JUNE 2015

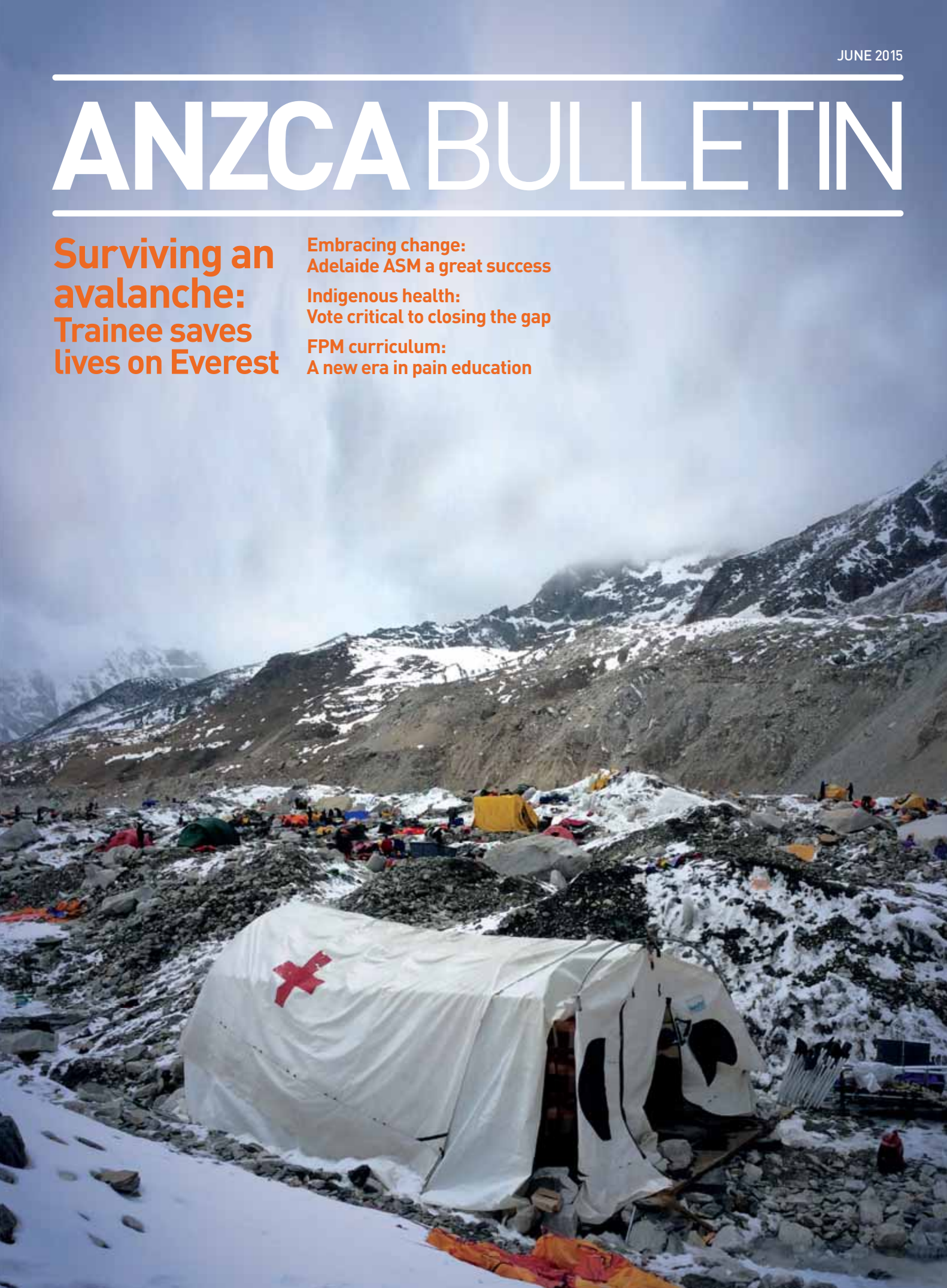
ANZCA BULLETIN

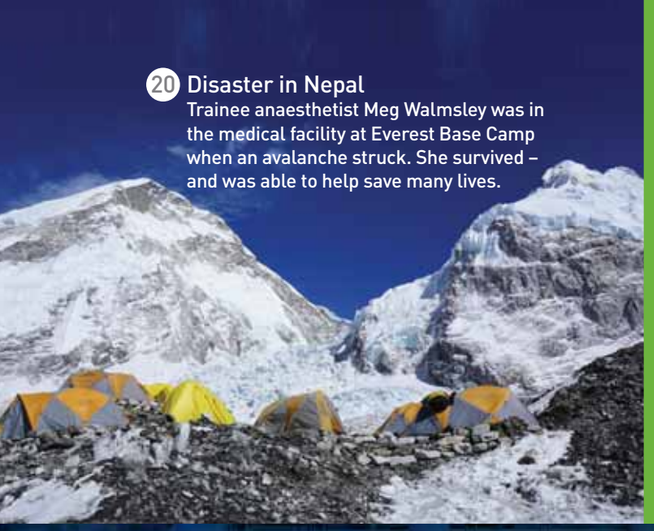
Surviving an avalanche: Trainee saves lives on Everest

