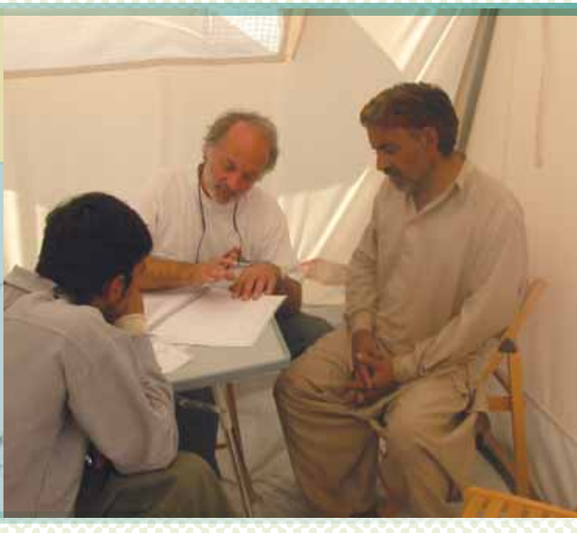
Sri Lanka (1997): Tentatively walking down a dirt road from our safe house at night in Point Pedro, swinging a kerosene lamp hoping to remind the opposing forces to be lenient towards me. Reaching the hospital with its wounded to find two combatants – one Tamil Tiger, the other Sinhalese – both with haemo-pneumothoraces – holding each others' hands as I placed their chest drains.

Libya (2011): The remarkable group of young locals during the ongoing Grad missile attacks in Yafran, who appeared in what was left of the hospital, desperate to help. None was medically trained, but during a lull in the battle I had a five-day window to show them what hypovolaemic shock implied and teach cannulation, IDC insertion and so on. Then, when the fighting inevitably kicked off again three kilometres from where we were, having them by my side as 43 triaged-red hypotensive gun-shot and blast-injury patients came through. We worked together, resuscitating within the chaos, with me cajoling and reassuring their use of basic skills.

Syria (2012-13): The arrival of a teenage girl with bronchorrhoea in respiratory distress, due to an insecticide overdose at the end of a long, difficult day of trauma surgery in a reconstituted former chicken farm. The team had left for the safe house and I said I would remain. I intubated her, gave her multiple doses of Atropine and hand-bagged overnight. We had no Pralidoxime, but I was able to extubate her the next morning.

There are possible negatives to this work. We must accept some risk, despite sophisticated evaluation of changing contexts and on-the-ground intelligence. As individuals, we may sometimes appear almost selfish to our loved ones with our constant departures to the field.

But do we make a difference? Yes, with our very presence. To encourage hope and imagination.



Anaesthesia on the frontline (continued)

On the ground in Yemen

Médecins Sans Frontières (MSF) has 790 staff working in Yemen (726 Yemeni, 64 international), in Aden, Al-Dhale', Taiz, Sa'ada, Amran, Hajjah, Ibb and Sana'a. Activities include general medical consultations, surgical mobile clinics, mental health, water provision and sanitation, and distribution of non-food items and hygiene kits.

Since mid-March, MSF teams have treated 15,587 war wounded and distributed more than 400 tonnes of medical supplies. Over the past few months, the MSF Emergency Surgical Hospital in Aden has received an influx of landmine and unexploded ordinance (UXO) victims, mostly children, and this number increases every day.

A fuel blockade continues to cripple the country, impeding access to medical facilities. Hospitals have inadequate diesel supplies to keep their generators running and the general population can no longer afford transport. People who do not live near health structures have no means of transport to access healthcare. Fighting and airstrikes make it extremely difficult to assess needs and provide assistance.

Large civilian populations remain in towns and villages in Taiz, as well as near the Saudi border in Sa'ada and north Amran governorates. In Taiz, where MSF trucks have been prevented from delivering essential medical supplies (chest tubes, anaesthetic drugs, IV fluid, sutures and antibiotics), 14 of the 20 major medical infrastructures are closed and the remaining hospitals are overloaded; six out of the eight urban women-and-child health centres are closed and another is not running fully because of a lack of fuel. MSF has started a new mother-and-child project in one of the hospitals, and the first patient was seen on November 7. In late October, MSF teams started screening 2269 children for malnutrition in the area. The first round of analysis showed concerning results.

For updated information on Yemen, visit **www.msf.org**.

"We must accept some risk, despite sophisticated evaluation of changing contexts and on-the-ground intelligence."

Above: MSF has been running an Emergency Surgical Hospital in Aden since the beginning of 2015. When the Houthis took control of some neighbourhoods and encircled the city in March, the northern part of the city where the hospital is located stayed under control of the Southern Resistance. Access to health care was extremely difficult because of airstrikes, shellings, road blockages and snipers... MSF started running on April an advanced emergency post in Crater, a neighbourhood in the South of Aden controlled by the Houthis, to stabilize wounded. In May, MSF started outpatient surgical mobile clinics in two other neighbourhoods in the South of Aden.

All photos taken from emergency room in Aden hospital by Guillaume Binet.

Stop before you block

Dr Paul Slocombe is an anaesthetic registrar at Gold Coast Hospital in Queensland where in 2014 a patient was inadvertently given a wrong-sided block prior to shoulder surgery. This critical incident led Dr Slocombe to research and implement, with the support of his supervisor Associate Professor Simon Pattullo, a "stop before you block" campaign at the hospital. This became the subject of a project that won the Trainee Academic Prize at the 2015 ANZCA Annual Scientific Meeting in Adelaide and the Tess Cramond Prize at the 2015 Queensland Registrar's Scientific Meeting.

Last year a critical incident occurred at the Gold Coast Health Service, being a wrong-sided anaesthetic block. It occurred to a 74-year-old lady with a complex medical history listed for an elective total shoulder replacement. Fortunately her operation proceeded uneventfully, but she had difficulties with pain management post-operatively and required a second regional block to be placed on the operative side.

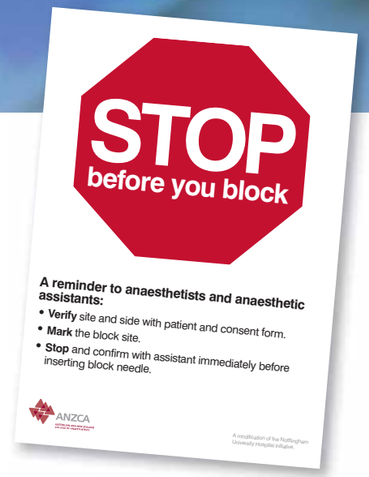
Wrong-sided blocks are a rare but easily prevented complication of regional anaesthesia. The true incidence of wrong-sided blocks is unknown and probably under-reported. The incidence in Australia and New Zealand is estimated at 0.04 per cent based on data from the AURORA database. Wrong-sided blocks have been described in the literature as "never events" because they carry significant risks, such as complications of the unnecessary block, local anaesthetic toxicity and delayed mobility or delayed discharge, along with the potential to proceed to wrong-side surgery. Reviews into wrong-sided blocks find common themes associated with their occurrence including distraction, time pressure, the time delay between WHO sign in and the performance of the block and the lack of a visible surgical mark nearby the block site.

Following a comprehensive review of the incident, our quality and safety team suggested implementing a formal block time-out and associated educational program around this. The most common site check in current practice is the "stop before you block" campaign from Nottingham University Hospital in the UK. This is in use across the UK and endorsed by UK anaesthetic bodies RA-UK and Safe Anaesthesia Liaison Group.

"Stop before you block" is a simple verbal check between the anaesthetist and their assistant immediately prior to inserting the needle to perform the block that involves two steps:

1. Visualising the surgical mark.
2. Confirming the correct side for the procedure via the consent form and asking the patient.

As part of my formal project and with the approval of the authors, I implemented this campaign across my hospital via survey, education program and audit. The survey was of a group of public and private anaesthetists (54) and found that 13 per cent of respondents had performed a wrong-sided block in the past and a further 13 per cent had had a near-miss experience. It also found the respondents would support the change with 98 per cent in favour of a site check prior to regional anaesthesia.



I presented educational talks to the anaesthesia department and to theatre and anaesthesia nurses about the process of "stop before you block". I then promoted the move through posters across the theatre complex and via the hospital newsletter and reminder emails.

After implementing the change, the audit involved reviewing all regional anaesthesia procedures over a three-month period to calculate the percentage of unilateral blocks that had a site check performed and documented. Unfortunately, despite widespread education, our uptake was limited to 57 per cent.

It was noted that blocks done in emergency procedures, outside of the theatre complex and by locum anaesthetists, were less likely to have a site check performed. The only way to truly prevent wrong-sided blocks is to have 100 per cent uptake so all blocks have a site check prior. Our conclusion from this study was that in order for this site check to become common practice it needs to be enforced and subject to ongoing audit.

Recently, regional anaesthesia has become more popular among anaesthetists particularly with the ageing population and the increasing numbers of patients presenting for surgery with multiple comorbidities. Current practice for regional anaesthesia in most health facilities does not include a pre-procedure pause or "time-out" to confirm the side of the procedure.

ANZCA has promoted changes in this area in its most recent revision of ANZCA professional document *PS03 Guidelines for the Management of Major Regional Analgesia* (November 2014). This document recommends all anaesthetists should perform a site check prior to regional anaesthesia and that there should be a block time-out prior to performing a block. It is simply a matter of time before this becomes the recognised standard practice and becomes mandated in all health facilities.

Stop before you block or some form of block time-out has been adopted by individual hospitals in Melbourne, Adelaide, Perth and Gold Coast, but its dissemination is inconsistent and there is no overall consensus or endorsed program. Most hospitals lack any form of block time-out.

In our opinion, to prevent wrong-sided blocks, there needs to be two parallel processes:

1. An educational package to be released to all anaesthetists across ANZCA.
2. A block time-out to be formally implemented as part of the WHO Perioperative Safety Checklist in all centres.

We have created an educational package, which has been designed so that any facility across Australia and New Zealand can download the package and implement this initiative at their hospital through education, advertising and audit. This package can be found at: www.anzca.edu.au/fellows/safety-quality/publications-and-resources.

The next step of this campaign is to incorporate a mandatory "block time-out" prior to regional anaesthesia into the WHO Safe Surgery checklist. We are currently approaching this problem at a state level in Queensland; however this should become uniform across Australia and New Zealand in future.

Dr Paul Slocombe
ANZCA trainee, Gold Coast University Hospital

Stop before you block
The "stop before you block" kit can be found at www.anzca.edu.au/fellows/safety-quality/publications-and-resources.

Medical alert – Central venous access device (CVAD) related air embolus

Last year Incident Information Management System (IIMS) NSW were notified of six patient deaths from central line related air embolus. However, the actual number of deaths is likely to be greater than this due to under reporting resulting from lack of awareness. All cases were avoidable.

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

- Direct communication between the atmosphere and the vasculature.
- A pressure gradient that favours air entry into the vessel, that is, the venous or intrathoracic pressure is lower than atmospheric pressure (this occurs during normal breathing).

The literature suggests air emboli are more likely to occur while the line is in situ and when the line is removed, but may also occur during insertion.

Relatively small volumes of air are sufficient to cause intractable cardiac arrest. These volumes may enter the circulation extremely quickly (over one to two seconds).

It is imperative that attaching any device to a central line (such as a three-way tap) is avoided, as this has the potential for it to be left open to air.

A review of IIMS data identified patients at greater risk of air embolus during CVAD removal, which included:

- Those with respiratory compromise who generated large negative intrathoracic pressures.
- Intravascularly depleted patients who may have negative venous pressures.

If the patient's observations are not within normal limits (sometimes known as the "white zone" on observation charts) the above conditions may be present. In this case, an escalation of procedure needs to take place including:

- Notification and attendance of a senior member of the medical team.
- Considering the benefits of delaying line removal if the patient's status is likely to improve in short term.
- The immediate availability of resuscitation equipment where the CVAD is removed.

It is highly recommended that CVAD be removed only by accredited staff. During CVAD removal particular attention must be placed on:

- The patient being in a slight head down position.
- The patient's observations being within normal limits.
- The patient remaining on a monitored bed (at least with an ECG) for 30 minutes post removal.
- An occlusive dressing being placed over the insertion site until it has healed.

This medical alert is one of several ongoing measures to help prevent CVAD-related air embolus. It is proposed that:

- There will be a centralised accreditation process for those inserting CVAD.
- There will be a centralised accreditation process for those removing CVAD.
- There will be a review and standardisation of all CVADs and CVAD attachments.
- Processes will be implemented to allow improved communication throughout CVAD management.
- There will be a review of the impact of implemented strategies.

Dr Robert Hackett, FANZCA
Royal Prince Alfred Hospital, NSW

For further reading please see:

1. Feil M, Reducing risk of air embolism associated with central venous access devices, Pennsylvania Patient Safety Advisory 2012 Jun;9(2):58-64
2. Clinical Excellence Commission, Clinical Focus Report – CVAD-related air embolus, Haymarket NSW 2015 From www.cec.health.nsw.gov.au/__data/assets/pdf_file/0008/278612/Clinical-Focus-Report-Hospital-Associated-Venous-Thromboembolism.pdf. Accessed November 9, 2015.

Update to user-applied labelling of injectable medicines, fluids and lines

The Australian Commission on Safety and Quality in Health Care has released the National standard for user-applied labelling of injectable medicines, fluids and lines – August 2015 (http://www.safetyandquality.gov.au/wp-content/uploads/2015/09/National-Standard-for-User-Applied-Labelling-August-2015-web-optimised.pdf). This standard replaces the National recommendations for user-applied labelling of injectable medicines, fluids and lines – February 2012.

Replacement of the recommendations with the standard is immediate however health services may transition to implementing the recommendations in due course.

webAIRS news

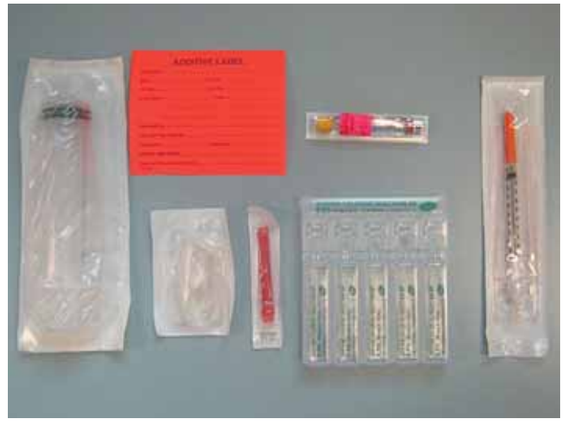
There have been 564 medication incidents reported to webAIRS from October 2009 up to April 2015. One hundred and fifty-one of these incidents involved a wrong drug either given in error or almost given in error. In the literature many of these errors are attributable to slips in attention due to busy or distracted staff[1]. Some, however, are a direct result of the packaging or associated with the use of unfamiliar medications.

webAIRS has analysed the incidents in which insulin was mentioned. Fourteen (14) incidents were directly related to errors or near misses specifically involving insulin. The analysis revealed there is a major problem in the labelling of the insulin ampoule in relation to the way the dose is expressed, compared with other drugs used in anaesthesia.

The ampoule shown in the illustration is the Novo Nordisk brand, but all brands of insulin ampoules sold in Australia or New Zealand use similar wording. The dosage written on the insulin ampoule label has the format 100 IU/ml 10mls whereas most other ampoules used during anaesthesia have the format mg/ml or mcg/ml. For instance, midazolam is labelled as 5mg in 5mls and fentanyl is labelled 100 mcg in 2mls.

Many of the insulin errors that have been reported to webAIRS have resulted from the assumption that there are 100 IU of insulin in 10mls. These errors were also associated with a doctor making up an insulin infusion on their own for the first time. It should be noted that the error might have been avoided if an insulin syringe had been used, as this displays the number of units that have been drawn up. The error also may have been averted if a formal double check of ampoules was always performed.

Fortunately, only one of the cases resulted in hypoglycaemia and this was detected early enough to prevent serious harm. It also should be noted that the Novo Nordisk product insert specifically states that the product is for use with a U100 insulin syringe[2]. It also is unlikely that the formulation or labelling will ever change because of the large user base of diabetics using this concentration and using insulin syringes. In addition to the errors highlighted in this article there are a number of other potential hazards associated with administration of insulin, which are set out in detail on the website for Institute for Safe Medication Practices. The authors recommend readers visit this website for more information relating to the safe administration of insulin[3].



