SEPTEMBER 2015

ANZCA BULLETIN

Which is which?

Drug labelling under fire

Fasting or starving? Spotlight on fasting guidelines

Propofol abuse: Surveys show big rise in 30 years

Get involved! National Anaesthesia Day – October 16

32 Surveys show propofol abuse rising
Three decades of substance abuse surveys show a dramatic potential rise in propofol abuse by anaesthetists.

54 A new era in teaching
The ANZCA Educators Program is all about learning to teach. It builds on the successes of the Foundation Teacher Course.

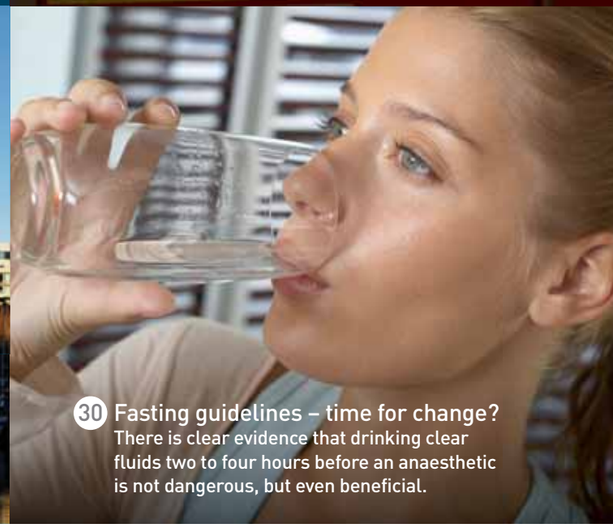
ANZCA CLINICAL TRIALS NETWORK

50 Clinical trials – a great history
The ANZCA Clinical Trials Network (formerly ANZCA Trials Group) has a long, successful past.

37 Difficult airway trolley
Patient safety has been improved through the development of difficult airway trolleys.

24 Push to prevent medication errors
Improved drug labelling would reduce the number of medication errors in a significant way, say doctors pushing for change.

58 Drawn to Tasmania
Australia's smallest state boasts a variety of clinical services, including a strong retrieval service, with spectacular surroundings nearby.



30 Fasting guidelines – time for change?
There is clear evidence that drinking clear fluids two to four hours before an anaesthetic is not dangerous, but even beneficial.

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: Despite very similar labelling, ephedrine sulfate and heparin sodium have vastly different effects on patients.

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

Raising the profile of anaesthetists and enabling others to understand the scope and value of our work is an ongoing challenge for the profession.

Well over two million anaesthetics are administered in Australia and New Zealand each year. Every single one of these professional interactions provides an exceptional opportunity to demonstrate that we are specialists (or trainee specialists) not only to our patients and their carers, but also the perioperative team.

It is likely that our behaviours will be noted and remembered just as much as our technical expertise, so these interactions are critically important to ensure we are recognised as specialist doctors, not just technical experts.

National Anaesthesia Day on October 16 is another opportunity to interact with the general public and workers from other areas of your hospitals and clinics. I hope you are all giving some thought as to how you can best use this occasion to inform, demystify, explain, impress and possibly even entertain – to promote key health messages. This year's theme is "Obesity complicates anaesthesia".

This is a sensitive topic to discuss with patients, however we are experiencing an obesity epidemic across all age groups, in Australia, New Zealand and neighbouring countries such as the Pacific Islands, and with it a rise in associated co-morbidities. Only one third of our populations has a healthy weight and the incidence of obesity is impacting significantly on our economies in terms of rising healthcare costs and lost productivity.

Anaesthetists represent around 14 per cent of specialist doctors, excluding GPs, according to the Australian Institute of Health and Welfare Medical Labour Force Survey, 2009.

As president of ANZCA I represent the College on the council of the Royal Australasian College of Surgeons (RACS), the board of the College of Intensive Care Medicine (CICM) and the Committee of Presidents of Medical Colleges (CPMC) which meets four times a year. The Medical Board of Australia (MBA), the Australian Medical Council, the Chief Medical Officer, Medical Deans Australia and New Zealand, the National Health and Medical Research Council (NHMRC), the Australian Commission on Safety and Quality in Healthcare and the Australian Medical Association all report to the CPMC in person.

Government bodies also report, depending on what is topical at the time (for example, the Medical Benefits Schedule review, or workforce). A similar body, the Council of Medical Colleges (CMC) meets regularly in New Zealand.

ANZCA therefore has an ongoing opportunity to be directly informed about the relevant health issues of the day and to have direct access to representatives of these bodies.

ANZCA's Policy unit plays an important role in advocating on behalf of our Fellows and trainees. ANZCA and FPM regularly respond with up to 50 submissions each year to government consultations on both sides of the Tasman. Some of these are confidential but many are listed on the ANZCA website – www.anzca.edu.au/communications/advocacy.

A recent success with advocacy efforts includes the announcement a few weeks ago from the Queensland government of $1.7 million over three years to fund a statewide paediatric persistent pain service, as well as evaluation of the current draft of the persistent pain management strategy for the state, with a view to its implementation into the future.

ANZCA has a growing profile in the media with the College actively promoting the work of anaesthetists and pain specialists with good results. This year alone there has been widespread media coverage based on the work of the Mortality Sub-Committee (allergies) and the Australian and New Zealand Anaesthetic Allergy Group (links between pholcodine and anaphylaxis). The FPM statement on cannabis, its call for a ban on over-the-counter codeine sales and the Faculty's revised training program has received much attention in the media and more recently, the issue of perioperative fasting was in the news. Our media releases can be found on the website – www.anzca.edu.au/communications/Media.

Finally, it is important Fellows and trainees have a voice with their College. I urge you to participate in evaluations of continuing medical education meetings and continuing professional development activities so that they continue to be relevant and of a high standard and to participate in surveys when they come your way.

A survey to develop values for ANZCA was recently launched. Trainees will be conducting an online survey later this year via their trainee committees; heads of department in New Zealand have recently participated in a workforce census to obtain an accurate snapshot of department staffing, funding availability and unmet demand. We hope to roll out a similar census across the Australian regions in a few months. The results of the census will assist in ANZCA having contemporary high quality data for our advocacy efforts in workforce deliberations (ANZCA's Workforce Action Plan – data, advocacy and communication).

ANZCA awaits with interest two reports. The first is from the National Medical Training Advisory Network (NMTAN) which has been examining workforce data for three specialities, psychiatry, general practice and anaesthesia.

The second is the MBA, which commissioned independent overseas research into an evaluation of revalidation methods overseas and a recommendation for a possible model for Australia. The MBA will consider the findings and issue a report in November 2015.

Dr Genevieve Goulding
ANZCA President

ANZCA's new CEO

Mr John Ilott is ANZCA's new chief executive officer, starting at the College on Monday September 28.

An experienced senior executive, John was the director of Finance and Corporate at the Australian Health Practitioner Regulation Agency (AHPRA) from 2009 to 2014 and played a key role in its formal establishment in 2010.

"I developed a good understanding of the work of the Medical Board of Australia (MBA) in my five years at AHPRA," John said. "I have great respect for the sensitive and professional way in which the MBA approaches complex issues.

"I look forward to forging similar relationships with the Medical Council of New Zealand and working with the president and the Policy unit in representing ANZCA."

John has led several organisations during his long, successful career, including the Victorian branch of the Pharmaceutical Society of Australia, the Victorian division of St John of God Pathology, and hospital management company Healthcare Management Services.

He said his experience in a membership-based organisation with the pharmacy profession had provided a good background in understanding the nature of ANZCA.

"My approach to the job is based firmly on the principles of consultation and stewardship," he said.

"The best leadership I can provide is built around seeking knowledge and guidance from the members and leaders within ANZCA then turning that into strategic direction and achievement.

"Through the existing forums within ANZCA I look forward to meeting as many Fellows and trainees and attending as many committee meetings as possible during my time as CEO."

John also has vast experience in public and private hospitals as chief executive at Wangaratta District Base Hospital, St Andrew's Private Hospital (Ipswich) and the Mater Hospital (Rockhampton). More recently he has been a consultant in business development.

"I have worked closely with the medical profession throughout my career and without exception I have enjoyed the close working relationships that have developed," he said.

Over the years he has formed close associations with medical professionals, including anaesthetists.

"I appreciate the hard work that the leaders of the profession have contributed to the recognition it enjoys today," he said.

"The ongoing development of the Faculty of Pain Medicine also provides a wonderful synergy to extend the reach of the profession more widely into the community."

ANZCA President Dr Genevieve Goulding said John had strong skills in leadership, change management and corporate governance and had built sound relationships with government, the health professions and other stakeholders.

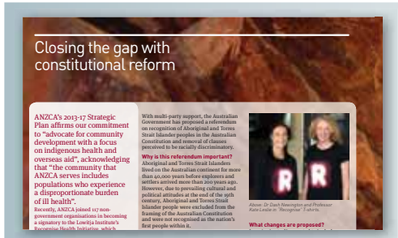
"John has a strong commitment to service and quality and an open collaborative style," she said.

"He is an experienced CEO and senior executive and has an extensive background in both the private and public health sector."

John said it was a privilege to be joining ANZCA as chief executive officer.

"I am excited by the opportunity to lead this prestigious organisation and to continue the strong and visionary leadership of the profession," he said.

Letters to the editor


Closing the gap with constitutional reform

ANZCA's 2013-17 Strategic Plan affirms our commitment to "advocate for community development with a focus on indigenous health and overseas aid", acknowledging that "the community that ANZCA serves includes populations who experience a disproportionate burden of ill health".

Recently, ANZCA joined 117 non-government organisations in becoming a signatory to the Lowitja Institute's Recognise Health Initiative, which

With multi-party support, the Australian Government has proposed a referendum on recognition of Aboriginal and Torres Strait Islander peoples in the Australian Constitution and removal of clauses perceived to be racially discriminatory.

Why is this referendum important?

Aboriginal and Torres Strait Islanders lived on the Australian continent for more than 40,000 years before explorers and settlers arrived more than 200 years ago. However, due to prevailing cultural and political attitudes at the end of the 19th century, Aboriginal and Torres Strait Islander people were excluded from the Australian Constitution as citizens and were not recognised at the nation's first people within it.

Above: Dr Dash Reddy (right) and Professor Kate Leslie in "Recognise" t-shirts.

What changes are proposed?

College should not advocate partisan political views

Along with all Fellows of ANZCA, I agree with the College's mission to "serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine".

I respect the right of each and every Fellow of the College to have their own personal, political, religious and ideological views.

However, it is wrong for the College to advocate partisan political views that are not a part of its mission and are probably very different to a substantial proportion of its membership.

I refer specifically to the article "Closing the gap with constitutional reform" (*ANZCA Bulletin*, June 2015).

ANZCA's newfound position of political promotion is even more disturbing in the broader national context where the model for proposed constitutional reform is still open to debate among its advocates.

The blatantly contradictory position of ANZCA is shown where its proponents write:

- "That section 51 ... (which allows the parliament to make special laws for people of any race) be repealed.
- That a new section 51A be inserted, recognising Australia's first people and giving the parliament the power to make laws with respect to them."

My personal view is that to single out any ethnic group in the Australian Constitution indicates a racist intent, which will be open to abuse. I find it abhorrent that ethnicity should override the principle that all Australians should be equal before the law.

Those Australians who need assistance should be helped on the basis of need and not race.

Dr David Brooks, FANZCA
Castle Hill, NSW

Dissenting view to constitutional changes

I wish to express a dissenting view to that of the College on the subject of possible changes to the Australian constitution (*ANZCA Bulletin*, June 2015).

Good intentions pave the roads to some unfortunate destinations; those who need reminding of this should visit one of the remote indigenous communities into which have been poured many millions of dollars worth of good intentions over the past 40 years.

Australians pride themselves on their egalitarianism – it doesn't matter to us (we tell ourselves) who your family is, we will take you as we find you. The proponents of the recommended changes, however, wish to turn this on its head, so that it will matter; they want people to be singled out, to have special status in the constitution if their mother, for example, or their great-grandfather was indigenous.

The Australian Constitution is the theoretical framework of our systems of government and law, and makes no mention of any specific racial group, but those supporting the Recognise movement (lavishly funded by public monies – some $15 million to date) claim this is adversely affecting the health and wellbeing of Aboriginal and Torres Strait Islander people.

Such a claim is impossible to prove or disprove, but the Lowitja Institute, among others, treats this as a fact, and now ANZCA is running with it.

There are striking ironies in the recommendations. The expert panel proposes to rescind the power of parliament to make special laws for people of any race, but to enable parliament to make laws with respect to Aboriginal people. It proposes to prohibit racial discrimination, but to permit the passage of laws for the purpose of overcoming indigenous disadvantage. This is logically impossible because if a law discriminates in favour of the members of a particular race, it ipso facto discriminates against those who are of other races.

I would be astonished if – as you suggest – the Medical Board of Australia expects each of us to support the mooted constitutional changes in conformity with "good medical practice for doctors in Australia". I urge College members not to support the creation of a special class of Australian citizen in the constitution.

Dr Toby Nichols, MRCP FANZCA
Perth, Western Australia

Dr Rod Mitchell responds

I thank Dr Brooks and Dr Nichols for raising a number of important issues.

While ANZCA's mission is "...fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine", we might ask where does our role extend to in terms of "fostering"?

There is clearly more to promoting safety and high quality care than simply providing excellence in direct clinical care. The College is often called upon to contribute to broader health debates, with smoking, alcohol and government treatment of refugees being recent examples.

Where do we as a professional health organisation see the extent of our involvement in discussions such as these? Two community health issues that the ANZCA Council has decided to give particular attention to in recent times include indigenous health and overseas aid, as reflected in the College's Strategic Plan (www.anzca.edu.au/about-anzca/our-college).

Constitutional recognition dovetails with the broader drive for improvements in indigenous health. It is not controversial that large numbers of colonised indigenous people all around the world are in poorer health than the descendants of their first world colonisers. This is a public health problem, which falls within the College's mission to serve the community by fostering safety and high quality patient care.

I agree the proposed changes are still being vigorously debated. The final proposed model is undecided. However, the principle of constitutional reform enjoys undisputed bi-partisan parliamentary support. The College's position is not party-aligned.

Section 51 currently reads: "...allows parliament to make special laws for people of any race". This provision has allowed for governments to pass laws that discriminate against indigenous peoples.

The suggested amendment would replace this clause with one that recognises that there may be occasions when it is appropriate to pass laws for the benefit of Aboriginal and Torres Strait Islander peoples, that is, "...to preserve the Australian Government's ability to pass laws for the *benefit* of Aboriginal and Torres Strait Islander peoples" (see www.recognise.org.au) I acknowledge that this distinction was not made clear in the original article.

The Medical Board of Australia (MBA) has no stated position on constitutional change. ANZCA is exploring how we may better equip our colleagues to improve healthcare delivery to indigenous patients. We believe this concurs with the expectation of the MBA in relation to best practice.

There is an expressed reluctance to single out any specific group of people for special consideration in Australia's constitution. The indisputably negative social, economic and health status of our indigenous population requires, at the very least, consideration of extraordinary measures when compared to other groups within our community.

I accept good intentions don't always have good outcomes, but they are the logical place to start, while remaining aware of the lessons of history.

*Dr Rod Mitchell was one of the authors of "Closing the gap with constitutional reform" (*ANZCA Bulletin, *June 2015), is an ANZCA councillor and past chair of the ANZCA Indigenous Health Committee.*

Examiner insights


Be kind! Reminiscences of an old teacher and examiner

Kester Brown was Victoria's first education officer from 1970-1975 and examined anaesthetists for almost 50 years. He was a Faculty of Anaesthetists primary examiner from 1975-88.

It was interesting to read the typically insightful article by Dr Kester Brown (*ANZCA Bulletin*, June 2015).

In it he mentions an intoxicated candidate he was once confronted with. Laurie Mather and I, his fellow examiners at the time, remembered the incident well, but Kester has omitted a couple of relevant details. The candidate himself was a very large and aggressive footballing type, while Laurie, nearest the door, weighed 50 kilograms dripping wet. The calming (?) question from Kester was, in fact, to seek information from the candidate about the metabolism of alcohol.

It was to the relief of all of us in the room that the candidate appreciated the humour of the situation.

Dr Gavan J. Carroll, FANZCA
Queensland

Anaesthetic technicians deserve recognition

At present anaesthetic technicians are not recognised as health practitioners by the Australian Health Practitioner Regulation Agency (AHPRA). This limits their career structure, their career advancement and their pay scales.

Many enjoy recognition in other countries and most anaesthetists would agree that they play an important role in the theatre environment. Many of us often find them better trained, more experienced and more useful than their nursing counterparts. Those trained in Australia and New Zealand have often had more formal training in anaesthesia than the operating department assistants and operating department practitioners that we are importing from the UK.

In the past, anaesthetists have supported the establishment of these roles and many of us have assisted in their training. Isn't it about time we pushed for their recognition?

Peter McLaren, FANZCA
Southport, Queensland

Dr Patricia Mackay

Dr Patricia Mackay, OAM, who made an outstanding contribution to safety and quality in anaesthesia over more than 50 years, passed away on Tuesday September 1.

Born in New Zealand, Dr Mackay graduated from Otago University in Dunedin in 1949 and completed postgraduate training in anaesthesia in New Zealand, Australia and the UK.

She was appointed to the Department of Anaesthesia at the Royal Melbourne Hospital in 1954 and pursued an outstanding career in anaesthesia, intensive care and pain medicine in Australia, including establishing the first acute pain service in Victoria. She became director of the Department of Anaesthesia at the Royal Melbourne Hospital in 1984 and held this position until 1992.

Dr Mackay served as chair of the Victorian Consultative Council on Anaesthetic Mortality and Morbidity from 1991 until 2005. She attended ANZCA's inaugural Quality and Safety Committee meeting in May 2006 and remained a committee member until November 2012.

She was recognised as a foundation member of the Australian Patient Safety Foundation and as a life member of the World Federation of Anaesthesiologists. In 2000 she was awarded the ANZCA Medal, in 2001 the Centenary Medal of the Order of Australia and, in 2008, an OAM.

An obituary will appear in the December edition of the *ANZCA Bulletin*.

Awards

Anaesthetist appointed to NHMRC

Professor David Story has been appointed to the 2015-18 council of the National Health and Medical Research Council (NHMRC) of Australia.

The NHMRC is an authority established by the Australian Government to identify and support high quality research and researchers, to provide evidence-based advice on health issues to governments and the community and to uphold the highest ethical standards in healthcare and research.

The council of the NMHRC is appointed by the Australian minister for health and sport to provide advice to the NHMRC chief executive officer. Its work is undertaken through a network of principal committees, working committees and expert panels. Membership includes the chair, the chief medical officers of the Commonwealth, states and territories, community representatives and experts in healthcare and medical research.

Professor David Story, MBBS (Hons), MD, BMedSci (Hons), FANZCA, is the Foundation Chair of Anaesthesia at the University of Melbourne and head of the Anaesthesia, Perioperative and Pain Medicine Unit at the Melbourne Medical School.

Professor Story completed his medical education at Monash University and his anaesthesia training through the Alfred rotational training scheme. He joined the specialist staff at the Austin Hospital in 1997 with clinical interests in cardiac and liver transplant anaesthesia.

Professor Story's research interests include acid-base physiology, multi-centre clinical trials and engaging new investigators and sites in anaesthesia and pain medicine research. He is a chief investigator on NHMRC grants with funding of more than $8 million (POISE-2, RELIEF and PADDI).

He has had many roles at ANZCA including primary examiner (physiology), as a member and chair (2005-11) of the ANZCA Clinical Trials Network Executive, and as a member of the Perioperative Medicine Special Interest Group Executive, ANZCA Research Committee and ANZCA Safety and Quality Committee.

Appointment to the council of the NHMRC is an enormous personal achievement for Professor Story, but also is a very significant achievement for our specialities of anaesthesia and pain medicine, providing recognition for the high quality of our clinical care, record in safety and quality, and achievements in medical research.

It provides our speciality with an opportunity to help shape the national and international agenda in perioperative care over the next triennium.

Professor Kate Leslie
Chair, ANZCA Clinical Trials Network Executive

Anaesthetist awarded Churchill Fellowship

Melbourne anaesthetist Dr Phoebe Mainland has been awarded a Churchill Fellowship.

Dr Mainland will explore the implementation of devices with "small bore connectors" in the US and UK next year in preparation for the introduction of these to Australia. The aim of her research is to enhance the safety of Australian patients by reducing misconnections between medical devices.

The Churchill Trust was established in April 1965, soon after Sir Winston Churchill's death in January that year. Since then, more than 4000 Australians have been awarded fellowships that have enabled them to explore a subject of merit for the benefit of Australian communities.

Correction:
Queen's birthday honours list
The Queen's birthday honour awarded to Dr Peter Luckin was incorrectly described as the Medal of the Order of Australia. Dr Luckin received an AM (Member of the Order of Australia) for significant contributions to emergency medicine and as an authority on survivability during search and rescue operations.

Safety and quality hit the headlines

The inappropriate use of conscious sedation and local anaesthetics for cosmetic surgery was the subject of several articles in the media over past months.

ANZCA's Safety and Quality Committee Chair Dr Phillipa Hore was interviewed by Fairfax (*The Age* and *Sydney Morning Herald*) journalists.

"ANZCA is now pushing for training in the use of local anaesthetics for cosmetic surgeons and says facilities should be licensed and audited," the story says.

"Phillipa Hore from ANZCA's safety and quality committee says cosmetic surgeons can provide local anaesthetic without any training."

Dr Hore is quoted as saying: "It's difficult to understand that in our sophisticated society with world-class medical care there is this practice going on."

ABC Radio National's PM program also interviewed Dr Hore on the issue and the stories that appeared online, in print and on radio reached an estimated combined cumulative total audience of nearly 400,000, according to our media monitoring service iSentia.

A presentation by Dr David Rowe in July, to a meeting of anaesthetists as part of the Rural Special Interest Group meeting in Tasmania on fasting before anaesthesia, struck a chord with the public and received an enormous response from media outlets across New Zealand and in every state and territory in Australia.

Dr Rowe gave eight interviews and appeared in rural, regional and metropolitan publications; online and across radio including ABC, Radio NZ, 3AW, 2GB, Triple J, Fox FM and 6PR Perth. The estimated combined cumulative audience for this topic alone was close to three million.

The revised FPM curriculum was the subject of a media release which led to a lengthy live radio interview on ABC's Afternoons radio program, where Dr Meredith Craigie spoke about the philosophy behind the revised curriculum which she explained as taking a holistic approach to the patient in pain.

Ebru Yaman
Media Manager, ANZCA

Since the *June Bulletin* ANZCA and FPM have generated:

- **More than 35 radio reports.**
- **At least 25 print reports.**
- **More than 30 online reports.**

Media releases since the June *Bulletin*:

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

July 15: Respected former AHPRA executive to be ANZCA's new CEO

July 6: "Nil by mouth" hazardous, meeting hears

July 1: The whole patient in pain: specialists take new approach

New policy directions

Australia

National registration and accreditation scheme

In early August, the Australian Health Workforce Ministerial Council released a communiqué indicating their response to the Independent Review of the National Registration and Accreditation Scheme for Health Professions. The response of health ministers to the recommendations were categorised as follows:

- Improving consumer responsiveness.
- Consolidation of national boards.
- Accreditation functions.
- Governance arrangements.
- Entry into the national scheme.

Of particular note to the College was that health ministers are concerned about the significant issues relating to the high cost, lack of scrutiny, duplication and the prescriptive approach to accreditation of education programs.

A further piece of work will be commissioned to investigate this function of the scheme with a report due to be delivered by late 2016.

A key part of our submission to the review was a recommendation that the mandatory notification provisions in the national law be amended to exempt doctors treating impaired colleagues from reporting them to the medical board.

There are mandatory notification exemptions for treating practitioners established in the Western Australian law. A consistent national approach in this area is critical and ANZCA's position was consistent with the views of the Australian Medical Association and numerous other professional associations who view these requirements as a barrier for impaired doctors seeking the help that they need.

The health ministers rejected calls for a revamp of the mandatory reporting laws and have requested the Australian Health Practitioner Regulation Agency (AHPRA) undertake further research on the need for legislative change.

Ministers will consider a national approach to mandatory notifications upon receipt of this additional advice.

Expanded training

Healthcare in Tasmania is undergoing substantial reform as three separate health services combine into one statewide service.

This is resulting in a change to services across the state and this is having some flow on impact regarding the delivery of the ANZCA-managed Australian government program, Training More Specialist Doctors in Tasmania (TMSDT).

There are funds held by the College for this program. Staff have been working with the TMSDT project steering committee to try to reallocate some of the unspent funds. To date the proposals that have been presented to the government have been rejected.

Staff will continue to work with Fellows to develop a proposal that fits with the key principals of the funding and helps to deliver better outcomes for Fellows, trainees and the local community in Tasmania.

Similarly, staff have been working with Fellows in WA to try and get a Specialist Training Program (STP) post reallocated due to the decommissioning of the Swan District Hospital Campus in late 2015.

It is anticipated that the government will agree to this change, thereby ensuring continuity of training for registrars on that rotation. However to date we have not received a formal response.

New Zealand

Health strategy review

The Ministry of Health is leading an update of the New Zealand Health Strategy, which was published in 2000. The update intends to clarify the government's direction for the health sector for the next three to five years.

The update is being supported by two externally-led reviews on health system funding arrangements, and on the capability and capacity of the health system. These reviews will be used to provide advice to the Minister of Health, Dr Jonathan Coleman.

Following approval by the minister, the draft updated New Zealand Health Strategy will be open for public consultation later this year. The ministry hosted workshops in May and June with members of the health sector about the New Zealand Health Strategy, which ANZCA New Zealand staff attended.

Key themes that emerged during the workshops included: focus on prevention, wellness and investing in children and families; better engagement with other sectors such as education and housing; a shift towards primary care; and stronger leadership from the Ministry of Health.

Health outcome data

The discussion of public release of health outcome data continues in New Zealand among government departments, district health boards and medical colleges. This was prompted by two media requests under the Official Information Act for surgical outcome data for individual surgeons.

"A key part of our submission … was a recommendation that the mandatory notification provisions in the national law be amended to exempt doctors treating impaired colleagues from reporting them to the medical board."

The Health Quality and Safety Commission (HQSC) and the Ministry of Health are leading the issue, with the HQSC currently developing a literature review and statement on New Zealand's position on the transparency of health data.

ANZCA will provide feedback to the HQSC on any position developed. In July, the ministry and HQSC facilitated a workshop to seek consumer feedback on the issue. ANZCA Executive Director of Professional Affairs Dr Leona Wilson and New Zealand staff attended the workshop.

Stakeholder meetings

In May, Dr Nigel Robertson, immediate past chair, New Zealand National Committee (NZNC) and Heather Ann Moodie (General Manager, New Zealand National Office) attended a meeting with Health Workforce New Zealand (HWNZ) to discuss the development of a nurse endoscopy training program, including the standards, competencies and training that would be required for nurses performing endoscopy.

The issue of how sedation would be delivered in this model was raised, and ANZCA representatives reiterated that any model would need to align with *PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures*. Discussion on this issue will be ongoing.

In June, Dr Gary Hopgood, Chair, NZNC and New Zealand staff attended the Council of Medical Colleges Board meeting. The Minister of Health attended and discussed his priorities for the health sector, including: increasing focus on early intervention in primary care to decrease pressure on secondary and tertiary care; childhood obesity; greater collaboration and reduced fragmentation across regions; and development of clinical leaders.

The minister said he was keen to have meaningful clinical engagement, including meetings with district health board heads of surgery and anaesthesia. Accident Compensation Corporation representatives provided updates on work around treatment injury and noted they were keen to engage more with medical colleges, and HWNZ discussed the sources of data they use to assess workforce demand and supply.

Submissions

Australia

- RACS Expert Advisory Group on discrimination, bullying and sexual harassment – issues paper.
- Medical Board of Australia – Registered medical practitioners who provide cosmetic medical and surgical procedures.
- Medical Board of Australia – Revised Guidelines on Supervised practice for international medical graduates.
- NSW Health – Junior Medical Officer (JMO) Recruitment Strategy Review: Phase 1 report.
- Department of Health – Electronic Health Records and Healthcare Identifiers: Legislation Discussion Paper.
- NSW Health – Discussion Paper: Model Scopes of Clinical Practice for Senior Medical and Dental Practitioner.
- NSW Health – Discussion Paper Health Practitioner Regulation National Law (NSW).
- Department of Health and Human Services (Tas) – White Paper Delivering Safe and Sustainable Clinical Services.

New Zealand

- Ministry of Health – New Zealand and the Protocol to Eliminate Illicit Trade in Tobacco Products.
- Ministry of Health – draft Diabetes Mellitus Elective Perioperative Pathway for Adults.
- Health Quality and Safety Commission – review of the New Zealand Tall Man Lettering list.
- Pharmac – proposed approach to market share procurement for hospital medical devices; the establishment of Pharmac labelling preferences.

Feedback was also provided to the Council of Medical Colleges on its paper responding to the Medical Council of New Zealand about publication of health outcome data.

Jonathon Kruger
General Manager, Policy
ANZCA

ANZCA's first position statement: Health of people seeking asylum

ANZCA is the fourth largest of Australia's 15 and New Zealand's 14 medical colleges.

In Australia, the 15 presidents meet four times a year as the Committee of Presidents of Medical Colleges (CPMC). The CPMC has regular interactions with the chief medical officer, the Australian Medical Council, the Department of Health, the Medical Board of Australia, the National Health and Medical Research Council, the Council of Medical Deans, the Australian Council on Safety and Quality in Healthcare and representatives of the Minister for Health and the Opposition Health Minister.

This results in a two-way flow of information between key players in health policy and the medical colleges. In New Zealand, the Committee of Medical Colleges performs a similar role.

All colleges regularly receive documents from these and other organisations for consultation and a response is always made. ANZCA also receives requests from other organisations to endorse or co-badge their documents.

These requests are very carefully considered and any discussion to proceed is approved by the ANZCA Executive Committee and ANZCA Council.

In April 2015 ANZCA Council approved the development and promulgation of a new type of document for the College; position statements.

Position statements are a primary mechanism used by the College to provide public statements on significant issues of health policy. They are the most authoritative statement that the organisation can make on an issue.

Some may consider that making statements about certain key health issues is outside the remit of a medical college.

However, health advocacy is one of ANZCA's key roles. It is one of six ANZCA Roles in Practice embedded in the ANZCA curriculum. It is also a key part of ANZCA's professionalism document "Supporting Anaesthetists' Professionalism and Performance: A guide for clinicians" that is now being piloted.

The constitution also states that objectives of the College are to "advocate on any issue that affects the ability of members to meet their responsibilities to patients and to the community" and to "work with governments and other relevant organisations to ... improve health services".

Position statements are documents that provide a short background to an issue, outline the principles that the College sees as essential to improving the issue and provides a set of actions that ANZCA will advocate. They are succinct, evidence-based and may include key references to support the stance.

All position statements will be internally consistent with existing ANZCA policy and regulations and should be no more than a page, including references.

In developing the content of a draft position statement, the ANZCA Council considers the following:

- Is the intent of this draft position statements consistent with ANZCA's objectives and other ANZCA policies/professional documents (have other relevant ANZCA policy instruments been referenced)?
- Is this a significant issue to the profession and is a position statement the most appropriate policy format for this issue?
- Is the information the most current and reliable, both scientifically and politically (for example, have existing strategies and plans been taken into account)?
- Is the proposed position statement actionable and will it lead to discernible outcomes that we will be able to assess/evaluate?
- Will the proposed position be relevant for the life of the position statement?