Embracing change:
Adelaide ASM a great success

Indigenous health:
Vote critical to closing the gap

FPM curriculum:
A new era in pain education





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Trainee anaesthetist Meg Walmsley was in the medical facility at Everest Base Camp when an avalanche struck. She survived – and was able to help save many lives.

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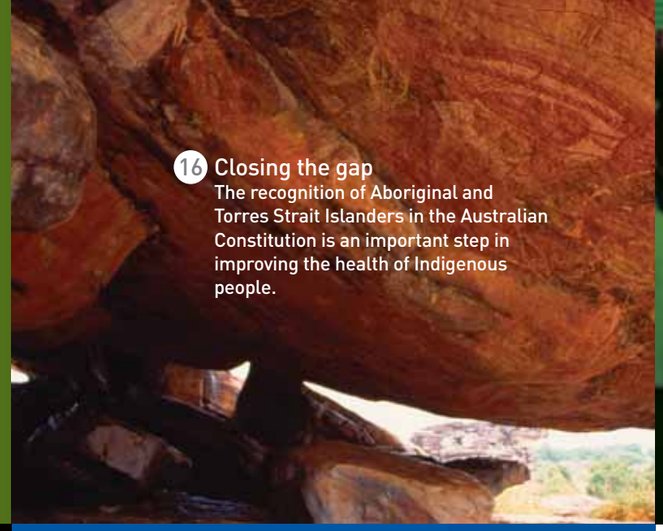
There is little evidence cannaboids are effective in most chronic non-cancer pain cases.



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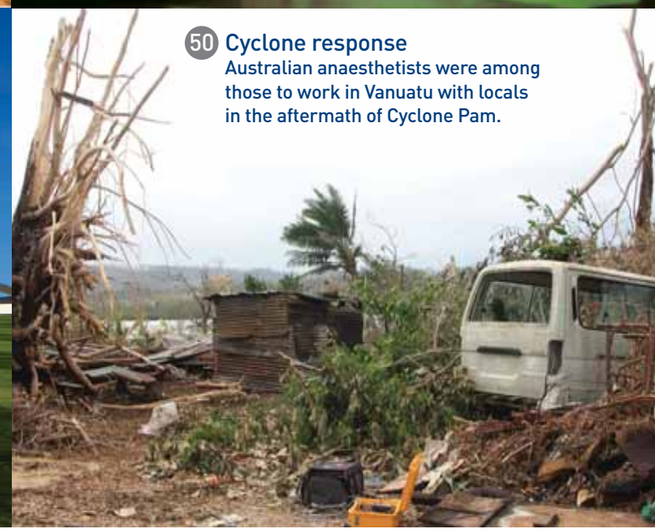

50 Cyclone response

Australian anaesthetists were among those to work in Vanuatu with locals in the aftermath of Cyclone Pam.

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 mainly in Australia and New Zealand and serves the community by upholding the highest standards of patient safety.

Cover: The Everest Base Camp ER clinic after the earthquake – and subsequent avalanche – hit on April 25.

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

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President's message

ANZCA's 2015 annual scientific meeting (ASM) in Adelaide has just concluded. The meeting had all the elements of a successful meeting – challenging invited speakers discussing cutting-edge topics, a diverse program of lectures, workshops and small group discussions, a spacious well-located and well-designed convention centre in the charming, cultural, laidback city of Adelaide.

My congratulations to the Regional Organising Committee, led by convenor Aileen Craig, and the ANZCA Events team for putting on a top show. Once again, the Virtual ASM was available, so if you missed some, or all, of the meeting, I recommend you log on.

The recent ANZCA Council election returned Vanessa Beavis for a second term, along with Michael Jones, who joined the council in late 2014 after Frank Maloney stepped down. Also new to council is Scott Ma, from Adelaide, who recently was appointed as the New Fellow councillor. Scott (along with Giresh Chandra) was a co-convenor of this year's New Fellows Conference, which was held before the ASM in the Adelaide Hills. It was a privilege for me to mix with a great bunch of talented new Fellows from all the ANZCA training regions, and Dr Pauline Wake, from Papua New Guinea.

At the ASM, ANZCA launched a pilot version of its new publication *Supporting Anaesthetists' Professionalism and Performance – A guide for clinicians*. (www.anzca.edu.au/resources/professional-documents) I hope Fellows and trainees will find it a practical resource for self-assessment, as well as teaching the elements of professionalism and performance relevant to anaesthesia practice.