The authors recommend an insulin syringe always be used to draw up insulin whether for subcutaneous injection or for the preparation of intravenous infusions. In addition, it may be worthwhile preparing an insulin kit containing the above items and storing them together in a sealed plastic bag in the medications fridge. As each of the items is in a sterile container it is not necessary to sterilise the outer bag. An article containing the complete set of data and recommendations is in the process of being prepared for submission to *Anaesthesia and Intensive Care*.

(continued next page)

webAIRS news (continued)

There has been a steady increase in reporting since the webAIRS program was released in 2009, including 881 events that have been reported so far this year. An analysis program is being developed for use by the local administrators of each registered site. It has been released in beta test mode and local administrators can request online to be part of the testing phase. Reporting incidents to webAIRS is an important source of information to increase the knowledge learnt from adverse events as well as attracting two continuing professional development credits per hour in the practice evaluation category.

Dr Mir Wais Sekandarzad, FANZCA
Royal Prince Alfred Hospital

Dr Martin Culwick, FANZCA
ANZTADC Medical Director

Dr Genevieve Goulding, FANZCA
Royal Brisbane and Women's Hospital, ANZCA President

References:

1. Pamela Nichols, Tandy-Sue Copeland, Ian A Craib, Paul Hopkins and David G Bruce. Learning from error: identifying contributory causes of medication errors in an Australian hospital. Med J Aust 2008; 188 (5): 276-279.
2. Product information. Human Insulin. Page 8. www.novonordisk.com.au/content/dam/australia/affiliate/www-novonordisk-au/Health%20Care%20Professionals/Documents/Inshpi12a_MarketingVersion.pdf
3. Institute for Safe Medication Practices. A clinical reminder about the safe use of insulin vials. www.ismp.org/newsletters/acutecare/showarticle.aspx?id=42.

For more information contact Dr Martin Culwick or administration support at anztadc@anzca.edu.au.

To register visit www.anztadc.net and click on the registration link at the top right hand side of the page.

To view a demo, visit www.anztadc.net/Demo/IncidentTabbed.aspx.

Safety alerts

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

Recent alerts:

- Central venous access device (CVAD) related air embolus.
- Ampicillin and amoxycillin shortages.
- Draeger anaesthesia machines alert (ECRI alert).
- Becton-Dickinson syringes warning.
- Death of child using Tramadol oral drops.
- Risperidone risks in dementia patients.
- Check "synch" before cardioversion.
- Infections and bronchoscopes (ECRI alert).
- Astra Zeneca Marcain 0.5% Spinal Heavy solution – update October 2015.
- New Zealand – Urgent Medicine Recall from Biomed Ltd.
- Peripherally Inserted Central Catheter (PICC) line fault – might be relevant to anaesthetists.
- Astra Zeneca Marcain 0.5% Spinal Heavy solution – update September 2015.
- Pump modules may stop infusing.
- Problems with Philips-HeartStart XL+ defibrillators/monitors.
- Astra Zeneca Marcain 0.5% Spinal Heavy solution – update August 2015.
- Workstation power supply batteries may fail.
- Patient monitors may lock up.
- Care needed with CareFusion system.
- Infusion pump occlusion alarms cannot detect infiltrations.

Dr Peter Roessler,
Communication and Liaison Portfolio
Safety and Quality Committee

webAIRS
Anaesthetic Incident Reporting System from ANZTADC

Planning helps solo specialists achieve CPD goals

Practitioners are professionals who strive to achieve the best possible outcomes.

This desire is irrespective of the environment in which we work, whether public or private. There are two aspects to this. One is an indication of professionalism in aspiring to achieve peak performance through quality improvement. The other is to meet standards through quality assurance and avoid the consequences of clinical mishaps. In addition to our own expectations, there are the expectations of the community.

The question, of course, is how do we know how well we are performing? To have any meaningful idea of our performance we need to gauge against accepted standards as well as against our own performance over time. Collecting data and information about our practice is essential. The ANZCA Continuing Professional Development (CPD) Program helps us achieve this.

As a solo practitioner working in small private practice facilities, some of which are devoid of anaesthesia departments, my clinical commitment is around 0.5 full-time equivalent (FTE). My commitment to the College as a director of professional affairs is 0.4FTE (contributing to College activities has some CPD benefits in addition to all the other benefits).

Updating knowledge and skills is something we are all effective at doing, and this component of CPD is straightforward, presenting no challenge to achieving the minimum required CPD credits.

It makes sense that we need to remain effective in managing critical events, which occur so rarely there is inadequate clinical exposure to maintain experience. The CPD emergency responses are entirely appropriate and the requirements not too onerous. The necessary activities often can be achieved concurrently at major (and some smaller) conferences, which offer ANZCA-approved workshops or simulations.

While the practice evaluation component of CPD is critical, it may be challenging for those of us in solo private. Meeting audits and multi-source feedback (MSF) requirements depends to some extent on the nature and size of the facility.

The toolkits are useful resources and can assist staff in completing these tasks.

Over many years I have performed personal audits on post-operative nausea and vomiting, fasting, post-operative recovery and post-operative temperature. The samples have required some modification of the "old" data collection, however they have posed no problem and I continue to review performance in these areas, which contributes CPD credits for this section.

The difficulty in my practice is the MSF. Working with a private surgeon and his nursing team in a larger facility limits feedback to one surgeon and one nursing team, all of who will provide an inflated response (hopefully without bribery). The situation is similar in a small private facility. While it may be of limited value in this setting, it is not too difficult to perform.

Finally, patient surveys can be undertaken and, in some of the smaller facilities where there is comprehensive post-operative follow up, this can be readily achieved and most informative.

Getting in early with these activities avoids the need for panic towards the end of the triennium. Identifying relevant activities in the plan at the beginning of the triennium has helped me to focus on starting the process and ensuring its timely completion. This has resulted in a surplus of credits, which sadly cannot be sold!

Dr Peter Roessler
Director of Professional Affairs, Professional Documents

Seeking your feedback about CPD

The ANZCA Continuing Professional Development (CPD) Program was revised 18 months ago to reflect contemporary developments in CPD and a changing regulatory environment, with a dual focus on evaluation of practice and traditional, pure learning activities, and the addition of the new emergency response category.

To help improve the relevance of the CPD program and technology that supports the CPD portfolio, the CPD Committee seeks your feedback on elements of the program you find particularly positive or negative.

Feedback from Fellows and other CPD program participants has led to improvements in the CPD portfolio and the addition of activities and supporting resources.

The committee also seeks volunteers to do a 30-minute telephone interview. If you don't have time to complete the survey but would like to be interviewed, this is possible.

To volunteer and/or complete the survey, please email: cpd@anzca.edu.au

New in the library

New online books

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

Pharmacology for anaesthesia and intensive care / Peck, T E; Hill, S A. -- 4th ed -- Cambridge: Cambridge University Press, 2014.

Leadership in surgery / Kibbe, Melina R [ed]; Chen, Herbert [ed]. -- Cham: Springer, 2015.

A case approach to perioperative drug-drug interactions / Marcucci, Catherine [ed]; Swide, Christopher E [ed]; Seagull, F Jacob [ed]; Kirsch, Jeffrey R [ed]; Sandson, Neil B [ed]; Hutchens, Michael P [ed]. -- New York: Springer, 2015.

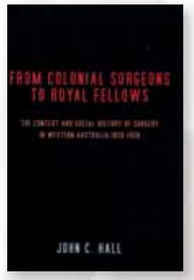
The SAGES / ERAS® Society manual of enhanced recovery programs for gastrointestinal surgery / Feldman, Liane S [ed]; Delaney, Conor P [ed]; Ljungqvist, Olle [ed]; Carli, Francesco [ed]. / Society of American Gastrointestinal Endoscopic Surgeons; ERAS Society. -- Cham: Springer, 2015.

Atlas of implantable therapies for pain management / Deer, Timothy R [ed]; Pope, Jason E [ed]. -- 2nd ed -- New York: Springer, 2016.

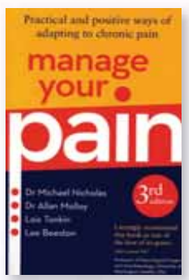
New books for loan

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

Blood, sweat and fears: medical practitioners and medical students of South Australia who served in World War 1 / Verco, Christopher; Summers, Annette; Swain, Anthony; Jelly, Michael. / Army Museum of South Australia; Army Health Services Historical Research Group. -- Keswick, SA: Army Health Services Historical Research Group, Army Museum of South Australia Foundation, 2014.



From colonial surgeons to Royal Fellows: the context and social history of surgery in Western Australia 1829-1958 / Hall, John C. -- Fremantle: Western Australia Vivid Publishing, 2014. Kindly donated by Dr Richard Riley.



Manage your pain: Practical and positive ways of adapting to chronic pain /Nicholas, M; Molloy, A; Tonkin, L; Beeston, L. / Australian Broadcasting Corporation (ABC); Royal North Shore Hospital of Sydney. Pain Management Centre. -- 3rd ed --Sydney, Australia: HarperCollins Publishers, Inc., 2011.

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

OvidToday is now available on Android devices and a new update for iPad version

Many ANZCA and FPM Fellows and trainees are making great use of the Ovid journals app for iPads. OvidToday allows you to access the latest issues of journals such as *Anesthesia & Analgesia*, *Anesthesiology* and *Regional Anesthesia & Pain Medicine*. With the latest version, you can now:

- Access six months worth of rolling content.
- Browse specialty categories and tables of contents.
- Read PDF articles anywhere, at home or work.
- Add articles to a personal reading list.

For more information, including download details, visit the ANZCA Library homepage: www.anzca.edu.au/resources/library/

New open access journal on anaesthesia case reports

JA Clinical Reports is a companion journal to the *Journal of Anesthesia* (JA), the official journal of the Japanese Society of Anesthesiologists (JSA). This journal is an open-access, peer-reviewed, online journal related to clinical anesthesia practices, such as anesthesia management, pain management and intensive care.

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

ECRI health device reviews

Point-of-care ultrasound systems evaluated

ECRI have published ratings and test results for the following models:

- GE Venue 50. Easy to use, and has the performance necessary for most point-of-care applications, the exception being those needing quantitative Doppler modes.
- Terason uSmart 3200T. Suitable for a wide range of point-of-care applications. Offers good ease of use and performance and has all modes of operation needed for point-of-care scanning.

Contact the library to obtain any ECRI publications: library@anzca.edu.au

Articles on obesity

Ortiz VE, Kwo J. Obesity: physiologic changes and implications for preoperative management. BMC Anesthesiol. 2015;15:97.

Fernandez-Bustamante A, Hashimoto S, Serpa Neto A, Moine P, Vidal Melo MF, Repine JE. Perioperative lung protective ventilation in obese patients. BMC Anesthesiol. 2015;15:56.

Tjeertes EE, Hoeks SS, Beks SS, Valentijn TT, Hoofwijk AA, Stolker RJ. Obesity - a risk factor for postoperative complications in general surgery? BMC Anesthesiol. 2015;15:112.

Articles on guideline updates

The European Resuscitation Council Guidelines for Resuscitation 2015 provide specific instructions for how resuscitation should be practiced and takes into account ease of teaching and learning, as well as the science. They were developed by Europeans and have been specifically written with European practice in mind.

European Resuscitation Council Guidelines: www.cprguidelines.eu/

Neal JM, Barrington MJ, Brull R, Hadzic A, Hebl JR, Horlocker TT, et al. The second ASRA practice advisory on neurologic complications associated with regional anesthesia and pain medicine: Executive summary 2015. Reg Anesth Pain Med. 2015;40(5):401-430.

Skubas NJ, Shernan SK, Bollen B. An overview of the American College of Cardiology/American Heart Association 2014 valve heart disease practice guidelines: What is its relevance for the anesthesiologist and perioperative medicine physician? Anesth Analg. 2015;121(5):1132-1138.

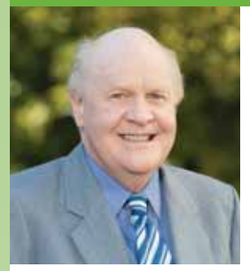
Articles on research in anaesthesia

Gibbs NM, Gibbs SV. Misuse of 'trend' to describe 'almost significant' differences in anaesthesia research. Br J Anaesth. 2015;115(3):337-339.

Kehlet H, Joshi GP. Systematic reviews and meta-analyses of randomized controlled trials on perioperative outcomes: An urgent need for critical reappraisal. Anesth Analg. 2015;121(4):1104-1107.

Faculty of Pain Medicine

Dean's message



Rescheduling of codeine in Australia

An interim proposal to delete the schedule 3 (pharmacy only) entry for codeine, and reschedule all current schedule 3 codeine to schedule 4 (prescription only), due to issues including morbidity, toxicity and dependence, was issued by Australia's Therapeutic Goods Administration (TGA) on October 1[1].

There was a brief opportunity until mid-October for further comment to the Advisory Committee on Medicines Scheduling. The proposed implementation date is June 1, 2016. This date should allow time to educate consumers, pharmacists and medical practitioners about pain management and alternative analgesia options available. It should have implications later on for New Zealand as well.

Codeine is the most commonly used opioid analgesic globally. Severe harms have been described with codeine use, especially from the consumption of high doses of combination products[2].

Over-the-counter use was intended for management of acute self-limiting pain, and is inappropriate for use in chronic pain.

Although codeine can be considered a relatively weak opioid analgesic, it is nevertheless addictive. The number of patients with codeine dependence seen in general practice, hospital and specialist drug treatment services is mounting[2].

In overdose, codeine produces respiratory depression and a reduced level of consciousness. The increasing codeine-related mortality being reported in many countries underlines the urgent need for effective codeine dependence treatment[2]. Caution in its access is needed when the rate of opioid dependency is rising in Australia. In Australia, between 1992 and 2007, there was a 300 per cent increase in the number of opioid prescriptions dispensed in the community[3].

Codeine is a weak opioid. In acute pain, even at a dose of 60mg, codeine has a number needed to treat (NNT) to achieve one patient obtaining a 50 per cent pain relief response over four to six hours of 12 (8.4 to 18)[4]. It is even less potent at smaller doses.

Compound analgesics containing codeine plus paracetamol or codeine plus ibuprofen have lower NNTs, such as 6.9 (4.8 to 12) for 300mg paracetamol plus 30mg codeine[5], or an NNT of 2.2 (95 per cent confidence interval 1.8 to 2.6) for ibuprofen 400mg plus codeine 25.6mg to 60mg[6]. However, combination preparations in overdose expose consumers to liver toxicity (with paracetamol)[7] and to gut ulceration and liver failure (with ibuprofen)[8,9].

Codeine should not be used in children under the age of 12 years even as an antitussive medication[10]. This follows the US Food and Drug Administration Black Box warning in 2013 after respiratory arrest in children after tonsillectomy or adenoidectomy for sleep apnoea[10].

Codeine should not be used by mothers who are breastfeeding, because it can pass to the baby through breast milk and create the danger of codeine toxicity in neonates and infants[10].

Codeine is metabolised by the enzyme cytochrome p450 2D6 (CYP2D6) to morphine, that has a 200 times higher affinity to the mu-opioid receptor than codeine[10]. Poor metabolisers have reduced metabolite formation and minimal pain reduction[11]. However, ultra-rapid metabolisers have an increased risk of toxicity[11].

In May 2015 the Faculty made a submission to the Therapeutic Goods Administration (TGA), arguing that the widespread availability of codeine in pharmacies was a serious public health concern with increasing numbers of people misusing the medication[12].

The Poppy Research Program in Australia will use national dispensing data to estimate opioid use and costs, including problematic or extramedical use in the Australian population. In time it should demonstrate whether the TGA decision is validated or not[13].

To conclude, many of you have contributed to our Faculty's success this year. This year marked the launch of our redesigned curriculum, the culmination of months of work by the authoring groups and the Curriculum Redesign Steering Group. Our Fellows have worked hard on our committees (in professional development and scientific meeting oversight, learning and development, education, examination, hospital accreditation, research) and on our sub-committees. My sincere thanks go to my fellow board members, the chairs of our portfolio committees, regional committees, and the NZ National Committee of FPM for their faithful service to the Faculty.

My gratitude extends to Milton Cohen, our director of professional affairs, and our general manager, Helen Morris, and her committed staff, our ANZCA President Genevieve Goulding, the ANZCA CEO John Ilott and his staff.

I wish all our Faculty Fellows and trainees a well-deserved rest, good health and safety over the holiday period.