Position statements will ordinarily be approved by ANZCA Council and uploaded to the advocacy page of the website.

To avoid confusion with professional documents, they will be badged as position statements.

Asylum seeker position statement

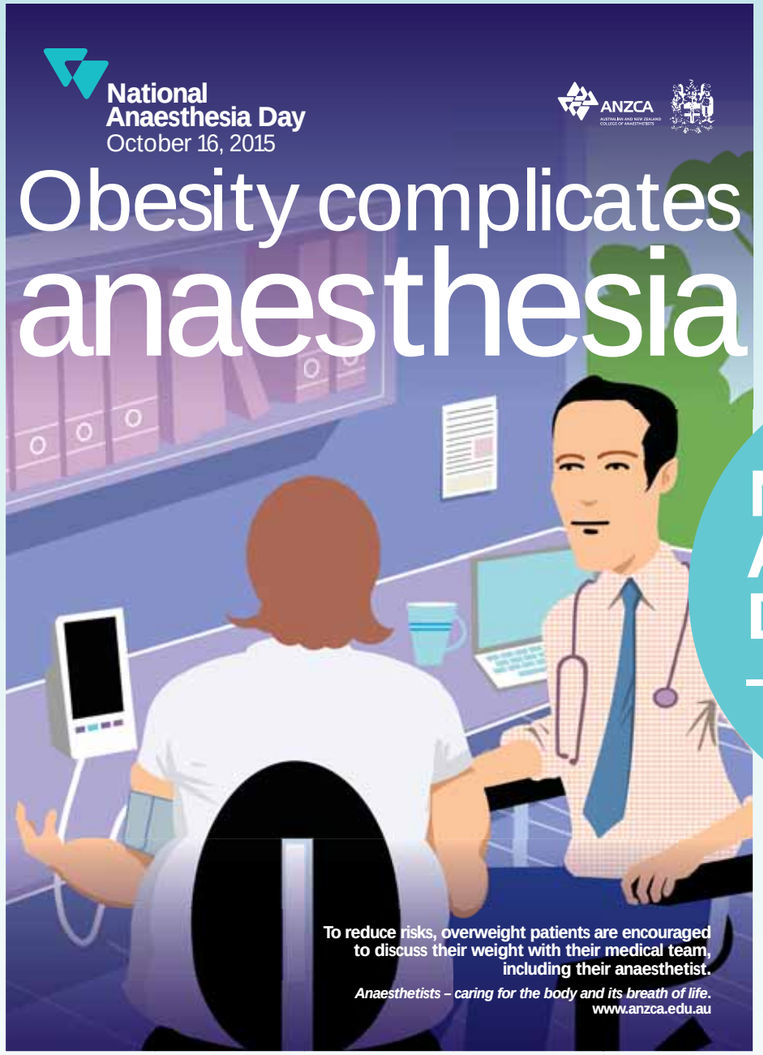
ANZCA Council has approved a position statement on the health of people seeking asylum. This document is based on one drafted by the College of Intensive Care Medicine of Australia and New Zealand and the Australian and New Zealand Intensive Care Society. The statement focuses on access to safe affordable surgery and anaesthesia when needed, including adequate pain relief.

This statement emphasises the importance of health care for asylum seekers within the framework put forward in the recent *Lancet Commission Global Surgery 2030: evidence and solutions for achieving health, welfare, and economic development*.

The Australian Society of Anaesthetists, New Zealand Society of Anaesthetists and Faculty of Pain Medicine have endorsed the document.

It can be accessed via the ANZCA website at www.anzca.edu.au/communications/advocacy.

Dr Genevieve Goulding
ANZCA President



National Anaesthesia Day 2015 – get involved!

We are all affected by the obesity epidemic.

As we are only too well aware, patient obesity is affecting our profession more and more.

Some six years ago, when confidential inquiries into maternal deaths in the UK told us of the greatly increased risks of maternal morbidity and mortality, as well as perinatal mortality in patients with a body mass index (BMI) of 35 or more, my hospital, the Royal Brisbane & Women's Hospital, was inundated with referrals of overweight patients from smaller hospitals unwilling to take the risk with bigger maternity patients.

At the time, our maternity pre-anaesthesia clinic took on such patients with a BMI of 35 or greater for an antenatal consultation, to identify risks and develop an anaesthetic management plan for labour and delivery, but soon we weren't coping with the number of referrals so the minimum BMI was reset at 40.

The hospital still couldn't cope and now the clinic is only able to accept maternity patients with a BMI of over 45, which means unless there are other serious co-morbidities, many obese patients will only receive a brochure on obesity in pregnancy and why it might be necessary to see an anaesthetist, and the patients are referred to us in labour.

The ANZCA Council has recognised this growing issue facing anaesthetists and has started to discuss establishing guidelines and/or a professional document related to managing obese patients perioperatively.

So it is timely that this year's National Anaesthesia Day on Friday, October 16 is focusing on obesity and overweight patients are being encouraged to talk to their medical team about what they can do to reduce their risks during surgery.

I urge you all to embrace National Anaesthesia Day and support the ANZCA mission to "serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine".

National Anaesthesia Day aims to help raise awareness in the community about our profession – this year focusing on one of the most challenging issues facing anaesthetists in recent times.

You will be sent a survey on October 16 asking about your experiences with patient obesity the previous day – please take a few minutes to fill it in.

As we do more in the perioperative sphere, encourage your patients to talk to their medical team about what they can do to make their operation safer. Maybe you and your colleagues can directly address this problem at your hospital's morbidity and mortality meetings.

Dr Genevieve Goulding
ANZCA President

ANZCA is celebrating National Anaesthesia Day on October 16, again marking the anniversary of the day ether anaesthetic was first demonstrated in 1846, in Boston, Massachusetts.

Obesity complicates anaesthesia

This year our theme, "Obesity complicates anaesthesia", was chosen after hearing an overwhelming number of Fellows voice concern at the increasing challenges of caring for patients with excess weight.

Over the past 20 years, the rate of obesity has soared in Australia and New Zealand. In Australia, the latest report on national weight trends by the Australian National Preventive Health Agency found that in 2011-12, one in four adults was obese compared with one in five adults in 1995. The most recent figures for children under five years of age show one in five is obese.

In New Zealand, the prevalence of obesity in adults has increased threefold – from 10 per cent in 1977 to 30 per cent in 2011-13. Between 2006-07 and 2011-13, the rate of obesity among two to 14-year-olds increased from 9 per cent to 11 per cent.

"There's something you can do" – a key messages for patients

While informing patients and their carers about the complications to anaesthesia caused by obesity, a key message for them is that there is something they can do. To start with, they should talk to their medical team, including their anaesthetist.

The risks to an obese patient having an anaesthetic are well known, with excess weight associated with:

- Health problems such as type 2 diabetes, high blood pressure and heart disease – conditions that compromise anaesthesia and make it more difficult to heal.
- Difficulties in positioning patients properly for an operation, finding veins and keeping airways open during anaesthesia.
- Putting the heart under extra pressure, especially under anaesthesia.
- Complicating maternity care – for instance, making it very difficult to accurately insert an epidural.
- Making some procedures under anaesthesia difficult to carry out, and sometimes too risky to have an operation at all.
- Difficulties in managing pain following surgery and anaesthesia.

Your support is essential

The aim of National Anaesthesia Day is to lift the community profile of the specialty.

A Community Attitudes Survey commissioned by ANZCA two years ago found that, despite 96 per cent of people reporting experience of a general anaesthetic (personally or through a close family member), only 50 per cent were aware that all anaesthetists are doctors (of these, 41 per cent know they are doctors with the same training/qualifications as other specialists).

Nearly one in 10 does not think anaesthetists are doctors and another 49 per cent are unsure. And 50 per cent don't feel informed about anaesthesia.

The most effective way to improve the community's understanding of anaesthesia happens every day through face-to-face interactions between anaesthetists and their patients. National Anaesthesia Day is another, more focused way to draw attention to the specialty.

In September, ANZCA will send kits to hospitals, private practices and others on its database. These will contain "Obesity complicates anaesthesia" posters and other promotional materials, including the "Who is your anaesthetist (an-ees-the-tist)?" flyer. More of these can be printed from the ANZCA website at www.anzca.edu.au/communications/2015_national-anaesthesia-day.html.

Patient information sheets also are available for printing from the website at www.anzca.edu.au/patients/information-sheets.

To get involved in National Anaesthesia Day, please consider:

- Displaying National Anaesthesia Day posters prominently in hospital foyers or the pre-admission clinic.
- Setting up a display of equipment and mannequins, with anaesthetists on hand to answer questions and to hand out our flyers and patient information sheets.

Obesity survey

On October 16, a brief survey will be sent to Fellows to assess the impact of obesity on anaesthesia. The four-question survey will aim to establish how often anaesthesiologists experience obesity as a pre-existing condition and its effect on perioperative risks.

Please take the time to complete the survey. Results will be published in the December *ANZCA Bulletin*.

"Over the past 20 years, the rate of obesity has soared in Australia and New Zealand."

- Drawing attention to your display or poster by attaching National Anaesthesia Day balloons.
- Taking photos of your display for ANZCA's December *Bulletin* and to help us promote National Anaesthesia Day next year.

Media campaign and other support

ANZCA's Communications team is available to support or discuss any initiative for National Anaesthesia Day 2015 and we can send more promotional material if required.

We will distribute media releases to newspapers, TV and radio stations throughout Australia and New Zealand, talking to our health and medical reporter contacts, and organising interviews between College leaders and the media.

Contact the Communications team about National Anaesthesia Day via Media Manager, Ebru Yaman at communications@anzca.edu.au. In New Zealand, NZ Communications Manager, Susan Ewart, is available at communications@anzca.org.nz.

More information can be found at www.anzca.edu.au/communications/2015_national-anaesthesia-day.html.

We hope you enjoy National Anaesthesia Day!

Clea Hincks
General Manager, Communications
ANZCA

Hospitals across Australia and NZ last year marked National Anaesthesia Day with displays and demonstrations, from left: The new Fiona Stanley Hospital in Perth; Lismore Base Hospital in NSW; Wellington Hospital, NZ; NZ Health Minister Dr Jonathon Coleman visited the displays at Auckland City Hospital.

What would you do?

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

Inappropriate comments about a patient

Just when you think you've heard it all something comes along to demonstrate that truth is stranger than fiction. I'm referring to an article in *The Age* that many of you may have read about the anesthesiologist in the US who made disparaging remarks about their patient during a procedure (see www.theage.com.au/world/anaesthesiologist-caught-out-mocking-and-insulting-sedated-patient-20150624-ghw44n?).

The patient was anaesthetised but, unbeknown to everyone in theatre, used the recording function on his mobile phone to record instructions that may have been issued while he was drowsy and may not recall.

While we need to be aware of the enormous scope of modern technology and its applications, this is not the issue I wish to consider. The issue is the behaviour of the anesthesiologist who belligerently expressed a desire to cause physical harm, ridiculed the patient, and then made a fraudulent entry in the patient's record. It is difficult to reconcile the motivation for such intense and persistent behaviour and raises concerns about the attitudes and/or the health of the practitioner who was clearly not acting in the best interests of their patient.

Even more intriguing was the attempt to mitigate the seriousness by arguing the patient did not suffer any physical injury or miss days of work.

There may be occasions when unflattering or unkind remarks are made about patients, but I am unaware of anything of this nature and degree.

So, the question I would like to raise on this occasion is what would you do if a colleague or staff member made inappropriate comments about a patient? Clearly, there are degrees. Nevertheless, would you join in on "a bit of harmless fun", or do nothing, or would you say something, and if so, to whom?

Interestingly, the gastroenterologist apparently did nothing to discourage the anesthesiologist's actions and comments.

What would you do?

If faced with this situation there are a number of issues to consider in deciding on what action to take. Negative comments tend to be counterproductive and have a demoralising effect on teams and their performance. If they are frequent, repetitive, and inconsiderate they become an irritation to those subjected to such behaviour. It may be appropriate to contemplate this as the ITCH factor:

- Intent – What is the reason or the purpose for making the comment? Is it intended to be derogatory and demeaning towards the patient?
- Toxic – Is there anything to be gained by making the comment or is it simply an inappropriate but innocent comment?
- Content – Does the comment reflect a factual observation poorly expressed or is it a deliberately twisted interpretation?
- Health or impairment issue – Is this an unusual, one-off situation that may signify the presence of a recent and acute psychological problem, or is this a normal pattern for this individual that warrants significant concern?

The following resources may assist in evaluating and addressing behavioural issues. All can be found at www.anzca.edu.au/resources/professional-documents:

- *Supporting Anaesthetists' Professionalism and Performance: A guide for clinicians* (pilot). See page 11 (playing an active role in clinical teams and working to prevent and resolve conflict), page 12 (examples of good behavior) and supporting others on page 13. Also page 18 (observing ethics and probity).
- Code of Professional Conduct. See section 5.

The Welfare of Anaesthetists Special Interest Group has well-considered and useful documents at www.anzca.edu.au/fellows/special-interest-groups/welfare-of-anaesthetists/introduction.html. These include *RD13 Impairment in a Colleague*, RD24 *Mandatory Reporting 2011* and RD25 – *The Disruptive Anaesthetist 2011*.

These documents address matters of process, procedures and recommended strategies/actions.

Inactivity in the face of behaviour that impacts negatively on team performance is effectively contributing to poor outcomes. The question then is to decide the most appropriate time, place/environment, to address the issues and by whom. The nature of the comment and the relationship between the team members present will determine at what stage action should be taken, and whether or not there is a need to escalate the matter.

Sometimes practitioners are unaware of their behaviours and simply being made aware may be helpful.

As Fellows and professionals we all have responsibilities to our patients, but also to our colleagues to support each other in professional development. This is promoted and facilitated by our College through continuing professional development, but there are opportunities for each of us as individuals to contribute.

Dr Peter Roessler
Director of Professional Affairs,
Professional Documents

Transition to CICO report

The ANZCA Airway Management Working Group has prepared a comprehensive report on transition from supraglottic to infraglottic rescue in the "can't intubate can't oxygenate" (CICO) scenario, which is now available on the ANZCA website (www.anzca.edu.au/resources/college-publications).

This is a comprehensive review of the background to CICO, the importance of providing appropriate education and support in decision-making regarding when to proceed, and also the development of a cognitive aid to help at point-of-care. The decision to transition to a surgical airway is an important but difficult step in airway management and while many algorithms for managing the difficult airway have been promulgated, the contents of this report provide cutting-edge information consistent with practice in Australia and New Zealand.

The report provides a comprehensive resource that underpins the upcoming professional document *PS61 Guidelines for the Management of Evolving Airway Obstruction: Transition to the Can't Intubate Can't Oxygenate Airway Emergency* and its accompanying background paper. It also supports the next stage of the practical implementation of this decision-making process, which is the continuing professional development-based CICO component under emergency responses.

The Airway Management Working Group was convened by the ANZCA Safety and Quality Committee and includes members of the Airway Special Interest Group, who have worked hard to achieve this result.

It is the first of a number of airway resources to be published by ANZCA. The next will be on airway assessment.

Professional documents – update

ANZCA Australian and New Zealand College of Anaesthetists | FPM Faculty of Pain Medicine ANZCA

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.

PS52 *Guidelines for Transport of Critically Ill Patients* is co-badged with ACEM and CICM and has recently been released following the close of pilot review. The main change has been to emphasise that supplies, including oxygen and pharmacological agents, should be in excess of that estimated for the maximum transport time.

Three draft professional documents are undergoing consultation with ANZCA stakeholders:

- *PS18 Recommendations on Monitoring During Anaesthesia* (regular review).
- *PS50 Recommendations on Practice Re-entry for a Specialist Anaesthetist* (major refresh).
- *PS61 Guidelines for the Management of Evolving Airway Obstruction: Transition to the Can't Intubate Can't Oxygenate Airway Emergency* (new document for consideration).

A comprehensive report on "Transition from supraglottic to infraglottic rescue in the "can't intubate can't oxygenate" (CICO) scenario" has been prepared by the ANZCA Airway Management Working. This report provides a comprehensive resource that underpins the PS61 background paper.

In addition to these, the Safety and Quality Committee has agreed to review the fasting guidelines (currently found in *PS15 Recommendations for the Perioperative Care of Patients Selected for Day Surgery*).

The Faculty of Pain Medicine has recently released the revised *PM01 Recommendations Regarding the Use of Opioid Analgesics in Patients with Chronic Non-Cancer Pain*. The main changes in the 2015 version are:

- A new section addressing the evidence base related to chronic opioid therapy, which points to a lack of clear evidence supporting ongoing opioid prescription for treatment of chronic non-cancer pain.
- Updated information regarding the practical details of an opioid trial within a multidisciplinary context.
- A new section providing pragmatic advice about opioid weaning.
- A newly updated Opioid Dose Calculation table (Appendix 2).

Queries or feedback regarding professional documents can be directed to profdocs@anzca.edu.au.

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

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

ANZCA Library a great resource

While many Fellows and trainees utilise the ANZCA Library and take advantage of its services, it is important that we continue to promote and communicate the specialist nature of the library and all that is on offer.

A recent library review supported greater marketing of the library and an increase in collaboration between the library and other College units. A number of initiatives are planned covering online resources and activities as well as practical initiatives designed to support information gathering and workflow.

We are working with colleagues from the education and research areas of the College to develop a one-and-a-half hour workshop on tips and tricks for using the library for research that will be held at the 2016 ASM in Auckland.

This workshop will be modified so that it can be presented at other College education events and will support the scholar role as part of the training curriculum. Remember also that the library is a constant presence at all annual scientific meetings (ASMs) and will be at the New Zealand ASM in Wellington from November 5-7, 2015. Please feel free to drop by the ANZCA stand and find out more about library services and resources.

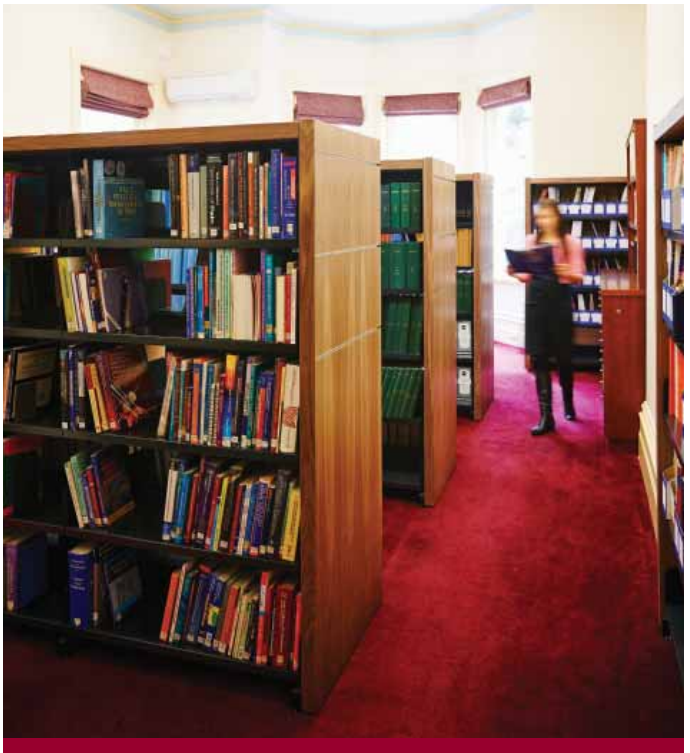
One other area where the library is providing resources and ensuring that these are relevant and valuable to Fellows and trainees is through the College's learning management system, Networks. We are ensuring resources relating to continuing professional development (CPD), exams and the curriculum are progressively being linked and embedded in areas of learning.

Are you following us on Twitter? The library regularly sends out updates, requests and new releases weekly, so keep an eye on Twitter @ANZCA. If you think there are other ways that we can interact with you on social media please let us know.

The appointment of Leana Bezuidenhout, our new librarian, is another important initiative from the library review and provides extra resourcing for the library. Leana has worked in a number of specialist libraries and understands the value of customising and enhancing resources and services to suit the user.

Feedback is welcome. We are always interested in hearing from you on ways we can provide you with the specialist information and resources that you need. Please contact us on library@anzca.edu.au.

Jan Sharrock
General Manager, Fellowship Affairs
ANZCA



Did you know?

Did you know that in the first six months of 2015, there have been more than 170,000 downloads from the online textbook collection? This already exceeds the number of downloads for all of 2014.

The ANZCA Library provides a specialised collection of anaesthesia and pain medicine-related resources, 24 hours a day, seven days a week, regardless of the user's location.

Recognising the traditional owners of the land

Council meetings are held at ANZCA House in Melbourne and the following acknowledgement of country is used: "We would like to acknowledge the peoples of the Kulin nation as the traditional owners of this land and we pay our respects to their elders past and present."

In September 2014, the ANZCA Council discussed appropriate and respectful ways for ANZCA to recognise the traditional owners of the land in Australia and New Zealand. Discussions centred on the increasingly common practice for meetings in Australia to include an acknowledgement of the traditional owners of the land on which the meeting is being held and the installation of plaques at ANZCA offices recognising the local aboriginal peoples on which the offices are situated.

There was strong support from members of the council with such public expressions of acknowledgement said to contribute in the following ways:

- Recognises and pays respect to indigenous peoples, cultures and heritage.
- Affirms that indigenous cultures are living, dynamic entities.
- Assists in building relationships and partnerships.

The Indigenous Health Committee was also engaged in the process and, following council endorsement, undertook research to identify the Aboriginal people in each Australian state and territoryfor the specific area where an ANZCA office was located. Land councils, government bodies and local councils as well as indigenous Fellows were consulted as there can often be spirited debate as to which Aboriginal nation and people hold responsibility for lands. Once confirmed, the information was incorporated into the wording and design of a glass plaque installed at ANZCA head office and now at each regional office.

As well as the plaques, council confirmed that it would endorse the use of an acknowledgement of country at significant ANZCA meetings, most particularly before each council meeting and at significant meetings like the annual scientific meeting.

New Zealand staff have discussed recognising the indigenous owners of the land where the New Zealand office is located with members of the Te Atiawa iwi (tribe), which has current mana whenua (authority) for that land. While appreciating the intent behind the plaque concept, Te Atiawa are more concerned with the wider relationship between

ANZCA and Maori overall. The New Zealand National Committee (NZNC), too, recognises its responsibility to acknowledge Maori on a national basis, rather than just locally. It is more common in New Zealand to acknowledge the Treaty of Waitangi as the founding document that underpins the relationship between Maori and the Crown and, accordingly, the NZNC and New Zealand staff are exploring the concept of a document acknowledging the treaty, and perhaps Te Atiawa, in a form appropriate to Maori.

Dr Sean McManus, ANZCA Councillor and Chair of the Indigenous Health Committee

Making a serious drug error shouldn't be so easy...

"Some will have first-hand experience of a significant drug administration error, most will know of a local episode and all of us are aware of the persistently large number of medication errors...reported."

You are working in a busy theatre complex preparing for a day of anaesthesia.

During the pre-operative consultation your first patient describes significant anxiety at the prospect of undergoing surgery so you offer to provide a small dose of intravenous midazolam when they arrive in the theatre induction room.

Talking to your patient you reassure them that the medication you are injecting will soon take effect and will make them feel "warm and relaxed". Moments later they tell you that it feels "strange to swallow", soon followed by "I can't breathe..." as a look of panic comes across their face and they struggle to move in the bed.

You quickly check the medication and syringe you believed had been so carefully prepared only to realise the clear glass ampoule you had selected contained the paralysing agent cisatracurium and not the anxiolytic midazolam you had intended.

Recognising the error you act quickly to ensure the patient is oxygenated and general anaesthesia is induced safely. The surgery proceeds uneventfully and the patient makes a full recovery but subsequent follow up reveals they have developed a disabling post-traumatic stress disorder requiring ongoing counselling and therapy.

The problem

Anaesthetists will immediately recognise the chilling scenario described as a frightening consequence of an error in the preparation and administration of medications commonly used in our practice.

Some will have first-hand experience of a significant drug administration error, most will know of a local episode and all of us are aware of the persistently large number of medication errors, and the harm that results, reported in anaesthetic and medical literature.

Medication incidents are the second most common event reported in health services with sobering estimates of patient harm and associated costs. Prospective research suggests drug errors may occur as frequently as one in every 133 anaesthetics although the true incidence is likely greater due to under-recognition and under-reporting. A report from the Institute of Medicine in America identified labelling and packaging deficiencies as contributory in as many as one third of medication errors.

Why do errors occur?

Twenty-five years ago the landmark report of the committee on Quality of Health Care in America, "To err is Human", identified that causes of error in the provision of healthcare are multifactorial and reflect system and process complexity.

With the provision of a single dose of medication to a patient in a critical care setting estimated to require between 80 and 200 individual steps from prescription to preparation and administration, the potential for errors is obvious.

Environmental and situational factors such as time pressure, cognitive overload and distraction undoubtedly contribute to the likelihood of making a medication error in anaesthesia.

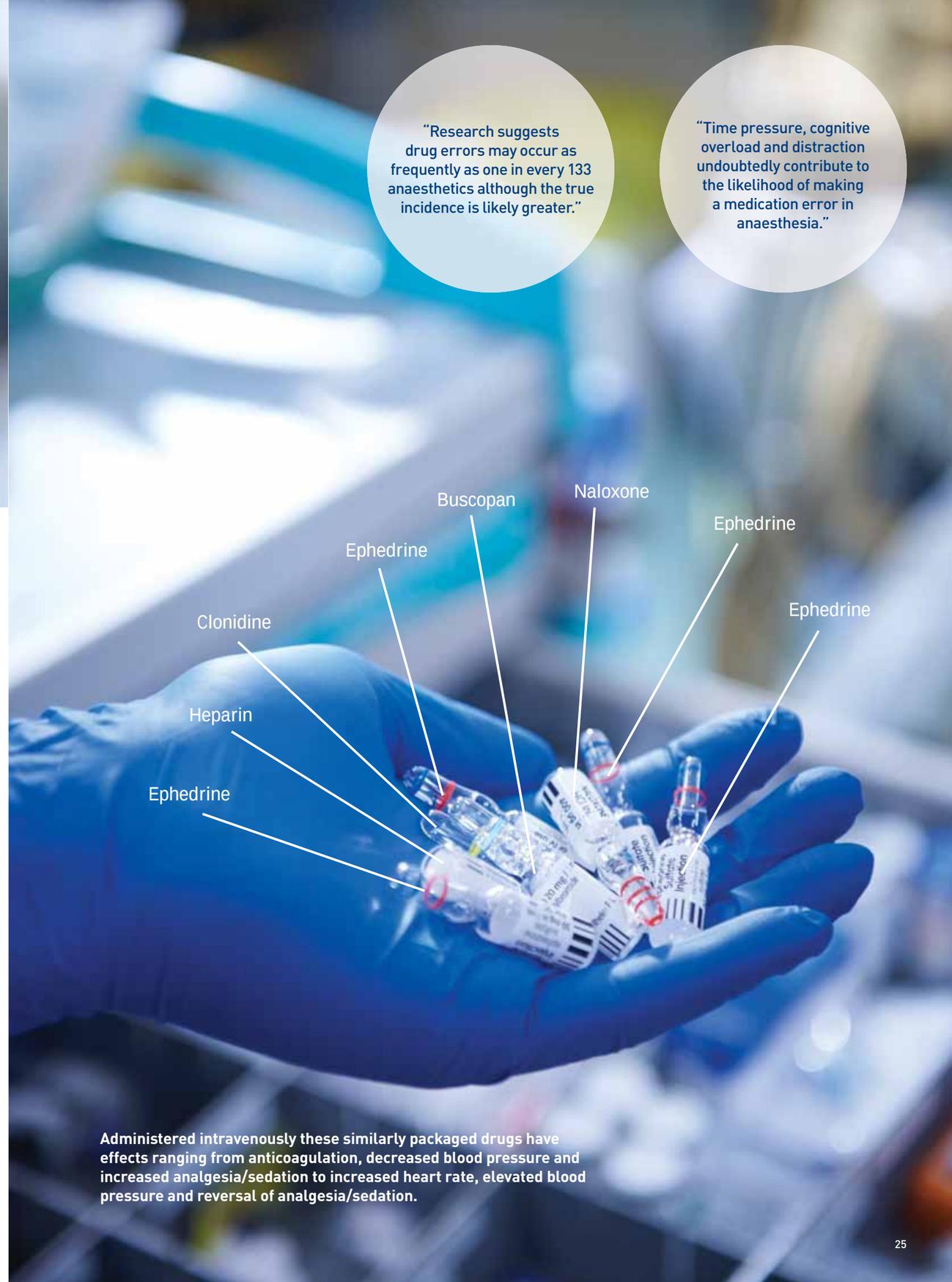
Theorising about the fundamental causes and mechanisms of accidents, psychologist James Reason described the concept of latent errors. These preconditions can be thought of as "accidents waiting to happen".

The variable and indistinct packaging and labelling of injectable medications is a clear example of such a latent error and an obvious contributor to the type of administration error described in the above scenario.

(continued next page)

"Research suggests drug errors may occur as frequently as one in every 133 anaesthetics although the true incidence is likely greater."

"Time pressure, cognitive overload and distraction undoubtedly contribute to the likelihood of making a medication error in anaesthesia."



Administered intravenously these similarly packaged drugs have effects ranging from anticoagulation, decreased blood pressure and increased analgesia/sedation to increased heart rate, elevated blood pressure and reversal of analgesia/sedation.

Making a serious drug error shouldn't be so easy... (continued)

"More than 75 per cent of participating clinicians had experienced a 'near miss' which they attributed to medication packaging."

What is being done?

Anaesthetists have long been contributors to improvements in safety in medication handling and administration. Research by Professor Bill Runciman and Professor Alan Merry, among others from Australia and New Zealand, remains some of the most widely cited work examining both the extent of medication errors and potential solutions.

User applied labelling of syringes with ISO 26825:2008 standard colours for injectable medicines was a change championed by ANZCA with the Australian Commission on Safety and Quality in Health Care (ACSQHC).

This has undoubtedly been a significant step forward but continues to rely on the user correctly identifying a drug in its original ampoule. Recently documented examples of high-risk medication swaps highlight the limitations of such an approach.

ANZCA is also vocal at a government level on medication safety issues, with the New Zealand National Committee recently submitting responses to consultations on drug labelling from both Pharmac and the Health Quality and Safety Commission in New Zealand. The submissions highlighted that illegible labelling, small lettering on small drug ampoules, monochrome labelling and poor contrast all magnify an underlying propensity for human error. The committee encouraged Pharmac to consider these issues when making drug purchasing decisions, and the Health Quality and Safety Commission to consider these issues as part of its medication safety program.

The professional document *PS 51 Guidelines for the Safe Administration of Injectable Medicines in Anaesthesia* condenses much of the available evidence and knowledge to promote safe practices.

Some recommendations of the guideline include:

- Ensuring sound understanding of all drugs being used, having open and clear communication and safe environments for drug preparation.
- Considering drug safety at the time of product purchase to minimise look-alike and sound-alike products.
- Optimising drug storage environments to facilitate clear product identification.
- Making user applied labels readily available and minimising the time between drug selection and administration.

Above left: Sitting among normal saline is Chirocaine (levobupivacaine), which is potentially fatal if injected.

Above right: Atracurium (centre) could easily be mistaken for magnesium or flumazenil.

Good practice and safe behaviours are fundamentally important but anaesthetists will be familiar with the ever-changing presentation of medications that require ongoing "reactive" responses.

Assuming human fallibility underpins the philosophy that further success in reducing medication errors will depend on continuing to address the latent errors in the system including the packaging and presentation of high-risk medications.