In December 2012, the Medical Board of Australia (MBA) asked medical colleges to "begin the conversation" about revalidation – the process that ensures doctors maintain the skills to provide safe and ethical care throughout their working lives. ANZCA has closely monitored changes in formal regulatory processes overseas, especially in the UK and North America, for the past few years.

The MBA and the Medical Council of New Zealand (MCNZ) consider continuing professional development (CPD) as being the demonstration that doctors are competent to practise via a process of practice audit, peer review and continuing medical education. However the medical colleges maintain CPD is not the appropriate way to demonstrate competence. (Note the MCNZ uses the term "recertification" rather than revalidation).

MCNZ has some requirements that are more prescriptive than the MBA's – for example, there must be audit of medical practice and, for anaesthetists, enrolment and participation in the ANZCA Continuing Professional Development Program is mandatory. In NZ, the MCNZ is engaged in ongoing work with the medical colleges to define processes to assess, monitor and remediate Fellows/non-Fellows undertaking CPD with competence concerns. (www.mcnz.org.nz/assets/News-and-Publications/2015-Business-Plan.pdf)

In 2013, ANZCA updated its CPD standard and program to better reflect changes occurring overseas, including the need to demonstrate currency of practice. It also introduced practice assessment and peer review. The mandatory "emergency responses" are unique to ANZCA among anaesthesia colleges/societies. The revised program was launched in 2014 and has been very well received by Fellows. Provisional Fellows (ANZCA trainees in the final year of training) and international medical graduate specialists proceeding to fellowship also are enrolled in the program so they are familiar with this aspect of professionalism by the time they become Fellows.

In February, the Committee of Presidents of Medical Colleges (CPMC) sent the MBA a document outlining what the committee felt were the guiding principles for any revalidation process relevant to practice in Australia and New Zealand. This document is available on the CPMC website.

In March, the MBA announced it had commissioned a public survey as well as research to guide its decisions about revalidation, so they are effective, evidence-based and practical. The research is being conducted by the Collaboration for the Advancement of Medical Education Research and Assessment (CAMERA) at Plymouth University. The results are expected to be available in June for the MBA's consideration.

ANZCA has also been closely monitoring workforce trends and enacting its Workforce Action Plan (advocacy, data, and communication). In February, ANZCA's president, vice-president and CEO met with the Australian Society of Anaesthetists and the Australian Medical Association. A combined submission was made to the National Medical Training Advisory Network (NMTAN), a body specifically examining medical training from student to specialist and making workforce calculations and recommendations. NMTAN met in March and is initially focusing on psychiatry, anaesthesia and general practice.

The results of our two Graduate Outcome Surveys have been published in former issues of the *Bulletin*. New Zealand has completed a workforce census via all heads of departments (yet to be analysed) and it is hoped this can be repeated in Australia although this will be more problematic, as a large amount of anaesthesia work is done in private hospitals. I also plan to meet heads of ANZCA training departments in every region. In early June, there were more than 40 full-time equivalent vacant consultant posts in Australia and New Zealand, and at least three areas in Australia are about to declare themselves an area of need as they are unable to recruit local FANZCAs.

At least three Australian states are undergoing a major restructure of their hospital networks and several large hospitals have recently opened or will soon. This has also contributed to the state of flux.

Finally, I would like to acknowledge our Chief Executive Officer Linda Sorrell who leaves the College next month. Linda has been an excellent CEO who has achieved much in nearly four years with the College and ANZCA Council and I wish her well.

Dr Genevieve Goulding
ANZCA President

Chief executive officer's message

After nearly four years at ANZCA, I am still amazed at the hours and hours of dedicated work undertaken by so many Fellows and trainees for the benefit of their College and their colleagues.

This occurs at hospital level, by supervisors and other teachers, right through to the regional and New Zealand committees. It also occurs with a large number of other committees that oversee safety and quality, research, education, training, accreditation, examinations, continuing professional development and countless other areas of the College, through to the ANZCA Council.

This will be my last message as ANZCA's chief executive officer as I retire from full-time work on July 3 having joined the College in September 2011.

It has been a pleasure to have attended regional and New Zealand committee meetings and made hospital visits over the past few years.

I've visited 38 hospitals since I commenced working at ANZCA. I have had an opportunity to meet many of you and to answer questions relating to the work of the College.

Your feedback has always been relayed to the College's senior leadership team and the ANZCA Executive Committee and taken into account, along with other information, when we do our business planning each year.

I was privileged to oversee the roll out of the biggest College project ever undertaken, the 2013 revised ANZCA curriculum.