Professor Ted Shipton
Dean, Faculty of Pain Medicine

References:

1. Codeine. Scheduling proposals referred to the August 2015 meeting of the Advisory Committee on Medicines Scheduling, Therapeutic Goods Administration (https://www.tga.gov.au/interim-decisions-matters-referred-expert-advisory-committee-11#codei), October 1, 2015.
2. Nielsen S, Bruno R, Murnion B, Dunlop A, et al. Treating codeine dependence with buprenorphine: Dose requirements and induction outcomes from a retrospective case series in New South Wales, Australia. Drug Alcohol Rev 2015: in press.
3. Leong M, Murnion B, Haber P. Examination of opioid prescribing in Australia from 1992 to 2007. Intern Med J 2009;39:676–81.
4. Derry S, Moore RA, McQuay HJ. Single dose oral codeine, as a single agent, for acute postoperative pain in adults. Cochrane Database Syst Rev 2010;(4):CD008099.
5. Toms L, Derry S, Moore RA, McQuay HJ. Single dose oral paracetamol (acetaminophen) with codeine for postoperative pain in adults. Cochrane Database Syst Rev 2009;(1):CD001547.
6. Derry S, Karlin SM, Moore RA. Single dose oral ibuprofen plus codeine for acute postoperative pain in adults. Cochrane Database Syst Rev 2015;2:CD010107.
7. Serper M, Wolf MS, Parikh NA, Tillman H, et al. Risk Factors, Clinical presentation, and outcomes in overdose with acetaminophen alone or with combination products: Results from the acute liver failure study group. J Clin Gastroenterol 2015: (in press).
8. Pilgrim JL, Dobbin M, Drummer OH. Fatal misuse of codeine-ibuprofen analgesics in Victoria, Australia. Med J Aust 2013;199(5):329-31.
9. Frei MY, Nielsen S, Dobbin MD, Tobin CL. Serious morbidity associated with misuse of over-the-counter codeine-ibuprofen analgesics: a series of 27 cases. Med J Aust 2010;193(5):294-6.
10. Lazaryan M, Shasha-Zigelman C, Dagan Z, Berkovitch M. Codeine should not be prescribed for breastfeeding mothers or children under the age of 12. Acta Paediatr 2015; 104(6):550-6.
11. Somogyi AA, Coller JK, Barratt DT. Pharmacogenetics of opioid response. Clin Pharmacol Ther 2015;97(2):125-7.
12. Pain specialists call for codeine ban. Media release, Faculty of Pain Medicine (www.anzca.edu.au/communications/Media/releases/pdfs/FPM-Codeine-2015.pdf), May 1, 2015.
13. Degenhardt L, Blanch B, Gisev N, Larance B, Pearson S. The POPPY Research Programme protocol: investigating opioid utilisation, costs and patterns of extramedical use in Australia. BMJ Open 2015;5:1e007030.

News

Admission to fellowship of the Faculty of Pain Medicine

By examination:

Dr Wais Sekandarzad, FANZCA, Qld.
Dr Scott Smith, FANZCA, Qld.
Dr Jeffrey Mott, FANZCA, Qld.
Dr James Olson, FRCA, FANZCA, NZ.
Dr Moira Rush, FANZCA, Vic.

This takes the total number of Fellows admitted to 416.

Training unit accreditation

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

Royal Melbourne Hospital, Vic.
Royal Hobart Hospital, Tas.
Royal Perth Hospital, WA.
Princess Alexandra Hospital, Qld.
Nepean Hospital, NSW.
Hunter Pain Clinic, NSW.
Singapore General Hospital, Singapore.

The number of accredited pain units now stands at 34.

Acute pain book available online in December

The fourth edition of *Acute Pain Management: Scientific Evidence* will be available online this month at www.anzca.edu.au/resources/college-publications, following public consultation in November.

Published every five years, *Acute Pain Management: Scientific Evidence* aims to combine the best available evidence for acute pain management with current clinical and expert practice, and to summarise this evidence in a concise and easily readable form for practising clinicians. The fourth edition incorporates evidence that has become available for many aspects of acute pain management between August 2009 and August 2014.

ANZCA and FPM Fellows and trainees can download the edition in "flipbook" format onto all devices from the ANZCA website. The format includes navigation and search functions to help you find topics of interest faster, and includes zoom and full-screen modes for ease of reading. Hard copies will be available to those who register their interest by emailing APMSE4@anzca.edu.au.

Producing a highly regarded publication such as *Acute Pain Management: Scientific Evidence* takes considerable time and effort and we are indebted to those involved for their generous contributions.

ANZCA and FPM would particularly like to acknowledge working group chair, Professor Stephan Schug, and the members of the editorial sub-group, Associate Professor Greta Palmer, Associate Professor David A Scott, Dr Richard Halliwell and Dr Jane Trinca. The contributions of editorial advisory group members Dr Mark Rockett and Professor Karen Grimmer, the members of the multidisciplinary consultative committee, and the large panel of contributors are also acknowledged.

Faculty celebrates curriculum success

This transition year from the old to the 2015 Faculty of Pain Medicine curriculum and training program is drawing to a close. Twenty-five trainees are undertaking the core training stage of the revised program, with the intention of progressing to the practice development stage in 2016 or 2017.

Overall, the roll-out has been successful, with considerable positive feedback obtained throughout the year.

Trainees and supervisors of training appear to have adapted well to the sociopsychobiomedical philosophy underpinning the revised curriculum, and we anticipate it will gradually become established within the training units and broader fellowship. This philosophy will continue to permeate the essential topic area e-Learning resources, clinical skills courses, and the formative and summative assessments of the training program.

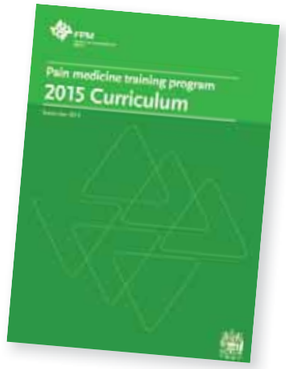
A particularly well-received component of the program is the pair of face-to-face clinical skills courses, one conducted in Melbourne and one in Sydney. All attendees indicated they would recommend the courses to fellow trainees. Valuable suggestions for improvement will contribute to further development of the courses for 2016.

Feedback is being collated on the essential topic area e-Learning resources, and enhancements will be implemented next year. We aim to promote further trainee engagement with these resources and associated discussion forums in 2016. End-of-year surveys have recently been circulated to supervisors of training and heads of department seeking their reflections at the end of this transition year, and suggestions for improvement.

The more staggered summative assessment of the 2015 training program has presented challenges for the Examination Committee, however they have taken the opportunity to update relevant processes and documentation. Both trainees and supervisors of training recognise the value of the new formative workplace-based assessments. Their ongoing integration into everyday practice is evolving, as everyone becomes familiar with the processes and requirements.

The 2015 curriculum and training program not only have been well received by trainees and the fellowship, but also have gained international recognition. On review of pain medicine curricula across the globe, the European Federation of IASP Chapters recently requested permission to use the Faculty's curriculum as a basis for developing its own program. The board was delighted to approve the request, which is testament to the hard work, dedication and expertise of all those involved in its development.

The Faculty has a very optimistic outlook on future training in pain medicine. There are now 28 applicants sitting the foundations of pain medicine examination over the November to January period. The implementation



of the practice development stage will present its own challenges. A number of regions are exploring training pathways for the practice development stage within smaller units and private clinics. We are confident the opportunity to explore a more individualised program in the practice development stage will promote more confident, well-rounded trainees and we look forward to seeing how this stage of training evolves.

The 2015-17 FPM curriculum evaluation strategy will continue to present opportunities for trainees, supervisors and Fellows to provide feedback and suggestions. Your feedback will ensure the program is refined and enhanced to best meet your needs, and ultimately deliver the best outcomes for our patients.

Dr Meredith Craigie
Chair, Learning and Development Committee

"Medicinal cannabis" recommendations ignore expert advice

A proposed Victorian scheme could place specialist pain medicine physicians in an untenable ethical situation.

In the June edition of the *ANZCA Bulletin*, the Faculty of Pain Medicine presented its stance on the issue of the role of cannabinoids in the management of patients with chronic non-cancer pain.

Essentially the view is non-endorsement until a clear therapeutic role for cannabinoids is identified in the clinical scientific literature. This is argued in detail in FPM's statement on "medicinal cannabis" (professional document PM 10 – see www.fpm.anzca.edu.au/resources/professional-documents).

Since then, the Victorian Law Reform Commission (VLRC) "has identified a set of conditions and symptoms as the basis for initially making medicinal cannabis available", including "severe chronic pain where, in the view of two specialist medical practitioners, *medicinal cannabis may in all the circumstances provide superior pain management by contrast with other options*" (emphasis added)[1].

How that last decision would be determined clinically was not addressed. This has been promulgated in the face of the expert advice sought by the commission and given by two Faculty Fellows. That advice, supported by the International Association for the Study of Pain (IASP) after 20 years of research, was that the current evidence does not support the efficacy of cannabinoid products for chronic non-cancer pain and that, given the major challenge of performing trials in this area, the argument for promoting them is weak.

Although perhaps not surprising, it should be a major source of concern to Fellows that measured expert opinion could be ignored in such a matter. The VLRC itself has recognised this, stating "international experience has shown that, without the support of a significant percentage of medical practitioners, any medicinal cannabis scheme will face significant hurdles as a public health measure"[2].

Accordingly, the Faculty has written to the Victorian health minister indicating the proposed "medicinal cannabis" scheme for chronic pain is not only misconceived from the scientific, clinical and public health points of view, but also that, by creating a community expectation, it would place specialist pain medicine physicians in an untenable ethical situation.

There is a parallel clinical and public health situation from which lessons could not only be learned, but implemented. Despite the best intentions of all concerned, the long-term use of opioids for chronic non-cancer pain has turned out to be ineffective often and harmful frequently.

Those problems, with highly controlled S8 drugs the pharmacology and clinical pharmacology of which have been well described, came about because of poor understanding of chronic pain (inappropriate prescribing) on the one hand and leakage of prescription opioids into the non-clinical community (unsanctioned use) on the other.

There is a high risk of the unsanctioned use of cannabinoids should they become available on prescription and we expect there will be a reluctance among informed clinicians to prescribe them without clearer evidence of efficacy and safety. In this light the intentions of governments are likely to be quite counter-productive.


FPM
PM10
2015
Faculty of Pain Medicine
Australian and New Zealand College of Anaesthetists
Statement on "Medicinal Cannabis" with particular reference to its use in the management of patients with chronic non-cancer pain

The Faculty has urged the Victorian Minister for Health, Jill Hennessy, and the Federal Minister for Health, Sussan Ley, to reconsider its promotion of the role of cannabinoids in this area. The Faculty has also offered to meet with these ministers in order to discuss alternative approaches that would better meet the needs of Victorians and other Australians (and indirectly New Zealanders as well) suffering from chronic non-cancer pain.

Professor Milton Cohen,
FPM Director of Professional Affairs

References:

1. Victorian Law Reform Commission. Medicinal Cannabis. Victoria. Victorian Law Reform Commission, 2015; pp. xxi. http://lawreform.vic.gov.au/all-projects/medicinal-cannabis. Accessed November 4, 2015.
2. Victorian Law Reform Commission. Medicinal Cannabis. Victoria. Victorian Law Reform Commission, 2015; pp. 209. http://lawreform.vic.gov.au/all-projects/medicinal-cannabis. Accessed November 4, 2015.

"It should be a major source of concern to Fellows that measured expert opinion could be ignored in such a matter."

FPM 2015 Spring Meeting

Above clockwise from top left: Delegates at the Spring Meeting; Enjoying the view from the conference dinner venue, Skyline Queenstown; Dean, Professor Ted Shipton with keynote international speaker Dr Beth Winkelstein; Professor Shipton with meeting convenor, Dr Duncan Wood; The Kapa Haka Group performing.

The FPM 2015 Spring Meeting "Adventures in pain" was held in Queenstown, New Zealand, on October 2-4.The 99 delegates were treated to spectacular views from the conference room at the Heritage Queenstown, while enjoying a varied scientific program.

The meeting's theme, "adventures in pain", encompassed acute and chronic pain management in trauma, sports and remote settings. The meeting featured international speaker Professor Beth Winkelstein, who gave informative presentations on the biomechanics of whiplash injury and the mechanisms of persistent neck pain. These talks were complemented by cutting-edge research presented by scientists from a range of disciplines, and speakers with personal experience of working in extreme environments or managing elite athletes. The meeting closed with an inspiring session by Dr Tony Fernando on compassion in medical practice.

The meeting coincided with Australia's Therapeutic Goods Administration announcing its decision to make codeine a prescription-only medicine and a media release was issued with FPM Dean Professor Ted Shipton welcoming this as being in line with FPM policy. His comments were reported in the *Adelaide Advertiser* and Professor Shipton was interviewed on New Zealand's National Radio.

Three other media releases were issued based on presentations to the meeting. One, to New Zealand media only, was about New Zealand's Accident Compensation Corporation looking at the overall, and not just direct, costs of injury and ongoing pain. The other two were about the need for pain medicine specialists to manage of often-unrealistic expectations of their patients (Dr Diarmuid McCoy) and the dangers of using anti-inflammatory medication before exercise (Dr Hamish Osborne). This was reported in the *Dominion Post* in Wellington, the *Press* in Christchurch and the *Medical Observer* in Australia. The releases also were published on several websites including those of *Pharmacy Today*, *NZ Doctor* and the NZ Pain Society.

FPM Opioid calculator smartphone app

The Faculty of Pain Medicine has developed a free application for Apple iPhone, iPads and smartphone devices, which calculates dose equivalence of opioid analgesic medications. The FPM Opioid Calculator is a functional adaptation of the Opioid Dose Equivalence table researched, developed and endorsed by the Faculty's Education Committee to provide consistency in converting combinations of opioids.

The app calculates total oral morphine equivalent daily dose for combinations of opioids. The calculations are based on the standard used by the Faculty of Pain Medicine in professional document PM01 (Appendix 2) *Opioid Dose Equivalence – Calculation of Oral Morphine Equivalent Daily Dose (oMEDD)*.

The app was developed to fill a void in this important aspect of medical research, education and clinical practice where consistency and accuracy is essential.

oMEDD calculation is complicated by the lack of a single, accepted table of analgesic equivalence. Often clinicians are required to use multiple references, usually produced in the most accessible form by pharmaceutical companies and focusing on information related to their own product.

The application of opioid equianalgesic ratios in research, education and clinical practice can therefore be difficult and susceptible to miscalculations, misinterpretation and compounding inaccuracies.

The consequences of inaccurate equianalgesic calculations include inaccurate trial data collection, misleading scientific assumptions, inconsistent educational messages and, in clinical practice, increased dose-related complications.

The process of calculating a single opioid equianalgesic dose for an individual on multiple medications is complex. The requirement to calculate oMEDD for each opioid medication a patient is consuming, and the addition of the value of each, is a source of potential error.

A calculation of opioid equianalgesic value needs to be made for each opioid active medication. The sum of the individually calculated oMEDD values for the patient's combined medications must then be determined, resulting in a single value oMEDD for each patient, which can be used as a guiding quantitative value of opioid consumption. This single patient value can be used to compare that patient's pain requirements at different times or for use in trials to compare to different patients or in pooled data comparisons for groups of patients.

Clinically, this oMEDD figure can be used to guide decisions regarding the patient's total ongoing opioid use even in the context of multiple and changing medication regimes.

The oMEDD also can help informed decisions of dosing when changing from one opioid to another. Many factors require consideration in this event and the clinical consequences of miscalculation of equianalgesic opioid dose may be very serious or fatal.

The app has features to promote good clinical practice including clear, frequent reminders about factors that need to be considered when prescribing opioids. It includes recommendations and clinical warnings, such as adopting an evidenced-based "traffic light" warning system for escalating opioid doses.

"Traffic light" opioid dose warning system

The Faculty of Pain Medicine has adopted a "traffic light" warning system to warn against the potential harm of escalation of opioid doses and provide a new level of clinical caution.

GREEN: Low risk of dose-related harm if used in accordance with clinical guidelines.

AMBER: CAUTION – Increased risk of dose-related harm.

RED: ALERT – High risk of harm due to predictable adverse effects, dependence or inadvertent overdose.

The app has a user-friendly format and contains links to information and educational material about the safe prescribing and use of opioids. It is based on scientific evidence and provides convenient smartphone access.

The app will be a valuable tool for all involved in the management of patients on opioids.

How do I get access to the app?

Download the app by connecting with the iTunes store and searching for Opioid Calculator.

An Android version of the FPM Opioid Calculator app is in production and will soon be available for download.

For more information or if you have difficulty downloading the app, please contact us at opioidcalculator.fpm@anzca.edu.au.