Time for change

A report prepared by the Departments of Anaesthesia and Pharmacy at Western Health in Melbourne documents recent medication errors with neuromuscular blocking agents and proposes that Australia adopt standardised packaging and presentation of these drugs.

The report, endorsed by ANZCA, was submitted to the Therapeutic Goods Administration earlier this year and echoes previous calls by the ACSQHC to "require distinctive labelling and packaging of neuromuscular blocking agents in labelling regulatory changes".

Existing recommendations in Canada and the US suggest NMBDs be presented in ampoules with a red vial cap and the words "Warning: Paralyzing Agent".

Despite the widespread adoption of this and other measures by international manufacturers, it is not yet supported by any binding standard. Should the proposals of the "Time for change" report be fully implemented as a mandatory standard, Australia would be positioned as a world leader in this area of regulatory innovation.

The changes proposed are clearly only one small part of reducing the risk of medication error and neuromuscular blocking drugs are just one target. The safe administration of any medication during anaesthesia will continue to depend on the expertise and vigilance of the anaesthetist.

Ensuring human factor considerations in the design and manufacture of high-risk medications will support us by seeking to make it "easy to do the right thing and hard to do the wrong thing".

Our profession has a proud history of prioritising and achieving gains in patient safety that sees us well placed to support and lead such changes.

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

Making a difference – the EZDrugID campaign

EZDrugID is a global campaign to reduce medication errors by addressing issues related to pharmaceutical packaging, with a particular emphasis on the problem of "look-alike drugs".

The EZDrugID campaign was initiated in December 2014 and is active in Australia, New Zealand, the United Kingdom, South Africa and the US. Online petitions to the relevant regulatory authorities in each country have been established, calling for mandatory national standards which incorporate consideration of human factors principles into the design of pharmaceutical packaging so as to maximise the distinctiveness of different drug classes and high risk drugs.

Anaesthetists will already be familiar with the international standard for colour coding by drug class which comprises part of the national recommendations by ANZCA and the Australian Commission on Safety and Quality in Healthcare (ACSQHC) for user applied syringe labels.

Among other strategies, EZDrugID proposes extending this colour coding system to elements of manufacturer applied pharmaceutical packaging.

The tip of the iceberg

The frequency of errors related to look-alike drugs is difficult to gauge as a lack of mandatory reporting means that many "near miss" events and errors not causing patient harm do not get captured.

Even where serious adverse patient outcomes do occur, institutions may keep such events confidential. As a result, the episodes reported in the medical literature, logged in incident reporting databases or appearing in the media represent only the tip of the iceberg.

A survey conducted in conjunction with the EZDrugID campaign revealed that more than 75 per cent of participating clinicians had experienced a "near miss" which they attributed to medication packaging. Nearly 30 per cent of respondents had been involved in an actual medication error related to medication packaging, with serious patient harm being reported in about 10 per cent of these cases.

(continued next page)

What they're saying

In 2005, UK pilot Martin Bromiley's wife Elaine died during routine surgery as a result of errors to which human factors made a significant contribution. In 2007, he founded the Clinical Human Factors Group which brings together experts, clinicians and enthusiasts who place understanding of human factors at the heart of improving patient safety.

He is strongly supportive of the EZDrugID campaign.

"It'll save a multitude of lives, and avoid placing clinicians and patients in error prone situations."

Other comments

Following is a selection of comments from doctors and others from the Change.org website – www.change.org/p/therapeutic-goods-administration-improve-mandatory-national-standards-for-drug-packaging

"It'll save a multitude of lives, and avoid placing clinicians and patients in error prone situations."

"Doctors make errors that can kill. This is one way to make that better. It's what our patients expect and deserve."

"The potential for catastrophic events due to drug errors that could be easily avoided with better packaging is significant."

"Medication errors are common, dangerous and unnecessary."

"So many errors just waiting to happen, and can easily see myself making one of these errors."

"Drug error is a major problem. Better drug labelling is an obvious and simple solution."

"Almost every week there seems to be a change in packaging and presentation of these drugs. It makes the potential for drug error even more likely."

"I'm a nurse and have witnessed multiple near misses and medication errors."

"It's ridiculous how many drug packages are similar and we need to provide safer patient care."

"We must take every effort to engineer safety to limit human error and minimise patient harm."

"I am a nurse and none of us want to have a medication error so having different packaging would make me more comfortable and confident in drug administration."

Making a difference – the EZDrugID campaign (continued)

A global healthcare issue

The issue has resonated with clinicians worldwide. Paramedics, nurses and doctors across numerous specialties have shared images of look-alikes from their clinical environments via social media. The EZDrugID campaign provides a forum for clinicians to highlight concerns, describe incidents and propose potential solutions.

The campaign has gained the support of several prominent human factors campaigners in the healthcare arena including the chair of the Clinical Human Factors Group in the United Kingdom, Martin Bromiley, as well as British anaesthetist, author and television presenter Dr Kevin Fong.

Prevention rather than cure

While hospitals attempt to deal with the issue of lookalikes internally via institutional purchasing, labeling and storage practices, these solutions are not robust enough to provide adequate protection to patients. Changes in purchasing and packaging make it too easy for look-alikes to "slip through the cracks", to be recognised only after patient harm has occurred.

The importance of prospectively addressing the look-alike issue before drugs reach the market was recently highlighted by the near identical packaging of commonly stocked brands of glycopyrrolate and oxytocin.

In the right circumstances, substitution of these drugs has the potential to cause serious foetal harm. Although oxytocin is not usually stocked on anaesthetic trolleys, it was found inadvertently mixed together with the glycopyrrolate in some Australian operating theatres.

Even though the pharmaceutical company involved worked collaboratively with regulatory bodies to address the packaging issue, the realities of the time taken to approve designs, manufacture new packaging and deplete existing stock meant that for a period of more than six months the look-alike packaging stayed in clinical areas, exposing patients to continued risk.

Dr Nicholas Chrimes, FANZCA
Monash Medical Centre, Victoria

Above: Some labels are difficult to see when they are in dark drawers.

Play your part

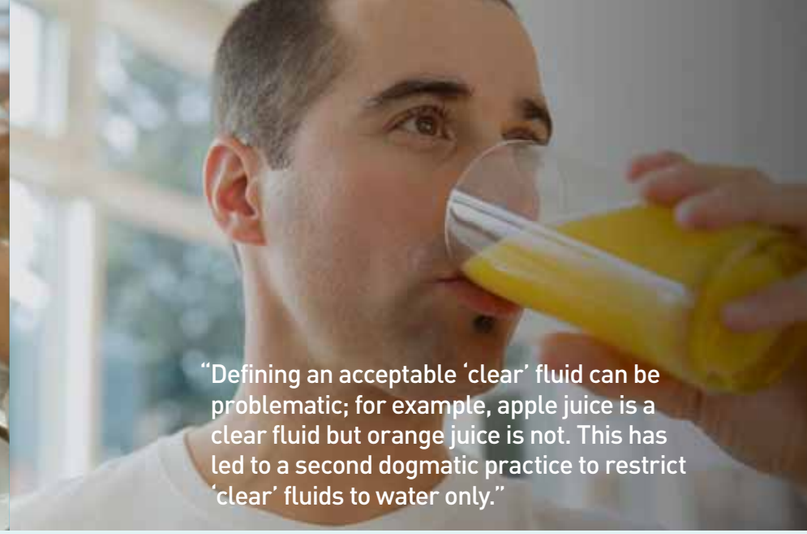
Healthcare professionals do their best to provide the safest possible care for their patents but despite this vigilance, errors still occur.

This risk is increased in situations of stress, distraction, time pressure or fatigue – making anaesthetists particularly vulnerable to such errors.

To learn more about the problems, potential solutions and participate in addressing this serious patient safety issue by signing the online petition, visit the website at:

EZDrugID.org

"Many national guidelines have stipulated a six-hour fast for solids and a two-hour fast for clear fluids for more than a decade so it is not unreasonable to ask why 'nil by mouth from midnight' is still advised by some."



"Defining an acceptable 'clear' fluid can be problematic; for example, apple juice is a clear fluid but orange juice is not. This has led to a second dogmatic practice to restrict 'clear' fluids to water only."

Fasting – not starving – before an anaesthetic

Next year will mark the 70th anniversary of Curtis Mendelson's landmark paper "The aspiration of stomach contents into the lungs during obstetric anesthesia" published in the *American Journal of Obstetrics and Gynecology* in March 1946[1]. This noteworthy occasion should encourage us to reflect on current fasting practices, to ask if we are achieving the goal of an empty stomach, and whether we are causing harm by prolonged fasting.

Curtis Mendelson showed that stomach acid entering the lungs during face mask anaesthesia was responsible for the asthma-like syndrome of cyanosis and dyspnoea witnessed in 66 of 44,016 maternities between 1932 and 1945.

Preoperative fasting has been an integral part of preparation for an anaesthetic ever since. The need to provide a simple clear message, often delivered by nursing staff or other doctors, and to be absolutely certain that no harm befalls the patient has, over time, generated dogmatic practices that merit challenging.

Our concerns should be focused on fluids. There is good reason to continue the current restrictions on solids. In Mendelson's study, the only two patients to die, did so from the inhalation of solids.

Achieving an empty stomach

The first dogma to challenge is that a prolonged fast results in an emptier stomach than a short fast, the classic "nil by mouth from midnight" that many of us were introduced to as medical students doing our first surgery rotations. The logic that follows from Mendelson's paper is that to prevent aspiration of stomach acid the stomach should be empty at the time of inducing anaesthesia.

The 2011 European fasting guidelines[2] clearly state that patients should be encouraged to drink clear fluids up to two hours before the induction of anaesthesia citing level 1A evidence from papers dating back to the mid 1980s.

There is clear evidence that drinking clear fluids two to four hours pre-anaesthesia (unrestricted volume) results in a smaller residual gastric volume with a higher pH (less acidic) than restricting fluids for greater than four hours. Fluids dilute the acid that is continually secreted and stimulate the stomach to empty. The guidelines go on to state that patients traditionally thought to have delayed gastric emptying – the obese, diabetic, pregnant or those with reflux – can follow the same advice.

Many national guidelines have stipulated a six-hour fast for solids and a two-hour fast for clear fluids for more than a decade so it is not unreasonable to ask why "nil by mouth from midnight" is still advised by some.

Indeed a 2006 paper in the *British Journal of Anaesthesia*'s continuing education supplement titled "Pre-operative fasting – 60 years on from Mendelson" declared "nil by mouth from midnight" has no place in modern perioperative practice[3].

Avoidance of over-fasting is not a new concept. Lord Lister, the father of modern surgery, noted in 1882 that prior to chloroform anaesthesia "it will be found very salutary to give a cup of tea or beef-tea about two hours previously"[4].

Reducing the metabolic effects of starvation

Defining an acceptable "clear" fluid can be problematic; for example, apple juice is a clear fluid but orange juice is not. This has led to a second dogmatic practice to restrict "clear" fluids to water only.

The unintended consequence is that most patients on a morning list will have no caloric intake for at least 12 hours and will arrive in theatre with a catabolic metabolism characterised by insulin resistance.

This is worsened by the stress response to surgery which induces further insulin resistance proportionate to the severity of surgery. This disadvantageous metabolic state is associated with an increase in short term complications and reduced long term survival[5].

Prevention of insulin resistance was initially achieved using complex glucose infusion regimes. Recent research has looked into the safety and effectiveness of preoperative oral carbohydrates (POC).

The 12 per cent carbohydrate drinks contain maltodextrins that achieve the dual aims of a carbohydrate load large enough to produce a metabolically fed state with a low osmolality (260-300 mOsmol/KgH_2O) to ensure gastric emptying is not delayed.

POC three hours before an operation has been shown to reduce post-operative insulin resistance by 50 per cent[5]. POC has been given safely to diabetics[2] and has been demonstrated to be safe in a small scale trial of ASA 3 and 4 patients having cardiac surgery[6].

Preoperative oral carbohydrates in practice

Carbohydrate rich drinks offer a simple alternative to prolonged fasting and the restriction of clear fluid intake to water only.

The Armidale Rural Referral Hospital, NSW introduced POC as part of its pre-anaesthetic instructions in January 2015. Local pharmacies were asked to stock the drinks and patients were asked to purchase their own drinks (cost $A10*) and instructed to drink two bottles (400ml) before 6am if on the 8.30am list or 10am if on the 1.30pm list.

Patients completed a questionnaire on arrival in theatre and when compared to a control group using the old fasting guidelines the time since last eating and drinking had not changed but the time since last calories had dropped from 13.5 hours to 6.6 hours. Seventy five per cent of patients had taken the drinks as instructed and 80 per cent reported that they tasted okay, though some found them too sweet. Patients also felt better on arrival in theatre with a 30-40 per cent reduction in the incidence of hunger, thirst, headache and nausea.

Summary

There has been clear evidence for decades that it is not dangerous, and probably even beneficial, for patients to drink clear fluids two to four hours before an anaesthetic.

An increasing body of literature supports the use of pre-operative carbohydrate rich drinks to reduce the stress response to surgery, to shorten length of hospital stay in major surgical cases and improve patient wellbeing on arrival in theatre.

Anaesthetists need to retake ownership of the pre-anaesthetic fasting message and look to include recommendations for the use of carbohydrate rich drinks in their fasting protocols to ensure that patients arrive in theatre comfortable and in an optimal metabolic state.

The current ANZCA fasting guidelines apply to "healthy" patients and conservatively restrict fluid intake to 200ml per hour up to two hours pre-anaesthetic. In a welcome move, the College announced in the August 2015 *ANZCA E-Newsletter* that its Safety and Quality Committee has decided to review the current fasting guidelines found in *PS 15 Recommendations for the perioperative care of patients selected for day surgery*.

There needs to be a robust and thorough review to define best practice. If developed and published in time, perhaps our profession can use the 2016 National Anaesthesia Day to reclaim and redefine the fasting message to celebrate the 70th Anniversary of Mendelson's landmark paper.

Dr David Rowe, FANZCA
Armidale Rural Referral Hospital, NSW

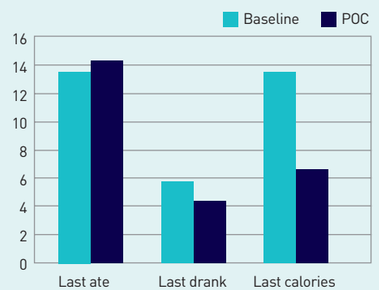
Acknowledgement:
I'd like to thank Dr Bruce Burrow FANZCA, Princess Alexandra Hospital, Brisbane for his assistance in preparing this article.

References:

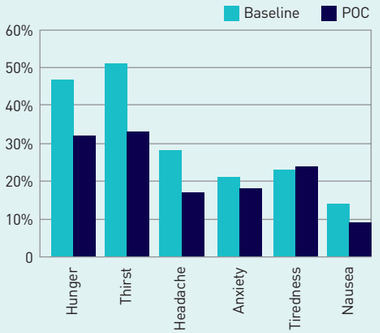
1. Mendelson CL. The aspiration of stomach contents into the lungs during obstetric anesthesia. Am J Obstet Gynecol 1946;52:191-205
2. Smith, I et al Perioperative fasting in adults and children: guidelines from the European Society of Anaesthesiology, European Journal of Anaesthesiology: August 2011 - Volume 28 - Issue 8 - p 556–569
3. Levy D, Pre-operative fasting—60 years on from Mendelson, Contin Educ Anaesth Crit Care Pain (2006) 6 (6): 215-218.
4. Lister J. On anaesthetics: part III. In: The collected papers of Joseph Lister. Birmingham (AL): Classics of Medicine Library; 1979. vol. 1. p. 172-3.
5. Nygren J, et al Preoperative oral carbohydrate therapy, Curr Opin Anesthesiol 2015, 28:364–369.
6. Breuer JP et al. Preoperative oral carbohydrate administration to ASA III-IV patients undergoing elective cardiac surgery. Anesth Analg. 2006;103:1099–1108

* Prices vary but 400ml (2 x 200ml) of a recognised POC drink can be as low as $A4 (depending on the state and bulk purchasing arrangements).

Fasting in Armidale hospital, NSW – Results time since (hours)



Fasting in Armidale hospital, NSW – Results incidence of pre-operation (%)



PROPOFOL ABUSE ON THE RISE

"LITTLE HELPER" POSES PROBLEMS

Janet was desperate. Doing a research fellowship made access to her "little helper" –the milk of amnesia 2,6-diisopropylphenol – really problematic. She knew she could try obtaining it over the internet, but that just increased the risks. She'd leave that to an act of last resort. Posing as a nurse in the accident and emergency unit she had just slipped the drug out of a drawer in the procedure room when she was confronted by the charge nurse. The rest is history.

Three decades of substance abuse surveys indicate a dramatic potential rise in propofol abuse by anaesthetists.

Propofol is involved in 56 per cent of new cases of substance use disorder reported in anaesthetic registrars[1]. Sadly this also seems to be associated with a high mortality rate.

Often available unsecured and unregulated in a variety of locations within a hospital, propofol is relatively easy to access unlike opioid medications. It is short acting, has a rapid clear-headed recovery and appears to have minimal hangover effects. Like most addictive drugs or activities, it enhances dopamine levels in the mesocorticolimbic reward area of the brain, which also reinforce the repeated associated behaviour of obtaining and injecting the drug[2]. Sub-anaesthetic doses appear to provide a sense of euphoria and relief to sleep-deprived shift workers.

Substance use disorder and addiction are chronic medical conditions, and while they are treatable, they also are subject to exacerbations and relapses, especially without appropriate therapy and follow up.

Recognition and identification of an anaesthetist with substance use disorder continues to be difficult and subjective, with denial by both the addicted individual and the observer common[3].

Unfortunately late signs such as direct observation or intoxication are the most frequently reported methods by which cases are identified and the more subtle signs are often missed.

What to do if you suspect a colleague

In the situation where an anaesthetist is suspected to have a substance use disorder, written evidence should be collated and any oral evidence documented. This will need confidential confirmation by an appropriate investigation.

"Available, unsecured and unregulated in a variety of locations within a hospital, propofol is relatively easy to access unlike opioid medications."

In the interim, protection of the individual and their patients is paramount, and should be overseen by an intervention team member, senior consultant anaesthetist, registrar or, in some circumstances, a senior nurse or technician. It is now mandated that the appropriate health authority be notified.

Further investigation that should be considered includes an observer report, retrospective audit(s) of escalating drug usage and prospective observation for ongoing discrepancies.

Definite evidence is required for a successful intervention so careful observation for signs and symptoms of abuse and documentation is essential. A more rapid intervention should be considered if major signs have been observed or documented, such as conclusive evidence of self-injection or intoxication.

An intervention team, including the head of department, an expert in the field such as a psychiatrist and possibly the welfare officer, should outline in advance the plan for an intervention, including the post-intervention strategy and treatment options.

The intervention is best conducted early on a normal operating day when the anaesthetist in question is normally on duty.

The suspect should be informed of the intervention on arrival at work and concurrently given the opportunity to appoint an advocate. The anaesthetist should then be accompanied at all times for their protection against self-harm.

An effort should be made where possible for the chosen advocate to attend the meeting. If this is not possible, the intervention team should appoint a mentor to act on behalf of the anaesthetist under investigation.

It is the responsibility of the intervention team to ensure the safety and emotional needs of the person being investigated are met.

Depending on the situation, the intervention meeting should culminate in one of two ways to ensure the safety of the anaesthetist. If medical detoxification is considered necessary, a qualified person should accompany the anaesthetist to the prepared detoxification unit. If discharge back into the community is considered, this should only occur after a psychiatric assessment for suicide risk.

Record the results of the intervention meeting and subsequent treatment plans then confidentially file this together with the other relevant records.

Rehabilitation

Unfortunately rehabilitation following substance abuse is often complex and relapses and even death may occur.

The optimal management of the impaired anaesthetist is controversial. The most evidence guiding management originates from the Physicians Health Programs in the US.

These programs combine multidisciplinary management with long-term professional and peer support, and involve contracts committing to rehabilitation and abstinence.

These studies shown success rates of 75-90 per cent after five years for US physicians treated through Physicians Health Programs and preliminary data from the Victorian Doctors Health Program indicates similar Australian five-year success rates[4,5,6].

(continued next page)

WHAT TO LOOK FOR

MAJOR SIGNS

- Direct observation of suspicious behaviour.
- Drugs found in non-work areas.
- Injection marks.
- Signs of intoxication or withdrawal.
- Illegible or inaccurate records.

MINOR SIGNS

- Social withdrawal, elusiveness.
- Mood swings, depression, euphoria.
- Poor hygiene, weight loss.
- Long toilet breaks, long sleeves.
- Temperature sensitivity.
- Absenteeism, inappropriate conduct.
- Volunteering for extra duties or cases.

TRAINEES AT RISK

Anaesthesia training in Australia and New Zealand could be considered a high-risk occupation due to the impact of substance abuse on the profession, according to a review of the past 30 years of data from three retrospective surveys.

Eleven deaths (23 per cent) associated with substance use were identified in the survey period, with five directly identified as being related to substance abuse or overdose, and seven described as suicide.

The estimated mortality rate of 39 deaths per 100,000 anaesthetic registrars is very high, especially considering the most dangerous Australian industry, freight trucking, has a death rate of 29 deaths per 100,000.

The overall incidence of substance abuse was 1.7 cases per 1000 registrar years, or potentially as many as one in every 133 registrars entering training[1]. The recent 10-year survey indicates that trainee suicide may be three times that of specialists and that propofol has become their most common drug of abuse for registrars (56 per cent), with opioids falling to 44 per cent[2].

Lewis Fry,
Medical student

References:

1. Fry RA, Fry LE, Weeks A. Substance use disorder amongst New Zealand and Australian anaesthetic trainees: an analysis of 30 years of data. Anaesth Intensive Care. 2015 43:4:530.
2. Fry RA, Fry LE, Castanelli DJ. A retrospective survey of substance abuse in anaesthetists in Australia and New Zealand from 2004 to 2013. Anaesth Intensive Care. 2015 43:1:111–7.

PROPOFOL ABUSE ON THE RISE (CONTINUED)

A recent survey of Australian and New Zealand teaching hospitals indicates poorer outcomes compared to the US with only 32 per cent of substance abusing anaesthetists successfully remaining in their chosen profession, although 80 per cent treated for more than 12 months successfully returned to anaesthesia.

The statistics

Demographic results indicate that the "typical" anaesthetist diagnosed with substance use disorder will be a male consultant aged between 30 and 49 years of age (incidence 0.8/1000 anaesthetic years).

However the incidence appears to be twice as high in registrars (1.5/1000) and (1/1000) for females.

Seventy per cent of cases had one or more contributing comorbid conditions with mental health issues (anxiety and depression) and family problems making up more than 80 per cent of these.

Compared to the previous surveys, there has been a reported increase in the use of propofol and alcohol, with a decrease in opiate abuse, of which fentanyl remains the most common agent.

Substance use disorder is a significant issue recognised by the profession worldwide.

It is essential we are aware of the signs of substance abuse and that departments have access to the expertise to deal with these issues to best assist impaired anaesthetists.

"It is essential we are aware of the signs of substance abuse and that departments have access to the expertise to deal with these issues to best assist impaired anaesthetists."

ANZCA has a number of strategies to address this issue including continually updated doctors welfare resources on the ANZCA website (see www.anzca.edu.au/resources/doctors-welfare), devoting sessions to welfare at most conferences, supporting the establishment of departmental welfare officers and working with the Royal Australasian College of Psychiatrists to improve the diagnosis and treatment of at-risk individuals.

Dr Rob Fry, FANZCA
Welfare of Anaesthetists
Special Interest Group

References:

1. Fry RA, Fry LE, Weeks A. Substance use disorder amongst New Zealand and Australian anaesthetic trainees: an analysis of 30 years of data. Anaesth Intensive Care. 2015 43:4:530.
2. Bryson EO, Frost EA. Propofol abuse. Int Anesthesiol Clin 2011; 49:173-80
3. Baldisseri MR. Impaired healthcare professional. Critical Care Medicine. 2007;35(Suppl):S106–16.
4. Skipper GE, Campbell MD, DuPont RL. Anesthesiologists with Substance Use Disorders: A 5-Year Outcome Study from 16 State Physician Health Programs. Anesth & Analg. 2009;109(3):891–6.
5. Wile C, Frei M, Jenkins K. Doctors and medical students case managed by an Australian Doctors Health Program: characteristics and outcomes. Australian Psychiatry. 2011 Jun;19(3):202–5.
6. McLellan AT, Skipper GS, Campbell M, DuPont RL. Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. BMJ. 2008;337:a2038.
7. Fry RA, Fry LE, Castanelli DJ. A retrospective survey of substance abuse in anaesthetists in Australia and New Zealand from 2004 to 2013. Anaesth Intensive Care. 2015 43:1:111–7.

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

Pain scores: Help or hindrance?

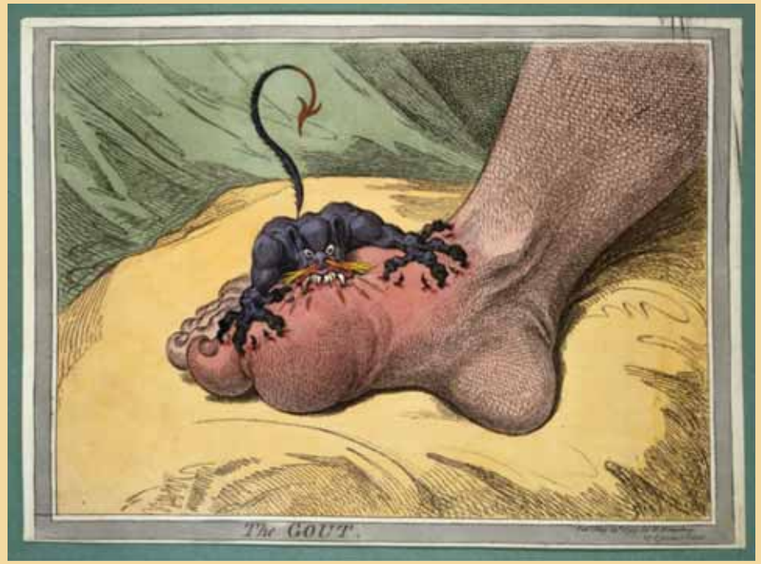
In an attempt to avoid undertreating pain, pain scores have become an almost universal measure. It's easy to think this is the ideal way of communicating acute pain. But are there downsides to that number out of 10? Perhaps. Not only do pain scores reduce a complex, multidimensional experience to a single (and perhaps misleading) dimension, they also can adversely affect the pain.

The widely accepted definition of pain acknowledges it is an experience with sensory and emotional (and other) components[1]. When faced with the complexity of this very human condition, simplifying communication by using a scoring system has appeal. It may be efficient and it's certainly easier than a pain history. But is this approach too simplistic?

Take the well-known etching "The Gout" by British artist James Gillray. This gout sufferer's description might run "it's like a fire-breathing devil is piercing my skin with his fangs and claws, and my whole foot feels swollen and on fire" or alternatively "well, it's 10 out of 10".

A pain score potentially suppresses our understanding of this pain, at worst limiting our empathy or therapeutic approach. Once a number has been mentioned, there is the risk that the doctor's mind is already moving on to a treatment focus, managing the pain score rather than the patient.

Dr Charles Pither, writing in the book Perceptions of Pain, provides a poignant example: "If my back is painful and I'm out of work and my wife has left me, where do I hurt?"[2]. How much information will we get from this person presenting with acute back pain if we limit ourselves to a grading out of 10? Where is the remainder of his story – his expectations, his grief, his isolation, the physical and the financial costs of his pain?



Above: "The Gout" by British artist James Gillray.

Most lay people do not think of their pain in terms of numbers (unless educated by the health system to do so). Scores are convenient and efficient for doctors and nurses and sometimes for the patient. However, for the person experiencing pain, there are many more dimensions.

Additionally, pain scores may have a negative impact on the patient's experience by repeated negative suggestion. For example, in 300 women following caesarean section randomised to either a pain scale or a comfort scale, those using pain scores reported greater pain severity and were more likely to experience "tissue damage and injury" rather than "healing and recovery"[3].

Lang and colleagues[4] found the use of negative descriptors during interventional radiology procedures increases patients' pain and anxiety. This is the nocebo effect, the "expectation of a negative outcome (leading) to worsening of a symptom"[5]. It is the opposite of the placebo effect and has a neurobiological basis. It leads to the question "Can words hurt?"[4] – the answer is almost certainly yes!

In conclusion, pain scores are not valueless, but they are limited and limiting. They are convenient and can assist us in obtaining a response and in evaluating our treatments. They save time, but at what cost? They reduce the multidimensional qualitative experience of pain to a single quantitative dimension. They are not centred on the person's experiences, and they introduce negative suggestion into clinical interactions that can adversely affect the person's experience of pain and impair its treatment.

As doctors, we rely on the patient as our guide to their experiences. Not everything that counts can be determined by a number!

Dr Lindy Roberts, FANZCA, FFPMANZCA
Dr Suyin Tan, FANZCA, FFPMANZCA
Dr Allan Cyna, FANZCA

References:

1. International Association for the Study of Pain definition of pain. www.iasp-pain.org accessed July 14, 2015.
2. Padfield D. Perceptions of pain. Dewi Lewis Publishing, UK, 2003.
3. Chooi CS et al. Brit J Anaesth 2013;110:780-7.
4. Lang EV et al. Pain 2005;114:303-9.
5. Benedetti F et al. Neuroscience 2007;147: 260-71.

The Communication in Anaesthesia Special Interest Group (SIG) aims to help improve anaesthetists' clinical interactions with patients, other clinicians, managers and the media. In addition, the SIG promotes and assists with research and teaching in communication. We are looking for new members so if you are interested, please email events@anzca.edu.au.

Evolution of an adult difficult airway trolley

A difficult airway trolley (DAT) is essential in all operating theatre complexes.

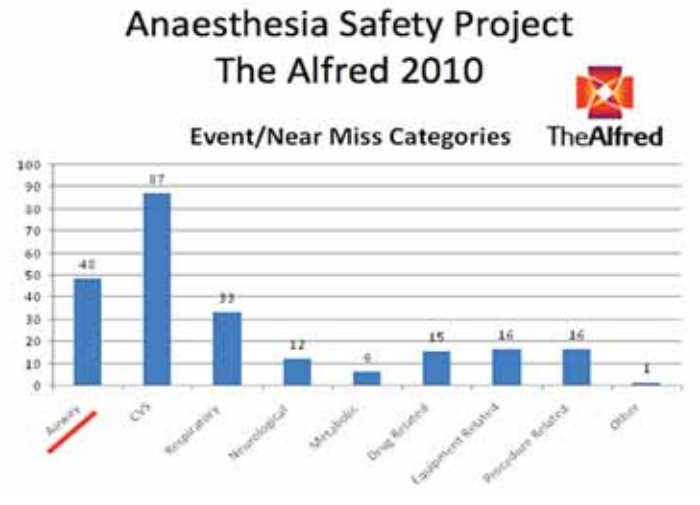
Adverse events involving the airway continue to account for a significant proportion of morbidity reports.

At Melbourne's The Alfred hospital (2008-2010), airway-related adverse events were consistently the second-most reported (figure 1) and featured highly in morbidity meetings. It is a major cause of reported morbidity in Victoria and continues to represent significant risks for morbidity and mortality.

Coupled to this, the number of devices to assist in difficult intubation has expanded exponentially. This increases the complexity and range of anaesthetic technical skills required but makes it difficult to prioritise which equipment to use.

Recent evidence recognises and supports the need for ongoing simulated practice to improve the preparedness of anaesthetists and intensive care specialists to manage can't intubate can't oxygenate (CICO) events[1,2].