Work on the revised curriculum began in 2008 and involved hundreds of Fellows and staff until 2012, when many resources to support the revised training program were launched, including the curriculum itself, the training portfolio system, the handbook for training and accreditation, workplace-based assessment training sessions and a wealth of online educational resources.

More recently, the Faculty of Pain Medicine has revised its curriculum and it has been introduced this year. The Faculty has achieved much over the past few years including the online pain management education program, Better Pain Management, for healthcare professionals, and the Pain Device Implant Registry pilot.

This, and all the other work achieved by the Faculty, is extraordinary for such a small group of Fellows.

Last year, the revised ANZCA Continuing Professional Development (CPD) Program, accompanied by the new online CPD portfolio, was introduced following a substantial review. The revised program has been well received, especially once Fellows have had the chance to familiarise themselves with it.

The introduction of Networks, our new learning and collaboration system, came into effect this year. This has provided a much more suitable environment for learning to take place and streamlined much of our committee work.

I am very proud of the establishment of the History and Heritage Expert Reference panel, which will ensure the College's collection of portraits, paintings, furniture, silver, antiques, anaesthetic equipment and paraphernalia, books, archives and documents are maintained for future generations of anaesthetists and specialist pain medicine physicians.

The relocation of an upgraded Geoffrey Kaye Museum of Anaesthetic History into a new knowledge centre within the College's historic Ulimaroa building has been a major achievement. I encourage Fellows to visit the museum when they are in Melbourne – it is world-class.

Also in the new cultural hub is a Fellows' room for use by Fellows visiting Melbourne and, of course, an upgraded ANZCA Library, a resource widely used and appreciated by Fellows and trainees.

I hope many of you are now using the FANZCA (www.anzca.edu.au/fellows/benefits-of-fellowship) and FFPMANZCA (see www.fpm.anzca.edu.au/fellows) logos, which we introduced in 2012.

The fellowship survey told us how much you appreciate the *ANZCA Bulletin* and I hope you like the new, improved format. I also hope you enjoy the *College Conversations* CD, which we introduced in 2013 to give you an alternative means of receiving information.

More and more of you are getting involved in National Anaesthesia Day, which we relaunched in 2013. We have a strong media relations focus at the College, which is steadily raising the profile of ANZCA, FPM and anaesthesia and pain medicine. But the most effective means of doing this is through your own personal interactions with patients, so I encourage you to embrace National Anaesthesia Day on October 16 each year.

It has been a privilege to represent ANZCA and FPM at high-level external meetings, such as meetings with the health ministers, Health Workforce Australia and Health Workforce New Zealand. Our voice is being strongly heard at senior government levels in Australia and New Zealand and this is of critical importance for the future of our professions.

I must thank the ANZCA staff, particularly my deputy Carolyn Handley. ANZCA is staffed by a very talented group of individuals, who greatly enhance the work of Fellows and trainees and provide excellent support.

Finally, thank you to the ANZCA Council, in particular current president Dr Genevieve Goulding and her predecessors Dr Lindy Roberts and Professor Kate Leslie, as well as the many committees who I have worked with over the past few years.

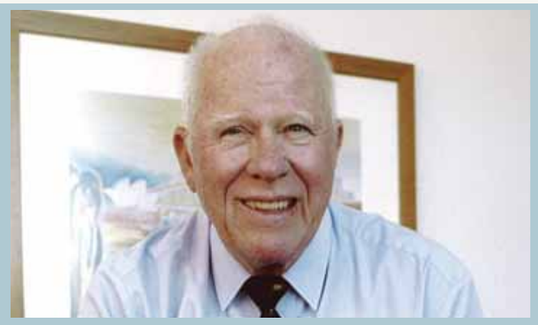
I am confident that in these safe hands, the College will continue to hold its place as one of the leading medical organisations in Australia and New Zealand.

Linda Sorrell
Chief Executive Officer, ANZCA

Awards

Queen's birthday honours

Medal of the Order of Australia (OAM)
Dr Paul Luckin, Queensland
For significant service as an authority on survivability in search and rescue operations in international rescue work.



Member (AM) in the general division
Professor Ross Beresford Holland, NSW.
For significant service to medicine in the discipline of anaesthesia, as a clinician, to healthcare standards, and to professional medical bodies.

ANZCA staff recognised

Earlier this year, ANZCA President Dr Genevieve Goulding presented certificates to winners in the second annual Staff Recognition Awards.

The awards align with the College's strategic priority to ensure ANZCA is a sustainable organisation though the objective of developing and retaining our best staff.

Frederick Rhoads from Records Management won the Staff Excellence Award for Customer Service with highly commended certificates going to Belinda Hofmeyr (Training and Assessments), Anna Kleskovic (Corporate Office) and Shilpa Dumasia (Human Resources).

The Policy unit's Donna Fahie won the Staff Excellence Award for Innovation and Process Improvement and the Staff Excellence Team Award was won by the Events team.