Associate Professor Brendan Moore,
Immediate past Dean

Faculty of Pain Medicine (continued)

2015 FPM examinations

The written section of the fellowship examination was held on November 13 with the clinical section held on November 28. For the first time the clinical section was held outside a pain medicine unit at the Pullman Hotel in Melbourne. Twenty-one of the 28 candidates were successful.

Barbara Walker Prize

The Barbara Walker Prize for Excellence in the Pain Medicine Examination was awarded to Dr Charlotte Hill.

Dr Charlotte Hill studied medicine and neurosciences at the University of Otago, Dunedin. She completed her anaesthetic training at Wellington and Hutt hospitals. She trained in pain medicine at the Wellington Regional Pain Management Service and in Sydney at the Royal Prince Alfred Hospital and Concord Repatriation General Hospital acute and chronic pain services. She has professional interests in persistent pelvic pain, persistent post-operative pain and obstetric anaesthesia. She plans to return to her position as a specialist anaesthetist and pain medicine trainee in Dunedin and is an honorary clinical senior lecturer at the University of Otago. Dr Hill is thankful to her colleagues and family for much kind encouragement and support.

A merit award went to Dr Jacquelyn Nash (Geelong, Vic).

Clockwise from top left: Dr Charlotte Hill with Chair of the FPM Examination Committee Dr Newman Harris; the successful candidates; the Court of Examiners; Dr Jacquelyn Nash and Dr Harris.

Successful candidates

Twenty-one candidates successfully completed the FPM final examination and are listed below:

Hong Kong
Fiona Tsui

New South Wales
John Prickett
Anand Ramachandran

New Zealand
Leinani Aiono-Le-Tagaloa
Charlotte Hill
(studied in NSW)
Christopher Rumball
Rachel Sara
Maartje Tulp

Queensland
Catherine Abi-Fares
Khaldoon Alsaee
Raveendran Harish
Matthew Keys

South Australia
Michelle Harris
Tuan Vo

Tasmania
Nina Loughman

Victoria
Michael Bassett
Jacquelyn Nash
Stiofan O'Conghaile
Noam Winter
Bethany White

Western Australia
Rajiv Menon

Foundations of pain medicine examination

On November 13, 26 candidates sat the foundations of pain medicine examination. Twenty candidates were successful.

CTN news

ANZCA CLINICAL TRIALS NETWORK

American Society of Anesthesiologists Annual Meeting 2015

Members of the ANZCA Clinical Trials Network featured heavily in the "Late-breaking clinical trials" session at the American Society of Anesthesiologists annual meeting in San Diego, US.

The session was co-chaired by Dr Daniel Sessler and Professor Paul Myles. In the session, Dr Alparslan Turan (Outcomes Research) presented the results of a sub-analysis of the SIRS study looking at the effect of high-dose steroids on the development of chronic pain.

Professor Kate Leslie presented the results of the ENIGMA-II one-year follow-up study. Professor Andrew Davidson made the first presentation of the GAS study results.

Finally Professor Myles gave an update about anaesthesia and perioperative medicine trials in progress, including the ATACAS, RELIEF, Balanced and PADDI studies. Researchers from our region were acknowledged as world leaders in large perioperative clinical trials.

National Health and Medical Research Council awards

Professor Paul Myles has been awarded $A2.3 million project grant from the National Health and Medical Research Council (NHMRC) in the 2015 grant round for IV iron for Treatment of Anaemia before Cardiac Surgery (ITACS). This five-year study will be co-ordinated at The Alfred, Melbourne. This large grant builds on the success of the PADDI, RELIEF and Balanced Anaesthesia trials in securing multi-million dollars grants since 2012.

Associate Professor Lisbeth Evered was awarded a special joint NHRMC Australian Research Council Dementia Research Development Fellowship, 2016 – 2019, for Predicting perioperative cognitive disorders in the elderly based on cardiovascular risk, Alzheimer's disease risk and new biomarkers.

Congratulations to both for their scientific excellence in achieving these competitive research awards.

For a full report on the NHMRC 2015 grant round, please see page 70.

ITACS

Study design: This randomised double-blind, controlled phase IV trial will compare the efficacy, safety and cost-effectiveness of preoperative IV iron with placebo in patients with anaemia before elective cardiac surgery.

Study size: 1000 patients.

Primary outcome: Days alive and out of hospital from surgery to 30 days following operation.

Secondary outcome: Includes blood transfusions, perioperative complications, hospital stay, mortality, quality of life and disability-free survival.

Study duration: Five years.

For more information and to register your interest, email Sophie Wallace at **s.wallace@alfred.org.au**.

Mentoring policy

The CTN Executive has developed a mentoring policy for ANZCA or FPM Fellows and trainees who are undertaking, or wishing to undertake, research in anaesthesia, perioperative medicine, pain medicine or related disciplines. The mentoring policy outlines eligibility and the mentoring process, which is arranged by the CTN Executive. To obtain a copy of the policy, visit www.anzca.edu.au/ctn.

Save the date – Strategic Research Workshop 2016

The 8th annual strategic research will be held in Coogee Bay, NSW on August 12-14, 2016. Registrations and abstract submissions will open in early 2016.
For up-to-date information, please visit www.anzca.edu.au/ctn.

2015 endorsed studies

The CTN Executive congratulates the following investigators on their endorsed trials:

- CELSUS Study (Professor Paul Myles).
- C-CaFe: Colorectal cancer, anaemia and iron management: a large, multicentre, stepped wedge, cluster randomised, controlled trial (Professor David Story).
- EPICS-Australasia: Epidemiology of Critical care provision after Surgery (Professor Paul Myles).

Current and upcoming trials

RELIEF: Restrictive versus LibEral Fluid therapy in major abdominal surgery

Recruitment 1959/2800. Recruitment target is expected around mid 2016 and new sites are welcome. For further information and to register your interest please go to www.relief.org.au.

Per patient payment for your department: $A700.

Balanced Anaesthesia Study

Recruitment 3200/6500. New sites are welcome. For further information and to register your interest please go to balancedstudy.org.nz. Per patient payment for your department: $A600/$NZ500.

PADDI: Perioperative ADministration of Dexamethasone and Infection

Recruitment target 8800. The PADDI trial is about to get underway. Fellows are able to register their interest in participating in the PADDI trial by contacting Jaspreet Sidhu +61 3 9903 0809. For further information, visit www.paddi.org.au.

Per patient payment for your department: $A400.

ITACS: IV iron for Treatment of Anaemia before Cardiac Surgery

Recruitment target 1000. This trial is expected to get underway in early 2016. Fellows are able to register their interest in participating in the ITACS trial by contacting Sophie Wallace at s.wallace@alfred.org.au. Per patient payment for your department: estimate $A1000.

CTN business case

For further information about these trials or to request a copy of the business case to help justify the employment of a research co-ordinator for your department, please contact Karen Goulding, CTN Clinical Trials Network Manager, on +61 9 9903 0942 or at ctn@anzca.edu.au.

Thank you to all the hard working people across our sites, nationally and internationally, who contribute to the success of our multicentre research.

ANZCA researchers lead grant success

ANZCA and Faculty of Pain Medicine research leaders have received more than $A12 million in the latest National Health and Medical Research Council (NHMRC) funding round.

Associate Professor Alicia Dennis, from the Royal Women's Hospital, was awarded an early career fellowship of $A187,322 to study "Myocardial structure and function in preeclampsia using cardiac magnetic resonance and echocardiography" through the University of Melbourne. This continues her work, which attracted a $A59,245 ANZCA Anaesthesia and Pain Medicine Foundation grant in 2014 for "Haemodynamics and myocardial tissue characteristics in women with preeclampsia".

Professor Paul Myles from Monash University is the lead investigator for "IV iron for Treatment of Anaemia before Cardiac Surgery (ITACS Trial)", which was awarded $A2,285,290.

Professor David Hillman is part of a University of Western Australia study "Predicting Obstructive Sleep Apnoea using 3D Craniofacial Photography", which received $A424,715. In 2011, Professor Hillman was awarded a $A60,000 ANZCA foundation grant for "Airway collapsibility during sedation and anaesthesia in patients with and without obstructive sleep apnoea".

Professor John Myburgh is part of a team that secured $A5,984,819 awarded to the University of Sydney for the Plasma-Lyte 148® versus Saline (PLUS) Trial.

Three specialist pain medicine physicians also received funding.

Professor Maree Smith is leading a $A796,950 University of Queensland study titled "Novel prolonged-release polymeric microparticles for relief of intractable cancer-related pain", while Professor Andrew Somogyi is part of the "Ketamine therapy among patients with treatment-resistant depression: a randomised, double-blind, placebo-controlled trial" at the University of New South Wales, which received $A2,069,382.

FPM Director of Professional Affairs Professor Milton Cohen is part of a University of New South Wales team, which received $A775,922 for "Pharmaceutical opioids for chronic non-cancer pain: Evaluating health outcomes and economic impact over five years".

These latest anaesthesia and pain medicine research grants add to the list of ANZCA's foundation-funded projects that have helped facilitate further NHMRC funding for major studies. They demonstrate the importance of ANZCA and foundation seed-funding support for the career development of anaesthesia and pain medicine researchers.

In addition to the 2015 grants, Associate Professor Ian Seppelt received the NHMRC Research Excellence Award for the top-ranked project grant for 2014, presented by the minister of health in Canberra in September, for "A cluster randomised controlled trial of selective decontamination of the digestive tract in critically ill patients", which received $A3,958,206. In 2012, Associate Professor Seppelt was awarded a $A42,000 foundation grant for "An exploratory study of perceived risks, benefits and barriers to the use of Selective Decontamination of the Digestive tract in Australasian ICUs (SuDDICU)".

Two ANZCA Fellows from the Peter MacCallum Cancer Centre in Melbourne, Dr Jonathan Hiller and Associate Professor Bernhard Riedel, recently received news of success with a US grant through the National Cancer Institute of the National Institutes of Health. The study they are involved with is "A Phase II randomised study of perioperative beta-blocker versus placebo on gene expression in newly diagnosed breast cancer".

From 2007 to 2015, ANZCA foundation research grants have totalled $A7,946,946 with the NHMRC contributing $A9,205,005 towards studies directly linked to foundation projects. Other NHMRC grants involving prior foundation grant recipients totalled over $A25 million. Of the total contributed by the NHMRC, more than $A23 million has been directed to ANZCA Clinical Trials Network studies.

New Zealand Health Research Council (NZHRC) has contributed $A1.2 million for ANZCA Clinical Trials Network (CTN) studies following a foundation pilot grant of $A5000.

Rob Packer
General Manager, Anaesthesia and Pain Medicine Foundation
ANZCA

Foundation news

New partnership with Perpetual

The Anaesthesia and Pain Medicine Foundation is very pleased to announce a new partnership between ANZCA, the foundation and Perpetual, one of Australia's most experienced wealth managers.

The partnership involves Perpetual continuing its sponsorship of ANZCA events and its presence in ANZCA publications, and providing financial support for research through the foundation as a major sponsor. The foundation greatly appreciates Perpetual's partnership commitment, which runs over three years and is subject to annual review.

For more than 128 years, Perpetual has been working with successful individuals and their families.

Perpetual Partnership Executive Michelle Gianferrari said: "With no ties to any major banks or life insurance company, our medical professional specialist advisers can provide trusted advice to help anaesthetists and pain medicine specialists invest, manage and protect their wealth, ensuring they achieve their financial objectives and lifestyle goals.

"Perpetual has been committed to the medical industry since 1987 and specifically our relationship with ANCZA commenced in 2013. We are delighted to be given the opportunity to partner with ANCZA, enabling us to extend our support to the ongoing education and professional development for anaesthetists and pain medicine specialists."

New Pfizer major sponsorship

The foundation is delighted to announce that Pfizer again will be a major sponsor in 2015-16, including continued support for the long-standing Pfizer ANZCA Research Award for pain medicine research.

In 2016, the award will go to Professor Stephan Schug, director of pain medicine at Royal Perth Hospital, and his team, for the project "Obesity and chronic pain management: Piloting a new model of care". A more detailed project overview appears on page 19.

Pfizer is a founding sponsor and has been a major sponsor of the foundation since 2007. The foundation greatly values the support.

Western Australia lunch

The foundation thanks Dr Brien Hennessy, the head of the Department of Anaesthesia at Perth's Sir Charles Gairdner Hospital, and foundation chair Dr Lindy Roberts, for conducting a tour of the anaesthesia and pain management departments at Sir Charles Gairdner Hospital for guests of a lunch hosted by Board of Governors member Mr Warrick Hazeldine in September.

Guests, representing philanthropic and business interests in WA, expressed interest in maintaining contact with the foundation and have since received updates on foundation-supported projects for 2016.

Board of Governors lunch in Melbourne

The Board of Governors held a promotional lunch in Melbourne on September 28. The foundation thanks deputy chair Mr Rob Bazzani and KPMG for hosting the function, board members including the chair, Ms Kate Spargo, for inviting guests, and keynote speaker ANZCA Clinical Trials Network (CTN) Chair Professor Kate Leslie.

Professor Leslie outlined ANZCA Fellow investigators' recent research successes and publications, from small foundation-funded seed studies to translational research and large clinical trials funded by the National Health and Medical Research Council. She highlighted increasing international recognition of the CTN as a world leader in anaesthesia and pain medicine clinical trials research. Sixteen guests attended, representing significant Melbourne philanthropic and business organisations.

Research grants for 2016

On August 28, the ANZCA Research Committee met to allocate research funding grants through the foundation for 2016 (see page 16).

All grant applicants have been individually informed of the outcomes. The foundation and the ANZCA Research Committee congratulate the successful applicants and thank all grant applicants for the considerable time and effort made for each submission. While the process is necessarily demanding and competitive, 23 of 46 applicants received full or partial funding, a strong success rate.

A total of $A1,445,821 has been allocated across all grant categories including existing multi-year commitments. The foundation thanks the Fellows, donors and sponsors who have generously given to the annual grant program supporting research and continuous improvement in science, practice and patient outcomes.

Rob Packer,
General Manager, Anaesthesia and Pain Medicine Foundation

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

Helping the trainee in difficulty

Trainees face many challenges during their training, which can have a significant impact on training. These may be related to learning about anaesthesia and perioperative medicine, or life events such as moving to a new place, having children or assisting sick family members.

Why do we have the TDP?

The College has developed the "trainee experiencing difficulty process" (TDP) to guide trainees and their supervisors in how we can best help deal with such challenges. Outlined in the *Handbook for Training and Accreditation*, the TDP provides trainees and their supervisors with a format, checklist and list of potential resources to guide remediation of an issue. It aims to enable a trainee to progress and complete their training.

Getting support sooner rather than later

There can be barriers to undertaking such processes, as it can feel uncomfortable to address difficult issues; often it's easier to reassure ourselves, falsely, that all is well. However, avoiding an issue can compound the difficulties with the trainee failing to progress, potentially necessitating a trainee performance review process (TPR), or running out of training time and being removed from training.

For most trainees it is advisable to start early with assistance, so we can help trainees learn how to deal successfully with challenges and quickly get back on track. It's really the working out of the expression "a stitch in time saves nine".

Doing away with TDP stigma

Some trainees have said undergoing a TDP can feel like failure and they are concerned it will impact adversely on their careers. The College would like to emphasise that the reason the TDP is used is to try to avoid any trainee struggling on without support, and circumstances deteriorating. It's about ensuring the trainee gets the help they need to successfully complete their training.

The remediation interview is one specific type of TDP, and is designed for use with trainees who have had multiple attempts at ANZCA examinations. It includes feedback from a current examiner on the trainee's examination performance, and input from a supervisor. This aims to help the trainee to better understand how the examiners assessed their performance and how to focus their preparation on issues that will improve their performance to the greatest extent.

New resources coming soon

The College recently concluded a project looking at early indicators of a trainee in difficulty with the aim of supporting trainees to successful remediation of challenges.

The project identified five early indicators of a trainee in difficulty: exam failure or failure to present for an exam, performance, professionalism and insight deficiencies, illness and global concern.

For each early indicator, a checklist has been developed to guide supervisors in how to approach an issue with a trainee. The checklists help to develop a plan of action appropriate to the trainee's needs. They also provide links to a wealth of College resources, tailored to the area of need, in order to support both the trainee and their supervisor as they work through remediation.

These checklists will be available in Networks, in the "Supervisor orientation and support" network from early 2016.