Figure 1: The pattern of adverse events reported to The Alfred Anaesthesia Safety Project 2010 (with permission from Schmik solutions Pty Ltd.)



In 2009, we redeveloped difficult airway trolleys at The Alfred.

The primary principles and goals of the project were to:

- Limit the number of devices available at the point of care.
- Standardise the equipment across the entire Alfred Health network.
- Support an ongoing education program surrounding difficult airway management.
- Develop a systematic approach to improve preparedness to manage CICO events.
- Incorporate human factors into the airway trolley layout.

Limiting equipment was justified, as too much equipment on the difficult airway trolley makes finding the required equipment difficult in an emergency.

We aimed to modify the temptation to "try every device" instead of developing a well-reasoned sequence of actions in advance.

Every staff member involved in airway management should be familiar with the use of every component on the trolley.

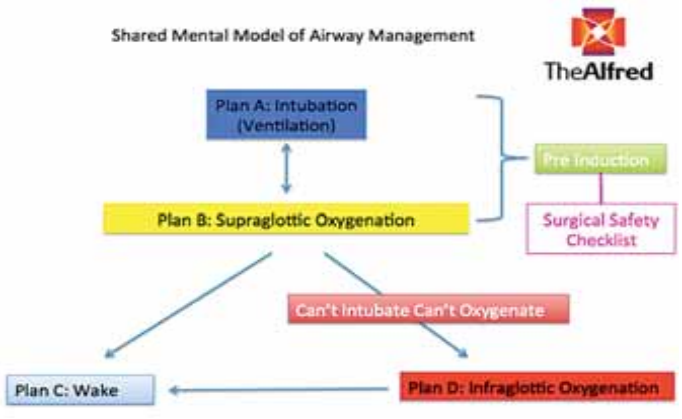
We designed an integrated shared model for difficult airway management that paralleled education and, above all, simplified and improved the abilities of the clinical team to act collectively and respond appropriately.

We incorporated information from the 2009 *BJA* CICO paper[3], airway experts' feedback and allied health staff to ensure we had an optimised difficult airway trolley.

A CICO pack was provided that could be deployed rapidly in all theatres and be used to provide percutaneous emergency oxygenation during a CICO crisis.

The education model separated plan A (intubation) from plan B (supraglottic oxygenation) and plan D (infraglottic oxygenation). Importantly oxygenation was central to the model and forms part of the pre-induction planning. Plan C (wake up) represented the final aim and although it didn't require specific equipment, it is critical to the underlying education program that surrounded the management of failed intubation and CICO events (figure 2).

Figure 2: The planning process around a difficult airway trolley.



The model supported clear pre-induction planning and recognised the interaction between plan A, plan B and plan C. Educationally these processes represent everyday practice and the trolley was designed with that in mind.

The difficult airway trolley was designed around the model to include seven colour-coded drawers (figure 3). Plan A drawers are colour coded blue, plan B are colour coded yellow and plan D, red or black. In addition, there is a cognitive aid, fibrescope and a range of bougies and catheters on each trolley. The colour coding provides the user of the trolley with instant visual feedback as to which drawers are required for plans A, B and D in a systematic stepwise process and assists those involved in any scenario knowing where they may be in the model.

Central to the deployment of the difficult airway trolley was an orientation package that included a cognitive aid, talks and simulated practice program.

(continued next page)

Evolution of an adult difficult airway trolley (continued)

Figure 3: The Alfred and Epworth difficult airway trolleys.

Over the period of time The Alfred difficult airway trolley was used, it became apparent certain aspects could be improved upon, in part from additional papers reviewed[4,5,6] and ANZCA *PS56 Guidelines on Equipment to Manage a Difficult Airway During Anaesthesia*, new technologies available and that some products were not as effective as perceived[7].

We decided to increase the ratio of airway trolleys to theatres to improve patient safety, which was justified by the increasing complexity of patients, surgery and our risk management evaluations.

Subsequently there was a chance to upgrade the Epworth difficult airway trolley. This enabled us to re-evaluate our initial design in relation to the new environment and the opportunity to increase the standardisation of the trolleys at different organisations across Victoria. This would increase the comfort of visiting anaesthetists and reduce stress about when orientating to a new environment.

Videolaryngscope usage increased over time such that the non-reusable and reusable blades were the main things that had to be restocked daily.

The decision was made to remove the videolaryngoscopes from the difficult airway trolley and to increase the number of freestanding videolaryngoscopes mobile units around the anaesthetising areas. In the ideal world, there would be advantages to having one in each theatre.

These changes allowed for a narrower trolley with smaller dimensions to be used so it was lighter, more mobile and easier to store. It was specially designed to be a seven-draw distinctive red colour configuration to allow easy recognition.

A rapid deployment disposable fibreoptic scope became available, which could fit down the Aintree catheter and was not easily breakable, so replaced the fibrescope.

The fibrescopes were relocated in a central storage area for use in the more elective setting. Sugammadex (2000mg) was added. A policy for its use was developed given its relatively high cost.

We subsequent envisage having a paediatric trolley with a different colour based along similar designs, and including capnography or CO_2 detectors to the off the floor trolleys.

Conclusions

Our goal in developing a mobile difficult airway trolley and learning package was to reduce the variability and complexity of factors in high-risk airway situations, standardise the equipment available across many different organisations, campuses and environments in Victoria and allow for the easy deployment of the trolley in remote anaesthetising locations. The trolley and its cognitive aid are designed to facilitate the smooth progression between the different airway plans.

Ultimately we hope this reduces the consequences of oxygen desaturation associated with difficult airway management by incorporating a standardised trolley to improve the interaction between healthcare teams, the equipment and skill sets.

Dr Chris Bain
Senior Staff Anaesthetist,
The Alfred, Melbourne

Dr Joel Symons
Senior Staff Anaesthetist,
The Alfred, Melbourne

Dr Pierre Bradley
Senior VMO Anaesthetist,
The Alfred, Melbourne
Executive, Airway Management Special Interest Group

Dr Simon Reilly
Chairman, Anaesthetic Services,
Melbourne

Acknowledgements:
Epworth Medical Foundation Charity
Esther Cohen, Emilie Tidd, Pauline Fogarty

References:

1. Cook TM, Woodall N, Harper J, Benger J, Fourth National Audit Project. Major complications of airway management in the UK: results of the Fourth National Audit Project of the Royal College of Anaesthetists and the Difficult Airway Society. Part 2: intensive care and emergency departments. *Br J Anaesth* Oxford University Press; 2011;106:632–42
2. Cook TM, Woodall N, Frerk C, on behalf of the Fourth National Audit Project. Major complications of airway management in the UK: results of the Fourth National Audit Project of the Royal College of Anaesthetists and the Difficult Airway Society. Part 1: Anaesthesia. *Br J Anaesth* Oxford University Press; 2011;106:617–31
3. Heard AMB, Green RJ, Eakins P. The formulation and introduction of a 'can't intubate, can't ventilate' algorithm into clinical practice. Blackwell Publishing Ltd; 2009;64:601–8
4. Baker PA, Flanagan BT, Greenland KB, et al. Equipment to manage a difficult airway during anaesthesia. *Anaesth Intensive Care* 2011;39:16–34
5. Greenland KB, Irwin MG. Airway management - 'spinning silk from cocoons' (抽丝剥茧 - Chinese idiom). 2014;69:296–300
6. Greenland KB, Acott C, Segal R, Goulding G, Riley RH, Merry AF. Emergency surgical airway in life-threatening acute airway emergencies--why are we so reluctant to do it? *Anaesth Intensive Care* 2011;39:578–84
7. Ilyas S, Symons J, Bradley W, et al. A prospective randomised controlled trial comparing tracheal intubation plus manual in-line stabilisation of the cervical spine using the Macintosh laryngoscope vs the McGrath(®) Series 5 videolaryngoscope. 2014;69:1345–50

"Limiting equipment was justified, as too much equipment on the difficult airway trolley makes finding the required equipment difficult in an emergency."

Epworth difficult airway trolley specifications (2014)

Bailida NC3706	**Narrow cart 37" red (special colour request) with full locking bar** Special draw configuration – 4 x 3 inch and 3 x 6 inch drawers. Four castors, dividers in two draws, push handle dimensions: 510 x 524 x 1056mm Auto return *Suppliers: National Surgical Corporation www.nationalsurgical.com.au*
VIV	IV pole, adjustable height, bolt on – chrome
VO2 and VPR-2	Oxygen tank holder 145 x 125 403mm with side rail mount
VCH and VPR-2	Catheter holder and side rail 100 x 100 x 480mm
Top and side of trolley	Cognitive aid 1 x Aintree catheter (19Fr) 1 x airway exchange catheter (19Fr) 1 x soft-tipped exchange catheter (11Fr) 2 x Frova catheters (8Fr) 1 x Ambu A3 scope 5.0 1 x Ambu A3 scope 3.8 1 x Ambu A view monitor 1 x oxygen cylinder 1 x air viva (with peep valve) 1 x long electrical powercord 1 x CICO needle cricothyroidotomy pack 1 x CICO surgical cricothyroidotomy pack
Drawer 1 Topicalisation	1 x cophenylcaine spray 1 x short nozzle 1 x long nozzle 2 x xylocard 10% 5ml 1 x medicine cup 1 x xylocaine 10% pump spray 1 x xylocaine 5% ointment 1 x lignocaine 2% oral gel 1 x tube lubricant 1 x DeVilbiss atomiser 1 x epidural kit
Drawer 2 Airway	Nebulisers/tracheostomy mask/Ovassapian 1 x Ovassapian airway 1 x nebuliser mask 1 x ACE spacer 1 x salbutamol inhalers 1 x nebuliser tee 1 x endoscopy mask 1 x tracheostomy mask 1 x bodai/swivel Y 2 x salbutamol nebulas 5mg 2000mg Sugammadex
Drawer 3 Guedel & Nasophayngeal	1 x guedels 1 (6),2 (7),3 (8),4 (9),5 (10),6 (11) 1 x nasopharyngeal 6,6.5,7,7.5,8,8.5
Drawer 4 Plan A Laryngoscopes	1 x short handle 1 x normal handle 1 x Kessel blade size 3 1 x Kessel blade size 4 1 x McCoy blade size 3 1 x McCoy blade size 4 1 x Miller blade size 2 1 x Miller blade size 3 1 x Miller blade size 4 2 x C batteries 2 x trachy tape
Drawer 5 Plan A Intubation – ETT/Stylet	1 x ETT sizes 5, 5.5, 6, 6.5, 7, 7.5, 8 1 x MLT sizes 4, 5 1 x Fastrach ETT sizes 6,7,8 1 x Parker Flexi-tip sizes 6, 7, 8 1 x Stylet 1 x Magills forceps
Drawer 6 Plan B Supraglottic oxygenation – LMA	1 x Supreme LMA sizes 3,4,5 1 x Classic LMA sizes 3,4,5 1 x Fastrach LMA sizes 3,4,5 1 x Fastrach ETT sizes 6,7,8
Drawer 7 Plan D Infraglottic oxygenation – Cricothyrotomy	1 x Manujet 1 x Manujet connecting tube 1 x Melker cuffed cricothyrotomy set

Mortality report helps inform risk of dying

New Zealand's Perioperative Mortality Review Committee (POMRC) presented its fourth report at a workshop held in Auckland in June.

The report outlines the risk of dying within 30 days of an operation and/or anaesthetic, providing information so that prospective patients and clinicians can factor the risk of dying into their informed choice and consent.

The information also looks at other available international mortality rates to inform the public on how New Zealand's healthcare compares with that in other countries. The full report can be found on the Health Quality & Safety Commission website www.hqsc.govt.nz/assets/POMRC/Publications/POMRC-fourth-report-Jun-2015.pdf.

The data used in producing the report covers almost all acutely admitted patients and the majority of electively admitted patients, thus providing an excellent picture of actual perioperative mortality in New Zealand.

It comes from the National Minimum Dataset (NMDS), which contains the coded healthcare data from all public hospitals and some private hospitals. This is then matched with the data from the National Mortality Collection (NMC) so that patients who died within 30 days of a procedure (either in hospital or after discharge including transfer to a second hospital) are identified and mortality rates calculated.

The procedures chosen for full analysis are those that are more common, have an increased mortality rate, or have been the focus of increased attention because of changes in healthcare or problems that have arisen.

Specific mortality rates are presented in table 1, which show the mortality for all patients undergoing the specific procedure, or having the specific postoperative complication, or with the specified ASA status.

The rates vary considerably between procedures, hence giving specific rates. While this doesn't give guidance about other procedures, it can help give an indication for similar procedures.

The outcomes are then analysed to look for independent effects of acute or elective admission, ASA status, age, sex, ethnicity, and socioeconomic status (NZDep, the New Zealand Index of Deprivation, a 1-10 scale measuring socioeconomic deprivation). The mode of admission, ASA status and age have very significant effects as demonstrated, using patients who develop severe sepsis post-operatively (table 2), while that of sex, socioeconomic status and ethnicity have limited effect apart from in a few specific procedures, such as worse Maori elective CABG mortality (OR 3.36) and female acute CABG mortality (OR 2.44).

To help with separating out the effect of underlying mortality, POMRC has the proportion of the New Zealand resident population who die within 30 days broken down by age. This is particularly important for low mortality procedures, such as bariatric surgery (table 3). Patients having this procedure had an age range of 15-74 years of age, with the peak at 45-49 and 75 per cent within 35-59.

Given that there were approximately three times more females than males having this operation, this would mean that, for a New Zealand-resident population, there would be one death expected, and the excess is two deaths, which would be within normal variability limits. The implication of this is that bariatric surgery is very safe, which, given the risks and co-morbidities involved, is an excellent result.

This was the first report that demonstrated a significantly increased risk for Maori having coronary artery bypass grafts (CABGs). The Maori caucus of the joint mortality review committees commented on this result, noting that there are multiple potential causes such as the higher prevalence of diabetes, hypertension and smoking.

The type of vascular disease may differ from that in other ethnicities, in that it is generally more diffuse and involves smaller vessels. The issues of access to treatment continue to be investigated and improvements made.

POMRC is a statutory committee comprising anaesthetists, surgeons, an intensivist, an obstetrician and gynaecologist, nurses and an epidemiologist to provide a whole-of-care perspective. It is part of the mortality group within the Health Quality & Safety Commission.

Table 1: 30-day all-cause mortality rates for specific ASA status, procedures, or post-operative complications.

Procedure that patients underwent/complication experienced/condition of patients	Acutely admitted patients	Electively admitted patients
CABG	4.3%	1.4%
PTCA	2.2%	-
Bariatric surgery	-	0.07%
Severe post-operative sepsis	22.7%	10.9%
ASA 4	17%	4%
ASA 5	53%	45% (? Erroneous ASA)
All types of cholecystectomies	0.82%	0.18%
Open cholecystectomy	4.23%	
Laparoscopic cholecystectomy converted to open	1.09%	
Knee TJR	-	0.17%
Hip TJR	7.0%	0.17%
Colo-rectal resection (first report)	9.8%	2.1%
Pulmonary embolus	0.01%	0.06%
General anaesthesia (day 0+1 only)	0.12%	0.03%
ASA 1 or 2	(not measured)	0.05%

Table 2: Effect of increasing ASA status or age: 30-day all-cause mortality.

ASA status / age	Severe sepsis – acute admission	Severe sepsis – elective admission
ASA 1&2	6.3%	1.4%
ASA 3	18%	7.3%
ASA 4&5	41%	26%
0-44 years of age	8.7%	3.4%
45-64 years of age	15%	6.3%
65-79 years of age	27%	14%
80+ years of age	44%	27%

Table 3: Deaths after elective bariatric surgery, compared with the deaths in the NZ resident population for the same number of people.

	Deaths (4067 people)		Rate	
Bariatric surgery	3		0.07%	
NZ residents	**Female**	**Male**	**Female**	**Male**
35-39 years of age	0	0	0.006%	0.010%
45-49 years of age	0	1	0.01%	0.02%
55-59 years of age	1	2	0.03%	0.05%
85-89 years of age*	33	41	0.8%	1.0%

*85-89 age group was inserted to indicate the increase in number of expected deaths with increasing age.

Dr Leona Wilson
Chair, Perioperative Mortality Review Committee

New high-risk medicine resources available in New Zealand

An abbreviation here, a back slash there – it doesn't take much to create confusion that can lead to a prescribing error. New Zealand's Health Quality & Safety Commission (HQSC) is encouraging doctors to make full use of new resources to help reduce harm from high-risk medicines.

Common confusions with prescriptions are included in a series of "One step for medication safety" fact and activity sheets available as downloadable PDFs from the HQSC's *Open for better care* national patient safety campaign website (www.open.hqsc.govt.nz).

Examples, in a one step on insulin prescribing, include the use of:

- U as the abbreviation for units – U read as 0 can lead to a 10 times overdose (for example, 80 units given instead of 8 units). U has also been mistaken for 4 and 6.
- Use of a / to separate doses. For example, 10/5 units, meaning 10 units in the morning and 5 units in the evening, can be interpreted as 15 units or even 105 units.
- Use of trailing zeros can lead to overdoses of 10x or 100x – for example, 4.0 units being interpreted as 40 units.
- IU as an abbreviation for insulin unit can result in I being read as 1. For example, 41 units given instead of 4 units when prescribed as 4IU.

Other resources include a downloadable poster "Communicating so people will understand", which suggests simple techniques to use when talking with someone about their health or medicines.

Susan Ewart
ANZCA Communications Manager, NZ

Anaesthetists need to be wary of postpolio syndrome

Postpolio syndrome (PPS) occurs in a significant proportion of polio survivors years after recovering from the original illness[1,2].

Anaesthetists need to be aware of the syndrome as polio survivors are relatively numerous (40,000 cases of paralytic polio in Australia from the 1930s to the 1960s), they are of an age where they will be increasingly presenting for elective and emergency procedures and the syndrome has important implications for the planning and delivery of anaesthesia[3,4].

Poliomyelitis results from an enteroviral infection that damages anterior horn cells in the spinal cord and results in flaccid paralysis with slow improvement over months or years. It may also be associated with encephalitic changes affecting the brainstem nuclei particularly in the medulla, the cerebellum and the reticular formation and as a result may cause bulbar and autonomic dysfunction as well as alterations in mental state[5].

PPS typically occurs 20 to 40 years after the acute poliomyelitis episode[5]. Although the exact mechanisms of the PPS are debated[1,3,5], neurological dysfunction worsens or recurs in areas affected during the original illness.

This is most commonly manifested as progressive muscle weakness, fatigue or pain in the muscles and joints. However respiratory failure, sleep disordered breathing and bulbar dysfunction with dsyphonia, dysphagia or poor cough may also occur[1,3]. Cold intolerance is also common[3,6].

Preoperative assessment in PPS patients should define the nature of the initial poliomyelitis episode including areas affected, severity and current functional capacity. A history of polio requiring mechanical ventilation, with bulbar dysfunction or resulting in kyphoscoliosis should prompt a detailed respiratory assessment and consideration of formal lung function testing and blood gas assessment as such patients are at highest risk for postoperative respiratory complications[3].

However, even patients who did not require ventilation during the initial illness may progress to respiratory failure after many years[2]. Detailed questioning regarding symptoms of sleep apnoea and nocturnal hypoventilation such as morning headache, daytime somnolence and fatigue is also appropriate and should prompt investigation when present[1]. Without specific questioning PPS patients who are high risk for perioperative respiratory failure may be missed[2,7,8].

Patients with PPS are generally considered to have increased sensitivity to opiates, muscle relaxants, sedative and anaesthetic drugs leading to recommendations to start low and titrate carefully[3,6,9]. This is probably multifactorial reflecting changes in the reticular activating system, muscle atrophy and weakness due to denervation and reduced volume of distribution due to muscle loss.

In relation to muscle relaxants, PPS patients are said to be twice as sensitive to non-depolarising muscle relaxants with a recommendation to use a short-acting agent, starting with half the usual dose and carefully titrating therapy with neuromuscular monitoring against a baseline twitch response[3,10].

Avoidance of suxamethonium where possible is recommended as it may result in greater post-operative muscle pain[9] and concerns remain regarding the risk of hyperkalaemia although evidence is lacking[3,11]. Regional anaesthesia has been successfully used[3,4,12] and where feasible may result in fewer complications although delayed muscle recovery may occur[4,6].

Other intraoperative factors to consider are patient positioning which may be difficult due to contractures, a high fracture risk from associated osteoporosis and increased risk of nerve injury due to abnormal muscles and tendons[3,4,6].

Awake positioning prior to surgery may minimise these risks. Attention to warming introperatively is important to prevent hypothermia and distressing post-operative shivering due to abnormal thermoregulation[3,4,6].

Postoperative respiratory failure related to oversedation and weakness has been reported[7] and consideration should be given to increased post-operative monitoring in an HDU environment[3,4,8]. Slow emergence and respiratory concerns will preclude day surgery for the majority[4,6]. Pain management may be difficult both due the presence of chronic pain and concerns relating increased sensitivity to the sedative and respiratory depressant effects of analgesics[3,9].

Postpolio syndrome patients present a number of potential problems for the anaesthetist. However for those who are aware of the syndrome, careful assessment and planning should minimise the risk of perioperative complications and provide optimal patient outcomes.

Dr Anthony Tobin, FCICM
Deputy Director, Intensive Care Unit,
St Vincent's Hospital, Victoria

References:

1. Gonzalez H, Olsson T, Borg K. Management of postpolio syndrome. The Lancet Neurology 2010;9:634-42.
2. Howard RS, Wiles CM, Spencer GT. The late sequelae of poliomyelitis. The Quarterly journal of medicine 1988;66:219-32.
3. Lambert DA, Giannouli E, Schmidt BJ. Postpolio syndrome and anesthesia. Anesthesiology 2005;103:638-44.
4. Schwartz A, Bosch LM. Anesthetic implications of postpolio syndrome: new concerns for an old disease. AANA journal 2012;80:356-61.
5. Kidd D, Williams AJ, Howard RS. Poliomyelitis. Postgraduate medical journal 1996;72:641-7.
6. Bruno, RL. Preventing complications in polio survivors undergoing surgery. Harvest Press, 2002. (Accessed 30 June 2015, at http://www.postpolioinfo.com/lib_surgical.php.)
7. Magi E, Recine C, Klockenbusch B, Cascianini EA. A postoperative respiratory arrest in a post poliomyelitis patient. Anaesthesia 2003;58:98-9.
8. Spencer GT, Reynolds F. Postoperative respiratory arrest in a post poliomyelitis patient. Anaesthesia 2003;58:609-10- author reply 10.
9. Calmes, SH. Summary of Anesthesia Issues for the Post-Polio Patient. (Accessed 30 June, 2015, at http://www.post-polio.org/edu/hpros/sum-anes.html)
10. Gyermek L. Increased potency of nondepolarizing relaxants after poliomyelitis. Journal of clinical pharmacology 1990;30:170-3.
11. Connelly NR, Abbott TC. Successful use of succinylcholine for cesarean delivery in a patient with postpolio syndrome. Anesthesiology 2008;108:1151-2- author reply 2-3.
12. Rezende DP RM, Costa VV, Arci EC, Saraiva RA. Patients with Sequelae of Poliomyelitis. Does the AnestheticTechnique Impose Risks. Revista Brasileira de Anestesiologia 2008;58:210-9.

Further information can be found at
www.postpoliovictoria.org.au/category/resources/

Three-fold opioid variation a cue to look at prescribing

Evidence that the number of people being given opioids varies up to three-fold around New Zealand is a cue for hospitals, as well as primary health care providers, to take a close look at their prescribing, says New Zealand's Health Quality & Safety Commission (HQSC).

The variations are recorded in the opioid domain of the HQSC's Atlas of Healthcare Variation – a series of easy-to-use maps, graphs, tables and commentaries that chart the provision and use of specific health services and outcomes. The atlas is available at www.hqsc.govt.nz .

The HQSC notes that while highly effective for managing pain, opioids are also the class of medicine most commonly implicated in patient harm. The opioid atlas records subsidised opioids dispensed from community pharmacies in 2013, but many may have come from a hospital prescription, with nearly half of those people dispensed a strong opioid having been a public hospital inpatient or outpatient in the week prior.

An average of 64/1000 people received a weak opioid; with a two-fold variation between district health boards (DHBs), and an average of 17/1000 people received a strong opioid, with a greater than three-fold variation. The atlas also reports variations based on age, gender and ethnicity as well as the type of opioid prescribed.

The HQSC says it is unlikely all – or even most – of the variations shown by the atlas are due to district health boards (DHBs) having different populations with different needs so it is encouraging doctors to look at their prescribing and whether they should be exploring alternatives. The HQSC is also suggesting DHBs consider investigating why their usage is different from other DHBs.

Susan Ewart
Communications Manager, NZ
ANZCA

A critical force to optimise allogeneic blood transfusion

A significant proportion of blood transfusions are used as an intervention in the perioperative and critical care settings. This makes anaesthetists and intensivists a critical force in any effort to optimise allogeneic blood transfusion through improved clinical practice.

Transfusion should not be the default decision

There is a growing weight of evidence that allogeneic blood transfusion has potentially a wide range of adverse clinical outcomes and that transfusion should not be the default decision.

Instead, the decision whether to transfuse should be carefully considered, taking into account the full range of available therapies, and balancing the evidence for efficacy and improved clinical outcome against the potential risks. Transfusion decisions for patients should also take into account each individual's clinical circumstances and physiological status, and their treatment preferences and choices.

Patient blood management

The range of approaches to help patients optimise and conserve their own blood and subsequently minimise the need for transfusion is known collectively as patient blood management (PBM). As a consequence of better management, patients usually require fewer transfusions of donated blood components thus avoiding transfusion-associated complications.

There are various techniques to ensure this. For example, the three pillars of PBM model shows how various practices can be initiated during pre-, intra- and post-operative stages of surgery.

PBM guidelines

The National Blood Authority (NBA), in conjunction with key clinical groups, has developed evidence based PBM guidelines to support improvements in transfusion practice and associated patient outcomes.

The guidelines are the world's first national evidence based patient blood management guidelines and are developed by clinical/consumer reference groups (CRG) representing specialist colleges, organisations and societies, with consultation from the wider clinical community.

The guidelines, approved by the National Health and Medical Research Council (NHMRC), provide evidence-based recommendations to health professionals that support the implementation of PBM.

The PBM guidelines can also assist hospitals in meeting the requirements for *Standard 7 Blood and Blood Products* of the *National Safety and Quality Health Service Standards*. Specifically, action 7.1.1 of standard 7 requires health service organisation to have policies, procedures and protocols in place that are consistent with national evidence based guidelines.

Where to find the PBM guidelines

Over 100,000 copies of the PBM guidelines and their accompanying quick reference guides have already been downloaded or ordered in more than 60 countries. They are also available as an iPad app in the iTunes store. Details of each module's systematic review, provided in a two-volume technical report are available on the NBA's website. The website also lists the endorsements each module has received from specialist colleges and societies.

www.blood.gov.au/pbm-guidelines

National Blood Authority, Australia

webAIRS news

WebAIRS was involved in two sessions and two workshops at September's Australian Society of Anaesthetists/New Zealand Society of Anaesthetists Combined Scientific Congress in Darwin.

The first session about cognitive tools for crisis management addressed how anaesthesia crises are managed as well as cognitive tools and cognitive aids to assist with crisis management. Starting with observations regarding the immediate response to a crisis during simulation, this was followed by a presentation on new approaches to simplify the immediate response. Finally cognitive aids were presented for a formal approach to ensure that nothing is overlooked.

The second session looked firstly at webAIRS data relating to catastrophic events that might occur during an otherwise simple routine case. Professor Keith Ruskin, who is a renowned international speaker, presented data from the American Society of Anesthesiologists Anesthesia Quality Institute database on how large databases can be used to develop training programs.

The use of bow-tie diagrams as a potential new tool for anaesthesia risk management was also described.

The workshops highlighted the mechanism and benefits of incident reporting to webAIRS.

There has been a steady increase in reports since the webAIRS program was released in 2010 including 738 incidents in 2015.

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.

Program improvements

The updated webAIRS registration program was released in January 2015 and appears to be functioning well.

Since last year, a group of sites has been automatically forwarding denominator data. This includes de-identified data from 42,629 records collected from May 20, 2014 to June 3, 2015. Improvements to the morbidity and mortality meeting tool, the home page and the incident reporting page are also being developed.

During this phase of program improvement there could be unexpected issues with the program stability.

If you notice any problems with the system please report the problem to ANZTADC so that it can be investigated and corrected.

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

webAIRS
Anaesthetic Incident Reporting System from ANZTADC

Death following appendicectomy

In 2012, a previously healthy 15-year-old boy weighing 45 kilograms underwent surgery at a rural hospital for acute appendicitis that lasted about 30 minutes.

He was anaesthetised by a locum anaesthetist who administered 10mg of morphine and 150mcg of fentanyl.

After extubation in theatre, the patient was transferred to PACU. During transit he stopped breathing and was hypoxic on arrival. The anaesthetist diagnosed laryngospasm and applied oxygen and PEEP, and breathing resumed.

However, the patient remained hypoxic in PACU, with saturations recorded in the low 90s. At one point he coughed up some pink or red fluid. He was prescribed high-flow oxygen and discharged to the children's ward, where his saturations were 95 per cent most of the night despite high-flow oxygen.

The nurse removed the pulse oximeter at 5am, and the patient was found moribund at 6.30am. Despite resuscitation, he died a few days later. At post-mortem he was found to have global hypoxic brain injury and signs of pulmonary oedema. The cause for his sudden collapse after some hours of apparent stability was not clearly established.

There was some uncertainty about why the patient stopped breathing and seemed to have no respiratory effort. Despite the diagnosis of laryngospasm, the experts assisting the Health & Disability Commissioner (HDC) pointed out that residual neuromuscular blockade, residual anaesthesia or the effects of opioids could all have this effect.

The anaesthetist had examined the patient's chest on two occasions and reported that it was clear, but did not document her findings. She did not account for his hypoxia but charted oxygen at up to 10l/min via Hudson mask. She did not request close observations overnight or recommend high-dependency care.

In his report of March 18, 2015, New Zealand's HDC found that the anaesthetist should have further investigated the cause of the patient's hypoxia before allowing him to go to the ward, and should have arranged closer observation or a review during the night. He was also critical of the anaesthetist's failure to use the high-dependency unit and her poor record-keeping, which did not comply with professional standards. Criticism was also levelled at several nursing and systems failures.

Locum doctors are especially vulnerable to mishap. Their lack of familiarity with a hospital's organisation, its layout or its facilities can cause problems if they make assumptions based on practice elsewhere. They may not have had the opportunity to develop productive working relationships with colleagues.

Locums are advised to make every effort to equip themselves with a good working knowledge of a new hospital and its staff, especially a rural hospital which may have fewer out-of-hours resources than larger centres.

Thorough, clear and contemporaneous documentation is a cornerstone of safe clinical practice and can form the backbone of a successful defence if a doctor's practice is scrutinised.

The full texts of all the HDC reports are available free on its website, www.hdc.org.nz.

Dr Aidan O'Donnell, FRCA FANZCA
Lead obstetric anaesthetist,
Waikato Hospital, New Zealand

Safety alerts

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

Recent alerts:

- Astra Zeneca Marcain 0.5% Spinal Heavy solution.
- Propofol adverse effects, June 26, 2015.
- Teleflex Hudson RCI Sheridan SHER-I-BRONCH Endobronchial Tubes – NZ.
- Trading of TARGIN® in NZ has ceased.
- Propofol adverse effects May 25, 2015.
- HeartWare Ventricular Assist System.
- Recall: ResMed devices that use Adaptive Servo-Ventilation therapy.