ANZCA also recognised six staff who achieved career milestones of five years' service in 2014 – Eric Kuang, Kerri Thomas, Clea Hincks, Christian Langstone, Tina Papadopoulos and Lee-Anne Pollard.

Left from top: Highly commended certificate recipients Shilpa Dumasia, Anna Kleskovic and Belinda Hofmeyr with winner of the Staff Excellence Award for Customer Service, Frederick Rhoads; The Staff Excellence Team Award winners, the Events team.

Undergraduate prize winners

Undergraduate prize winners for 2014 are:

ANZCA
Susan Keynes, Flinders University, South Australia
Clinton Ellis, University of Tasmania
Yassar Alamari, University of Otago, New Zealand

FPM
Chloe Attree, The University of Notre Dame Australia, WA
Elliot Anderson, Monash University, Clayton Campus, Vic

ANZCA and FPM in the news

Cannabis statement gets wide coverage

Medicinal cannabis caution urged

USING medicinal cannabis to relieve chronic pain in people who don't have cancer is likely to be far more risky than beneficial, say specialists.

THE evidence supporting its use by those sufferers is weak and based more on anecdote than sound clinical science and practice, they say.

The Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists on Wednesday urged caution in the face of ongoing calls for cannabinoids to be used to treat chronic non-cancer pain.

Faculty director of professional affairs, Professor Milton Cohen, referred to a lack of any sound evidence showing the treatments were effective saying its efficacy needed to be rigorously demonstrated.

"At this stage we are concerned that the risks of medicinal cannabis are likely to greatly outweigh any benefit in patients with chronic non-cancer pain," he said.

Those risks included adding another drug to a condition where patients are often over-prescribed, and the effects of cannabis-based preparations on motivation and cognitive function.

Medicines were only one aspect of their pain management which also looked at psychological and social initiatives, Prof Cohen said.

But, he told AAP, there may be a case for the use of cannabis-based preparations for cancer and end-of-life patients after appropriate trials.

Faculty vice-dean, Dr Chris Hayes, said drugs were no longer the front line of chronic non-cancer pain treatment.

Warning on dangers of medi-dope

THE use of medicinal cannabis to relieve chronic pain in people who don't have cancer is likely to be far more risky than beneficial, specialists say.

The use of medicinal cannabis was proposed by the State Government this week, but experts said the evidence supporting its use by sufferers of chronic non-cancer pain is weak and based more on anec-

inbrief

Medicinal pot caution urged – specialists

ADELAIDE: Using medicinal cannabis to relieve chronic pain in people who don't have cancer is likely to be far more risky than beneficial, say specialists. The evidence supporting its use by those sufferers is based more on anecdote than sound clinical science, they say. The Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists urged caution in the face of ongoing calls for cannabinoids to be used to treat chronic non-cancer pain.

Medicinal cannabis caution is called for

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But he said there may be a

The Faculty of Pain Medicine released a position statement on the use of cannabis-based medicines for pain relief in chronic non-cancer pain in April, which led to FPM Director of Professional Affairs, Professor Milton Cohen, Dean Professor Ted Shipton and Vice-Dean Dr Chris Hayes giving 15 interviews to print, online and radio outlets.

This position statement featured in 19 media reports and reached a potential combined cumulative audience of nearly 500,000.

The statement outlined the Faculty's position that it does not recognise a need for greater availability of pain medicines in general and "in particular does not endorse the use of cannabinoids in chronic non-cancer pain until such time as a clear therapeutic role for them is defined in the scientific literature".

The ANZCA and FPM annual scientific meeting (ASM) in May drew significant media attention (see page 44) with interest across Australia and New Zealand peaking around ASM-delivered presentations on a call for a ban on over-the-counter codeine medicines, driving in the elderly and the complications in anaesthesia posed by paediatric obesity.

An ACCUTE/Trauma Special Interest Group meeting, held on Friday May 1 in Adelaide, also attracted media attention. Dr Stefan Mazur gave interviews about his presentation on the challenges for all first-response medical professionals, including anaesthetists, in dealing with the rise in street violence, particularly knife wounds to the chest. This story featured on radio and in regional print outlets, including the *Illawarra Mercury* and the *Newcastle Herald*.

Since the March *ANZCA Bulletin*, stories generated by the ANZCA Communications team, including ASM coverage, have reached an estimated combined cumulative audience of more than 25 million people and appeared in more than 600 reports online, in print and broadcast media.

ANZCA recently upgraded its media monitoring service, which now more accurately reflects our potential reach by including audience figures for news items appearing online and those that have been syndicated.