Dr Sarah Nicolson, Chair, TDP Early Indicators Working Group

Dr Leona Wilson, Executive Director of Professional Affairs

Successful candidates

Primary fellowship examination August/September 2015

One hundred and twelve candidates successfully completed the Primary fellowship examination at this presentation and are listed below:

AUSTRALIA

Australian Capital Territory
Pallavi Kumar
Victor Kang-Lung Loa

New South Wales
Gareth Owain Andrews
Vanessa Ellen Bodel
Francene Christie Woodsell Bond-Rhodes
Andrew Bower
Murray Peter Campbell
Oliver Frederick Clifford
Thomas Conallin
Andrew Emanuel
Martin Facini
Sameer Garg
Daniel David Gorman
Darcy Thomas Buchanan Hamilton
Lyvia Chwee Ling Khong
Gila Lepar
Mateusz Lisik
Leela Manik
Ciaran McNamara
Jessica Nghiem
Charles Besnard Richards
Dana Michael Perrignon Roth
Aylin Seven
Louise Marie Sweet
Tony Vuong
Sarah Jane Wong
David Benjamin Yong
George Zhong

Northern Territory
Justin Shih Sunn Ti

Queensland
Sonia Arwadi
Anita Sonia Farmer
Danielle Ashleigh Volling-Geoghegan
Rachel Erin Graham
David Te-Wei Hung
Alistar Todd Hustig
Yena Hwang
Graham J Langerak
Peter Malcomson
Laura Fay McDermott
Christine Marie Pirrone
Kate Elizabeth Sewell
Thomas J Shepherd
Christopher Slattery
Tiffany Shiu Hin Tam
Michael Howard Toon

South Australia
Tristan Roy Adams
Alexandra Barratt
Julia Jane Cox
U-Jun Koh
Ravindran Samuel Nathan
Louis Thomas Papilion
Haran Somehsa
Marthinus Vermeulen
Samuel Jeremy Whitehouse

Tasmania
Nickolas Hai Ngoc Ha
Nathaniel Guy Jackson
Harry Arthur Laughlin
Kristie Jade Whyte

Victoria
Waltraud Maria Almhofer
Jonathan Li Wern Au
Lucy Hanna Barnett
Jeremy David Broad
Nicholas John Cameron
Grant Ralston Crawford
Jane Jing Dang
Henry James Davidson
Kathryn Anne Donaghy
Jina Hanna
Jackson Thomas Hawkes-Sutton
Zacchary James Ivey
Matthew Wayne Jenke
Yasmin Safia Lennie
Nirnitha Manivasagan
Alexander John McCann
Therese Rose Nigro
Phuong Anh Phuc Pham
Georgia Catherine Preece
Ramanan Rajendram
Dashiell Reed
Yuet Ching Sing
Harridharshan Janahan Sivakumar
Liam George Twycross
Peter Daniel Williams
Elliot Wilson

Western Australia
Lisa Mariana Parisouk Alarcon
Vincent Anderson
Shruti Chitnis
Lucy Ann Dempster
Laura Jane Margaret Hamilton
Jeremy Hickey
Christopher Kennedy
Yelena Gwendolyn Raser
Kahina Wotton-Hamrioui

NEW ZEALAND
Christopher Dean Badenhorst
Alexandra Claire Cardinal
Jane Christy Carter
Tze Ying Chan
Simon James Davis
Daniel Reto Frei
Nicholas Stephen Harrison
Arezoo Kahokehr
Bo-Ying Paula Lam
Brian Sun Lee
Aaron James Macdonald
Fynn Maguire
Ravi Natvar Mistry
Kathryn Helen Percival
Matthew Byron Rowe
Tsan Yue Siu
Mark William Welch
Maya Williams

MALAYSIA
Seleen Cheah

Renton Prize

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

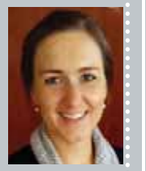
Daniel Reto Frei, New Zealand

Dr Daniel Frei from Palmerston North Hospital in New Zealand, gained his BSc and MBChB from the University of Otago and is a dual anaesthetic and intensive care medicine trainee. He also has worked at Hawkes Bay and Wellington hospitals. He is interested in medical ultrasound, regional anaesthesia and clinical research. Dr Frei plans to pursue a career in anaesthesia and intensive care medicine. He would like to acknowledge his late mother, a lover of education and learning, who passed away unexpectedly in April.

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

Frank Benjamin Marroquin-Harris, NSW

Dr Mincho (Frank) Marroquin-Harris is undertaking his anaesthesia training at Royal North Shore Hospital, Sydney. He studied at the University of Newcastle (University Medallist 2010) and completed a master of medicine in clinical epidemiology in 2013. He is keen to divide his time pursuing both clinical anaesthesia and research. His other interests include music, travel and film.



Kaylee Anne Jordan, Tasmania

Dr Kaylee Jordan studied at the University of Tasmania and has so far spent her anaesthesia training in Tasmania at the North West Regional Hospital in Burnie and Royal Hobart Hospital, Hobart. She has enjoyed all the specialties she has been exposed to and plans to pursue a generalist career in Tasmania.

Merit certificates

Merit certificates were awarded to:

Harry Arthur Laughlin, Tasmania
Shruti Chitnis, Western Australia

Final fellowship examination August/October 2015

One hundred and fourteen candidates successfully completed the Final fellowship examination at this presentation and are listed below:

AUSTRALIA

Australian Capital Territory
David Burns
Anthony Robert Gray
Jennifer Margaret Howie
Ben Wilson

New South Wales
Jason Charles Bendall
Jovan Brdaroski
Steven Raymond Bruce
Marc James Capon
Jasveen Kaur Chadha
Mazyar Danesh Firooz Abadi
Lisa Marie Doyle
Sean Robert Duncan
Michael Julian Hicks
Anna Hickson
Christina Anne Jenkins
Amit Kapoor
Richard Alan Lam
Kar Man Lee
Nathan William McCubbery
Monique Genevieve McLeod
Hoi Yee Clara Mok
Nicola Alexandra Moore
Michael Galvin Mould
Christopher James Mumme
Leonid Pinski
Katelyn Priester
Rebecca Jacklyn Scott
Clare Margaret Shiner
Kieran Paul Somerville
Penelope Gaye Taylor
Sobana Thillainathan
Sheung Hei Anthony Wan
Alice May Whyte
Chaminda Wijeratne
Ling-Chu Yap
Yee Ching Yeow
David Jack Zalcberg

Queensland
Deanna Ba Pe
Sandra Ivannia Concha Blamey
Gerard Michael Eames
Jennifer Johanna Gaffney
Christopher John Gorton
Kristin Ann Hielscher
Riaz David Hooshmand
Sim Wei How
Alexander Norman Kippin
Alan Lim
Annette Carin Lye
Jodie McCoy
Elizabeth Joanne McLellan
Edward James Pilling Hannah
Victoria Reynolds Leanne Kerry Ryan
Lily Samedani
Claire-Mary Jeanette Thomsett
Thomas Michael Walsh
Lisa Erin Webb
Nicole Rebecca Whitlock David
Edwin Young

South Australia
Brigid Jane Sturgeon Brown
Torin Clack
Chelsea Anne Hicks
Robyn Ruth Wangui Maina
Ravinder Neil Singh Sandhu Lee
Edward Tayler

(continued next page)

Successful candidates (continued)

Victoria
Daniel Banyasz
Matthew Luke Durie
Douglas Francis Hacking
Sarah Louise Madden
Ilonka Meyer
Gloria Jieyu Seah
Kelly Maree Tarrant
Carolyn Varney
James Ming Zeng

Western Australia
Kevin Wai Kee Chan
Trevelyan Thomas Edwards
Zaki Abdul Aziz Ibrahim
Ottilia Ananda Anna Elvira Magnusson
Wayne Reynolds
Sonya Ting

NEW ZEALAND
Robert James Barr
Michael David Booth
Duncan John Macgregor Brown
Jesse Jordan Chisholm
Carolyn Xiaoxia Deng
Joachim Dieterle
Morgan Cavalle Edwards
Mark William Fisher
Setareh Ghahreman
Kathryn Margaret Goldstone
Chen Gong
Michael Frederick Hamilton
Nicholas Patrick Hingley
Zhao Kun Koo
Jane Jie Li
Brendan Paul Little
Sallie Elizabeth Malpas
Caroline Mary Mann
Fergal Patrick McDonagh
Elizabeth Mary Page
Kate Alexandra Elizabeth Romeril
Ann-Marie Stevenson
Julie Ann Thompson
Gayatri Vanugopal

HONG KONG
Ka Kit Chan
Karen Sze-Wai Lee
Sen Yin Stevienne Tam
Yip Yu Yeung

MALAYSIA
Tjung Wai Wong

SINGAPORE
Ju In Jason Chan
Margareth Kwok H M Kurniawan
Chiong Ling Yvonne Wong
Yeo Soo Hoon Lynn

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

AUSTRALIA
New South Wales
Sally Ibraheem Abdulhameed Alani

Queensland
Maria La Macchia
Thumme Hewage Janaka Vijith Kaushalya Fernando

NEW ZEALAND
Heike Hundemer
Raviraj Raveendran

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

Jennifer Margaret Howie, ACT

Dr Jen Howie studied medical biology and medicine at the University of Edinburgh, UK, and after two years in the National Health Service moved to Perth, Western Australia, to pursue a career in critical care medicine. Her anaesthetic training has been divided between WA and Canberra, where she hopes to develop her skills as a generalist with professional interests in perioperative medicine and crisis management. She is grateful for the support of colleagues, friends and family throughout her training.

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

Bronwyn Claire Scarr, Victoria

Dr Bronwyn Scarr studied medicine at the University of Melbourne, Victoria, and trained at The Alfred in the Eastern Training Scheme. She is interested in developing and maintaining comprehensive skills to enable her to care for any patient, and plans to undertake fellowships in paediatric and cardiac anaesthesia.

Merit certificates
Merit certificates were awarded to:

Christopher James Mumme, ACT
Jennifer Johanna Gaffney, Qld
Nicole Rebecca Whitlock, Qld
Matthew Durie, NZ

Examining the examiners

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

More than 150 Fellows make up ANZCA's panels of examiners for the primary and final exams. A subset of these panels forms the court of examiners for each exam.

These examiners come from diverse backgrounds, including tertiary-level teaching hospitals (public and private), regional centres, rural and remote practices with representation from states, territories and provinces across Australia and New Zealand.

Each panel is overseen by sub-committees – the Primary Examination Sub-Committee (PESC) and the Final Examination Sub-Committee (FESC) – which in turn report to the Educational and Training Management Committee (ETMC).

The examiners are actively involved with contemporary and busy clinical practice to ensure that examination material is relevant and clinically important.

The FANZCA exams are core business for ANZCA and the role of chair of examinations is held by a member of ANZCA Council. In addition, the president and vice-president retain a very keen interest in all matters pertaining to exams and make attending the vivas and presentation of successful candidates a key priority.

Becoming an examiner is a professionally rewarding and important way in which Fellows can become involved with their College. The ANZCA website has information that outlines the pathway for Fellows to become examiners.

To be considered for appointment as an examiner, a specialist has to be at least three years post-fellowship for the primary exam panel and five years post-fellowship for the final exam panel. A formal application needs to be submitted with three references, one of which needs to be from a current or former examiner.

Any Fellow with the prerequisite experience can apply, although the relevant sub-committee will consider past/contemporary contributions to ANZCA, sub-specialist expertise and the current needs of each panel. A key skill is the ability to work collaboratively with the wider court for each exam.

All deliberations, discussions and communications within the court remain strictly confidential.

Fellows who work closely with trainees, such as supervisors of training, are particularly encouraged to apply. Finally, the examination sub-committees welcome applications from any Fellow to attend the vivas as an observer.

All successful applicants undertake a weekend training workshop and need to attend at least one exam each year.

Examiners are subject to reappointment every three years, a process involving assessment of their contribution and performance as determined by examiner assessors, who provide feedback relating to individual examiners and the examination process, and the relevant exam sub-committee. The maximum period an examiner can serve is 12 years.

Examiners are an exceptionally hard-working group, committed to ensuring trainees have the best possible opportunity to prove they have met the required standard across a range of exam platforms, including multiple-choice questions, short-answer questions and medical and anaesthetic vivas.

Having been an examiner for 12 years and an examiner assessor for four years I am immensely proud of the rigorous assessment our candidates are subjected to, and the rigour with which the courts constantly review the way in which this assessment occurs. The quality assurance is extraordinary.

We also are fortunate to have fantastic administrative support from the examinations team from ANZCA's Training Assessment unit.

Once each exam is over there is then a serious commitment to R&R! The primary exam group has a tradition at their dinner of new examiners speaking about their passions and hobbies (aid trips, wine, sport, singing, collecting bus tickets…).

The final exam group has developed an indulgence for themed parties, resulting in some outstanding costumes, including a Michael Jackson clone, flight attendants from Easy Airways and our very own netball side.

On behalf of the ANZCA Council I thank the examiners for the time and effort they provide ensuring our training program keeps producing anaesthetists who are the envy of the world.

Dr Michael Jones, FANZCA
Chair of Examinations

More information about being an examiner can be found:

ANZCA website: www.anzca.edu.au/fellows/benefits-of-fellowship/contributing-to-your-college.html
(under primary and final examiner).

ANZCA website: www.anzca.edu.au/fellows/benefits-of-fellowship/duties-of-a-primary-examiner.html.

ANZCA training program handbook (page 187) – www.anzca.edu.au/training/2013-training-program/pdfs/training-accreditation-handbook#page=188

Vanuatu: Friendly in the face of adversity

Clockwise from left: Dr Andrew Liley teaching Alani about caudals. A British medical student on elective provides airway support; Paediatric anaesthetist Dr Andrew Liley with anaesthetic officer Jocelyn; Carrying out the WHO Surgical Safety Checklist; The French and English influence is evident in local signage. The writing in the middle is Bislama, the lingua franca.

An Overseas Aid Trainee scholarship offers a valuable insight into providing anaesthesia when resources are scarce.

The Pacific Islands Program (PIP) celebrated its 20th birthday in 2015. I joined a PIP paediatric surgical team on a one-week visit to Vanuatu in June, with funding provided by the ANZCA Overseas Aid Trainee scholarship. Paediatric anaesthetist Dr Andrew Liley was my supervisor.

Vanuatu is a geographically isolated Y-shaped archipelago of 83 islands scattered over 1300 kilometres in the South Pacific ocean. Known as the New Hebrides before it won independence in 1980, it was jointly administered by France and the UK and the Franco-British influence remains evident.

Our flight to Vila had a large contingent of Ni-Vanuatu people returning home after working in New Zealand as part of the Recognised Seasonal Employer scheme, which facilitates Pacific Islanders gaining employment in horticultural industries in New Zealand. In Vila, a friendly local guide took us to our basic but comfortable accommodation conveniently close to the hospital.

Being a Sunday, the town was deserted. There was still evidence of the extensive damage caused by Tropical Cyclone Pam, a meteorological monster with winds gusting over 300 kilometres an hour. Pam ravaged the central and southern islands of Vanuatu in March 2015. Most locals live in what are essentially shantytowns, and rely on what their gardens produce for food, so food supplies were significantly jeopardised by Pam.

Our first task was arranging operating lists for the week. Dr Basil Leodoro, a Ni-Vanuatu surgeon with an interest in paediatric surgery, had arranged a triage clinic. Some patients had come from the outer islands, such as Santo and Tanna. We all crammed into a small, hot room in the outpatients department. There was a range of pathology from hernias and hypospadias, to neck lumps and bumps. Neurosurgical and orthopaedic pathology was left to future visiting specialist teams. Clinical decision-making under these conditions is heavily reliant on history and examination. Monday afternoon was spent in the new operating theatre, paid for with assistance from the Japanese Government.

On Tuesday, the team met for breakfast at 7.30am. I had a poor night's sleep – this was to be a feature of my stay. A veritable cacophony of barking dogs, fighting cats, crowing roosters and the dawn chorus meant I seemed to intermittently doze off. We did a ward round at 8am then went to theatre.

We encouraged local adoption of the WHO Surgical Safety Checklist. Frequently patients arrived from the ward with no identification. Typically we performed a gas induction with Halothane before inserting an IV cannula. The people are generally much thinner than New Zealanders and I found my rule of thumb for paediatric weight (age x3) +seven to be an overestimate.

A comment on the anaesthesia services in Vanuatu: doctors undergo postgraduate training in Fiji, initially completing a one-year diploma then a three-year masters in anaesthesia. Anaesthetic officers complete a one-year diploma, but are not medically trained.