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

Leading the world in clinical trials for 20 years

The ANZCA Clinical Trials Network (formerly the Clinical Trials Group and then the Trials Group) had its beginnings in the establishment of the MASTER Trial in 1995. In the ensuing 20 years, the network has grown to be the pre-eminent anaesthesia, perioperative medicine and pain medicine clinical trials network in the world, thanks to the support of the College and the hard work of investigators, trial co-ordinators and Fellows around the ANZCA training regions.

The MASTER trial

The MASTER (Multicentre Australian Study of Epidural Anaesthesia) trial of epidural versus intravenous analgesia in high-risk patients having noncardiac surgery was the brainchild of Associate Professor John Rigg of the University of Western Australia.

With Dr Konrad Jamrozik, an epidemiologist, and emerging anaesthesia researchers (Paul Myles, Philip Peyton and Brendan Silbert), Associate Professor Rigg established a network of sites in Australia and south east Asia, and completed a landmark study that changed practice around the world.[1]

In 1996, the MASTER Trial became the first anaesthesia clinical trial funded by the Australian National Health and Medical Research Council (NHMRC). The study provided invaluable lessons for the emerging investigators, including the need for strong research methodology, advice from epidemiologists and a skilled trial co-ordinator workforce.

Associate Professor Rigg has since been honoured with the ANZCA Robert Orton medal for his role in establishing clinical trial research in anaesthesia in our region.

The B-Aware Trial

The role of the new depth of anaesthesia monitors in preventing awareness during anaesthesia was a hot topic in the late 1990s.

Paul Myles and Kate Leslie established the B-Aware Trial to determine whether bispectral index (BIS) monitoring would reduce the incidence of awareness in patients at risk of awareness during general anaesthesia.

Building on the lessons learned from the MASTER trial, the B-Aware trial group broke new ground by expanding the network of sites and investigators to New Zealand and Europe and by establishing a collaboration with biostatisticians associated with Monash University, in particular Andrew Forbes.

The results of the B-Aware Trial generated a great deal of media interest when they were published[2], and changed practice with respect to the care of patients at high risk of awareness.

Formalising trials group governance

ANZCA had been a strong supporter of research for many decades through the research grant program funded through Fellows' subscriptions and donations. The above trials received seed funding from ANZCA.

During his ANZCA presidency Professor Michael Cousins formally established the ANZCA Clinical Trials Group Executive as a committee of ANZCA Council under the inaugural chairmanship of Paul Myles.

The executive set about developing the various programs that support the network, including the annual strategic research workshop, grants to support pilot studies for multicentre trials, and policies and processes to facilitate survey research by Fellows and trainees.

ANZCA established the role of the trials group co-ordinator (now manager) within the College, and formed a relationship with the Department of Epidemiology and Preventive Medicine at Monash University to share support of the co-ordinator.

Ornella Clavisi, Stephanie Poustie and now Karen Goulding have ably assisted the executive in building the trials group and expanding its activities and influence.

Onwards and upwards

Since its initial trials and the establishment of the ANZCA Clinical Trials Network (CTN) executive the network has gone from strength to strength. The ENIGMA-I[3] and ENIGMA-II[4] trials, the POISE-1[5] and POISE-2[6,7] trials (in collaboration with the Population Health Research Institute in Canada) and the ATACAS trial (www.atacas.org.au) have been completed and provided a wealth of new information about preventing major adverse cardiac events and other unwanted complications of anaesthesia.

The network has formed new international collaborations and involved new sites and investigators in north America, the UK, Europe, the Middle East and Asia in its current large multicentre trials – the Balanced Anaesthesia Study (principal investigator, Tim Short), RELIEF (principal investigator, Paul Myles), METS (principal investigator, Mark Shulman in collaboration with Canadian and UK researchers) and PADDI (principal investigator, Tomas Corcoran).

The last six NHRMC grant applications for network trials have been successful with the crowning achievements of being awarded the largest grant in the 2014 grant round ($4.6 million for PADDI) and the highest ranked grant in 2012 round for RELIEF.

Conclusions

ANZCA is the only specialist medical college to support a major clinical trials network. Through this support the research careers of numerous investigators and trials co-ordinators have been nurtured and the lives of millions of patients have been improved through the provision of high quality clinical trial evidence that translates into safe and effective practice in anaesthesia, perioperative and pain medicine.

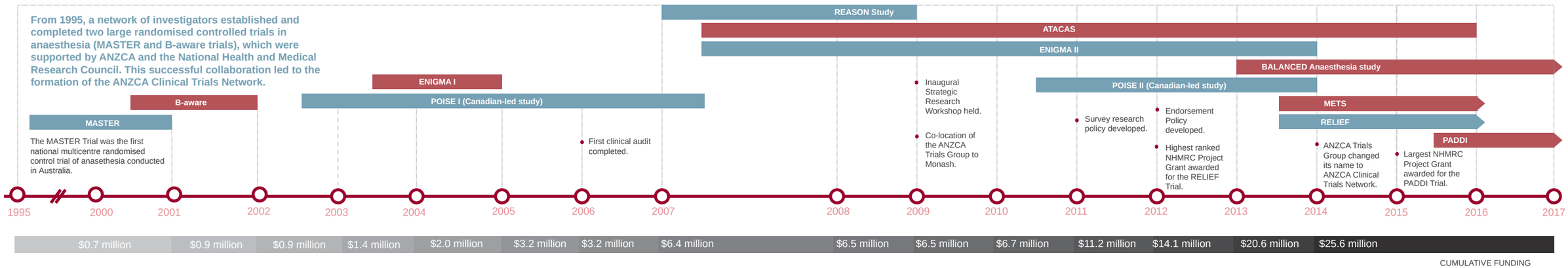
Professor Kate Leslie
Chair, ANZCA Clinical Trials Network Executive

References:
1. Rigg J, Jamrozik K, Myles P, Silbert B, Peyton P, Parsons R, Collins K. Epidural anaesthesia and analgesia and outcome of major surgery: a randomised trial. Lancet 2002;359:1276-82.
2. Myles P, Leslie K, McNeil J, Forbes A, Chan M, Group B-AT. A randomised controlled trial of BIS monitoring to prevent awareness during anaesthesia: The B-Aware Trial. Lancet 2004;363:1757-63.
3. Myles P, Leslie K, Chan M, Forbes A, Paech M, Peyton P, Silbert B, Pascoe E. Avoidance of nitrous oxide for patients undergoing major surgery: A randomized controlled trial. Anesthesiology 2007;107:221-31.
4. Myles P, Leslie K, Chan M, Forbes A, Peyton P, Paech M, Beattie S, Sessler D, Devereaux P, Silbert B, Schricker T, Wallace S, investigators. ATGftE-I. The safety of addition of nitrous oxide to general anaesthesia in at-risk patients having major non-cardiac surgery (ENIGMA-II): a randomised, single-blind trial. Lancet 2014;384:1446-54.
5. Group PS. Effects of extended-release metoprolol succinate in patients undergoing non-cardiac surgery (POISE trial): a randomised controlled trial. Lancet 2008;371:1839-47.
6. Devereaux P, Sessler D, Leslie K, et al. Clonidine in patients having non-cardiac surgery. N Engl J Med 2014;370:1504-13.
7. Devereaux P, Sessler D, Mrkobrada M, et al. Aspirin in patients having non-cardiac surgery. N Engl J Med 2014;370:1494-503.

"The network has grown to be the pre-eminent anaesthesia, perioperative medicine and pain medicine clinical trials network in the world."

ANZCA Clinical Trials Network timeline

From 1995, a network of investigators established and completed two large randomised controlled trials in anaesthesia (MASTER and B-aware trials), which were supported by ANZCA and the National Health and Medical Research Council. This successful collaboration led to the formation of the ANZCA Clinical Trials Network.



Largest attendance at workshop

Opposite page clockwise from top left: Research co-ordinators and early career researchers workshop; Group discussions at Research coordinators and early career researchers workshop; Conference dinner at the Land of Awesomeness at Dreamworld; Professor David Vaux and Professor Kate Leslie; Ms Pauline Coutts, Ms Davina McAllister, Dr Jeni Reynolds and Dr Jonathon Hiller.

The ANZCA Clinical Trials Network will be a world leader in delivering high quality trial evidence that translates into safe and effective practice in anaesthesia, perioperative and pain medicine.

More than 130 investigators, trial co-ordinators, trainees and interested Fellows met to discuss new ideas and share triumphs and challenges at this year's Clinical Trials Network workshop – the biggest and best yet.

The 7th annual ANZCA Clinical Trials Network Strategic Research Workshop was held from August 14-16 at the Intercontinental Sanctuary Cove on the Gold Coast.

The main aims of the workshop are to develop proposals for new large multi-centre trials and to promote networking among participants, enabling emerging investigators and sites to get involved in established trials and receive advice on new ideas. A great side-benefit of the meeting is that it provides a fantastic update on all the hot topics in anaesthesia, perioperative and pain medicine.

The meeting opened with a workshop for trial co-ordinators and new investigators chaired by the Research Co-ordinators' Special Interest Group chair, Ms Jeanene Douglas. The workshop focused on developing a sustainable trial co-ordinator workforce at sites and across the network. Topics included developing a good position description and discussing "a day in the life" of a trial co-ordinator.

The formal part of the meeting then opened with a keynote address from Professor David Vaux, deputy director of the Walter and Eliza Hall Institute of Medical Research, on "Researchers behaving badly". In his presentation Professor Vaux identified a number of features of a research paper that should provoke reviewers, editors and readers to probe further about the veracity of the data. He also described several high-profile research fraudsters, many of whom unfortunately were anaesthetists. Later in the meeting Professor Vaux inspired established and new investigators alike with a presentation entitled "Reflections on a research career – walking through the valley of (cell) death".

The Clinical Trials Network always invites a biostatistician to the workshop to enlighten us about the latest trends in the statistical management of large trials. This year Dr Jessica Kasza from Monash University spoke about how to handle missing data and about survivor causal analysis. In large multi-centre trials it is inevitable that some baseline data will be missing (for example, age, ASA physical status, co-morbidities) and that some patients will be lost to follow-up. If we assume that patients with missing data are the same as patients with complete data, we may come to the wrong conclusion. Dr Kasza explained various statistical methods to deal with this issue.

The majority of the meeting was spent discussing proposals for new clinical trials. It was particularly exciting to hear proposals from new investigators.

Dr Anjalee Brahmbhatt and Dr Raymond Hu suggested trials related to improving the success of renal transplantation and arterio-venous fistulae respectively; Dr Claire Furyk proposed a study on "pre-hab" for elderly patients presenting for major surgery, and Dr Susan Humphreys and Dr Paul Lee-Archer described studies designed to improve the safety of endotracheal intubation and the post-operative recovery of young children having surgery.

Large trials and cohort studies were also proposed on topics including videolaryngoscopy, goal-directed haemodynamic therapy, postoperative cognitive decline and delirium, sedation for endoscopy, pain management in tonsillectomy and prevention of postoperative thrombotic complications.

We also heard about progress with pilot studies on ketamine to prevent postoperative pain and tranexamic acid to prevent bleeding in joint replacement; progress on our ongoing endorsed trials including ATACAS, RELIEF, Balanced and METS, and updates of studies that have been submitted in this National Health and Medical Research Council (NHMRC) or New Zealand's Health Research Council grant round.

On the Saturday afternoon of the meeting, Professor Tomas Corcoran, Dr Ed O'Loughlin and Ms Jaspreet Sidhu ran the site initiation meeting for the PADDI study. The PADDI study is a large (8880-patient) multicentre randomised controlled trial designed to establish the safety of the administration of 8mg of dexamethasone to adult patients undergoing non-urgent surgical procedures under general anaesthesia. The primary outcome is the incidence of surgical site infection at 30 days postoperatively. PADDI received the largest project grant awarded by the NHMRC in 2014 ($A4.6 million) and will start soon in dozens of centres around Australia, New Zealand and abroad.

The meeting closed with a panel discussion on adverse event reporting in large comparative studies of established treatments. Adverse events are untoward events occurring following administration of the study intervention that may or may not be related to that intervention. Our study patients suffer many adverse events and reporting them is resource-intensive. The panel discussed promoting a "leaner" approach to adverse event reporting for ANZCA Clinical Trials Network studies.

When closing the meeting, the ANZCA Clinical Trials Network Executive chair, Professor Kate Leslie, congratulated the presenters on their work, pointing out that no other anaesthesia clinical trials network in the world could have presented so many fantastic ongoing studies and proposals. She thanked Sarah Chezan (ANZCA events), Karen Goulding (ANZCA Clinical Trials Network Manager) and Jeanene Douglas (Research Co-ordinator Special Interest Group Chair) for organising a fantastic meeting, and invited everyone to the next meeting on August 12-14, 2016.

Professor Kate Leslie
Chair, ANZCA Clinical Trials Network Executive

CPD update

Doing you own clinical audit

Did you know you can do your own clinical audit as part of the practice evaluation category in the continuing professional development (CPD) program?

Many Fellows find undertaking practice evaluation activities difficult, especially if they are working in private practice, in rural/remote settings or in locum roles.

Others are simply uncomfortable asking others to assist them with multi-source feedback or patient experience surveys.

The practice evaluation activity of the revised CPD program includes the activity "clinical audit of own practice or significant input into a group of audit practice".

ANZCA has just added three new sample audits with templates for participants to use, bringing to nine the total available.

Each comprises a guide, a data collection form and a summary of results sheets. They are:

- Paediatric POV prophylaxis.
- Perioperative normothermia.
- Residual neuromuscular blockade.
- PONV prophylaxis.
- Epidural analgesia.
- Pain management program.
- Management of chronic pain.
- Difficult airway equipment.
- Incidence of PONV.

All can be found at www.anzca.edu.au/fellows/continuing-professional-development/handbook-and-resources/clinical-audit-samples.

Handbook updates

The *CPD Handbook* has just been revised to include updated information about qualified privilege in Australia and protected quality assurance activities (PQAA) in New Zealand.

The latest version of the handbook can be found at www.anzca.edu.au/fellows/continuing-professional-development/handbook-and-resources/cpd-handbook-and-appendices.

Next verification of CPD activities cycle

The random selection of CPD participants for the 2015 verification of CPD activities process will occur by the end of September.

A total of 7 per cent of CPD participants, including ANZCA and FPM Fellows and non-Fellows (but excluding provisional Fellows) will be selected.

Those selected will have until the end of 2015 to update their portfolio and submit evidence of their CPD activities to ANZCA. The verification of activities entered in to the CPD portfolio will begin in January 2016.

Dual FANZCA/CICM Fellows

Dual ANZCA/College of Intensive Care Medicine (CICM) Fellows who practise intensive care medicine only are required to achieve the CICM CPD standard to maintain their ANZCA fellowship.

However, ANZCA does not recognise the CICM CPD standard/program as satisfying the requirements of the ANZCA CPD standard for anaesthesia.

Dual ANZCA/CICM Fellows who practise anaesthesia are required to meet the ANZCA standard either by completing the ANZCA CPD program (required in New Zealand) or by confirming annually with ANZCA that they are meeting the ANZCA CPD standard in another program or a self-directed program (in Australia only).

Making the most of your mobile device

ANZCA has produced a leaflet, "Making the most of your mobile device" for distribution at continuing medical education meetings.

Look out for the flyer at your next ANZCA-run meeting or print it by going to www.anzca.edu.au/fellows/continuing-professional-development

Dr Vanessa Beavis
Chair, CPD Committee
ANZCA

DPAs bring clinical expertise and more to College workforce

Many Fellows and trainees are unaware of the work that goes on behind the scenes at ANZCA. This article, about the Directors of Professional Affairs (DPAs), is part of a series on the activities undertaken by ANZCA committees.

Directors of Professional Affairs (DPAs) work within ANZCA to support the Fellows who give an amazing amount of voluntary time and effort to our College's affairs, from the president through committee members to supervisors of training and annual scientific meeting (ASM) organisers, and many others too numerous to name.

We do work that has tight timelines, such as DPA assessors' approval of trainees' requests, or requires considerable time, such as the development or revision of our policy documents, or needs specialised knowledge, such as advances in medical education.

We bring knowledge of medical practice and culture, anaesthesia, perioperative medicine, pain medicine and hospitals and healthcare to our activities. While we each have foci of work, we all work across the College in support of various departments' activities, depending upon our skills and knowledge. Often, when a large bundle of work is being contemplated by a committee, the cry goes up "what about a DPA, can we have one please?"

Dr Ian Graham is the dean of education who leads and provides professional advice on educational matters, and chairs the Education, Training and Assessment Executive Committee, which oversees the College's education activities. He also brings his expertise in curriculum writing (having led the development of the Australian Curriculum Framework for junior doctors) and information technology support for educational activities. As well, he was a significant part of the development of the ANZCA professionalism guide, having led the development of similar guides for the Royal Australasian College of Surgeons and the Royal Australasian College of Physicians.

The DPA assessors are a group led by Dr Vaughan Laurenson, with Dr Michelle Mulligan and Dr Maggie Wong. Dr Steuart Henderson was the first DPA assessor. Before him, assessor decisions were made by a councillor with the assessor role usually occurring at the end of the day after their hospital work.

Assessors provide assessments of and decisions on trainee progress at critical times in their training (for example, entry to both examinations, admission to fellowship, approval of interrupted/overseas training, recognition of prior learning) and take part in the committees which oversee various aspects of education, training and assessment.

Dr Peter Roessler is the DPA, policy documents, although that only begins to describe his role. He is involved in drafting all policy documents and provides advice to the policy unit on drafting papers and other policy matters. As such he sits on the Professional Affairs Executive Committee, Safety and Quality Committee, the IMGS Committee and the Continuing Professional Development Committee. He also oversees the safety and quality section and writes the "What would you do?" column in the Bulletin. He also provides wise guidance to Fellows and patients who call the College asking for advice about clinical matters.

Dr Nicole Phillips is the DPA, ASM, and chairs the ASM and Events Planning Committee. She works with and provides advice and a Fellow/convenor perspective to the ASM and events team. She brings her previous experience as the ASM Officer (when she was the new Fellow on ANZCA Council) and as an ASM convenor to this role.

I'm the Executive DPA, the DPA with responsibility for the Trainee Performance Review (TPR) and DPA, IMGS. The Executive DPA is the leader of the DPA group (which is by far the easiest part of the role), is a member of the ANZCA Executive Committee and provides chief medical officer-type advice to the chief executive officer. DPA, TPR involves chairing that subcommittee and overseeing arrangements for individual reviews. DPA, IMGS approves reports received and position descriptions for international medical graduate specialists (IMGS) being assessed and assists the IMGS team in administering the IMGS assessment process in both Australia and New Zealand.

Professor Milton Cohen, a former FPM dean, is the Faculty's DPA. His roles include support for the board and its committees, interaction with government agencies and joint stewardship of the revised curriculum and program for training in pain medicine.

Dr Leona Wilson
Executive Director of Professional Affairs
ANZCA

Above: Dr Leona Wilson; Dr Ian Graham; Dr Vaughan Laurenson; Dr Steuart Henderson; Professor Milton Cohen; Dr Nicole Phillips; Dr Peter Roessler; Dr Michelle Mulligan; Dr Maggie Wong.

A new era in ANZCA teaching

ANZCA has an extensive network of supervisors, including more than 320 ANZCA and FPM supervisors of training, who are all part of making our training programs among the best in the world.

Since 2010, ANZCA has been running courses that enable ANZCA and FPM Fellows to learn how to supervise trainees – to teach, assess and inspire the next generation of anaesthetists and specialist pain medicine physicians.

The ANZCA Educators Program, formerly known as the Foundation Teacher Course, is also available to international medical graduate specialists (IMGSs) and provisional Fellows.

It has received excellent feedback over the past five years.

Now, ANZCA's Teaching and Learning Sub-Committee is looking at new ways to increase the availability and accessibility of the course. Five new modules are being developed, to add to the eight already being taught as the committee seeks to further enhance the breadth of the course.

I encourage all Fellows and trainees to learn more about the program.

Dr Genevieve Goulding
ANZCA President

Introducing the ANZCA Educators Program

(formerly the Foundation Teacher Course)

ANZCA Educators Program
Learning to teach

The new ANZCA Educators Program will build on the successes of the Foundation Teacher Course that it replaces.

Why do we need an educators program?

In Australia and New Zealand, the training of doctors to become specialist anaesthetists and specialist pain medicine physicians is conducted entirely by ANZCA and its Faculty of Pain Medicine. ANZCA has a well-developed educational structure consisting of numerous committees, education officers, unit directors, supervisors of training, etcetera.

It requires this network because the training programs utilise a traditional method, an apprentice model, requiring the trainee to be supervised and to interact with consultants in delivering anaesthesia and pain services to patients. This educational network underpins the programs, and without the dedicated time and effort of those involved in these roles, the training program would not be possible.

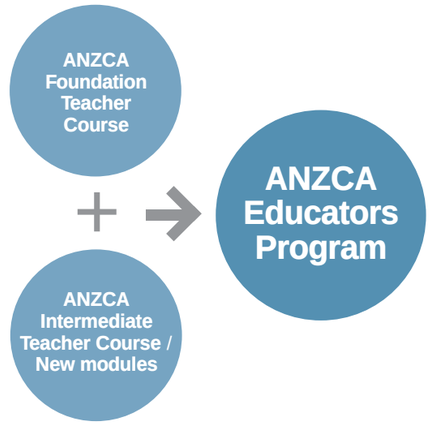
All anaesthetists and specialist pain medicine physicians involved in teaching or supervising the work of trainees require a basic level of knowledge, skills and attitudes relevant to teaching and assessment.

Although it may appear to be a natural phenomenon, education (and teaching) is based on theoretical concepts that need to be learnt and practised to be effective. Those involved in the organising or elements of education beyond teaching and supervising require a higher level of educational expertise.

There is a paucity of resources or teaching programs for anaesthetists and specialist pain medicine physicians specifically designed for education in anaesthesia and pain medicine. The recent addition of the scholar role is one step in addressing the deficiency within the College related to education.

Universities offer medical education courses at a graduate certificate to masters level that are conducted between six months or up to three years. The Foundation Teacher Course was designed for anaesthetists and specialist pain medicine physicians responsible for teaching and supervising trainees who are not intending to complete a university degree in educational theory.

The course has had excellent feedback in its evaluation but is limited in its delivery due to personnel and resourcing issues, and a recent survey has identified the need for more material to be included.



What makes up the new program?

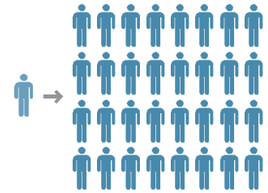
ANZCA's Teaching and Learning Sub-Committee is developing new methods of delivery and new content to be able to offer more opportunities for training of educators.

These new developments have driven the need for changing the name of the Foundation Teacher Course to the ANZCA Educators Program so that it better represents the future of educational offerings for educators.

Enhancing delivery and accessibility

This program will include the existing Foundation Teacher Course in its current format, but will also cover new models of delivery such as local facilitation of content. These include:

- Course delivery expansion
- More facilitators (Fellows)
- More accessible delivery
- Flexibility for delivery
- Utilisation of Networks



(continued next page)

A new era in ANZCA teaching (continued)

New modules in development

There is a project group working to develop five new modules and these will be piloted in 2016. The new modules are:

- New modes of teaching and learning.
- Teaching in multiple settings.
- Concepts in assessment.
- Organisation of education in departments.
- Trainees experiencing difficulty.

These will complement the existing eight modules:

- Doctor as educator.
- Planning effective learning and teaching.
- Feedback to enhance learning.
- Interactive learning and teaching.
- Teaching in the clinical environment.
- Teaching practical skills.
- Authentic assessment.
- Clinical supervision.

Associate Professor Kersi Taraporewalla
Chair, Teaching and Learning Sub-Committee
ANZCA

ANZCA Educators Program
Learning to teach

ANZCA
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

How to sign up

Do you want to learn to teach? Can you supervise a trainee to get the best outcomes for both patient and trainee? Do you understand the various ways a trainee can and should be assessed and what the consequences of assessment are?

If you want to learn to teach, sign up for our courses.

Registration will open mid-November 2015 for five face-to-face and two online courses running in 2016. These courses will include the existing eight modules. The face-to-face courses will run over two-and-a-half days, with a two-day version offered before the 2016 ANZCA Annual Scientific Meeting in Auckland. The online course takes about 18 weeks to complete.

There is no charge to attend the course.

Visit the ANZCA Educators Program on the ANZCA website or look out for notices on the ANZCA homepage for when registration is open.

www.anzca.edu.au/anzca-educators-program

Claiming CPD

Both the online and face-to-face courses are eligible for continuing professional development (CPD) credits.

2009
Foundation Teacher Course developed

2010
Course delivered (five face-to-face/year)

2013
First online course delivered

2015
Course rebranded ANZCA Educators Program

Five new modules in development

New models of delivery planned

2016
Locally-facilitated courses to be delivered

TASMANIA SETS THE PACE

Australia's southern isle is popular with anaesthetists who come for the lifestyle and stay for the variety and challenge.

Tasmania holds a unique place in Australia and, more specifically, in the minds of Australian anaesthesia. The safe anaesthesia journey now experienced by thousands of Australians every day was first performed almost 170 years ago in Launceston.

The story of Dr William Russ Pugh is well known to Australian anaesthetists and is a source of pride for those practicing today in Launceston and Tasmania.

Pugh was something of a Renaissance man, arriving in Hobart Town in 1835 before walking 200 kilometres to Launceston. He ignored encouragement by settlers along the walk to take up sheep farming, instead persisting with a long, unconventional and sometimes adversarial, medical career.

Shortly after seeing the first European depiction of Hooper's ether inhaler in the *Illustrated London News*, Pugh made medical history. Using a modified Nooth's Apparatus, a household device for making carbonated water, Pugh performed the first Australian anaesthetic in Launceston in 1847.

Living true to the old-school anaesthesia adage that "there is no case that cannot be cancelled", Pugh also has the honour of cancelling the first surgical case for anaesthetic reasons being unable to perform the third and final surgery due to a medical euphemism that lives on today – "equipment issues".

Come and sample the sites, tastes and extremes of Tasmanian anaesthesia in February 2016, at the combined ANZCA and Australian Society of Anaesthetists Tasmanian 2016 Annual Scientific Meeting: "Anaesthesia in the extreme". World-renowned experts will be a highlight, including Professor Peter Slinger from Toronto General Hospital, along with the return of the cadaveric difficult airway workshop. See you in February!

The can-do attitude of Australia's first anaesthetist remains strong in Tasmanian anaesthesia. Despite its relatively close proximity to Melbourne, Australia's smallest state punches above its weight in the breadth and variety of clinical services and scientific advancements contributed by the state's anaesthetists.

Tasmania's vast wilderness makes it a popular eco-tourism destination, with sites as varied as Australia's largest temperate rainforest, the Tarkine, and the world-famous Cradle Mountain National Park. The relative remoteness of these destinations, coupled with extreme weather changes, means the state's retrieval services play an important role in maintaining the safety of people who visit these sites.

Anaesthetists have made a strong contribution to Tasmania's aeromedical retrieval services. Retrievals by anaesthetists from the Royal Hobart Hospital have even included the extremes of Antarctica, including the retrieval of patients from an Australian Antarctic Division helicopter crash on the Amery Ice Shelf in 2013.

The importance of aeromedical retrieval to Tasmania's emergency services has been highlighted by the push to establish a helipad on the roof of the Royal Hobart Hospital. The significance of the Golden Hour is even greater when trauma may be mixed with exposure to an unforgiving climate.

The effects of extreme weather are not limited to Tasmania's wilderness. Recent cold weather saw snow in suburban Hobart in mid May. Extreme snowfall again in August meant one ANZCA exam candidate was at risk of being snowed in and missing his exam!

Bass Strait creates something of a moat for Tasmania, producing a relative remoteness considering its short, one-hour flight from Melbourne. As the tertiary referral centre for the state, this remoteness requires the Royal Hobart Hospital to provide services across a range of surgical and perioperative domains, including hyperbaric, paediatric, cardiac, advanced thoracic and neurosurgical services.

This breadth of practice, from the routine to the extremes of surgical and physiological pathology, makes anaesthesia practice in Tasmania one of constant variety. Recent years have seen both former Tasmanians and new anaesthetists relocating to the southern isle. They return for the family-friendly lifestyle, the bushwalking and world-class mountain-biking, the incredible fresh food and dining, and the growing art and cultural scene encouraged by the likes of the Museum of Old and New Art (MONA).

But what keeps anaesthetists in Tasmania, which now has the greatest per-capita concentration of FANZCAs in Australia, is the professional satisfaction of working in a varied, challenging and collegial environment – routine and extreme.

Dr Daniel Jolley and **Dr Clare McArthur**
Hobart, Tasmania

Opposite page, bottom right: From left, Mr Ash Hardikar, Dr Trudi Disney, Associate Professor Marcus Skinner, Dr Meg McKeown (Antarctica doctor) and Jess Ling (medical student).

This page, from top left: Medical retrieval team from Royal Hobart Hospital at Wilkins Ice Runway, Antarctica, including Mr Ash Hardikar (cardiothoracic surgeon), Associate Professor Marcus Skinner (Director of Anaesthesia) and Dr Trudi Disney (anaesthetist); Royal Hobart Hospital redevelopment, artist's impression.

Photographs of Hobart and surrounds: Dr Roger Wong, FANZCA.

Anaesthesia in the land of the eternal blue sky

Australian specialists teach ultrasound-guided regional anaesthesia to their colleagues in Mongolia.

"In Xanadu did Kubla Khan
A stately pleasure-dome decree"
– A Vision in a Dream: A Fragment, Samuel Taylor Coleridge, 1816

The world's largest contiguous empire under the rule of Kublai Khan – grandson of the founder of the Mongol Empire, Genghis Khan – has retreated to more modest dimensions since the grandeur of Xanadu, the historical site of which is now located over the border in Inner Mongolia, China.

With no intention of wordly domination, Dr Max Majedi and Dr Katariina Jarvi (Sir Charles Gairdner Hospital, Perth), and Dr Jun Keat Chan and myself (Northern Hospital, Melbourne) visited Mongolia's capital city, Ulaanbaatar, to continue our hospitals' strong educational relationship with the Mongolian Society of Anesthesiologists (MSA).

Although it is the world's 19th largest country, Mongolia has a modest population of just over three million people. About 45 per cent of the population lives in the capital, with 30 per cent continuing a nomadic lifestyle in the varied geography of desert, steppe and mountains.

Ulaanbaatar is a fascinating mix of fading Russian monoliths and shiny glass towers, a juxtaposition of its recent communist past and current mining-fuelled economic growth. The health system maintains legacies of that recent past. Although there are many public hospitals, they are relatively poorly resourced, and foreign donations and training remain a vital part of healthcare delivery.

Medical training in Mongolia consists of a five-year degree course followed by a number of resident years before junior doctors can embark on specialist training. The previously brief anaesthetic fellowship of just three months has expanded now to a far more creditable two years of unpaid training.

Australian doctors have been visiting Ulaanbaatar annually for more than 10 years providing training in a variety of anaesthetic and surgical disciplines. In conjunction with improvements to training, there has been a gradual improvement in the amount and quality of medical equipment, such as anaesthetic machines and ventilators, available at the larger city hospitals. Much of it has been donated from foreign countries.

The topic for this particular trip was ultrasound-guided regional anaesthesia, and we planned a two-day workshop and then a number of days performing and teaching blocks in hospitals in the capital.

The use of ultrasound in the public-hospital setting in Mongolia is minimal due to a lack of equipment and training. We hoped to address both aspects by concentrating our teaching on a small number of consultant anaesthetists familiar with regional anaesthesia, and provide some equipment to be distributed at the behest of the MSA.