Ebru Yaman
Media Manager, ANZCA

Since the beginning of 2015 ANZCA and FPM have generated:
- **More than 46 print reports.**
- **More than 160 radio reports.**
- **More than 100 television reports.**
- **More than 200 online reports.**

Media releases since the March *Bulletin*:

May 4: Pre-school obesity poses serious risks

May 3: Round the bend? How old is too old to drive?

May 3: Pre-hospital computer-led checklist good for patients and doctors

May 1: Pain specialists call for codeine ban

May 1: Knife wounds pose new challenges for anaesthetists

April 29: The changing face of anaesthesia and pain medicine

April 22: Top pain specialists urge caution on "medicinal cannabis"

April 9: ANZCA Bulletin out

April 8: Winner of 2015 ANZCA Media Award announced

March 14: "Great expectations": anaesthetists meet in Canberra

Budgets handed down

Australia

Federal budget

A year ago the health sector was rocked by the impact of measures announced in the Abbott Government's first budget. Among the changes announced was the abolition of government agencies such as Health Workforce Australia and the Australian National Preventive Health Agency, the defunding and disestablishment of Medicare Locals and the freeze on indexation of Medicare rebates and public hospitals funding. It was hard to see a section of the sector not impacted in some way.

This year's budget, handed down by the treasurer on May 12, was far gentler for the health sector. Key announcements included:

- A review of Medicare, including amendments to the Medicare Benefits Schedule based on recommendations by the Medical Services Advisory Committee and the development of clearer Medicare compliance rules and benchmarks.
- A continued commitment to the Medical Research Future Fund. The first distributions of $10 million will occur in 2015-16.
- Developing a new geographical classification system to address workforce imbalances between metropolitan and rural/remote areas. Health Workforce Scholarships will be consolidated with recipients working in rural and regional areas for one year.
- Funding of $485 million to reform the national e-health electronic records system and renaming it myHealth Record.

The government has indicated in the forward estimates that it will continue to fund the Specialist Training Program at the current level of 900 positions each year. It is not yet clear whether there will be modifications that impact on the College.

Workforce

The establishment of the National Medical Training Advisory Network (NMTAN) was approved on August 10, 2012 by the then Standing Council on Health to enable a nationally controlled medical training system in Australia. The NMTAN was been established under the auspices of the former Health Workforce Australia and held its first meeting in February 2014. Since August 2014, the functions of the NMTAN are managed by the Health Workforce Branch in the Department of Health and Ageing.

The NMTAN provides guidance to the development of medical training plans to inform government, health and education sectors. In addition, the NMTAN will provide policy advice about the planning and co-ordination of medical training in Australia, in collaboration with other networks involved in medical training.

The NMTAN has three sub-committees that explore different aspects of medical training to inform future workforce planning.

- The "changing work with the increase in burden of chronic disease" sub-committee examines the implications of the increasing incidence of chronic disease and increased delivery of chronic disease management in a primary-care setting. Modelling of the medical workforce will be undertaken, based on three to four models of care. This work is expected to be finished in 2016.
- The "employment patterns and intentions of prevocational doctors" sub-committee aims to improve the modelling undertaken for the prevocational years in medicine and use this improved modelling to better inform career planning for junior doctors. The sub-committee has developed an internal report that provides a snapshot of the existing prevocational doctor workforce in Australia. This information will be used to develop fact sheets on each of the medical specialties, to be made available on the department's website. It is expected the fact sheets will be available from June 2016.
- The "capacity for and distribution of the medical training" sub-committee makes recommendations to the NMTAN Executive Committee on changes to policy and practices that could improve geographic distribution of medical training to produce the number and proportion of general practitioners and other medical specialists needed to provide specialist healthcare to Australians. The focus is initially on a small number of specialties seen to be at risk of workforce shortage and where there is capacity to address these issues with training. This is the first time the capacity and distribution of training will be undertaken and the first request of such data. Work is underway to model the psychiatry workforce, to be followed by anaesthetics and general practice.

ANZCA met representatives from the Health Workforce Branch in mid May to discuss anaesthetics workforce modelling. We have provided data to the staff undertaking the modelling and look forward to working with the department on what will be a comprehensive assessment of the workforce.

Specialist Training Program

Health Minister Sussan Ley has announced a 12-month extension of the Specialist Training Program (STP). Hospital sites receiving funding under this program have been notified and the College will be working with those sites to negotiate funding agreements for the extended period.

The College would like to acknowledge all the hospital sites, Fellows and trainees who have supported the recent advocacy strategy. The actions undertaken as part of this strategy have formed a solid foundation for further work in the future.

Submissions

- Selection Into Training Policy (RACP).
- Medical Intern Review (COAG).
- Review of accreditation standard for specialist medical education programs and professional development programs (AMC).
- National Pharmaceutical Drug Misuse Working Group – Priority Actions (South Australia Health).
- Proposed amendments to the poisons standard – Codeine (TGA).
- Drugs, Poisons and Controlled Substances Regulations 2006 (Department of Health and Human Services, Vic).