Thursday was grand round day. I delivered a talk on the Surgical Safety Checklist. My aim was to keep things simple. I spoke about why it was important, with an emphasis on the local environment, such as asking "is the surgical equipment sterile?" and "are antibiotics needed?"

There was only one patient on the list on Friday because patients who were meant to come from the southern volcanic island of Tanna did not show up. This illustrated the erratic nature of presentations. Often patients will stay for longer than is medically necessary in hospital or go to stay with relatives in Vila for months until they can afford the return fare to their island.

The trip provided a useful perspective on providing anaesthesia in a resource-poor environment. The hospital staff and locals are always friendly and the PIP team provided a week of great company.

Dr Joseph Mckerras,
2015 ANZCA Overseas Aid Scholar
Wellington, New Zealand

Special Interest Group events

Leadership and Management SIG leads the way to a successful meeting

What happens when you combine those with an interest in communication, education, management and welfare and put them together in small discussion groups? An interesting meeting, which takes an in-depth look at a variety of issues, promotes discussion and fosters new ideas.

In September, four special interest groups (SIGs) combined and more than 145 people participated in the 12th Annual Combined Communication, Education, Management and Welfare SIG Meeting. This year the Leadership and Management SIG (formerly known as Anaesthetists in Management SIG) convened the meeting.

Held in Noosa from September 25-27, the meeting offered workshops on mentoring and innovation in high-value healthcare, lectures on advanced-care planning and engaging consumers in the innovation process, as well as an inspiring and informative plenary session on "Leadership under fire – leading in a hostile environment" by Commodore Martin Brooker. A highlight for many was the "Reports, complaints and the doctor" session with the medical director of the Victorian Doctors Health Program, Dr Kym Jenkins, who was an informative and engaging speaker.

The international keynote speaker was the recently appointed chief financial officer for Kings Hospital NHS Trust in the UK, Mr Alan Goldsman, who provided attendees with great insight into challenges in the National Health Service and end-of-life planning.

During down-time, attendees and their families took advantage of the beautiful setting to participate in morning meditation sessions by enjoying a stunning sunset cruise down Noosa River, while others basked in the sun on Noosa beach.

The success of meetings relies on the generous support of many groups and individuals. The 2015 meeting was kindly sponsored by AbbVie and Avant, and we are most appreciative of the ongoing support of the healthcare industry. The chairs of each SIG spent many hours preparing the program, and received great support from the College secretariat led by Alexis Marsh. We thank them for their tireless efforts.

In 2016 the meeting will be held at the Novotel Sydney Manly Pacific, NSW, from October 7-9. The theme is "Building resilience – reflections, culture and changing minds". These are topics of importance in an increasingly challenging environment. The format of small-group discussions and interactive sessions will be retained, providing a relaxed opportunity to share thoughts and knowledge with colleagues. If you have any ideas for great speakers or sessions for this theme please contact events@anzca.edu.au.

Professor Guy Ludbrook
Convenor and Chair, Leadership and Management SIG

Clockwise from top left: Lagoon located near the conference facilities at Peppers Noosa Resort and Villas; Professor Alan Merry, delegates and their families enjoy a stunning cruise up Noosa River; winners of the conference dinner quiz proudly hold up their prizes; Convenor Professor Guy Ludbrook with international keynote speaker Mr Alan Goldsman.

Special Interest Group events (continued)

Sold out meeting proves Perioperative is the new black



More than 250 anaesthetists, trainees, allied health representatives, business leaders and nurses attended the 4th Annual Australasian Symposium of Perioperative Medicine titled "The post-operative period: From recovery into the unknown", in Noosa from October 15-17.

With specialists presenting from disciplines including general medicine, intensive care, cardiology, geriatrics, orthopaedic surgery and, of course, anaesthesia, the meeting promoted collaboration and highlighted a desire to formulate a multidisciplinary strategy to enhance perioperative medicine into the future.

International speaker Dr Kevin Froehlich from Vancouver General Hospital in Canada was outstanding and kept delegates engaged during his sessions on complex patients presenting for surgery and their experience developing the "intensive PACU" (post-anaesthesia care unit). Dr Max Majedi meshed his love of *Star Wars* into an entertaining and informative presentation on "Pain wars: The pre-emptive strike against latrogenecis associated with pain management", and geriatrician Dr Ming Loh provided an excellent presentation on the challenges in perioperative care of the elderly patient. Problem-based learning discussions were fully subscribed and great feedback was received for the discussions. Among others, Dr Nicola Broadbent received rave reviews for her problem-based learning discussion on "Moving past 30-day mortality: What happens to the high-risk patient who doesn't die?".

Interestingly, a new app was trialled for this meeting, which allowed delegates to ask questions throughout the sessions, rate the speakers, network with other attendees and participate in live polls. The effect of this innovation was captivating. When a group is asked to raise their hand in a choice of one action or another, the data can be skewed by a combination of trepidation and peer pressure. The data is far more accurate when users can give their response through an anonymous live-polling app. The results highlighted the reality of many ambiguous situations people face daily.

There were several other additions to the meeting this year, including a trainee breakfast. All trainees attending the SIG meeting were invited to come to breakfast and share their thoughts and experiences regarding the teaching of perioperative medicine at hospital, departmental and College level. This generated invaluable discussion, which has been summarised and fed back to the College. It will be a continuing feature of the meeting program.

Delegates also were able to choose from social activities including morning yoga, paddle boarding, wine and cheese tasting and a glorious sunset river cruise en route to the conference dinner, which was held on a floating restaurant down Noosa River. Organisers decided not to seek industry sponsorship for this (and next year's) meeting to facilitate networking between participants, and in recognition that limited industry support should focus on other meetings.

Overall the meeting was a huge success and the feedback was overwhelmingly positive with many planning to return next year. In 2016 the meeting theme will be based around surgery and the elderly. It is hoped to broaden the attendance to include strong participation by other specialty groups, including geriatricians, physicians and surgeons. There is a competition running and anyone with an idea for the title is asked to please email events@anzca.edu.au. If your title is used for the 2016 meeting you will receive free registration to the conference! The 2016 meeting will again be held at Peppers Noosa Resort and Villas from October 20-22.

Convenors Dr Jeremy Fernando and Associate Professor Ross Kerridge, along with Perioperative SIG Chair, Dr Dick Ongley, thank all the speakers and delegates who attended and contributed to such a successful meeting.

Above from left: Dr Dick Ongley, Chair of the Perioperative SIG (middle) with his wife, delegates and presenters, Dr Ming Loh (left) and Dr Kevin Froehlich (right) on the sunset river cruise (photo courtesy of Dr Max Majedi of Sir Charles Gairdner Hospital, WA); International speaker Dr Kevin Froehlich's plenary session; Delegates showing off their stand up paddling skills in Noosa River.

Iconic Arts Centre Melbourne hosts the Joint Airway Management and Obstetric Anaesthesia SIG meeting





With more than 240 delegates and 15 exhibitors attending the Joint Airway Management and Obstetric Anaesthesia Special Interest Group meeting on Saturday October 24, the Arts Centre Melbourne was buzzing with talk of difficult obstetric airways, including presentations such as "obstetrics and bariatrics – a growing problem" and "optimising blocks – how to get more for less".

In a dynamic collaboration, international speaker Dr Mark Stacey, a consultant obstetric anaesthetist and associate dean from Cardiff, Wales, and Dr Geoff Healy from Royal North Shore Hospital, NSW blew attendees away with an outstanding presentation on "The ultimate delivery – what can sport teach medicine?". Dr Healy and Dr Stacey met each other for the first time face-to-face on the morning of the presentation and had been collaborating via Skype in the lead up to the event. With the bar set spectacularly high, the day continued to inform, impress and educate with interesting lectures from national and international specialists.

It was obvious that the union of these two special interest groups worked extremely well. In a post-conference poll, 16 per cent of attendees said they were primarily interested in airway, 20 per cent in obstetrics and 64 per cent said they were interested in both, thus proving this important cross over between the groups.

The meeting ended with a cocktail reception, where attendees spilled out onto the balcony to soak up the remaining rays of sunshine while being entertained by a talented trio who played instruments including the saxophone, flute, bongos and DJ decks.

Congratulations to Dr Bernard Kwan, from ACT, and Dr Peter Reid, from Qld, for winning a $500 Apple voucher each in the exhibitor passport competition!

This meeting was supported by AbbVie, Ambu, bioCSL, Cook Medical, Covidien, Ferring Pharmaceuticals, Karl Storz, Link Healthcare, MSD, Perpetual, Priority Life, RAPP, Shire, Teleflex and Verathon. Convenors Dr Tish Stefanutto and Dr Jane Brown would like to thank the speakers, exhibitors and all those who attended and helped to make the day a fantastic success.

Clockwise from top left: Meeting convenors, presenters and executives enjoying a pre-conference dinner at Eureka 89 (photo courtesy of Dr Richard Semenov); The gorgeous Pavilion conference room at Arts Centre Melbourne; One of the winners of the Exhibitor Passport Competition, Dr Bernard Kwan; Delegates relaxing at the cocktail reception; Keynote Professor Michael Paech, convenors Dr Jane Brown and Dr Tish Stefanutto and International Keynote Dr Mark Stacey.

New Zealand news









Fireworks fitting finale for successful trauma ASM

With registrations continuing to come in even as the ANZCA NZ Annual Scientific Meeting got under way, there was plenty of interest in this NZ National Committee-hosted event, which featured aspects of trauma as its theme. There were 209 paid registrations, but with staff, speakers and others, total attendance was around 250. There also were staff for 22 booths at the healthcare industry exhibition.

The ASM was held at the national museum, Te Papa, in Wellington, from November 5-7, and organised by a Wellington Hospital-based committee. Its convenor, Dr Graham Sharpe, who is also a reservist senior anaesthetist with the NZ Army where he holds the rank of major, drew on his experience in the military and civilian fields when arranging the keynote speakers. All three came from the UK and covered various facets of the trauma theme.

Welsh anaesthetist Dr Rhys Thomas, a former lieutenant colonel with the British Forces, opened the business sessions with a presentation on how new ways of handling trauma to greatly reduce casualties in Afghanistan are being used in Wales' new Emergency Medical Retrieval and Transfer Service. UK haematologist Professor Beverley Hunt led sessions dealing with bleeding and coagulopathy, while the trauma that anaesthetists and trainees can experience through their work, and what can be done about it, was explored in sessions by UK mentoring expert Dr Nancy Redfern.

A Maori mihimihi welcomed delegates, organisers and keynote speakers with the Associate Minister of Health, Peter Dunne, formally opening the meeting. He took the opportunity to thank Faculty of Pain Medicine Dean Professor Ted Shipton and convenor Dr Graham Sharpe for their recent support over the medicinal cannabis debate.

A Wellington harbour fireworks display proved an overwhelming winner during the concluding gala dinner on the Saturday night. Events manager Fran Lalor from ANZCA's head office won high praise from Dr Sharpe – a veteran conference organiser – who said she was the best professional conference organiser he had worked with.

See www.anzca.org.nz for links to information about the sessions and to some of the presentations.

Busy day and night for NZNC in November

A full agenda kept the ANZCA NZ National Committee (NZNC) busy on November 4 (the eve of its annual scientific meeting).

Major points of discussion at the meeting focused on conscious sedation provided by non-anaesthetists, the respective roles of ANZCA NZ and the NZ Society of Anaesthetists (NZSA), the value of Protected Quality Assurance Activity (PQAA) protection for the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) and ANZCA Continuing Professional Development programs, the handling, storage and accessibility of propofol in hospitals, cultural competence, health equity and Maori engagement, along with a host of updates on continuing issues.

ANZCA's new chief executive officer, John Ilott, attended and spoke about ANZCA's business plan for 2016, the place New Zealand has within the College and initiatives the College is progressing. Also attending from head office were the general managers of Policy, Jonathan Kruger, Fellowship Affairs, Jan Sharrock, and Communications, Clea Hincks, who each spoke about their portfolios. ANZCA Vice-President David Scott updated the committee on the issues of workforce, bullying, curriculum, sedation, general practice anaesthesia in Australia and the 2015 Bangkok Declaration about the World Health Resolution, which calls upon the world to "Strengthen emergency and essential surgical care and anaesthesia as a part of universal health coverage".

The NZNC also welcomed two new members – Dr Rob Fry of Auckland and Dr Graham Roper of Christchurch.

That evening, the committee hosted a successful function for about 80 stakeholders. Dr Nigel Robertson's term as NZNC chair (June 2013 to June 2015) was acknowledged at the dinner that followed.

Safe Surgery NZ

With communication breakdown reported as the root cause in more than 50 per cent of operative and post-operative adverse events, New Zealand's Health Quality & Safety Commission (HQSC) is working with district health board surgical services on strategies to improve teamwork and communication within surgical teams in New Zealand to help reduce perioperative harm.

In 2015-16, the commission will support organisations to implement the following surgical teamwork and communication interventions: briefing; paperless surgical safety checklist; debriefing; and supporting communication tools, such as ISBAR (identify, situation, background, assessment, recommendation), two challenge rule, call-outs and closed loop feedback.

The interventions are being rolled out nationally in a staggered approach with district health boards divided into three cohorts. It is expected that private surgical hospitals will work with their local district health board to implement the interventions. The roll-out timeframe ensures each cohort has a three-month preparation and nine-month implementation period.

More information is available on the HQSC website www.hqsc.govt.nz.

Clockwise from top left: The setting for the ASM gala dinner; Dr Kerry Gunn, Dr Maria Au-Young, anaesthetic technician Karen Bennett and Dr Annette Turley at the HCI reception; Keynote speaker Dr Nancy Redfern; Morning tea at the ASM; ANZCA Vice President Dr David Scott with Associate Professor Jennifer Weller; Keynote speaker Professor Beverley Hunt; ASM organising committee member Dr Phil Thomas with Wellington Hospital clinical director Dr Derek Snelling; Keynote speaker Dr Rhys Thomas at the opening session of the ASM; Organising committee convenor Dr Graham Sharpe speaking at the HCI reception.

Annual update for clinical directors

The clinical directors of most of New Zealand's departments of anaesthesia, accredited and non-accredited, who met in Wellington on September 4, rated the annual all-day meeting highly in nearly all aspects. Hosted by the New Zealand National Committee, the event enables clinical directors to be updated on College developments and to discuss current relevant issues in depth.

This year, those issues include non-anaesthetist-delivered conscious sedation, welfare programs in hospitals, recruitment and remuneration, practice review processes, governance structure in anaesthesia, and theatre quality and efficiency. In the afternoon there was a workshop on dealing with difficult people.

ANZCA President Dr Genevieve Goulding spoke on workforce issues, NZNC Chair Dr Gary Hopgood spoke about committee activities and immediate past chair Dr Nigel Robertson presented the draft results of the workforce census that most clinical directors had completed earlier in the year. Others offered to provide more data and the results will be finalised once that has been analysed.

Feedback again showed this event is highly valued, especially for its networking opportunities, and there were suggestions that in future the day conclude with a social function and even that the event be extended across two days.

Part 3 Course highly rated

Advanced trainees at the Part 3 Course held in Wellington on November 7 rated all presentations highly in terms of their usefulness. The course was timed and located to coincide with the NZ annual scientific meeting so attendees could take advantage of both events. This proved valuable with more than 50 per cent of Part 3 participants also attending some ASM sessions.

The Part 3 Course attracted 18 participants, including one who registered on the day. They learned about CV preparation and interview skills, "selling yourself", where FANZCA can take them, College life, private practice, management, academia/research, working smarter, rural practice and the NZ Society of Anaesthetists (joint hosts with ANZCA NZ). The day concluded with a panel of experts answering trainee questions about "things I wish I had known", followed by drinks and nibbles, allowing participants and presenters to mix and network.

This was the last time ANZCA NZ will host this course jointly with the NZSA, which takes over sole hosting rights next year while ANZCA will implement a new Part Zero Course from 2016. In New Zealand, this will be delivered in each rotation around the start of each hospital year.

Clockwise from left: Clinical directors at their day-long meeting in September; Participants in the Part 3 Course; Convenors of the Part 3 Course, Dr Rachel Dempsey and Dr Elitza Sardareva.

Good turnout for educators day

Around 30 people attended a workshop and meeting of New Zealand's Education Sub-Committee held on October 27 at the ANZCA office in Wellington. They included most of New Zealand's supervisors of training, the rotational supervisors, NZ Education Officer Dr Brent Waldron, NZ Trainee Committee Chair Dr Lizi Edmonds and ANZCA staff, including several from head office. This enabled very useful dialogue about the improvements planned and others Education Sub-Committee members felt would be helpful.