Above from left: A typical rural scene of horses and Ghers; Participants in the workshop; Hospital teaching; Dr Max Majedi, Dr Katariina Jarvi, Mongolian anaesthetist Dr Nergui Sodnom, Dr Jun Keat Chan and Dr Mark Zammit; Workshop setup with donated ultrasound machines.

"The use of ultrasound in the public hospital setting in Mongolia is minimal due to a lack of equipment and training."

Four machines were donated: Two compact SonoSite machines from the anaesthetic department of Sir Charles Gairdner Hospital, and two WED 2018 portable ultrasound machines from Rotary Australia World Community Services as part of a specific equipment donation program.

A group of 15 consultant anaesthetists presented for the two-day workshop held at the Mongolian National University of Medical Sciences. We covered introduction to ultrasound, vascular access, upper limb, lower limb and abdominal wall blocks with a combination of lectures and hands-on scanning.

(continued next page)

Trip tips

Recommendations for future trips concentrating on ultrasound would include:

- Sending a small team of four to six for teaching to aid easy co-ordination, and having at least two practitioners with extensive clinical experience. (Mongolia required greater than five years consultant experience for registration purposes).
- Keeping the team together for the lectures and workshop component, and having a plan for models for live demonstration.
- Morning lectures and afternoon workshops worked well.
- Taking ultrasound machines to donate was the only model that will work in countries with limited access. There is little point teaching techniques requiring unavailable technology.
- Incorporating basic medical perioperative clinical teaching is essential, that is, hand hygiene, adjuvant analgesia and basic pain management.
- Repeat visits to assess impact are requisite.
- Planning a year ahead is vital to co-ordinate the team, equipment, visas and registration.
- Incorporating vascular access techniques increased the scope of practice and was particularly appreciated by the local doctors.

Anaesthesia in the land of the eternal blue sky (continued)

"We tried to concentrate our efforts on a smaller number of consultants in order to create a core group of 'sub-specialists' in the short time we had."

The provision of a goat leg was much welcomed for practising needling skills. This removed the need for acquiring expensive needling models and provided a realistic "feel" and appearance under ultrasound. The gel marinated and well-tenderised leg was donated to some local pets at the end of the day.

Workshop attendants also proved excellent models for scanning various regions of interest, and gave our team a good feel for the quality of image we could expect once we moved to a hospital environment.

Although the donated ultrasound machines did not have the resolution of machines available in Australia, they were more than adequate to achieve safe views for performing blocks. Importantly, they were robust machines with simple operating systems and requiring minimal servicing. Our course and the donated machines would be of little use if the machines did not stand up to the rigour of repeated daily use for years to come.

All the attending anaesthetists were keen to gain exposure to ultrasound, and were quick to pick up the skills required to achieve adequate views. Once we moved to the hospital environment, we tried to concentrate our efforts on a smaller number of consultants in order to create a core group of "sub-specialists" in the short time we had.

Our visits to the trauma hospital proved particularly fruitful. The hospital had nine theatres and covered all forms of trauma-related surgery, including neurosurgery. Patients came from Ulaanbaatar and from outlying regions where transfer times were often extended, resulting in significant deterioration by the time they arrived. We spent time in ICU (demonstrating ultrasound-guided central access on adults and children/infants), and in theatre.

We concentrated our efforts in theatre on orthopaedic surgery, where there was a significant caseload of long bone fractures from various mechanisms (for example, road trauma and horse-riding accidents). After demonstrating a particular block, we could then watch the local anaesthetists perform a number of blocks in succession.

We covered supraclavicular, axillary and femoral blocks, and had excellent success in providing anaesthesia sufficient to perform surgery with the blocks alone. This gave both the Mongolian surgeons and anaesthetists great confidence in using ultrasound for their blocks.

We were keen to reinforce safety aspects of performing regional anaesthesia under ultrasound, particularly with blocks where the potential for serious complications was greater (supraclavicular block and pneumothorax for instance).

The mantra "find the tip", or üzüüriig olokh, was repeated extensively, and the consultants took this on board quickly. From the perspective of improving needling skills, we emphasised that simple, safe blocks, such as axillary blocks, should be attempted first in significant numbers. Once confidence improved with finding and following the needle tip it was time to move on to the more difficult blocks. Visualisation of local anaesthetic within the ultrasound field while injecting was also emphasised.

Our great hope is that these anaesthetists will continue to use ultrasound, gain confidence with various block techniques, and then teach other anaesthetists in their hospitals. By teaching experienced anaesthetists who already were proficient in performing regional anaesthesia, we maximised the impact of the short time we had in Ulaanbaatar.

Our group plans repeat visits to Mongolia in the future to run further workshops and to assess the progress of anaesthetists in the hospitals that received the donated equipment.

Dr Mark Zammit MBBS FANZCA
Northern Hospital, Epping

Above from left: View of Ulaanbaatar from a city skyscraper; Presentation of donated ultrasound machines to Dr Unurzaya Lkhagvajav, President of The Mongolian Society of Anesthesiologists.

Essential Pain Management: Five years in five continents

EPM by the numbers

Over the past 15 years there have been:

- 173 EPM programs.
- 41 countries.
- 4770-plus participants.
- 56 instructor courses.
- 783 instructors trained.

Essential Pain Management (EPM) program instructors met at ANZCA house in Melbourne from July 24-26 to mark the fifth anniversary of EPM with a workshop designed to review the program's materials, planning and delivery.

The group of 15 experienced instructors reviewed the first five years of the program to date and reflected on the lessons learned from running programs across five continents. Monitoring and evaluation was a key focus with participants challenged to develop methods to demonstrate how the program was "improving lives around the world by training health workers to recognise, assess and treat pain".

EPM is a cost-effective, multi-disciplinary program working with health workers to improve pain knowledge, implement a simple framework for managing pain and addressing pain management barriers. From 2010 to June 30, 2015, 173 EPM programs have been organised in 41 countries, with over 4770 participants.

The program uses a train-the-trainer model which has seen 56 instructor courses training 783 instructors around the world. This model has been highly successful in providing educational tools and skills to local EPM champions with an interest in improving pain management. The program materials are made available free for download in seven languages under a creative commons license from www.essentialpainmanagement.org.

In partnership with the Association of Anaesthetists of Great Britain and Ireland, information about EPM programs are now available on the Global Anaesthesia Partnerships Map www.aagbi.org/international/thet which provides information regarding collaborative anaesthetic projects in low and middle income countries.

EPM is governed by the EPM Sub-Committee which has adopted a regional management approach. With membership from Australia, New Zealand, Malaysia, England and Honduras regional EPM champions have been able to further devolve the program.

In March, Dr Mary Cardosa and Dr Linda Huggins ran a program at the International Association for the Study of Pain Camp at Tagaytay Philippines with representatives from ten South East Asian countries.

In May, Dr Carolina Haylock Loor and Dr Juan Duarte ran the first South American program in Ecuador with representatives of anaesthesia societies from South American countries. These programs provided excellent opportunities to profile EPM leading to additional requests for new courses in the region.

Workshop participants reviewed the communications methods used to stay in touch and support the local EPM champions and the opportunities to provide them additional mentoring and support.

"In May, Dr Carolina Haylock Loor and Dr Juan Duarte ran the first South American program in Ecuador."

The workshop also provided an opportunity to analyse delivery of the program, assessing activities providing the most value, least value and what could be added to improve the running of the course.

Different approaches and experience with adult education were identified across many of the countries in which EPM operates. There was significant focus on the methods best suited to outcome evaluation, the group agreed to explore the place of quantitative assessments for EPM. The next 12 months will see workshop participants busy, refining and developing new materials to continue to improve EPM.

The EPM instructors' workshop program was supported by ANZCA and a grant from the Ronald Geoffrey Arnott Trust managed by Perpetual Trustees.

Associate Professor Roger Goucke
Chair, Essential Pain Management Subcommittee

Clockwise from top: The EPM team stops to take a photo; The course under review most value, least value and new; Maurice Hennessy leading a session on improving program delivery.

Simulators donated to PNG

Papua New Guinea has received its first anaesthesia simulator. The medical director of iSimulate (www.isimulate.com), Dr Anthony Lewis, donated the iSimulate equipment following discussions with ANZCA's Overseas Aid Committee.

"Simulation is incredibly valuable to clinical training at all levels but especially in developing countries," the chair of ANZCA's Overseas Aid Committee, Dr Michael Cooper, said.

"It is particularly suitable for such a rugged country as PNG as it can be carried as hand luggage with a mannequin and then can be set up at any one of the remote 22 provincial hospitals in the country."

The presentation was made at the Port Moresby General Hospital on July 21 and was followed by a clinical demonstration in the recovery ward of the main operating theatres, where Dr Roni Krieser from the Royal Melbourne Hospital took Dr George Tade and Dr Lian Painap through a very realistic scenario.

The College joined author Dr David Borshoff, from Perth, in donating 40 copies of the Anaesthesia Crisis Manual. "These manuals are invaluable and let the trainee learn how to deal with scenarios that occur with each emergency simulation," Dr Cooper said.

In early September, Dr Chris Acott presented a Dexter airway simulator to PNG anaesthetists at the PNG Medical Symposium in Port Moresby. The simulator is used to teach fibre-optic skills and was donated by Dr Colin Marsland, from New Zealand.

Above from top: From left, Dr Roni Krieser, senior anaesthetist Royal Melbourne Hospital, Dr Nora Dai, deputy chief anaesthetist, PNG, Dr Michael Cooper, chair, Overseas Aid Committee and Dr Harry Aigeeleng, president, Society of Anaesthetists of PNG; Dr Roni Krieser leading a realistic scenario with Dr Lian Painap and Dr George Tade; from left, Dr Violet Rangap, Dr George Tade, Dr Alu Kali, Dr Roni Krieser and Dr Michael Cooper.

Scholarship winner sets up pain clinic in Nairobi

Within six months of returning to Kenya from Sir Charles Gairdner Hospital in Perth, Dr Timothy Murithi Mwiti had helped start the first pain management services for Kenyatta National Hospital and The Mater Hospital in Nairobi.

Dr Mwiti, who received the ANZCA International Scholarship in 2014, spent six months in Perth to develop skills in pain medicine, a discipline he says is desperately under resourced in his home country of Kenya.

It was during and after his postgraduate training in anaesthesia and critical care that he developed a keen interest in pain management.

"There is little in-depth teaching and training in pain in most of the healthcare personnel training programs in Kenya," Dr Mwiti said.

"This has resulted poor pain recognition, assessment and treatment of all types of pain."

Under the tutelage of Dr Roger Goucke, Dr Max Majedi, Dr Chin-Wern Chan and Dr Mark Schutze, Dr Mwiti gained experience in the role of psychosocial input in the total pain perception, pain behaviours, detection and diagnoses of different types of pain and pain syndromes, rational use of imaging and laboratory investigations in pain management.

This has translated into new programs and initiatives since he returned to his hometown of Nairobi in December.

"At the Kenyatta National Hospital, our focus so far has been inpatients," Dr Mwiti said.

"The patients we see include those with post-surgical pain, burn pain, pain in critically ill patients, cancer-related pain, post-traumatic pain and patients with neuropathic pain syndromes.

"At the Mater Hospital, in addition to in-patient services we have recently started an outpatient pain service, which is very beneficial."

However, the overall pain training and management in Kenya is still in its infancy, as it is in many developing countries.

"There is widespread recognition now that pain has previously not received the attention it deserves in our country," Dr Mwiti said.

"A number of clinicians – especially specialists in other fields – are beginning to recognise their limitations in adequate pain treatment and are constantly referring patients to me so I can help out.

"I have made diagnoses like complex regional pain syndrome and chronic widespread pain, which clinicians here, because of the limited pain-training resources, hardly think about."

Part of the requirements for the successful candidate of the ANZCA scholarship is willingness to help with the development and delivery anaesthetic and pain services on their return home.

In the case of Dr Mwiti, this has been a resounding success.

Ebru Yaman
Media Manager, ANZCA

Above from left: Dr Timothy Mwiti, Jane Royle, Natalie Goodman, Brigitte Tampin, Denise Fairclough and Associate Professor Roger Goucke.

From etheriser to anaesthetist: The development of a medical specialty

More than 80 people enjoyed the fourth Pugh Day Lecture, "From etheriser to anaesthetist: The development of a medical specialty", in Launceston on June 21.

The former honorary curator of the Geoffrey Kaye Museum of Anaesthetic History, Dr Rod Westhorpe, delivered an amusing and informative lecture.

After the lecture, 18 guests enjoyed a pleasant dinner at the Quill and Cane restaurant in the Launceston Colonial Inn. Dr John Paull, dressed as Pugh's brother-in-law – 1840s solicitor and businessman John Ward Gleadow – addressed the dinner. In his speech, he queried Pugh's importance compared to himself – in his opinion a much more important citizen – but nevertheless thanking Dr Westhorpe and grudgingly offering a toast to Dr Pugh.

"Mr Gleadow" then presented Dr Westhorpe with a laminated poster advertising the lecture and the text of his address. The restaurant was chosen because of Pugh's role as a founding trustee and organiser of the Launceston Church Grammar School, which was established in the Colonial Inn building in 1847.

Dr Westhorpe was interviewed on Tasmanian ABC radio for 20 minutes prior to the lecture and a long article, "When surgery crossed the pain barrier", summarising the highlights of the lecture appeared in *The Examiner* newspaper the following day.

Dr Paull, ANZCA Fellow and historian Dr Dan Huon and Dr Lachlan Doughty created a major exhibition at the Queen Victoria Museum and Art Gallery at Inveresk, Launceston. Titled "The Evolution of Anaesthetic Equipment and Techniques, from Pugh to the Present", the exhibition ran through June and July.

Overall anaesthesia received significant media coverage before, during and after the lecture.

Dr John Paull, FANZCA
Honorary archivist

Clockwise from top left: Dr Rod Westhorpe delivering the fourth Pugh Day Lecture; Dr Dan Huon, Dr John Paull, Dr Rod Westhorpe and Dr Lachlan Doughty at the Pugh Day lecture; The exhibition "The Evolution of Anaesthetic Equipment and Techniques, from Pugh to the Present"; Mr John Ward Gleadow (AKA Dr John Paull) presenting Dr Westhorpe with a copy of the lecture advertisement and the text of Gleadow's toast to Pugh.

ANZCA Victorian Museum Awards 2015

The Geoffrey Kaye Museum of Anaesthetic History has been formally presented with a certificate of accreditation at the Victorian Museum Awards held on August 6 at the National Gallery Victoria.

Although officially notified of its status as an accredited museum in February this year, the Geoffrey Kaye Museum of Anaesthetic History was presented with a certificate of accreditation by the Minister for Creative Industries, Martin Foley.

Honorary Curator, Dr Christine Ball attended the awards with the museum's Curator Monica Cronin, Acting ANZCA CEO Carolyn Handley, General Manager, Fellowship Affairs Jan Sharrock and Knowledge Resources Manager Laura Foley.

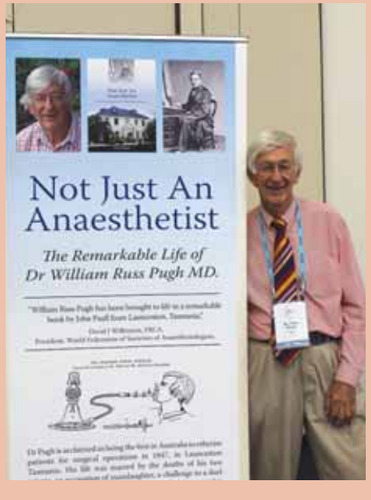
The minister said there were about 1000 collecting institutions within Victoria, which represents approximately one third of the museums and galleries in Australia. There are now 98 organisations in the accreditation program, with 28 still working toward accreditation.

The Museum Accreditation Program (MAP) has been running in Victoria for 25 years and is a highly prestigious and strategic qualification for the best museums and galleries in the state. The program is the envy of the other states and the Victorian model is potentially being adapted for use elsewhere.

The Geoffrey Kaye museum was one of only four museums to be awarded accreditation for 2015.

The museum was also nominated for an award in the small museum category, for the *Trailblazers & Peacekeepers* exhibition but in this important year of ANZAC commemoration, the category was won by the Caulfield RSL.

Above: Monica Cronin, Dr Christine Ball, Laura Foley, Carolyn Handley, Mr Martin Foley, MP, and Jan Sharrock. Image courtesy of Simon Fox, Deakin University.



Honorary archivist steps down

Dr John Paull has stepped down as ANZCA's honorary archivist after nearly two years.

Dr Paull was appointed to the position in 2013, coinciding with the formation of the History and Heritage Expert Advisory Panel.

In this role, Dr Paull worked towards last year's redevelopment and relaunch of the Geoffrey Kaye Museum of Anaesthetic History, provided initial support for the Gwen Wilson Archive Project, contributed to the museum's accreditation, and gave invaluable time and energy to ANZCA's Knowledge Resources team.

Dr Paull was a recognised author before accepting this appointment, with over 70 peer-reviewed scientific papers, a number of chapters for anaesthesia texts, and a comprehensive biography of the life and times of Launceston doctor William Russ Pugh. Research into the history of anaesthesia continues to be of interest to him and perhaps he will produce another gem like *Not Just an Anaesthetist: The Remarkable Life of Dr William Russ Pugh, MD.*

We wish Dr Paull all the best in his future endeavours.

Foundation news

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**

New Western Australian representative for Board of Governors

The foundation committee and the Anaesthesia and Pain Medicine Foundation Board of Governors voted unanimously in May to appoint Mr Warrick Hazeldine as its new WA representative on the Board of Governors. Mr Hazeldine is the co-founder and managing director of the WA public relations firm Cannings Purple, which is connected to advertising agency Ogilvy and Mather and Australia's largest communications firm, STW.

Mr Hazeldine is enthusiastic about promoting the foundation and raising money for research in anaesthesia, pain medicine and perioperative medicine, particularly in Western Australia.

Western Australia lunch event

The foundation and Mr Hazeldine arranged a lunch event at the Richardson Hotel in Perth in September to promote the foundation and ANZCA's research program to philanthropic and business contacts in Western Australia.

Western Australian research investigators Professor Tomás Corcoran, Professor Mike Paech, Professor Britta Regli-Von Ungern-Sternberg, and a life patron of the foundation, retired Associate Professor John Rigg, spoke at the event.

Melbourne Board of Governors luncheon

The Board of Governors and the foundation will hold a promotional lunch in Melbourne on September 28. The foundation thanks the Board's Deputy Chair, Mr Rob Bazzani, and KPMG for hosting the function.

The Chair of the ANZCA Clinical Trials Network Executive, Professor Kate Leslie, will speak to guests about how ANZCA research investigators are advancing knowledge and evidence-based clinical practice to improve patient outcomes. Guests will include members of the Melbourne philanthropic and business communities, including health insurance industry representatives.

Major sponsor Pfizer Pain Care

The Pfizer Pain Care brand again sponsored the foundation in 2015, including the long-standing Pfizer ANZCA Research Award for pain medicine research. This year the award was given to Dr Paul Wrigley for his project "optimising neurophysiological assessment of residual thermonociceptive sensation following spinal-cord injury". Professor Alan Merry presented the award at the Gilbert Brown Prize Session during the Adelaide annual scientific meeting.

A founding sponsor and major sponsor since 2007, Pfizer has been a consistent supporter of the foundation's efforts to increase support for pain medicine research in Australia and New Zealand. The foundation greatly values Pfizer's partnership.

Russell Cole Memorial ANZCA Research Award

The foundation and ANZCA investigators thank the family of the late Dr Russell Cole for their continued contribution to the advancement of pain medicine research through the Russell Cole Memorial ANZCA Research Award. The $70,000 contribution this year by Ann, Rowena and Victoria Cole allowed the foundation and the ANZCA Research Committee to make an important award to a worthy investigator and research project for 2016.

Excellence in Anaesthesia and Pain Medicine Research Appeal

Thank you to all those Fellows who have given generously to the 2016 appeal.

Donations can be made via the ANZCA website, by mail or by calling Rob Packer on +61 3 8517 5306.

ANZCA Research Committee meeting

The ANZCA Research Committee met at the College on August 28 to allocate research funding grants for next year. Recipients will be announced in the December issue of the *ANZCA Bulletin* after all grant applicants have been told the outcomes.

The committee had a total of $A1,445,915 to allocate to projects, including existing multi-year commitments, the academic enhancement grant, project grants, simulation/education grants, novice investigator grants and pilot grants.

The foundation thanks all Fellows, donors and sponsors whose commitments make it possible to distribute this funding to enhance research, continuous improvement and patient outcomes, and to support anaesthetists and pain medicine specialists in advancing perioperative medicine.

Rob Packer
General Manager,
Anaesthesia and Pain Medicine Foundation
ANZCA

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

Understanding cerebrovascular autoregulation

ANZCA Fellow Dr Alwin Chuan is excited by the brain, in particular its critical cerebrovascular autoregulation (CVAR) function – and it shows in his research.

"Let's think of it as the black box of the body," Dr Chuan said.

Cerebrovascular autoregulation, he explains, is the mechanism which regulates blood supply to the brain to prevent cell death, a mechanism which is impaired by age, chronic disease and – importantly – anaesthesia and surgery.

As part of a study to better understand the CVAR function, and in turn protect it in vulnerable patients, Dr Chuan is leading a pilot study: "The clinical significance of cerebrovascular autoregulation during non-cardiac anaesthesia".

"Impairment of the CVAR function has been associated with increased risk of perioperative stroke, poorer outcomes after brain surgery and acute kidney injury," he said.

"With an increased demand for surgery and anaesthesia by an ageing population, this represents a significant burden of disability, poorer recovery and an overall burden on the health system."

Dr Chuan is applying his research to non-cardiac patients undergoing anaesthesia and hopes to add to add to the growing body of knowledge of CVAR dysfunction in the elderly who are undergoing major non-cardiac related elective procedures. This will be done by using near-infrared spectroscopy (NIRS) which can now be used to measure CVAR function. It is a non-invasive process that involves attaching optical sensors to the patient's forehead.

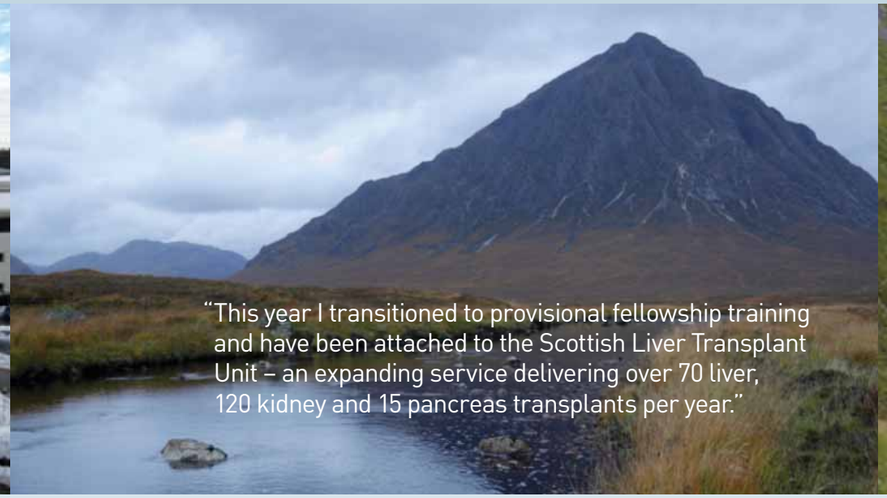
Dr Chuan will monitor his patients using NIRS and then follow up with them 12 months after their surgery to see if impairment of their CVAR mechanism caused worsening post-operative outcomes and their recovery.

This pilot study is designed as a sub study of the BALANCED clinical trial on the effect of depth of anaesthesia on patient outcomes.

The study received a 2015 $A15,000 novice investigator grant from the Anaesthesia and Pain Medicine Foundation and Dr Chuan hopes his work will provide further evidence to improve care of patients during anaesthesia, in understand better which patients are at risk.

Ebru Yaman
Media Manager, ANZCA

Winter is coming…reflections on working in Scotland



"This year I transitioned to provisional fellowship training and have been attached to the Scottish Liver Transplant Unit – an expanding service delivering over 70 liver, 120 kidney and 15 pancreas transplants per year."

In August of last year, bags packed with my warmest clothes, I headed to Scotland to work at the Royal Infirmary of Edinburgh. Living and working abroad has been immensely satisfying on a personal and professional level. If you're interested in a UK fellowship, the key to success is advanced preparation, patience during the registration process – and vitamin D supplementation.

The original Royal Infirmary was established in 1729 in a little (wee) house in Edinburgh's Old Town with four inpatient beds. There were 35 documented admissions in the first year for conditions such as pains, palsies and consumption.

Three moves and three centuries later, the new Royal opened in 2003 on the fringe of the capital – it is a monster of a hospital with 900 inpatient beds, 24 operating theatres and provides specialty services for patients from the south-east of Scotland and beyond.

The anaesthetic training program in the UK is structured in a similar manner to our own; consequently ANZCA trainees are able to slot into the British system with relative ease, although it does take time to become accustomed to the local lingo.

There were some awkward pauses in theatre in my first weeks when the surgeons would turn and ask "Rachel, whaur ar ye frae?" (where are you from?) and "kinnae 'ave more heid doon?" (can I have more head down?)

Having now experienced both systems, I feel ANZCA trainees are given relatively more responsibility at an earlier stage of anaesthetic training, which is appropriate given our training program is shorter (five years not seven).

ANZCA allows up to 12 months of any given training period to be undertaken overseas provided prospective approval is obtained.

Once a position has been secured, the relevant forms can be downloaded from the ANZCA website – and please note, there are separate documents required for the different training periods.

Registering with the General Medical Council (GMC), the UK's licensing board, is the next step and this can be a complicated, tedious and expensive process with the specialty requirements in a state of flux. My advice would be to look into all available pathways at least a year in advance and don't give up at the first hurdle.

During the first six months in Edinburgh, I completed advanced training with rotations in high-risk obstetrics, major vascular and colorectal/urology (applying for a job well in advance helped secure desired rotations).

The job did come with a hefty on-call commitment that started straight off the bat holding the obstetric bleep. What better way to get started in a new environment than covering the labour ward, responsible for 7000 deliveries per year and named after Scottish surgeon Sir James Young Simpson, who introduced analgesia to obstetrics (Edinburgh has a high epidural rate!)

This year I transitioned to provisional fellowship training and have been attached to the Scottish Liver Transplant Unit – an expanding service delivering over 70 liver, 120 kidney and 15 pancreas transplants per year. The unit also covers bariatric surgery, hepato-biliary surgery and all major upper GI and endocrine work.

The volume and variety of work has been terrific and I have particularly enjoyed the camaraderie and "chat" on the unit. Of course working in the National Health Service (NHS) is not all roses and there are daily challenges to overcome – theatre inefficiency for one, with the NHS being often under-resourced to deliver the optimum treatment to patients in a timely manner.

Working overseas has allowed me to reflect on some of the strengths and weaknesses of our own system and hospital culture and the broader issues facing healthcare.

After living here for more than a year, I've developed a strong affinity with Scotland. There is so much more to love about this country than the clichés of kilts, tartan, haggis, whisky, hairy coos and golf (although they all have their merits – except haggis!)

I've found the Scots are affable people who love good banter. They are incredibly proud of their heritage, have a strong sense of community spirit and I've witnessed humbling examples of locals helping each other and looking out for the less fortunate. Daily life is not bound by as many rules and regulations as it is in Australia (for example, dogs are welcome in pubs and on public transport and you can park your car in the street facing whichever way you like!)

Anyone with a love of the outdoors will appreciate the spectacular countryside all within a couple of hours' drive. Even on the most dreich (Scottish word for cold/damp/miserable/grim) of days, there really is no city quite like Edinburgh with its ancient streets and cobblestoned alleyways it looks like something straight out of a fairytale.

Many people worry about the weather but the truth is the Scottish summer has been lovely (this year it was on a Wednesday) and the long days do make up for the darkness over the winter. Besides, continental Europe is only a couple of hours away!

Lang may yer lum reek!

Dr Rachel Corris
Anaesthesia Fellow
Royal Infirmary of Edinburgh

Useful links:
www.gmc-uk.org
www.ahpra.gov.au

Above from left: Dr Rachel Corris at the Isle of Skye, Scotland; The Royal Infirmary of Edinburgh; Glen Coe, Scotland; Dr Corris at Ben Nevis, Scotland.

New in the library

New online books

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

Basic clinical anesthesia / Sikka, Paul K. [ed]; Beaman, Shawn T. [ed]; Street, James A. [ed]. -- New York: Springer, 2015.

Mastering communication with seriously ill patients: balancing honesty with empathy and hope / Back, Anthony; Arnold, Robert; Tulsky, James. -- 1st ed --Cambridge: Cambridge University Press, 2009.

Medical training review panel: eighteenth report / Medical training review panel. -- Canberra: Australian Government, Department of Health, 2015.

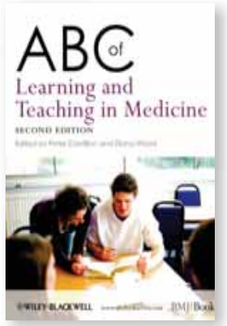
Reducing mortality in critically ill patients / Landoni, Giovanni [ed]; Mucchetti, Marta [ed]; Zangrillo, Alberto [ed]; Bellomo, Rinaldo [ed]. -- 1st ed -- Switzerland: Springer, 2015.

Sedation: a guide to patient management / Malamed, Stanley F. -- 5th ed. -- St. Louis, Mo: Mosby Elsevier, 2010.

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

New books for loan

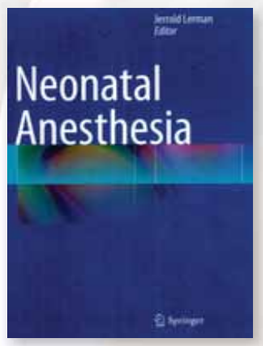
Books can be borrowed via the ANZCA Library catalogue: www.anzca.edu.au/resources/library/book-catalogue.html



ABC of learning and teaching in medicine / Cantillon, Peter [ed]; Wood, Diana [ed]. -- 2nd ed -- Chichester, West Sussex: BMJ Books, 2010.

Chronic pain / Jay, Gary W. -- New York, N.Y.: Informa Healthcare USA, 2007.

Australian Pain Society: the first 35 years / Godden, Judith. -- North Sydney, NSW: Australian Pain Society, 2015.



Neonatal anesthesia / Lerman, Jerrold [ed]. – New York: Springer, 2015. *Kindly donated by the editor Professor Jerrold Lerman.*

Trip database – find evidence fast

Trip is a clinical search engine designed to allow users to quickly and easily find high-quality research evidence to support their practice and/or care. The database has been online since 1997 and has developed into the internet's premier source of evidence-based content. Trip's motto is "Find evidence fast".

As well as research evidence, Trip allows clinicians to search across content types including images, videos, patient information leaflets, educational courses and news.

Trip recently introduced a free registration process, which allows clinicians to:

- Keep up to date with new research based on your clinical speciality and/or specific topics of interest. Each month, Trip will identify new content focused on your interests and email these to you.
- Save searches for future research.
- Keep track of activity that can be used for CPD purposes.

Available through the ANZCA Library databases list: www.anzca.edu.au/resources/library/databases

New Journal of Anesthesia History now available online

Launched in 2015, the *Journal of Anesthesia History* (JAH) is the next iteration of the Bulletin of History Anesthesia. The *Journal of Anesthesia History* is an international peer-reviewed journal dedicated to advancing the study of anaesthesia history and related disciplines. The journal addresses anaesthesia history from antiquity to the present. Its wide scope includes the history of perioperative care, pain medicine, critical care medicine, physician and nurse practices of anaesthesia, equipment, drugs, and prominent individuals. The journal serves a diverse audience of physicians, nurses, dentists, clinicians, historians, educators, researchers and academics. The webpage has articles, referenced quizzes, information about events and editors, and more.