New Zealand

Health increase in NZ budget

Under the New Zealand Government budget, announced on May 21, funding on health for the 2015-16 year totals $15.9 billion – up from $15.6 billion in the current year.

Health Minister Jonathan Coleman said there would be an additional $1.7 billion for New Zealand's public health services over the next four years, including:

- $320 million per year for district health boards ($1.3 billion over four years) for extra services and to help meet cost pressures and population changes.
- $98 million to provide more New Zealanders with timely elective surgery, and to improve the prevention and treatment of orthopaedic conditions.
- $12.4 million to extend the bowel cancer screening pilot at the Waitemata District Health Board.
- $76.1 million to help hospices expand palliative care services, including those provided at home.

Health data

Public release of health outcome data has been a key issue for the Ministry of Health, district health boards and medical colleges in 2015.

Recently, media organisations requested cardiothoracic and neurosurgical outcome data by individual surgeons under the Official Information Act. Some data was released at district health board level, as a previous opinion from the ombudsman indicated it is in the public interest to do so, citing transparency as important for quality improvement. Challenges are that available data lacks context and are of limited use in individual performance assessment.

The Ministry of Health is considering how New Zealand can move towards collecting high-quality health outcome data that reflects team performance, can be used by health practitioners for quality improvement, and can be presented in a user-friendly way for patients and the public.

The Deputy Chair of the New Zealand National Committee (NZNC), Dr Gary Hopgood, participated in a ministry-led workshop on how to approach this. The Medical Council of New Zealand (MCNZ) subsequently released a paper on the issue to stimulate discussion among the medical profession and the public. The ANZCA NZNC is developing a response to this discussion paper.

Workforce

Workforce issues continue to be a priority and the NZNC, in consultation with the New Zealand Society of Anaesthetists (NZSA), has developed a census of anaesthesia departments across New Zealand.

The census was distributed to heads of departments in April. It is intended the census will be repeated annually to establish workforce trends, and the information will be used to inform discussions about workforce planning with government departments, such as Health Workforce New Zealand.

NZNC Chair Dr Nigel Robertson, along with New Zealand staff, met with Dr Graeme Benny and Dr Ruth Anderson from Health Workforce New Zealand (HWNZ) in March to discuss the census. Other discussion topics included the training programs for anaesthetic technicians and registered nurse assistants to the anaesthetist, and HWNZ's working group for a nurse endoscopy training program. Dr Emma Patrick represents ANZCA and the NZSA on that working group.

(continued next page)

Budgets handed down (continued)

Stakeholder meetings

NZNC members and New Zealand staff have met with a number of other groups this year, including: the Auckland University of Technology, New Zealand Anaesthetic Technicians Society, NZSA, Medical Sciences Council of New Zealand and others to discuss anaesthetic technician training; New Zealand Treasury to discuss how Treasury works with the health sector; the MCNZ to discuss its memorandum of understanding with the College, recertification, ageing doctors and specialist accreditation standards; the Council of Medical Colleges for its board meeting, and with staff from other colleges to discuss sources of workforce data held in different organisations.

In May, NZNC representatives attended the New Zealand Medical Association Council meeting, and a Health Quality & Safety Commission forum, where leading health communicator Dr Atul Gawande is presenting.

Submissions

- Fact sheets provided to Health Workforce New Zealand for medical students and young doctors, now available here: www.kiwihealthjobs.com/rmo/fact-sheets.
- Input provided to the Council of Medical Colleges for a paper to HWNZ on factors that may shape the future of the medical workforce.
- The Ministry of Health about the strategic refresh of the Health Research Council.
- Nursing Council on its consultation on the scope of practice and qualifications for nurse practitioners.
- National Ethics Advisory Committee on cross-sectoral ethics arrangements for health and disability research.
- National Health Committee on:
  - Its Strategic Plan and Business Plan for 2015/16 – 2018/19.
  - Its consultation on intraoperative radiotherapy.
- Pharmac on:
  - Adding two additional preparations of erythropoietin alfa to the hospital medicines list.
  - Its proposal to list intravenous nicardipine.

Doctors unite against sexual harassment

The medical profession is working together to find a solution.

Following media revelations about sexual harassment in the medical profession on April 1, the Australia Medical Association (AMA) held a round-table meeting of representatives from all areas of the profession. The aim of the meeting was to elucidate the direction and role of the medical profession in addressing sexual harassment.

The meeting first considered the issue of prevalence and what is being done to tackle sexual harassment. This consisted of presentations from the sex discrimination commissioner followed by the associate CEO of the NSW Health Education and Training Institute, then a member of the Medical Board of Australia, the president of Royal Australasian College of Surgeons, and the president of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). All agreed that appropriate and adequate processes are essential as part of the solution.