Key discussion included current and future ANZCA education initiatives, using workplace-based assessments effectively, the best way to collect data and feedback on trainee performance, and implementation of the ANZCA Part Zero Course.

General Manager, Training Assessments Paula Stephenson gave an overview of her unit's work and Dean of Education Dr Ian Graham spoke about the release of new updates for the training program. General Manager Education Ollie Jones, joining by phone, provided an overview of current and future initiatives, including supervisor of training resources on Networks and an Effective Management of Anaesthetic Crisis course review.

Clockwise from left: Top two - guests at the ANZCA NZNC's stakeholder function; Dr Nancy Redfern, Dr Sarah Gibb, Robert Edeson and Dr Lindy Roberts at the stakeholder function; ANZCA Councillor Dr Vanessa Beavis with Murray Miher from the IT Board at the stakeholder function; New ANZCA NZNC member Dr Graham Roper with NZ Anaesthetic Technicians' Society Chair Angela Dewhirst at the stakeholder function.

Australian news

Tasmania

2016 Tasmanian meeting

The theme for the next combined Tasmanian Annual Scientific Meeting, "Anaesthesia in the Extreme", was inspired by Tasmania's unique wilderness, extreme weather and difficult access to the Antartic, the convenor, Dr Clare McArthur, said.

The theme provided the opportunity for a dynamic and stimulating scientific program, covering topics ranging from the routine to the extremes of physiology, pathology and anatomy, plus retrieval and hyperbaric medicine.

Dr McArthur said the committee wanted to bring Tasmania's unique offerings to the conference, where delegates will have access to world-renowned speakers and can gain hands-on experience in a small-group workshop environment.

The keynote speaker is Professor Peter Slinger from Toronto General Hospital, who is an international leader in anaesthesia for thoracic surgery. Professor Slinger will review general anaesthesia for patients with severe lung disease, including mediastinal masses and other lower airway problems. He also will present on lung protection ventilation in anaesthesia and the impact of ventilation strategies on patient outcomes.

Delegates will also benefit from the experienced airway specialist, Clinical Associate Professor Reny Segal, of Melbourne University, a cardiothoracic anaesthetist with an interest in complex and advance airway management. Clinical Associate Professor Segal is co-founder and former chair of ANZCA's Airway Special Interest Group and will present an update on airway techniques.

The director of anaesthesia at St Vincent's Hospital in Melbourne, Associate Professor David Scott has research interests that include cognitive outcomes following anaesthesia. He will review the impact of anaesthesia on the brain in the elderly.

Another impressive speaker is Associate Professor Larry McNicol, the director of anaesthesia, perioperative and intensive care services at Austin Health in Melbourne. Associate Professor McNicol is an expert in the field of critical bleeding and massive transfusion and will provide an update on current practice and advances in massive transfusion.

Delegates also will have an opportunity to attend one of two exciting workshops.

Due to strong demand at last year's meeting, a difficult airway workshop will be a highlight of the program. The workshop will use fresh cadavers and anatomical models to give hands-on experience with airway management, including scenario-based practice of "can't intubate, can't oxygenate" (CICO) situations. The workshop will allow delegates to complete their category three emergency response continuing professional development requirement in the management of the CICO scenario. Workshop convenor Dr Mike Challis said the workshop has been very popular and encouraged delegates to register early to avoid disappointment. Class size is limited to 20.

A critical bleeding and massive transfusion workshop will be offered on Sunday morning. This workshop also fulfills ANZCA's category three emergency response requirement and provides delegates with a chance to refresh their knowledge on an important topic.

Tasmania is known for its vast wilderness, extreme landscape and growing art and cultural scene. The social program will showcase some of the best Hobart has to offer. The Friday evening cocktail reception will be held at the Waterside Pavilion on Constitution Dock, where yachts berth after competing in the Sydney to Hobart race. The magnificent Hobart Town Hall, built in 1866, is the venue for the Saturday evening conference dinner.

The Organising Committee is very pleased to offer this conference to the anaesthetic community and looks forward to seeing you in February.

For more information or to register, please go to: www.anzca.edu.au/about-anzca/council-committees-and-representatives/Committees/tas-regional-committee/tasmania-regional-events.

South Australia and Northern Territory

ANZCA and ASA SA and NT continuing medical education dinner

One hundred and forty seven ANZCA Fellows, trainees and allied-health professionals attended a joint ANZCA and Australian Society of Anaesthetists continuing medical education event, "A polio epidemic and the emergence of clinical physiology", at the Adelaide Oval's newly developed venue on September 17.

A trade exhibition was held before the dinner presentation in the impressive William Magarey Room. Delegates enjoyed canapés and pre-dinner drinks overlooking the hallowed turf while A-grade AFL players trained.

Professor John B West, a professor of medicine and physiology at the University of California, San Diego, delivered the presentation. Professor West obtained his medical degree in Adelaide then moved to London where he obtained a PhD. Following the great polio epidemic in Copenhagen in 1952 when more than 300 patients had to be manually ventilated around the clock by 200 medical students, it was clear there was a major need for automated ventilation and more understanding of the gas exchange and acid base of these patients. Professor West discovered the coverage of respiratory physiology in textbooks was woefully inadequate and this ignited his passion to focus on this area of research to improve knowledge from physiology departments to the clinical setting. His physiology publications are the "bible" for anaesthesia trainees. Professor West has worked extensively at high altitude, joining Edmund Hilary's 1960-61 expedition. In 1981 he led the American Medical Research Expedition to Mount Everest, during which the first physiological measurements on the summit were obtained. He also was involved in an extensive research program with NASA studying the effects of weightlessness on pulmonary function.

Professor West was very generous with question time from the dinner guests and told many entertaining stories about living in Adelaide as a medical student. The presentation was followed by an outstanding dinner and attendees enjoyed a rare opportunity to talk "shop" in an exceptional venue and social environment.

South Australian FPM joint CME meeting

The South Australian Faculty of Pain Medicine held a joint continuing medical education meeting with the Medical Assisted Treatment for Opioid Dependence Prescribers (MATOD) on November 9. Specialist pain medicine physician Dr Dilip Kapur and senior lecturer in pain medicine at Flinders University presented on medical marijuana, and Dr Chris Holmwood, an addiction medicine specialist and director of clinical consultation liaison and standards at Drug and Alcohol Services SA, presented on trends in opioid prescribing. The meeting was well attended by Faculty members, addiction medicine specialists and pain unit nurses.

From top: SA ASA Chair Dr Simon Macklin, guest speaker Professor John B West, SA NT CME Chair Dr Nathan Davis and SA NT Regional Chair Dr Perry Fabian; Delegate dinner in the William Magarey Room; ANZCA trainees Dr Kritesh Kumar, Dr Elena Vowels, Dr Cristi Read, Dr Melissa Jusaitis, Dr Cheryl Chooi and Dr Nicole Diakomichalis; SA Maths and Science Course Convenor, Professor Michael Jones and Dr Peter Germann; Dr Colm Quinn, Dr Aileen Craig and Dr Munib Kiani.

Queensland

Primary exam practice vivas

The Queensland Regional Office welcomed another cohort of primary exam candidates for viva practice sessions in September. The two evenings went very well with both the candidates and observers benefiting from the opportunity to put their skills to use.

Sincere appreciation is extended to all the senior trainees and Fellows, some of whom travelled significant distances to attend, for their assistance on the night. Thanks also to our Queensland Course Co-ordinator, Katie Quan, for her seamless organisation.

Dr Joanne Cummins,
Primary Practice VIVA Course Convenor

Brisbane presents five of the best

Last night I attended a continuing medical education (CME) lecture at ANZCA's Queensland regional office in Brisbane. The evening was put on by the ANZCA/Australian Society of Anaesthetists CME Committee with an innovative concept of inviting five provisional Fellows to present a case they had encountered in their final year of training.

My first impression: "Interesting, what a good idea!"

Dr Phil Lee presented on "Massive retrosternal goitre in a super morbidly obese patient not suitable for cardiopulmonary bypass".

Dr Desiree Perez presented on "Anaesthesia for the mentally impaired/incapacitated adult patient".

Dr Kellie Bird presented on "Oesophagectomy in a medically complex patient".

Dr Anna Milanovic presented on "Occult sepsis and septic shock".

Dr Jane Chia presented on "Airway crisis in a code blue resuscitation".

I believe it is a great, innovative concept to have this as a finale to the year's CME events. Seeing presentations by young provisional Fellows was a great way to wrap up the year.

Well done to the committee for thinking outside the box!

Dr Kate Brunello

Practice viva sessions

The Queensland Regional Office hosted a successful series of practice viva sessions in September for the primary and final examinations. Although initially we seemed to be off to a shaky start trying to whip up enthusiasm among potential mock examiners, we were soon overwhelmed by the response from a wonderful mix of experienced ANZCA Fellows and recent graduates keen to grill our candidates.

Each session consisted of two intensive hours of vivas, feedback and words of encouragement, which helped to polish any rough edges and give our trainees a taste of what the exams would be like.

As always, the success of these sessions depends upon the generosity of our mock examiners, who give up their time to make them happen. As a grateful recipient of this generosity in years gone by, I know the practice viva sessions are part of our traditions. Long may they continue?

Dr Elizabeth Gooch,
Final Practice VIVA Course Convener

Australian Capital Territory

Workshop success

After a week of extreme weather in the nation's capital we were greeted with sunny blue skies on Saturday November 7 for three much-anticipated anaesthetic workshops. The workshops, hosted by the ACT Regional Committee, were held at the Australian Catholic University Clinical School and the theatre complex at Calvary Public Hospital. The morning session consisted of two emergency response workshops, advanced life support (ALS) and can't intubate can't oxygenate (CICO), and the afternoon session was a very valuable workshop on peripheral nerve block ultrasound scanning.

A small group of enthusiastic anaesthetists attended the hands-on, scenario-based, ALS workshop convened by Dr Carmel McInerney. The workshop facilitators included Dr Freya Aaskov, Dr Andrew Deakin, Dr Salam Al-Khoury and Dr Ashwini Tambe. We thank the facilitators for their commitment to this workshop and for providing an excellent learning environment for the participants. Extremely favourable feedback after the event confirmed the success of this workshop.

The fully subscribed CICO workshop, attended by Fellows and trainees, was convened by Dr Andrew Watson and held at the Calvary Hospital theatre complex. The CICO workshop, as with ALS, is a mandated emergency response activity under the ANZCA Continuing Professional Development Program and continues to sell out quickly in Canberra. Thank you to the facilitators, Dr Andrew Hehir, Dr Candida Marane, Dr Natalie Marshall and Dr Andrew Watson, for their excellent instruction and for volunteering their time to run this workshop.

The peripheral nerve block ultrasound-scanning workshop, convened by Dr Ross Peake, was a popular choice for Fellows and trainees on the Saturday afternoon. Sonosite kindly donated their time and four of their best machines for the workshop to give participants an excellent opportunity to scan the models (a very big thank you to our medical students for giving up their time to be our models). The workshop offered hands-on practical scanning to learn the best approaches for common blocks and new novel blocks, and both upper and lower limb blocks were covered in detail. Thank you to Sonosite and Admedus for their support of the workshop, and a special thank you to facilitators Dr Vaughn Oerder, Dr Ross Peake, Dr Valerie Quah and Dr Heman Tse.

Scan and ski workshop 2016

The ACT Regional Committee will host a new workshop in 2016 entitled "Scan and ski: Regional ultrasound scanning workshop for peripheral nerve blocks". Convened by Dr Ross Peake, the workshop will feature world-renowned ultrasound specialists Dr Alwin Chuan (NSW), Dr Peter Hebbard (Vic) and Dr Brad Lawther (WA). The workshop will be held on July 15-16 at the Thredbo Alpine Hotel and is expected to sell out quickly. The workshop will be limited to small groups to give participants maximum time with the instructors and equipment so register early to avoid missing out. Event details can be found on the ANZCA ACT webpage www.anzca.edu.au/about-anzca/council-committees-and-representatives/Committees/act-regional-committee/act-regional-events.

Above from left: Participants at the four ultrasound stations; Dr Ross Peake instructing his group; Upper limb scanning.

Victoria

Quality assurance meeting

The Victorian Regional Committee ran a quality assurance meeting/workshop at ANZCA House on Saturday October 17.

Four presentations were given:

- "Massive facial tumor, an African Experience" by Dr Vanessa Andean, Austin Hospital.
- "How much is too much – excessive fasting, a case of acidosis" by Dr Maryam Horriat, Austin Hospital.
- "Push hard, push fast, hazards of CPR" by Dr Amanda Baric, The Northern Hospital.
- "Known knowns, ...known unknowns, ...unknown unknowns – management of blocks in presence of anticoagulants" by Dr Charlie Heldreich, Austin Hospital.

The material covered in the presentations was well received and attendance was excellent.

Breakout sessions at which doctors present cases for discussion are always popular and this meeting was no exception. The program concluded with very interesting summaries of the discussions and requests from participants to continue to hold these informative meetings.

Dr Shiva Malekzadeh
Convenor

Victorian Registrars' Scientific Meeting

The 2015 Victorian Registrars' Scientific Meeting was held on Friday November 20 at ANZCA House. In accordance with the new curriculum, presentations were divided into pure research/clinical study/interventional research and a miscellaneous category, which included audits.

Four adjudicators – Associate Professor Alicia Dennis, Associate Professor Lisbeth Evered, Dr Chris Bain and Dr Raymond Hu – judged the presentations and chose two winners. There were 10 trainee presentations judged by category, and three informative and fascinating presentations by the judges.

Dr Matthew Lee was the recipient of the pure research category with a presentation titled *"Agreement in cardiac index monitoring during orthotopic liver transplantation"*.

The winner in the miscellaneous section was Dr Mellissa Haque with the pilot study *"Do multiple adverse drug reactions identify increased anxiety, somatisation and psychosocial load in patients on acute pain service"*. The winners were awarded a trophy.

The event was well-received and 65 trainee registrants attended. The high quality of presentations was reflected in the long deliberation time required by the judges to choose winners.

Special thanks to Ms Daphne Erler and her team, whose organisation, diligence and hard work made the event a success. Thanks also to the adjudicators and chairs for giving their time so generously. We also thank the College facilities staff whose assistance and co-operation are invaluable.

Dr Shiva Malekzadeh,
Convener, 2015 VRSM

Left from top:
(Back row) Dr Nicholas Lanyon, Dr Matthew Lee, Dr Adriana Bibbo and Dr Chris Bain. (Front row) Associate Professor Alicia Dennis, Associate Professor Lisbeth Evered, Dr Melissa Haque, Dr Raymond Hu and Dr Shiva Malekzadeh.

Presenters and session chairs: (Back row) Dr Matthew Lee, Dr Julia Taylor, Dr Jeremy Broad, Dr Nick Lanyon and Dr Adriana Bibbo. (Front row) Dr Jin Li, Dr Maysana Allaf, Dr Julia Dubowitz, Dr Kellie Bricks, Dr Melissa Haque, Dr Marissa Ferguson and Dr Melinda Miles.

Opposite page from top: Dr Charlotte Heldreich, Dr Maryam Horriat, Dr Amanda Baric and Dr Vanessa Andean; Quality Assurance Meeting/Workshop.

Western Australia

Left from top: St John Ambulance First Aid Course; Neuromuscular workshop by Claude Meistelman; Videolaryngoscope workshop.

2015 ANZCA and ASA Country Conference

The 2015 ANZCA and Australian Society of Anaesthetists Country Conference was held on October 16-18 at the Pullman Resort in Bunker Bay. The conference was attended by 107 delegates and was well sponsored, with 17 representatives from the healthcare industry in attendance.

Professor Claude Meistelman, whose attendance was sponsored by MSD, is a professor of anaesthesia and intensive care medicine and chair of the Department of Anaesthesiology at the University Hospital of Nancy, in France. He presentation, titled "Neuromuscular blockade in specific populations", was well received by delegates and was an exciting addition to the program. He also presented a workshop on "Anaesthesia of the obese patient", which tied in with the theme of National Anaesthesia Day on October 16.

Dr Chris Acott, a senior specialist anaesthetist from the Royal Adelaide Hospital, provided a hands-on workshop on different videolaryngoscopes, which were kindly provided by Western Biomedical, Covidien, Health Technology Supplies and CR Kennedy Medical. Dr Acott also presented a lecture detailing the advantages of different types of videolaryngoscopes and classifications.

"Advanced life saving" and "Can't intubate can't oxygenate" workshops were offered by Rockingham Hospital anaesthetic staff.