Access to the journal is available through the ANZCA Library online journal list: www.anzca.edu.au/resources/library/journals

Continuing Education in Anaesthesia, Critical Care & Pain name change

The companion journal to the *British Journal of Anaesthesia (BJA), Continuing Education in Anaesthesia, Critical Care & Pain (CEACCP)* has changed the journal title to BJA Education. This journal is very popular with ANZCA trainees as it supports the FRCA training program, and is well used by Fellows for continuing professional development. The change came into effect in June.

ECRI health device reviews

New infusion pump evaluations

ECRI has evaluated three large-volume infusion pumps: the B. Braun Infusomat Space, the B. Braun Outlook 400ES, and the CareFusion Alaris. The review describes how these pumps perform, as well as which desirable features they do – and don't – offer.

Position statement: Policies on the use of smartphones should balance the benefits and the risks

Smartphones have become an essential tool in many care environments. Nevertheless, these (and similar) devices are associated with risks that must be managed. ECRI has outlined recommendations to help confirm that your policies strike the right balance.

Why carbon dioxide is better than air for flexible GI endoscopic insufflation

ECRI Institute believes that carbon dioxide, rather than air, should be the preferred gas for insufflation during GI endoscopic procedures. ECRI states that this is the best way to avoid air embolisms, which, however rare, can cause devastating injuries.

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

Guidelines in AccessAnesthesiology

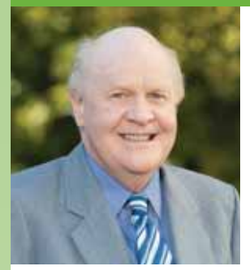
Under the guidelines section of AccessAnesthesiology you can find a collection of recommendations issued by governing agencies, expert panels and other professional and scientific organisations, readily accessible for clinical decision-making. Two recent guidelines added to the portal include:

- Most recent version of the ASA Guideline on the perioperative management of patients with OSA (obstructive sleep apnea).
- Digest of new ASRA Practice Advisory on LAST (local anaesthetics systemic toxicity).

Available through the ANZCA Library online textbooks list: www.anzca.edu.au/resources/library/online-textbooks

Faculty of Pain Medicine

Dean's message



Cannabis is the most widely used illicit substance in the world, with particularly high prevalence among adolescents[1,2,3]. In Australia and New Zealand, there are calls to legalise cannabis to treat a number of ailments[4]. Public approval is driving this without the scientific data normally required to justify a new medication[5]. General practitioners routinely treat patients who smoke cannabis for so-called medicinal reasons[4].

In New Zealand, Associate Health Minister Peter Dunne granted permission for the use of medical cannabis to treat 19-year-old Alex Renton, who died on July 1 after being in Wellington Hospital for three months, sedated with drugs to stop refractory status epilepticus[6]. Mr Dunne noted there was no clinical evidence of marijuana's efficacy[6].

Legalisation continues around the world. In Australia, the *Regulator of Medicinal Cannabis Bill 2014* is expected to be debated this year[7]. The use of cannabis for therapeutic purposes has been legalised in 23 US states, despite a federal ban[5], and in countries such as Canada, the Netherlands and Israel[8].

The NSW Government has committed to clinical trials to explore the use of cannabis and/or cannabis products for patients with debilitating and terminal illnesses, and Australia's first medicinal cannabis trial begins at the Calvary Mater Newcastle Hospital next year[9]. Queensland and Victoria will join NSW in decriminalising cannabis for trials involving patients with epilepsy, end-of-life pain and chemotherapy-related nausea[10,11]. In addition, a new cannabis research centre in NSW will receive $12 million over four years[12].

In Australia and New Zealand, there is no regulatory framework for medicinal cannabis or cannabinoid use. In New Zealand, there is a framework for the prescription of nabiximols (Sativex) in multiple sclerosis. Caution is essential.

A meta-analysis of randomised clinical trials of cannabinoids was undertaken for nausea and vomiting due to chemotherapy, appetite stimulation in HIV/AIDS, chronic pain, spasticity due to multiple sclerosis or paraplegia, depression, anxiety disorders, sleep disorders, psychosis, glaucoma, and for Tourette syndrome[13]. For chronic pain and spasticity, the evidence for efficacy of the use of cannabinoids was at best moderate[13].

However, cannabis use has been associated with substantial adverse effects[14]. There is growing evidence cannabis use can change neurophysiological structure and functioning[15]. Extreme caution should be exercised in the use of cannabinoids in patients with a history of cardiovascular disease or mental disorders, and in adolescents[4]. Cannabis use can result in addiction and can interfere with cognitive and motor functions[14].

In adolescents, repeated use may result in long-lasting changes in brain function that can jeopardise educational, professional and social achievements[14], including mental health disorders[16]; low educational achievement[17]; greater likelihood of other illicit drug use; and risks for dependence[16].

The increased use of cannabis for therapeutic purposes may therefore have effects on public health and safety[8].

In April, the Faculty released a position statement on medicinal cannabis with reference to its use in managing chronic non-cancer pain. In June, the Royal Australasian College of Surgeons (RACS) released its position statement opposing the use of medical cannabis until evidence demonstrates that the benefits significantly outweigh any risk[18].

Drawing on the experience of alcohol policies legalisation of recreational cannabis use is likely to increase use among current users, and increase the number of new users among young adults[19].

The result of any changes in law should be monitored and evaluated through well-designed studies to assess the impact of any law changes at individual and population levels[15] and a national database should monitor information about the medical prescribing of cannabis and nabiximols, similar to the way we collect information about the dispensed prescribing of opioid medications[4].

Professor Ted Shipton
Dean, Faculty of Pain Medicine

The statement on medicinal cannabis – PS 10 – can be found at www.fpm.anzca.edu.au/resources/professional-documents.

References:

1. Sznitman SR, Kolobov T, ter Bogt T, Kuntsche E, Walsh SD, Harel-Fisch Y. Investigating cannabis use normalization by distinguishing between experimental and regular use: a multilevel study in 31 countries. J Stud Alcohol Drugs 2015;76(2):181-9.
2. European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Annual report on the state of the drugs problem in Europe. Lisbon, Portugal 2011. Retrieved from www.emcdda. europa.eu/publications/annual-report/2011.
3. United Nations Office on Drugs and Crime. World Drug Report 2011. Vienna, Austria.
4. Shipton EA, Shipton EE. Should doctors be allowed to prescribe cannabinoids for pain in Australia and New Zealand? Aust N Z J Psychiatry 2014;48(4):310–3.
5. Maule WJ. Medical uses of marijuana (Cannabis sativa): fact or fallacy? Br J Biomed Sci 2015;72(2):85-91.
6. Anderson C. The great weed experiment. Weekend Press, Christchurch, July 25, 2015.
7. Parliament of Australia, Regulator of Medicinal Cannabis Bill 2014 (Internet). From www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Medicinal_Cannabis_Bill. Accessed June 15, 2015.
8. Sznitman SR, Zolotov Y. Cannabis for therapeutic purposes and public health and safety: a systematic and critical review. Int J Drug Policy 2015;26(1):20-9.
9. Medicinal cannabis trial in NSW next year. Australian Associated Press, July 27, 2015.
10. Remeikis A. Medical marijuana - one step closer in Queensland. Brisbane Times, July 27, 2015.
11. Kimmorley S. Victoria and Queensland will join NSW in medical marijuana trials. Business Insider Australia, April 19, 2015.
12. NSW $12m medicinal cannabis research centre to 'lead the world'. Australian Associated Press, June 14, 2015.
13. Whiting PF, Wolff RF, Deshpande S, Di Nisio M, Duffy S, Hernandez AV, Keurentjes JC, Lang S, Misso K, Ryder S, Schmidlkofer S, Westwood M, Kleijnen J. Cannabinoids for medical use: a systematic review and meta-analysis. JAMA 2015;313(24):2456-73.
14. Longo DL. Adverse health effects of marijuana use. N Engl J Med 2014;370;23:2219-27.
15. Ferguson DM, Boden JM. Commentary on Hall (2015): The health effects of recreational cannabis use. Addiction 2014;110:36-7.
16. Hall W, Degenhardt L. The adverse health effects of chronic cannabis use. Drug Testing and Analysis 2014;6:39-45.
17. Bachman, J, O'Malley, PM, Schulenberg, JE, Johnston, LD, Freedman-Doan, P, and Messersmith, EE. The education-drug use connection: How successes and failures in school relate to adolescent smoking, drinking, drug use and delinquency. New York, NY: Lawrence Erlbaum Associates/Taylor and Francis, 2008.
18. Use of Cannabis for Medicinal Purposes. Royal Australasian College of Surgeons Position Statement 2015; Ref. No. REL-GOV-034.
19. Hall W, Weier M. Assessing the public health impacts of legalizing recreational cannabis use in the USA. Clin Pharmacol Ther 2015;97(6):607-15.

News

Practice development stage opportunities

The practice development stage (PDS) provides an opportunity for Fellows to engage directly in the training program. In this phase of training, trainees are encouraged to go beyond Faculty-accredited training units and spend time developing skills in other centres. This may include work in private clinics, sites accredited for training by another medical college or in research.

Trainees have some flexibility in the PDS and, with their supervisors, should develop a program tailored to their interests and learning needs. They may explore topics such as interventional pain medicine, consultation liaison psychiatry and addiction medicine.

For pain medicine units and clinics, the PDS provides a potentially rewarding opportunity to engage a senior trainee and facilitate their transition from registrar to independent consultant. By becoming a PDS supervisor or placement supervisor, Fellows or other consultants can share their knowledge and expertise with the next generation of specialist pain medicine physicians without necessarily being a formal supervisor of training.

The PDS supervisor, who must be a Faculty Fellow, will provide overarching supervision and maintain regular contact with the trainee throughout the PDS, but will not necessarily be involved in day-to-day supervision. To support them in this role, PDS supervisors will have access to supervisor orientation and support resources within Networks and be eligible to attend supervisor-of-training workshops.

Another way to be involved is to become a placement supervisor. The placement supervisor oversees the trainee's clinical performance and workplace-based assessments during the placement at a nominated training site. With a minimum duration of 11 weeks for PDS placements, there is scope for this to be a relatively short-term commitment on behalf of the training site and supervisor.

Units and clinics interested in facilitating a PDS placement can find the details on the Faculty website or can contact the Faculty office for further information.

Completion of the FPM curriculum project

The curriculum project for 2015 concluded at the end of July. This year the project has developed essential topic area e-learning modules and online supervisor orientation and support resources, which are available in Networks, ANZCA's online learning and collaboration system. The requirements for the practice development stage have been further developed and sample optional topic areas created by subject matter experts.

The curriculum project is the biggest project ever undertaken by the Faculty and would not have been possible without the support, expertise and goodwill of our Fellows. We especially thank those involved in the many working groups and project groups. The new Learning and Development Committee takes over from the Curriculum Release 2 Project Steering Group to oversee the FPM training program.

News

Clockwise from top left: Dr Newman Harris, presenting on the mental state examination; Professor Milton Cohen, comprehensive spinal examination; Dr Paul Wrigley, pain-orientated sensory examination; The trainees enjoying lunch; Professor Milton Cohen and Dr Paul Wrigley, physical examination; Dr Damien Finniss, structural and functional assessment of the cervical spine, pectoral girdle and upper limb.

Clinical skills course

The advanced clinical skills course was held at the Royal North Shore Hospital, Sydney from July 25-26. The course was titled "So you want to be a Specialist Pain Medicine Physician – refining your skills!". Twenty-three trainees attended from across Australia, New Zealand and Hong Kong. Thank you to the convenor, Dr Paul Wrigley and all the facilitators involved.

2015 examination dates

The written exam will be held across Faculty of Pain Medicine regional and national offices on November 13. The clinical exam will be held in Melbourne on November 28. The closing date for registrations (written and clinical) is September 30. Further information is available on the Faculty website.

Retiring Training Unit Accreditation Committee reviewers

The Faculty would like to express their appreciation to Professor Julia Fleming and Associate Professor Leigh Atkinson for their long standing contribution to the Training Unit Accreditation Committee Reviewer Panel. The Faculty acknowledges with gratitude their wisdom, advice and time to this committee.

Admission to fellowship of the Faculty of Pain Medicine

By examination:

Dr Cameron Bruce Gourlay, FANZCA, Tasmania

Dr Alison Kearsley, FRCA, Western Australia

Dr Mark Alcock, FANZCA, Victoria

The total number of Fellows admitted is 411.

Training unit accreditation

Following successful reviews, Flinders Medical Centre has been accredited for pain medicine training while Kowloon East Cluster Pain Medicine Centre (Hong Kong) has been reaccredited. The number of accredited pain units now stands at 33.

Research in private practice

There are many benefits to adding research to a professional private practice.

While we are all familiar with research happening in public hospitals and government-funded research centres, the concept of research in private practice is not well developed. It generally is thought to be too difficult to achieve due to factors such as service demands, lack of access to research infrastructure, lack of experience in conducting research.

However private practice, be it anaesthesia, intensive care or pain medicine, provides a wealth of clinical experience and at times interesting and pertinent cases, which would be worthy of publication for the benefit of practitioners.

I have found adding clinical research to my professional practice has been rewarding, intellectually stimulating, has increased my professional network and reduced the sense of professional isolation that can sometimes affect private practice. It can even lead to new friends!

This may seem daunting, but there are a number of steps one could consider in exploring this pathway.

1. Define your interest and expertise area. Where is the boundary of your knowledge and what do you know a lot about? Do lots of reading – on new areas, research areas, new technologies, even in other fields. Read in areas of potential weakness, such as statistics, trial design etc.
2. Try your hand at simple literature publishing. If there is an interesting article that leaves you with questions (sub-group analysis, methodology concerns) then write a letter to the editor of the publication commenting or seeking clarification. Consider taking an interesting case and writing it up as a case report with short literature review and submitting it to a relevant journal. This gives you experience in the publishing pathway.
3. Join forces with like-minded individuals and start work on collaborative research where you may only enrol a small number of subjects and the back office functions are handled by more experienced principle investigators and teams. This leads to meetings and exposure to the process and "learning the ropes".
4. Consider hiring a medical writer on an ad hoc basis to assist with manuscript preparation. Look for a PhD as a good qualification to indicate they can do the job and read their publications and research output to gauge their capacity to help you. They may be better at writing up the paper than you, at least initially.
5. Cultivate the habit of corresponding with authors over their interesting work and develop a network. They may turn into collaborators, peer reviewers, mentors or even friends!
6. If you are in a large anaesthetic or intensive care unit group then consider pooling resources (time, jobs, financing) and develop an annual research plan and budget. It doesn't have to be huge, but from little things, big things grow. More people in the group may start to be interested in helping this way.
7. Establish a mentor – choose someone with a lifetime of experience who may be winding back and would have time to assist with advice and by sharing experience, expertise and wisdom. The value of this can be immeasurable. In my experience, people who are asked to be mentors rarely refuse. They are honoured to be asked and gladly help.

If this sounds challenging then remember the benefits. Patients may directly benefit from new therapy or validation of existing ones. It is intellectually stimulating and provides an additional creative output to "just doing cases". It can raise your profile and can be used for career development or subsequent broadening of work options.

At the end of the day, we owe it to our specialty to pass on collected knowledge and wisdom. If one never teaches, researches or publishes, then the risk is that one's accumulated knowledge disappears from the field upon retirement. This is a good way to avoid that and add professional enrichment.

Dr Marc Russo, MBBS DA FANZCA FFPMANZCA
Director, Hunter Pain Clinic, Hunter Clinical Research
Newcastle, NSW

Additional reading:

Practice-oriented research: what it takes to do collaborative research in private practice. Koerner K, Castonguay LG. Psychother Res. 2015;25(1):67-83. doi: 10.1080/10503307.2014.939119. Epub 2014 Aug 4.

An assessment of the perceived benefits and challenges of participating in a practice-basedresearch network. Curro FA, Thompson VP, Grill A, Craig RG, Botello-Harbaum MB, Matthews AG, Collie D. Prim Dent J. 2012 Oct;1(1):50-7.

Private practice outcomes: validated outcomes data collection in private practice. Goldstein J. Clin Orthop Relat Res. 2010 Oct;468(10):2640-5. doi: 10.1007/s11999-010-1397-2.

Special Interest Group events

Rural SIG meeting a great success

The Rural SIG held its 8th annual meeting at the Cradle Mountain Hotel in Tasmania from July 3-5 with the title "ERAS – Every Rural Anaesthetist Should….". The meeting continues to prove popular with more than 60 delegates attending. About a third were GP anaesthetists. Fortunately the snow that greeted us didn't hamper too many travel plans and only enhanced the beautiful scenery.

The clinical focuses of the plenary sessions were the Patient Blood Management (PBM) and the Enhanced Recovery After Surgery programs. Our keynote speaker Associate Professor Ross Kerridge, from Newcastle, did a fine job covering the three pillars of the PBM over three sessions and the ERAS topics were covered by Dr Judith Killen and Dr Igor Lemech from Wagga Wagga, Dr Kenneth Gilpin and Dr David Rowe from Armidale and Dr Mark Reeves from Burnie.

The final plenary session had an interesting discussion about GP Anaesthetist training, qualification and ongoing credentialing lead by Dr Craig Mitchell from Ballarat and Dr Patrick Coleman from Bunbury and some tips on completing department audit from Dr Joanna Sutherland from Coffs Harbour.

Two workshops covered CPD emergency scenarios with Dr Helen Kolawole from Melbourne covering anaphylaxis and Associate Professor Ross Kerridge covering major haemorrhage. The third workshop was hosted by Dr Joanna Sutherland and Dr Vida Viliunas from Canberra who explored ways of completing the practice evaluation aspects of the new CPD program.

The meeting continues to host a poster session with the prize going to Dr Patrick Coleman for his poster on credentialing GP anaesthetists in WA. We plan to run a poster competition in 2016 and the posters can be on any topic but must be relevant to rural anaesthesia.

The social events were well attended with delegates able to meet old friends and network during the drinks reception and dinner held in the hotel. Delegates were able to enjoy a bit of fresh air on the Saturday afternoon with an excursion into the national park that took in the original Waldheim Homestead and Dove Lake to see Cradle Mountain itself. For those not so keen on the great outdoors, a cheese and wine tasting session gave them a chance to sample some local delicacies.

The meeting was a great success and I would like to acknowledge the great work done by ANZCA events team member Elodie Garcia, hosting her first meeting, to ensure the smooth running of the meeting.

Plans for a meeting in June 2016 are in early stages with an ICU-themed meeting likely to be held in Canberra.

Dr David Rowe, Convenor

Clockwise from top: Delegates enjoying a guided tour of Cradle Mountain National Park; Delegates networking at the welcome reception; Dr Craig Mitchell (left) at the Karl Storz st and; Associate Professor Ross Kerridge, Dr Judith Killen and her husband; Wine and cheese tasting activity; Delegates testing Karl Storz equipment.

SIG name change

The Anaesthetists in Management SIG has been renamed the Leadership and Management SIG to reflect a broader interest of the group in the areas of innovation, leadership and management. Interested anaesthetists or those from the wider health business community are encouraged to get involved with the group by emailing events@anzca.edu.au.

High praise for inspiring CVP SIG meeting

Truly inspiring presentations, exceptional workshops and an amazing echo wet lab featured at the Cardiothoracic Vascular and Perfusion (CVP) Special Interest Group biennial meeting held in Darwin from July 5-8, with the added bonus of warm weather.

The meeting theme of "Times they are a-changing" was carefully crafted by key SIG executive members to reflect the rapidly changing nature of anaesthesia and procedure types in our fields of medicine. This involved plenty of discussions to achieve the optimal balance of international and national experts, while also giving some of the younger Fellows the opportunity to present. This hard work was evident from the quality of the conference. As well as a wonderful range of scientific topics, there were great practical real world presentations including on what your smartphone can now achieve in theatre monitoring!

The keynote speakers were Professor Stan Shernan, Associate Professor Nathaniel Weitzel and Dr Guillermo Martinez. Local speakers included a mix of CVP SIG members from across Australasia. This gave a truly well rounded perspective on many of the hot topics facing CVP practitioners.

While the plenary lectures covered a broad range of relevant topics, in a first for CVP SIG meetings the workshops were designed to allow all delegates to achieve at least one of the emergency response scenarios required for the ANZCA CPD triennium. Delegates appreciated the work required to pull this off in Darwin as well as the fact that the first workshop was included in registration. Many thanks to Dr Fran Rawlins for organising the workshops. Also for the first time at a CVP SIG meeting, a wet lab involving dissecting a pig heart and correlating it to echo images was held. It was a logistical challenge but a highly valuable experience for all participants.

Our meeting was well attended by 110 delegates from around the world. The provisional feedback received is inspiring and exciting.

The conference dinner was held at Pee Wee's at the Point and provided a perfect opportunity to mingle and enjoy a balmy Darwin evening.

The meeting was an outstanding success and I would like to thank the delegates for their attendance, the speakers for their contributions, the workshop faculty for their commitment and the college secretariat for their organisation and support. Finally, special thanks to Scientific Convenor Dr Ben Lloyd and the CVP Executive for their assistance in putting this great meeting together.

I'm already looking forward to the next meeting in 2017. The venue and dates are yet to be confirmed but the feedback is overwhelmingly in favour of Queenstown for our next get together.

Dr Michael Fanshawe
Chair, Cardiothoracic Vascular and Perfusion SIG

Above from left: Delegates participating in the Wet lab workshop; Associate Professor Nate Weitzel presenting; Delegates participating in the CICO workshop.

ANZAAG ASM

More than 100 delegates braved the cold to attend the Australian and New Zealand Anaesthetic Allergy Group (ANZAAG) ASM in Christchurch this August. The meeting was a success with excellent presentations from all the speakers and valuable discussions among attendees. On the Saturday evening, dinner delegates jumped on board an old-school double decker bus for a guided tour of Christchurch which is still recovering from the 2011 earthquake that devastated more than 70 per cent of the buildings in the CBD. Overall attendees thoroughly enjoyed their time in this city that has plenty of amazing cuisine and scenery to enjoy. Local convenors Dr Sue Nicoll and Dr Frances Cammack would like to thank all who attended and contributed to this informative and educational meeting.

Joint Airway Management and Obstetric Anaesthesia SIG Meeting

"The obstetric airway: A game of two halves"

ANZ Pavilion, Arts Centre,
Melbourne, Vic
Saturday October 24, 2015

For further information please contact the meeting organiser:
Sarah Chezan
T: +61 3 9093 4982
E: schezan@anzca.edu.au
www.anzca.edu.au/events/sig-events

New Zealand news

Visiting lectureship program proves popular

The NZ Anaesthesia Visiting Lectureship Program, which this year has five lecturers, is providing much appreciated in-house education at anaesthesia departments around the country, including several regionally-based meetings.

Hutt Hospital, near Wellington, wrote to the NZ Anaesthesia Education Committee (NZAEC), which manages the program, to express their appreciation for the presentation on August 6 from Dr Doug Campbell of Auckland City Hospital.

"Doug presented on anaesthesia research, concentrating on New Zealand involvement in multi-centre international clinical trials run under or with the support of the ANZCA Clinical Trials Group.

"We had an excellent turnout and this visit will serve as a focus for increasing Hutt involvement in research. It was also useful that we could meet and discuss this as a group within our own department; this aim is often not achieved if only a few of us can attend such sessions at off-site conferences."

On August 14, Dr Campbell joined Dr James Cameron (the new head of anaesthesia at the Hutt Hospital) to present at a regional meeting held at Hawke's Bay Regional Hospital for 30 attendees from Palmerston North, New Plymouth, Whanganui, Masterton and Hawke's Bay hospitals. Dr Cameron also presented at Nelson Hospital on August 7, and outlined ways to improve the safety of nerve blocks.

Head of anaesthesia at Hawke's Bay, Dr Murray Harty, who organised the combined meeting with Dr Nigel Waters from Palmerston North, said: "This is a cost-effective way for the lecturers to be able to present to more departments and it promotes regional collaboration."

A third speaker was added to the meeting – local anaesthetist Dr Tony Diprose, who spoke about being part of the NZ Medical Assistance Team's (NZMAT) response to Cyclone Pam in Vanuatu earlier this year. He said being able to respond quickly required prior planning, a co-operative employer, supportive colleagues and an understanding family.

Dr Ben Griffiths, from Auckland City Hospital, presented on "Emergency laparotomy perioperative outcome and quality improvement pathways: a UK and NZ perspective" at Whangarei Hospital on May 8 and will join Dr Emma Patrick to present at Tauranga Hospital on October 10. Anaesthetists, trainees, anaesthetic technicians and theatre nurses from Tauranga, Rotorua, Whakatane and Thames hospitals are being invited to this regional meeting.

Dr Patrick, whose topic is "Blood topics/transfusion update", will make her second presentation at Timaru Hospital on December 2.

The fifth lecturer, Dr Jeanette Scott from Middlemore Hospital, will speak about "What is new in difficult and failed airway algorithms?" at Grey Base Hospital on October 2 and at Dunedin Hospital on October 9, with this latter meeting being open also to anaesthetists from Southland Hospital in Invercargill.

Nominations for the 2016 NZ Anaesthesia Visiting Lectureships close on September 30. Visiting lecturers should be anaesthetists who can give stimulating, informative and well delivered presentations to colleagues and be willing to travel to two regional centres in New Zealand during 2016. NZAEC covers the travel costs involved in making the visits.

More information about the visiting lectureship program and a downloadable nomination form are available on the NZAEC website www.anaesthesiaeducation.org.nz. Departments wanting to host a lecturer in 2016 should complete an expression of interest form available at the same link.

Above from top left: Dr Nigel Waters, Dr Murray Harty, Dr Doug Campbell and Dr James Cameron pictured at the regional meeting held at Hawke's Bay Regional Hospital; The audience at the Hawke's Bay regional meeting for the visiting lecturers.

Change of officers for NZNC

Some office bearers for ANZCA's New Zealand National Committee (NZNC) changed at the June meeting. Dr Gary Hopgood took over as chair, succeeding Dr Nigel Robertson (Auckland), who had completed two years in the role, but remains as a committee member. Dr Hopgood, a generalist and cardiac anaesthetist at Waikato Hospital, has been a member of the NZNC since 2010, deputy chair for the last two years and is an ANZCA primary examiner. His interests include cardiac and thoracic anaesthesia, echocardiography and governance in healthcare.

Other new officers confirmed at the meeting were Dr Jennifer Woods (Christchurch) as deputy chair and Dr Brent Waldron (Hutt) as education officer. Re-elected were Dr Geoff Laney (Dunedin) as safety and quality officer, Dr Woods as formal project officer, Dr Sally Ure (Wellington) as deputy education officer, Dr Geoff Long (Waikato) as TAC officer and Dr Kerry Gunn (Auckland) as fellowship affairs officer.

The other elected committee members are Dr Sabine Pecher and Dr Indu Kapoor (both Wellington). Dr Vanessa Beavis and Professor Alan Merry are on the NZNC ex officio as ANZCA Councillors. Dr Kieran Davis is the FPM representative; Dr Rachel Dempsey, the New Fellows' representative; and Dr Lizi Edmonds, the NZ Trainee Committee representative.

Above: Some of the NZNC members for 2015-2016 pictured in June with the ANZCA President, from left: Dr Kieran Davis, Dr Jennifer Woods, Dr Kerry Gunn, Dr Sabine Pecher, Dr Vanessa Beavis, Dr Genevieve Goulding, Dr Gary Hopgood, Dr Sally Ure, Dr Brent Waldron.

ASM – great way to meet CPD requirements

The NZNC-hosted annual scientific meeting being held at Te Papa in Wellington November 5-7 provides a great opportunity to meet continuing professional development (CPD) requirements for emergency response through workshops being held before and during the ASM.

Perth-based Dr Andy Heard, who has more than a decade of experience in running airway management and fellowship programs, is guest facilitator for the CICO (can't intubate/can't oxygenate) workshops being held at the Wellington Hospital Simulation and Skills Centre. This is also the location for a trauma/anaphylaxis simulation-based workshop.
Other emergency response workshops cover advanced life support (ALS) and major haemorrhage, and there are various workshops in ultrasound-guided regional anaesthesia and thromboelastography.

On the welfare side, several workshops examine how to develop mentoring skills and how to support colleagues in difficulty, plus the secret to living a fulfilling life.

The main scientific program will explore trauma from various aspects. The clinical stream includes lessons to be learned from Pearl Harbour and the military generally, pre-hospital care, developments in coagulopathy and haematology, and airways and trauma.

Looking at the "trauma" practitioners may experience, sessions will cover the trauma of retirement, the trauma patients experience, and taking care of the welfare and mentoring of anaesthetists and trainees.

On the Friday, the NZNC will hold its annual general meeting for New Zealand Fellows.

See www.anzcanzasm2015.com for full information about the ASM and to register.

Award for cultural competence leader

A member of the group developing an ANZCA professional document on cultural competence, Associate Professor Suzanne Pitama, was presented with the Prime Minister's Supreme Award for tertiary teaching excellence in August.

Associate Professor Pitama is the Director of the Māori/Indigenous Health Institute (MIHI) at the University of Otago, Christchurch. Her teaching program has been described as "the most comprehensive indigenous health curricula (in medicine) in Australia and New Zealand".

Associate Professor Pitama also picked up two of six awards on offer at the Leaders of Indigenous Medical Education (a New Zealand and Australian network) conference held in Townsville, August 11-13. As well as being on the document development group for ANZCA, Associate Professor Pitama recently ran a workshop for the anaesthesia department at Christchurch hospital.

Australian news

Queensland

18th Annual registrars scientific meeting

The 18th Annual Queensland Registrars Scientific Meeting was held on Saturday May 30 at the ANZCA office in Brisbane.

The meeting provides an opportunity to present quality research to peers, and Queensland anaesthetic trainees and Fellows within one year of admission to fellowship were encouraged to showcase their scientific work.

Twenty-one registered delegates, including trainees and active and retired Fellows, enjoyed a relaxing Saturday filled with interesting lectures. We thank our adjudicators Dr Martin Heck, Dr Sarah Earnshaw and the Queensland Chair of the Australian Society of Anaesthetists, Dr Nicole Fairweather, for their meticulous assessment of all presentations.

Six presenters took up the invitation and delivered high standard speeches. We thank Dr Nathan Peters, Dr Nigel Thomson, Dr Rebecca Kamp, Dr Paul Slocombe, Dr David Goldsmith and Dr Peter Casey.

Congratulations to:

Dr Paul Slocombe who won the ANZCA Tess Cramond Award for his project "A safety checklist prior to regional anaesthesia to prevent wrong-sided blocks".

Dr Rebecca Kamp who won the ASA Chairman's Choice Award for her project "Evaluation of epidural extension at a tertiary referral hospital".

Dr Peter Casey who won the AXXON Health Award for his project "A clinical audit of intraoperative cell salvage transfusion practice within a large tertiary teaching hospital".

Special thanks to the staff of the Queensland Regional Office, whose support ensured a smooth day. The event was sponsored by BOQ Specialist and Avant.

We look forward to next year's showcase of registrars' research, which may present in a slightly different format.

Dr Kerstin Wyssusek
Convener
Formal Project Officer, Queensland
Chair, Queensland Regional Committee

Primary Examination Preparation Course

The June 2015 Primary Examination Preparation Course (PEPC) was well received by all 33 exam candidates. On the basis of the positive feedback received in January and June we intend to continue the new exam-focused format in 2016. The intention is to run it as a one-week intensive course before each sitting of the 2016 primary exam. Many thanks to all who presented and helped with the organisation of the 2015 courses. Please see the Queensland Regional Committee website for the dates of the 2016 PEPCs.