St John Ambulance attended to run a basic first-aid course for the children of anaesthetists attending the conference. They learnt basic skills, including how to call 000 and how to help a friend in need in the playground. You never know, they might be the next generation of anaesthetists!

We have received excellent feedback about the content of presentations as well as conference facilities, catering standards and the general organisation of the conference, resulting in a very successful meeting.

Thank you to the WA Continuing Education Committee for co-ordinating the WA ANZCA/ASA conferences for 2015. It is no easy task putting together quality meetings time and time again. We look forward to the 2016 calendar.

ANZCA/ASA Gilbert Troup Prize

On November 17 Professor Stephan Schug and Professor Thomas Ledowski conducted the prize viva to determine the 2015 recipient of the ANZCA/ASA Gilbert Troup Prize in Anaesthetics. The successful candidate was Ciselle Meier.

Library and museum visit New Zealand

Delegates vist the library and museum stand at the New Zealand ASM.

The ANZCA Library and Geoffrey Kaye Museum of Anaesthetic History packed their bags and headed to New Zealand to be part of the ANZCA booth at the annual scientific meeting

ANZCA Knowledge Resources Manager Laura Foley was on hand to provide assistance and advice for those wanting to know more about the library's 24/7 services. Fellows and trainees used the opportunity to pick up quick reference guides for online resource packages, which can be accessed remotely from any computer or device via the ANZCA Library.

The online version of the latest museum exhibition, Trailblazers & Peacekeepers, was on display at the booth, reminding Fellows that while the museum cannot move, it can be enjoyed anywhere in the world.

Copies of the accompanying *Trailblazers & Peacekeepers* book also were available and were of particular interest to speakers presenting about trauma in warfare.

Dr Patricia Mackay OAM
1926-2015

Patricia Mackay was born in New Zealand in 1926. She graduated in medicine from the University of Otago in 1947 and completed postgraduate training in anaesthesia in New Zealand, Australia and the UK. In 1954 she moved to Australia to take up a position as a specialist anaesthetist at the Royal Melbourne Hospital – an association she maintained until her retirement from clinical practice in 1992. During her long clinical career Dr Mackay also worked extensively in other Melbourne public and private hospitals. She was a fine clinician, an observant supervisor and a skilled teacher, who was admired by her colleagues and trainees in theatre.

Dr Mackay was one of the pioneering women in leadership in Australia and New Zealand. In 1984 Dr Mackay was appointed chair and head of the Department of Anaesthesia at the Royal Melbourne Hospital, a role she held until 1992. Dr Mackay was organised, hard-working and authoritative as a leader, but most importantly she was visionary. At the Royal Melbourne she instituted an acute pain service (the first in Victoria), a new and improved anaesthetic chart (which was still in use 25 years later), regular registrar teaching time, and morbidity and mortality meetings. She advocated for the strong participation of women and visiting anaesthetists in the life of the department – a legacy still felt today. Dr Mackay also was a leader outside the Royal Melbourne, as president of the Australian Society of Anaesthetists (1966-68) and later as chair of the Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM: 1991-2005).

Dr Mackay made a distinguished contribution to research in anaesthesia throughout her career. As a young doctor she published important work on the role of hypothermia in neurosurgery, airway management in tetanus and the effect of nitrous oxide on bone marrow. As a leader later in her career she fostered basic and clinical research in her department, as well as advancing the scientific analysis of adverse events occurring during anaesthesia.

Dr Mackay's most enduring legacy will be to patient safety in anaesthesia. At VCCAMM, Dr Mackay instituted a framework for adverse event classification, undertook a campaign to increase reporting of events, developed a close working relationship with the coroner's office and increased the diversity of VCCAMM membership. Her work at VCCAMM resulted in the removal of a problematic intravenous fluid from the market and greater awareness among anaesthetists of the dangers of intraoperative hypotension. Even after she stepped down as chair, Dr Mackay continued as emeritus consultant to the VCCAMM, often contributing a pithy and accurate assessment about a case with which other members had been struggling.

Throughout her career Dr Mackay made significant contributions to ANZCA. She was a member of the Victorian State Committee of the Faculty of Anaesthetists, and an examiner for 14 years. In 2005 she was appointed to the Quality and Safety Committee in the communications portfolio. In this role she brought news of quality and safety issues to the fellowship via the *ANZCA Bulletin* and the e-newsletter. Dr Mackay stepped down from the committee, and direct involvement in College life, in 2012. At that time she generously shared her reflections on her career in anaesthesia in an oral history recorded for the Geoffrey Kaye Museum of Anaesthetic History at ANZCA.

Dr Mackay was awarded many official honours, including the ANZCA Medal, life membership of the World Federation of Societies of Anaesthesiologists, the Australian Medical Association Woman in Medicine Award and the Centenary Medal of the Order of Australia. In 2008, Dr Mackay was awarded the Medal of the Order of Australia. These honours reflect her distinguished service to our speciality and the wider community.

As well as these magnificent professional achievements, Dr Mackay raised five wonderful children, maintained a passionate interest in Australian Rules football and horse racing (including associated wagering and tipping!), and enjoyed skiing, golf and bridge with her family and friends. She was a generous hostess and a great cook. At her funeral, mourners heard from her husband, Professor Ian Mackay, of their 57 years of happy marriage, built on respect and love, and from her son Ian (Migs) Mackay of her incredible faith in and support for all her children. It was not for nought that Patricia Mackay was known as "the Whizzer" within her family.

Dr Patricia Mackay was a giant of our specialty: a pioneer in patient safety and a visionary leader. She will be remembered with great fondness and esteem.

Professor Kate Leslie
Past ANZCA president

Associate Professor Larry McNicol
Chair, VCCAMM

Dr Christine Ball
Honorary curator, ANZCA

Dr Tuyen Ngoc Minh Tran
1986-2015

Tuyen Ngoc Minh Tran came to Australia from Vietnam in 2003 to complete years 11 and 12 at Eynesbury College in Adelaide.

Despite the passage of time, Eynesbury principal Claire Flenley has very fond memories of Tuyen, describing her as a conscientious, determined and focused student. Tuyen was always thoroughly prepared, consistent, very co-operative and highly respected by her teachers and fellow students. While Tuyen focused her studies on maths and sciences she was happy to explore other areas, such as legal studies.

Following the highly successful completion of her high school studies, Tuyen completed a medical degree at Melbourne University then returned to the Royal Adelaide Hospital followed by a service anaesthesia job at the Modbury Hospital (2012-13).

During this time, Tuyen volunteered for a scoping mission to provide anaesthesia and surgical services to a province near Ho Chi Min City in Vietnam. Tuyen provided contact, interpretation and liaison services during the mission and, according to the mission leader, plastic surgeon Dr Peter Riddle, she provided meticulous and outstanding service. Peter said Tuyen was committed to "giving back to her country".

During her time at Modbury, director of anaesthesia Dr Tim Hunt described Tuyen as a gentle person, at times timid, easygoing, but very intelligent and well organised. Tim remembers how excited Tuyen was when she was accepted into anaesthesia training.

Tuyen started working at the Queen Elizabeth Hospital (TQEH) on February 2, 2015 and, while very shy and quiet, immediately endeared herself to her fellow trainees, nursing staff and consultants.

During her time at TQEH Tuyen expressed some concerns about her resilience to deal with the pressures of training and her commitments to her family. Tuyen's family background was sad and tragic. While exact details are not available, some years ago she lost two brothers.

In keeping with her sense of responsibility and commitment to her family, Tuyen sponsored her mother and father to live in Australia in 2013 providing accommodation and financial support.

Balancing the pressures of family, work and study overwhelmed Tuyen and, unable to escape her past torments, resilience deserted her. Despite medical and pastoral support, she tragically took her own life on October 6.

In an email she sent just prior to her death, Tuyen regretted "lacking a strong personal foundation to fall back to in troubled times, which I had sought to create for years". Tuyen was very apologetic to all those who believed in her, and said being able "to work in anaesthetics was the best thing that happened to me".

She described her time as an anaesthetic resident at Royal Adelaide Hospital as "one of the most enjoyable times I had in my medical career".

Tuyen was looking forward to becoming an anaesthetist and pursuing humanitarian aid in Vietnam. She felt privileged to be part of "such a supportive camaraderie of anaesthetists".

Tuyen's achievements are remarkable. She came to Australia by herself as a teenager and, with English as a second language, performed brilliantly in school and medical school. As a young woman she was so impressive she was selected into one of the most prestigious and sought-after anaesthesia training positions.

Tuyen's premature death is such a waste and a sad loss to her family and the anaesthesia community. Her potential was endless, particularly in the humanitarian sphere.

We will all sadly miss her lovely, gentle nature and beautiful smile.

Dr Richard Watts, FANZCA
Queen Elizabeth Hospital, SA

For help or information, visit beyondblue.org.au or spinz.org.nz or call Lifeline (Australia) on 13 11 14 or Lifeline (New Zealand) on 0800 543 354.

More information including access to Welfare of Anaesthetists Special Interest Group resources can be found at www.anzca.edu.au/resources/doctors-welfare

Dr Desmond (Des) Dineen 1928-2015

Desmond Patrick Dineen was born in Murray Bridge on May 9, 1928, the first child of Daniel and Barbara Dineen. Daniel was the railway stationmaster at Murray Bridge and Barbara was an infant school demonstration teacher.

There were four more children, a brother Don (who predeceased Des) and three sisters, Barbara, Margaret and Rosie.

Des attended the local St Joseph Parish School in the country before the family moved to Adelaide. They were a Catholic family, who valued education and hard work. Des's education was a significant key to his success. He won a South Australian Railways Scholarship to Christian Brothers College and completed his schooling there. There he was provided with encouragement and the intellectual challenges needed to make him want to continue his education. Des completed leaving honours and was awarded dux of the school. He won a Commonwealth scholarship, which enabled him to study medicine at the University of Adelaide.

In his fourth year, he met a vivacious, stunningly attractive physiotherapy student, Genevieve Clark, when they both attended an Aquinas Catholic University students' club weekend in the Adelaide Hills. He was instantly besotted. Gen was to become the single most important person in Des's life. They became engaged when he completed medicine in 1951 and married two years later after he had completed his intern year at the Royal Adelaide Hospital and a resident medical officer year split between the Queen Victoria Hospital and the Adelaide Children's Hospital.

The next year, 1954, he spent as an anaesthetic registrar at the Royal Adelaide Hospital. After this, he explored a number of options, including working in country general practice, before deciding to settle in Adelaide.

Des bought into a general practice in Marion, a developing area on the fringe of Adelaide where new houses, including social housing, were interspersed with vineyards and farmland. They built a home in Marion to be close to his practice.

Des loved people, loved medicine and loved being a general practitioner. He was enormously popular and busy and seemed to work around the clock. The phone would ring in the middle of the night and Des would take his bag and dog Ricky and head out. Des always went when called. There were many struggling families, often with no phone, and young children were sometimes sent to call the doctor from an isolated public phone box.

During these early years they had their first five children in quick succession (Michael, Anne, Fiona, Helen and Christine). Daniel and Ruth arrived later. It was during this time that Des became involved in driving change around funding in Catholic schools, State Aid for Catholic Schools. He made a major contribution to this endeavour over many years with good outcomes.

His other passion was providing anaesthesia services, doing this at various hospitals in the morning and general practice consulting in the afternoon. Des decided he wanted to train to become a specialist anaesthetist.

He left general practice and spent six months studying for the primary examination, supported financially by a basic sciences fellowship from the University of Adelaide. He passed the primary examination on his first attempt in September 1964. He continued providing anaesthesia services in private practice until he started full-time training at the Royal Adelaide Hospital in 1966. He completed his training time in 1968 after also spending six months at the Adelaide Children's Hospital (under Dr Tom Allen's leadership). He passed his final examination in 1968 and was admitted as a Fellow of the Faculty of Anaesthetists, Royal Australasian College of Surgeons.

A period in private anaesthetic practice followed. An opportunity arose in 1970 for Des to do a six-month locum at the Adelaide Children's Hospital to cover Dr Allen's absence while he was in Vietnam as a member of a South Australian Civilian Surgical Team. Des thoroughly enjoyed this time and he was delighted to be appointed to the next available full-time staff specialist position in 1972. He valued the opportunity to work with a great team in an expanding paediatric anaesthesia department. Full-time staff specialists, who provided anaesthesia, intensive care and retrieval services to the children of South Australia, were replacing sessional visiting specialists.

He was an enthusiastic teacher and loved being involved in the support and supervision of anaesthesia trainees and other health professionals. He always made a particular effort to support country general practitioners. He encouraged the development of formal primary (Part One) and final (Part Two) courses and supported the expansion of the South Australian Rotational Training Program. He served on the regional committee and was chair from 1974-77. He was the South Australian regional education officer twice, from 1977-86 and from 1987-90.

Des was a great leader and great paediatric anaesthetist. He was active in supporting research and developing better ways of providing services. After Dr Allen's retirement in 1982, he was appointed deputy director while Dr Ian Steven (Steve) became director. He was the perfect foil for Steve and a great support for him. After Steve's retirement in 1989, Des was chief of surgery with overall responsibility for paediatric surgical, anaesthesia and intensive care services. Dr Johan van der Walt was the director of paediatric anaesthesia and Dr Neil Matthews was director of paediatric intensive care. The surgeons didn't always appreciate his no-nonsense approach as their chief. They would have preferred a surgeon as their boss!

In his leadership roles, Des was analytical, strategic, consultative, good with finances, optimistic and a great problem solver. In his various roles within the hospital and outside it, he was great with people and took them with him. He demonstrated great loyalty, sincerity and generosity of spirit. He had a fantastic sense of humour and sense of fun.

He was active in the formation and achievements of the South Australian Salaried Medical Officers' Association (SASMOA). There were major improvements in our pay and conditions as a result of the efforts of SASMOA during his involvement with the organisation. He was on the SASMOA Council for the maximum allowable years and remained a trustee until his retirement.

He joined the board of the Adelaide Children's Hospital in 1985 and remained involved during the difficult process of amalgamation with the Queen Victoria Hospital, which resulted in a new entity, the Women's & Children's Hospital. He continued as a board member until he was 80, when he lost this long-standing involvement with the organisation because the board was disbanded during yet another health service restructure.

Des understood the importance of seeing the hospital's work and delivery of services through the eyes of young people. The old formalities of hospital life and preoperative procedures could be unhelpful and confronting. Des led and supported the change to allow parental presence for anaesthesia induction. Children liked Des and warmed to him. He could connect and engage with them, he made them laugh with his silly rhymes and put them at ease. He introduced Teddy Ruxpin bears and used them to distract and relax children during induction.

Des retired the day he turned 65. He had to. At that time, in 1993, this requirement was entrenched in public sector employment law for staff specialists. He didn't want to retire, he wasn't ready for it, he enjoyed work and he still had Daniel and Ruth at school and was in no mood for retirement.

In the words of his eldest son, Mick Dineen: "Dad went from mover and shaker to idleness overnight. Medicine had been his life; it was what he did and what he knew. It was his lifestyle rather than a job. Mum was dreading having him at home all day. He put on a pair of old theatre blues and weeded the front lawn every day for three months. He finished it and that was that! It was all that he had planned for his forced retirement". Fortunately after these three months at home he was appointed to a locum position in the department and later to a project officer position leading the development of a day surgery service and day of surgery admission area. When he retired again he was ready for it. He ended up enjoying retirement.

His youngest child, Ruth, spoke at his funeral about his life as family man.

"He was a man with a huge intellect. In the days before the internet he was a human Google. He was a wise, calm and pragmatic man. He had a wonderful sense of humour, sense of fun and love of socialising. He was determined and driven (some might say bloody-minded). He had a wonderful sense of adventure. He was loyal and loving and much loved in return. In family life, Des still talked about Gen like it was the first day he saw her across the bridge table on that Adelaide Hills camp weekend. 'Isn't she the most beautiful woman? How did I get so lucky?' He was so proud of his seven children, he appreciated our partners and his heart grew bigger and fuller with the arrival of each of his 17 grandchildren. He was our patriarch."

His last years were dogged by physical ailments and decreasing mobility but he never lost his sense of fun or enjoyment of friends and family and his intellect remained razor sharp until the end. His slipped away peacefully in the early hours of July 5 at the family home in Martin Terrace, Fitzroy, with Gen beside him.

As son Mick said, he didn't have to choose between a great life and a long life, he had them both.

Farewell Des. As your colleagues and friends we will miss you!

Dr Margaret Wiese, FANZCA
South Australia