Dr Brown Thomas, Course convenor

Above from left: Dr Peter Casey received his award from Queensland Chair Dr Kerstin Wyssusek; Dr Rebecca Kamp receives her award from Dr Nicole Fairweather; Dr Paul Slocombe, winner of the ANZCA Tess Cramond Award, with Dr Wyssusek.

39th Annual Queensland ANZCA/ ASA Combined CME Conference

On a spectacular winter's day on June 27, 132 delegates gathered at the Brisbane Convention and Exhibition Centre for the 39th Annual Queensland ANZCA/ASA Combined CME Conference. The theme this year was "Enhanced recovery after surgery – the myths, methods and monitoring".

In the first session we had an informative reflection from our surgical and nursing colleagues regarding implementation of an ERAS program for colorectal surgery in a major metropolitan centre.

Following this, Dr Peter Schuller explained his groundbreaking research into the Bispectral Index undertaken in Cairns. Suffice to say the audience was amazed by video footage of the research. I commend all Fellows to follow this in his recent publication in the *British Journal of Anaesthesia*.

Dr Anton Booth was next, talking about the challenges of enhanced recovery principles in oesophagectomy patients, before the ERAS presenters were joined on stage by dietitian Sally Courtice and physiotherapist Mark Nelson, from QEII Hospital, for a panel discussion. This was well received by delegates, who were keen to explore the experiences of the panel especially from dietitians in this field.

Following lunch there were small group discussions covering topics such as ERAS for lower limb arthroplasty; goal-directed fluid therapy and monitoring; challenges in the endoscopy suite; a model morbidity and mortality meeting; and a session on completing the triennium.

As always, the organising committee has learned from the process and the presenters also gained insight about their topics. Feedback from delegates was positive, and was well received by the committee.

I thank the convenor Dr Helen Davies, the organising committee, Ms Ailsa Brown and all the presenters for their part in putting on an informative and enjoyable day.

Dr David McCormack
Chair, Queensland ANZCA/ASA CME Committee

Australian Capital Territory

ACT Trainee Committee

Following the completion of his training, we farewell Dr Ross Hanrahan from the ACT Trainee Committee. Ross has worked tirelessly on the committee over many years, most recently in the position of chair. We thank Ross for his efforts and congratulate him on his admission to fellowship. Dr Jennifer Hartley will take over as chair for the remainder of 2015 and will be joined by co-chair Dr Julia Hoy on her return to Canberra in January 2016. We also welcome a new member, Dr Pallavi Kumar, to the committee.

ACT Trainee Committee:
Dr Jennifer Hartley (chair)
Dr Julia Hoy (co-chair from January 2016)
Dr Anthony Gray (elected member)
Dr Pallavi Kumar (elected member)
Dr Chris Mumme (GASACT representative)
Dr Ben Wilson (elected member)
Dr Andrew Hehir (chair, ACT Regional Committee)
Dr Natalie Marshall (ACT education officer)
Ms Kym Buckley (ACT regional co-ordinator)

Contact the committee via act@anzca.edu.au or +61 2 6282 0524.

2016 Art of Anaesthesia

Save the date! Next year's Art of Anaesthesia scientific meeting will be held over the weekend of October 15-16, 2016. This coincides with the renowned Floriade Festival on the shores of Lake Burley Griffin and is a beautiful time to visit the nation's capital. Co-convenors Dr Carmel McInerney and Dr Girish Palnitkar have many wonderful ideas to make the meeting bigger and better than ever so save the date now!

Workshops

The ACT Regional Committee will present three workshops on Saturday November 7. Two emergency response workshops (CICO and ALS) will be held in the morning from 9-11am, and a workshop on Peripheral Nerve Block Ultrasound Scanning will be held during the afternoon from 1-5.30pm. The workshops will be held at Calvary Hospital (Bruce). Further information, including online registration, will soon be available on the ACT website: http://act.anzca.edu.au/

Victoria

FPM VRC Inaugural Victorian Registrars' Scientific Meeting

The FPM Victorian Regional Committee held its Inaugural Victorian Registrars' Scientific Meeting 2015 at ANZCA House on Wednesday August 12.

The meeting was devoted to presentations from four trainees and newly graduated Faculty Fellows, who presented their clinical case reviews. The quality of the four reviews was excellent and the topics quite varied, but relevant to everyday practice in pain medicine.

The presenters were Dr Jacquelyn Nash, Dr Mark Alcock, Dr Noam Winter and Dr Stiofan O'Conghaile. The inaugural prize was awarded to Dr Jacquelyn Nash.

Our sincere thanks go to adjudicators Dr Anthony Weaver and Dr Carolyn Arnold for their participation, and to the directors of pain units and other Faculty Fellows who attended and contributed to making our inaugural event a success.

We also thank our meeting sponsor, bioCSL, for their support of our academic endeavours.

Dr Diarmuid McCoy
Convenor
Chair, Faculty of Pain Medicine Victorian Regional Committee

Supervisors of training workshop

The Victorian Regional Committee hosted a half-day supervisor of training workshop at ANZCA House in Melbourne on the topic of "Teaching clinical reasoning by making expert thinking visible and accessible for students".

This seminar covered two main goals: to introduce a method for teaching clinical reasoning 'Making expert thinking visible thinking'; and to provide participants with an opportunity to practice the method and plan for future clinical reasoning teaching in the clinical area of anaesthetics.

The guest presenter was Associate Professor Clare Delany, from the Department of Medical Education at the University of Melbourne. Clare facilitated an interactive workshop entitled "Making thinking visible: An approach for teaching clinical reasoning in anaesthesia".

Participants worked through exercises to clarify the nature of our own thinking and explore how we can use this to develop thinking routines for our learners. While this was a challenging exercise, the workshop was enjoyable and generated practical guidance for use in our own teaching practice, with the annual supervisor of training dinner following as a reward!

Professor David Storey will present on clinical audit at our next meeting on Thursday November 5.

Dr Damian Castanelli
Education Officer, Victoria

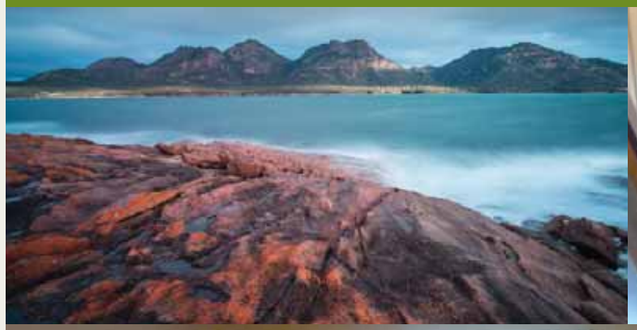
Above from top: Dr Kara Allen, Dr Mark Hurley, Dr Damian Castanelli, Dr Usha Padmanabhan, Dr Heather Kocent, Dr Bridget Langley, Dr Andrew MacCormick; Dr Burger van der Merwe, Dr Heather Loane, Dr Louise Parker, Dr Andrea Noar, Dr Heather Butler, Dr Al Motavalli, Dr Andrew Jones.

Combined CME meeting

Once again held on the last Saturday in July in Melbourne, a varied program was presented with the theme of "Art and science, tips and tricks". Convened this year by Dr Michelle Horne from the ASA, the meeting largely brought a pragmatic approach to sub-specialty anaesthesia practice. Full of enigmatic speakers, favourite sessions included new oral anticoagulants, point of care haematological testing and bedside ECHO, paediatric practice and "What's hot in (adult) ENT". The energetic Professor David Story concluded the meeting with the Embley Memorial Lecture on "The big questions for academic anaesthesia", attended by the president of the AMA (Victoria) Dr Tony Bartone. With more than 200 registrants and with a focus on audience engagement, themes of perioperative medicine, paediatrics, innovations in anaesthesia: iPads for induction, programmed intermittent epidural blouses for labour analgesia and where to in research anaesthesia (towards a more multi-specialty approach?) were explored. A live Twitter feed was employed throughout the meeting during panel discussions for the first time and we will seek participant feedback to see if it will become a usual fixture.

Above from top: Dr Debra Devonshire, Convenor Dr Michelle Horne, Dr Peter Seal and Dr Irene Ng; Dr Tony Bartone and Professor David Story.

Tasmania




Freycinet Winter Workshop

On a cold, wet and wintry weekend that saw snow and sleet hit the state, 35 dedicated participants made their way from all over Tasmania, as well as from warmer states to attend a one-day meeting at the beautiful Freycinet National Park.

Delegates had the choice of either attending one of two hands-on workshops in the morning, followed by an afternoon of speakers, all examining the "human face of anaesthesia".

Dr Marion Andrew travelled from South Australia to deliver a "Key-2-Me" Process Communication Model Seminar. This workshop provided participants with an introduction to a logical tool to assist them in gaining a deeper understanding of their behavior under stress. They also developed techniques to understand the motivations and needs of their colleagues in order to avoid conflict. Feedback from the workshop was positive with some acknowledging the importance both professionally and personally of gaining a greater understanding of human interactions.

Those who attended the Advanced Life Support Refresher Course also valued the teaching from this workshop. Delegates greatly appreciated the small groups that allowed plenty of hands-on learning.

The afternoon session included an array of speakers discussing topics such as medico-legal and interpersonal issues, crisis management and even emotional intelligence. A break in the afternoon allowed the delegates to enjoy delicious country scones, jam and cream.

Delegates appreciated the variety of speakers and the opportunity to listen to talks that didn't cover the "true classical anaesthesia content".

At the end of the one-day meeting, delegates enjoyed the opportunity to socialise together at a dinner that specialised in fresh local produce.

The meeting convenor, Dr Gregg Best was pleased with the outcomes of the day and thought that the workshops, presentations and opportunities to socialise with colleagues all coordinated well together to form the theme "the human face of anaesthesia".

Above clockwise from left: Coles Bay, Tasmania; Key-2-Me workshop; ALS workshop; Afternoon talks.

Western Australia


ANZCA/ASA Winter Scientific Meeting

The ANZCA/ASA Winter Scientific Meeting "Blood, sweat and TEGs" convened by the WA CME Committee was held on July 4. It was held at the University Club at the University of Western Australia with 109 delegates and 19 healthcare industry representatives in attendance.

Dr Paul Kruger, a haematologist and consultant physician at Fiona Stanley Hospital in Western Australia attended the meeting and spoke on the management of anticoagulants in the perioperative setting. Dr Anastazia Keegan, a transfusion medicine Fellow, also from Fiona Stanley Hospital presented on massive blood transfusion. Dr Simon Zidar, a cardiac trained anaesthetist and perfusionist spoke on "Platelets and perioperative/POC testing – no more graphs!" and Dr Surbhi Malhotra, a consultant anaesthetist and honorary senior lecturer at Imperial College NHS Trust presented on obstetric haemorrhage. This meeting also hosted several workshops including Cell Salvage, Rotem and CICO.

We have received excellent feedback in regards to content of presentations as well as conference facilities, catering standards and the general organisation of the conference resulting in a very successful meeting.

ANZCA/ASA Country Scientific Meeting

The ANZCA/ASA Country Scientific Meeting "Modern Challenges and Daily Dilemmas" will be held at The Pullman Resort at Bunker Bay on October 16-18, 2015, convened by the WA CME Committee. Registrations are now open via the ANZCA website and are filling quickly.

New South Wales

Difficult airway relativity

Clockwise from top left: Dr George Caponas; Dr Maury Scharf, Dr Susan Newton, Dr Anthony Burn; CICO workshop; Dr Catherine Ashes; CPR Workshop.

The "Difficult airway relativity" 83rd NSW regional meeting was held on June 13 at the Sydney Hilton. The meeting attracted anaesthetists from across Australia and New Zealand and was very well received with more than 360 delegates in attendance.

Some of the topics that the keynote lectures covered were: Airway management, Fires in the operating theatre, Obstetric airway update, Paediatric airway cases, OLV – old and new techniques for the non-thoracic anaesthetist. A highlight of the talks was the presentations given by Dr Anil Patel on Nap 4 – What have we learned and how do we implement change?, THRIVE nasal oxygenation to give more time for intubation and Strategies for safe extubation and the place for nurse-led awake extubation of low risk cases in recovery.

The PBLDs and workshops as always, were a great success and addressed new techniques and equipment facilitated by expert presenters. A highlight of the workshops was the emergency response workshop, that we have now become expert at facilitating.

We congratulate the NSW ACE Committee, convenors and NSW ANZCA staff on the success of this event and they are already planning for next year.

Foundation Teacher Course

Back, from left: Maurice Hennessy, Dr Justin Boyce, Dr Clare Farrell, Dr Liz Hessian, Dr Po Che Yip, Dr Andrew Cameron, Dr Juliana Kok, Dr Syed Huq, Dr Gerry Khong, Dr Karthick Nagarajan, Dr Claire Goldsbrough, Dr Alex Henry, Dr Jenny Lucas, Dr Shakeel Kunjo.

Front, from left: Dr Gerald Wong, Dr Caroline Yeoh, Dr Ann See, Dr Ammar Ali Beck, Dr Amy Taylor.

Foundation Teacher Course

The ANZCA Office in Sydney hosted a Foundation Teacher Course from June 17-19, 2015, with 18 Fellows and senior trainees attending from various regions across Australia and New Zealand. This interactive course was one of five face-to-face courses this year, with others held in Adelaide, Hobart and Perth, and the final course to run in Auckland in October.

The course enabled participants to engage with colleagues over three days, to work together to expand their knowledge and skills related to learning and teaching. Participants learned how to implement a learner-centred approach to facilitating trainees and came away with useful tools for facilitating learning in and out of the operating theatre.

The courses this year have been supported by Fellows and provisional Fellows who have committed their time to facilitate sessions within the course. We would like to thank and acknowledge Dr Elizabeth Chye, Dr Shona Osborn, Dr Jessie Ly, Dr David Law and Dr Emelyn Lee for their contribution. The Teaching and Learning Subcommittee are leading work to increase capacity for many more Fellows to become facilitators of the course in the future.

If you are interested in being notified when registrations open in November 2015, for courses running in 2016, please get in touch at ftc@anzca.edu.au. An article on the ANZCA Educators Program (formerly the Foundation Teacher Course) can be found on page 54.

South Australia and Northern Territory

CME meeting "Anaesthesia Research Update"

SA and NT Continuing Medical Education Meeting "Anaesthesia Research Update" was hosted by ANZCA/Australian Society of Anaesthetists on July 29 at the Women's and Children's Hospital. Dr Rachel Dawson, RMO at the Queen Elizabeth Hospital, opened the meeting with study outcomes she has been working on for the past three years on the "effect of perineural versus intravenous Dexamethasone on ankle block duration".

Dr Allan Cyna, Senior Consultant Anaesthetist at the Women's and Children's Hospital and Clinical Lecturer at the University of Adelaide presented "Research questions: What's hot and what's not?". Dr Cyna covered current research being undertaken at The Women's and Children's Hospital and the research guidelines they use such as "What is a good research question?" and "Should we be shooting sacred cows?" when we ask research questions. He queried the ethics of placebo and types of placebo and whether RCTs are the best way to answer a question and how they choose a primary outcome. Very interesting points were raised on communication and how it can affect anaesthesia outcomes such as "Do words hurt? Can they help?".

Dr Douglas Fahlbusch, Anaesthetic Consultant, introduced the attendees to the new PADDI (Perioperative Administration of Dexamethasone and Infection) Trial that will commence shortly with primary outcomes to address the impact of Dexamethasone on surgery site infection (SSI) and a range of secondary outcomes in relation to its safety profile. Of approximately four million operations around Australia per year, a quarter receive Dexamethasone postoperatively with up to 12 per cent of patients having SSIs – big numbers, very expensive to treat and morbidity and expense to the patient is at an estimated cost of $52 million per year in Australia and approximately $10 billion worldwide per year. This is an Australian-driven study that has potentially significant impact internationally.

Dr Roelof Van Wijk, head of the anaesthesia department at the Queen Elizabeth Hospital and Senior Clinical lecturer at the University of Adelaide told of why the Queen Elizabeth Hospital started their pilot study "Deep neuromuscular block reduces intra-abdominal pressure requirements during laparoscopic cholecystectomy". They wanted to know if deep neuromuscular block reduced the intra-abdominal pressure requirement during laparoscopic surgery and would you have a clearer view? How large is the effect size if you administer a high dose of Rocuronium and have a very deep block? They could not find an answer anywhere in literature, it was never quantified and if you can't quantify you can't do any research around it as you can't do a power calculation so you don't know how many patients you need for the trail – thus emerged the study comparing the effect of deep block versus no block.

The second CME meeting of the evening series was well attended with the meeting closing with a lucky door prize draw for a GoPro camera provided by our corporate sponsor with Dr John Dally being the lucky recipient.

Above clockwise from left: Dr Allan Cyna; Dr Douglas Fahlbusch; Dr Simon Macklin; Doorprize winner Dr John Dally; Dr Roelof Van Wijk; Dr Rachel Dawson.

NT Biennial ASM "New answers to old questions"

The 7th Biennial Northern Territory Anaesthesia CME meeting had a fresh look with a change of scene this year at Skycity Darwin, having outgrown the traditional venue. The theme of the meeting was "New answers to old questions", with the talks ranging from difficult airway management and perioperative cardiology to the latest in peri-operative diabetic management.

Our keynote speaker, Dr Keith Greenland, opened the day with a fascinating approach to the airway, a theme which was continued from a surgeon's perspective by Dr Graeme Crossland. Their unique approaches to the age-old problems gave us all new insights into the potential crises and their management for our patients.

A practical review of perioperative cardiological management was given by Dr Hussam Tayeb, a cardiologist from the Royal Darwin Hospital. His approach, that went beyond the guidelines, was extremely applicable to our daily practice and an exceptionally insightful bridge between cardiologists' and anaesthetists' perspectives.

Our local speakers Dr Nathan Oates, Dr Sorcha Evans and Dr JP Cotter also all gave us excellent insights into obesity and OSA, diabetes and renal failure respectively.

For the first time this year, there were also concurrent CICO and anaphylaxis workshops that enabled delegates to meet the ANZCA CPD emergency response criteria.

Finally a beautiful dinner at Char restaurant concluded a very successful meeting.

Dr Simon Roberts, FANZCA
Royal Darwin Hospital, NT ASM Organising Committee

Change of FPM SA chair

At the July SA FPM CME evening, Dr Graham Wright was thanked for his dedication and contribution as chair of the SA FPM Regional Committee over the past four years. Dr Wright's involvement has been integral from the inception of the committee and his input ensured informative CME evenings engaged South Australian members on a regular basis. His efforts continued to address issues in relation to strengthening the regional framework of the Faculty. We would like to thank Dr Wright for his dedication in serving his term and welcome Dr Bruce Rounsefell to the role as chair.

A synopsis of pain research was presented at the meeting by Dr Tasha Stanton, Dr Andrew Somogyi and Dr Susan Evans.

Above left, clockwise from left: Dr Keith Greenland; Dr Sorcha Evans, ANZCA trainee; Dr Hussam Tayeb.

Above: Dr Bruce Rounsefell and Dr Graham Wright.

Dr Colin Friendship
1927 – 2014

Colin James Friendship spent his early years at Bronte, attending Sydney Boys High School before graduating from the medical faculty at the University of Sydney in 1951.

After a few years in general practice in Kingsgrove, Col travelled to England, feeling his way through orthopaedics and obstetrics until he found his niche in anaesthetics, gaining a DA. More importantly while in Wales, he met and married Rita, and they settled in Caringbah in the Sutherland Shire of Sydney, where he worked as a GP anaesthetist for three years.

A career in anaesthetics beckoned with the opening of the Sutherland Hospital in 1958, and Col returned to England where he fulfilled the requirements for the Fellow of the Faculty of Anaesthetists of the Royal College of Surgeons (FFARCS) in 1961. His appointment that year as the inaugural visiting anaesthetist at Sutherland Hospital was followed by appointments at St George Hospital, Prince Henry Hospital and the Royal Hospital for Women in Paddington. His FFARACS was awarded in 1967.

Over the next 10 years, the onerous after-hours roster commitments at four hospitals forced him to relinquish the latter three positions to focus on the Sutherland Shire, the fast-growing area in which he raised his family.

He inevitably became involved in the acute management of critical incidents, made more frequent by the ubiquitous waterways and unfenced pools, the predominant paediatric population and proximity to Sydney's Royal National Park. In addition to drownings in home swimming pools, bays and beaches, he managed snake and funnel web spider envenomation and ciguatera poisoning.

In the ensuing decade, Col was the driving force behind a new intensive care facility, a 24-hour labour-epidural service and a training program for anaesthetics registrars in conjunction with the University of NSW group of hospitals. He provided unswerving and generous support to anaesthetic colleagues around Australia, especially those in single-practice, seeking respite.

Col was a superb anaesthetist in every sense: highly competent, safe, unflappable and reassuring. He loved children and would go out of his way to help them through a frightening hospital experiences. One of his endearing quirks was to tape a coin to the child's palm before emergence from anaesthesia as a reward for their courage.

Col committed himself to two tours of war-torn Vietnam in the early 1970s with the South-East Asia Treaty Organization (SEATO) gaining valuable experience in wartime anaesthesia and tropical medicine. His anaesthetic skills drew him to diving, snorkelling and scuba. This took him to exotic dives in the Coral Sea with Ron and Valerie Taylor, to Indonesia and New Caledonia with Peter Scott and Keith Shackleton. In addition, he worked on two summer tours as medical officer to the Mawson Base in Antarctica, where he made some of the earliest dives.

I first met Col in the early 1980s as a newly appointed orthopaedic surgeon. From the start, Col made me welcome in Sutherland Shire. A lasting friendship developed as we attended courses and presentations at the Sydney Museum and Macquarie University. He was a talented bird watcher and botanist, and a committed environmentalist long before it was popular.

We enjoyed many adventures together, bush walking and long-distance bike riding all over Australia, often off the beaten track. Inevitably, there were injuries and it gave us great confidence to have Col's cool demeanour, wisdom and skills during these dilemmas. He was a wonderful companion around the night camp. He loved nonsense rhymes of Edward Lear and James Thurber, and he drew on these with his own brand of irresistible, and sometimes wicked, humour.

Col was a quiet companion – on the surface humble, even self-deprecating – but he possessed a steely determination to pursue his goals based on a lifetime of sound judgment.

In his last year of life, Col developed complications of surgery, which warranted a long period of rehabilitation. Gradually this predicament became intolerable for such a private and independent person. He returned home to the wonderful support of his family – Rita, Keith, Jill and Mark.

One could not have asked for a better friend and he will be sadly missed by those of us privileged to have enjoyed the genuine friendship of this exceptional man.

Dr William Bye, FRACS
New South Wales

Dr Zoltan (Lefty) Lett
1916 – 2014

Zoltan Lett was born in Budapest on November 24, 1916 when the Great War was raging. His studies in medicine in Prague were interrupted when Czechoslovakia was invaded during the Second World War – he had to complete his studies in Oxford, UK, undertaking his internship at the University College Hospital, London. Zoltan enlisted and served in North Africa and in Burma for which he was awarded the Burma Star.

After the war, he trained in anaesthetics, obtaining his Diploma in Anaesthetics (DA) and then gained Fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons (FFARCS). A chance meeting in 1954 with Dr K C Yeoh, then Director of the Medical & Health Services of the Hong Kong Government who was on leave in the UK, led to him joining the public health service in Hong Kong as its first consultant anaesthetist. He also began as a part-time lecturer in anaesthetics at the Faculty of Medicine of the University of Hong Kong. Zoltan continued this association and was Reader in Anaesthetics when he retired from the university in 1983.

Lefty, as Zoltan was known to his friends, supported Dr Horacio Ozorio (who designed the eponymous endotracheal tube connector) in the founding of the Society of Anaesthetists of Hong Kong (SAHK) to promote anaesthesia as a specialty. He was Chair and then President of the SAHK for many years.

Being a key person in anaesthetics in the university, the public sector and the SAHK, Lefty was in a good position to promote the specialty and develop good clinical practice amongst colleagues. His many links with the international anaesthetic community were legendary. His perseverance in developing training in anaesthesia and access to specialist fellowship qualifications from the UK (FARCS) and Australasia (Faculty of Anaesthetists of the Royal Australasian College of Surgeons, FARACS) for Hong Kong anaesthetists helped to fulfil the needs of Hong Kong and, in particular, the public hospital expansion program from the 1960s onwards. His dedication and contribution to anaesthetics, especially in the public sector, was immense and lasted well into his eighties.

Lefty also founded the Hong Kong Society of Critical Care Medicine (HKSCCM) in 1984 and was its inaugural chairman. When the Hong Kong College of Anaesthesiologists (HKCA) was founded in 1989, Lefty was a promoter and founding fellow. Lefty remained closely associated with both the SAHK and HKCA even after his complete retirement from clinical practice in 1996. He was made an Honorary Member of SAHK and an Honorary Fellow of the HKCA. The SAHK celebrated its 60th anniversary and the HKCA its 25th anniversary just as Dr Lett passed away.

Lefty's contribution to anaesthesia and the profession was recognised not only locally, but also internationally. He received an emeritus professorship from the University of the Philippines for help with the World Health Organization Diploma in Anaesthetics training program in Manila; an honorary life membership from the Philippine Society of Anesthesiology; the Pask Certificate of Honour from the Association of Anaesthetists of Great Britain and Ireland (1978) for services to anaesthesia in Hong Kong; and an honorary fellowship from the British Medical Association (1979). He was also a Fellow of medical colleges around the world, including the Australia and New Zealand College of Anaesthetists and the International College of Surgeons.

Dr Zoltan Lett devoted practically his whole professional life to Hong Kong and has been labelled by many as the "Father of Anaesthesia" there for his contribution to the development of anaesthesia as a specialty in Hong Kong. Lefty remained clinically active until his eighties and continued to take part in scientific meetings in all parts of the world until a stroke confined him to living at home in Bexhill-on-Sea in the UK. He is fondly remembered as a kind, humble and approachable colleague, mentor and friend. He touched many people's hearts and lives, and his kindness, generosity and dedication will live on.

Lefty passed away peacefully on November 15, 2014 in his nursing home, just nine days short of his 98th birthday, with Angela, his only daughter, by his side. He is also survived by two grandchildren and a great grandchild.

We give thanks for the life of Lefty; may he rest in peace.

Dr J Ronald Lo
FRCA(Hon), FANZCA, FCICM, FHKCA, FHKCA(IC), FHKAM, MMed(Anaes)
Past President of the SAHK & HKCA, and Founding Secretary of HKSCCM

Dr Peter Yorke 1953 – 2015

Peter David Yorke was born on August 5, 1953 in Sydney, and died on April 14, 2015 in Canberra.

Peter grew up in Darlinghurst and Bexley, the only child of Reginald and Dorothy. He completed his schooling at Sydney Technical High School. After a stint working on the NSW Railways, he undertook his medical degree at the University of NSW. Having been in Canberra in his final year of medical school, he returned there for his internship in 1979. Living in the Woden Valley Hospital residents' quarters, his penchant for classic cars was readily apparent, either in the car park or on the ramp to the Casualty Department entrance!

After three years, he went to England with a plan to further his training in anaesthesia, obstetrics and possibly paediatrics. He never got past anaesthesia. After he completed his Diploma of Anaesthesia, he continued with anaesthesia training in Taunton, Somerset. The time in England was one he remembered with great fondness: the cricket, travel and great camaraderie with his medical colleagues.

Peter returned to Australia in 1985 and completed his anaesthesia training at Royal Hobart Hospital. In 1987, he took up consultant positions at Royal Canberra, Woden Valley, Calvary and John James Memorial hospitals. He returned to Hobart in 1992 but came back to Canberra in 1995 and quickly established a busy practice with a focus on John James Memorial Hospital.

Peter first joined the board of John James Memorial Hospital in 1990 and, after his Hobart sojourn, became chairman in 1998, holding that post until 2009. He was an active chair and did much to boost hospital morale by organising hospital picnics, car rallies and extensive 35th anniversary celebrations in 2001. He devoted much effort to help increase the hospital's business following the acquisition of the Lidia Perin Hospital, a day surgery. By 2004, the hospital's financial pressures forced him to spend a large amount of time negotiating the sale of the John James hospital business, which was eventually purchased by Calvary Healthcare. These were trying times and many meetings were held with clinicians, staff, and administrators.

The transition to Calvary John James Hospital and the resulting John James Foundation was difficult but ultimately successful and his efforts were recognised by lifetime membership of the foundation and the renaming of the Clinical Services Building in his honour in 2011. His chairmanship of the foundation was marked by the establishment of a volunteer specialist program in the Northern Territory in which he was a keen participant and a medical student elective program for James Cook University students in their final year.

As an anaesthetist, Peter Yorke was highly regarded for his considerable clinical skill, his attention to detail and excellent post-operative care. He was much appreciated by surgeons for his "unflappability" and his prompt starts to the operating day; the latter wasn't always liked by all nursing staff. He was very popular as a teacher of medical students, residents, registrars and nurses. Being a very capable anaesthetist, he gave those who showed interest and aptitude the opportunity to engage "hands-on" with the art of giving anaesthetics from early on. He made the day interesting and fun. There are quite a few doctors who were first exposed to anaesthesia by Peter and then encouraged, and supported, to make it their career; the author being one.

Peter was also a keen participant in the RACS Pacific Islands Project and first went to Tuvalu in 1997 and subsequently to the Marshall Islands, Pohnpei, Fiji and Nauru. He enjoyed the challenge of working in these primitive conditions, bringing specialist medical care to the people while enjoying the beautiful surroundings. As an extension of this, Peter joined the RAAF Reserve in 1999 and completed overseas deployments as Squadron Leader and Medical Officer to Bougainville and East Timor. He was awarded an Australian Service Medal and Active Service Medal.

Outside medicine, Peter's interests included his dogs, English Setters, classical music, art, cricket and restoring classic cars, including makes such as Aston Martin, Rolls Royce and Mercedes Benz. He restored his well known blue Aston Martin DB5 more than once, drove it regularly and ensured that its performance was occasionally tested. Other cars to occasionally grace the hospital car park included a wonderful 1934 Rolls Royce and a lovely 1967 Mercedes Benz 250SL "Pagoda" roadster. As a member, he regularly attended the New Year Sydney cricket test. He travelled widely and enjoyed sailing and opera in far flung places. More recently, he developed an interest in horse racing and was a part owner of two horses (or "nags" depending on how they fared at the track). The Melbourne Cup carnival, including Derby Day, was something he really looked forward to. He was a generous and charming host whose functions were always memorable affairs; the Australia Day functions at his south coast retreat were legendary. He was full of stories about cars, places and people and they usually left one laughing.

The diagnosis of oesophageal cancer in December 2012 was met with his usual quiet resolve and determination; treatment began immediately. The complication and further extensive treatment caused by the diagnosis of malignant melanoma did not alter this approach. After 12 months it seemed that treatment had been successful and he enjoyed a wonderful 60th birthday party. However, even Peter could not beat the odds this time and further chemotherapy and radiotherapy was needed. But this did not dent his incredible stoicism and up until February 2015, he enjoyed a busy social calendar meeting with friends and colleagues for coffee, lunch or dinner. He spent time with his family and focused on his 15-year replica Aston Martin DB3S racing car project, the completion of which eluded him.

That the Albert Hall was filled to capacity for his memorial service is testament to the large number of people, from within and outside medicine, from far and wide, who were influenced by him. He was a pleasure to be around and will be very much missed.

We send our condolences to his partner Andrea and son Will.

Dr Arne Schimmelfeder, FANZCA
ACT