While sexual harassment is generally included within bullying and harassment policies it is regarded as a distinct subsection. Legally it is clearly defined, but there was discussion around difficulties arising from lack of clarity and confusion in interpretations by both victims and offenders. This led to discussions about workplace characteristics, impact of sexual harassment and legal frameworks. The implications for employers and training providers also were considered.

As a result of the hierarchical system and the directive style of communication, associations were drawn between the military and the medical profession, and the prevalence of sexual harassment in the Australian Defence Force (ADF). Trends are improving and there have been genuine reductions, not simply a failure to report. This has resulted from the ability to engage the top commanders to adopt a zero tolerance policy.

There have been anecdotal instances of sexual harassment by Fellows towards trainees as well as colleagues, resulting in applications for trainee and staff positions being rejected.

The issues of reporting and the risks to the complainant were raised with 1:4 females being harassed, but the reporting being much lower, especially in hierarchical structures. Within the medical profession, power is overt due to the directive style of communication and women need to lead the changes through role models and leadership.

Within the workplace the culture needs to change. From the victim's perspective, resolution includes one or more of the following: changing the offender's behaviour so the behaviour stops; punishment or removal of the offender; support and counselling for the victim; and, on occasions, seeking compensation.

Finally, the relationship between the colleges and employers was discussed. While colleges hope to influence employers, they have no real power.

Presentations followed from a former chair of Doctors in Training Committee, and from the AMA director of workplace relations. These provided perspectives on what happens in the workplace.

Consideration of whether complaint processes are adequate and whether victims feel safe accessing them resulted in a list of requirements that need to be met in order to have a safe and effective process. In addressing these matters, the first and foremost is to establish what it is the complainant wants. Within organisations there needs to be a zero tolerance for sexual harassment, however, despite any policies and access to complaints, people will not complain if there is a risk.

The meeting concluded with deliberations on what the medical profession can do to tackle sexual harassment and the role of education. The influence of the ratio of females in specialties appears to be a factor; obstetrics and anaesthesia, both with high ratios of women, appear to have a low incidence.

The biggest challenge is to change the culture, the key to which is changing behaviour. In this context an understanding of the factors/reasons driving such behaviour need to be gained so as to appreciate how to modify it. Other questions that need to be addressed include when these behaviours arise and when they become identifiable. Bullying is still not uncommon in schools. Such understanding may assist in screening processes during selection in addition to the education process. There is a role for the medical profession to engage with education departments to explore this issue. While introducing education at all levels is likely to be helpful, it is more likely to be effective if begun earlier rather than later.

The meeting concluded that there had been productive discussion about sexual harassment, and an improved awareness of what it is, and the role of the medical profession and the colleges, as well as universities, engaging in the modification of the culture. Basic concepts for future consideration arose from the meeting, which recognised a need to progress the matter further.

The plan is to continue to engage the medical colleges and universities in developing a better understanding of the behaviour, consider effective education strategies, and ensure safe and effective processes are available to victims.

Dr Peter Roessler
Director of Fellowship Affairs, Policy

ANZCA policy

ANZCA considers bullying, discrimination and harassment unacceptable behaviour that will not be tolerated under any circumstances and has a *Policy on bullying, discrimination and harassment for Fellows and trainees acting on behalf of the College or undertaking College functions* (see www.anzca.edu.au/resources/corporate-policies).

Fellows and trainees acting as College representatives are responsible for their behaviour and should ensure an environment free of bullying, discrimination and harassment.

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 aims to promote understanding of the link between health and wellbeing and constitutional recognition of Aboriginal and Torres Strait Islander peoples.

This advocacy for constitutional change supports ANZCA's initiatives, in collaboration with the Committee of Presidents of Medical Colleges and the Australian Indigenous Doctors Association, in training more Aboriginal and Torres Strait Islander medical specialists and improving the ways in which medical specialists work with their indigenous patients.

These initiatives are consistent with the accreditation standards of the Australian Medical Council and the expectations of the Medical Board of Australia in relation to good medical practice for doctors in Australia.

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 framing of the Australian Constitution and were not recognised as the nation's first people within it.

This lack of recognition is acknowledged as an impediment to "closing the gap" in health outcomes between indigenous and non-indigenous Australians. The Royal Australian and New Zealand College of Psychiatrists identified this link between lack of constitutional recognition, socio-economic disadvantage and adverse health outcomes, stating:

"The lack of acknowledgement of a people's existence in a country's constitution has a major impact on their sense of identity, value within the community and perpetuates discrimination and prejudice, which further erodes the hope of indigenous people."[1]

The framers of the constitution also included clauses that would allow discrimination on the basis of race. These powers have been exercised at various points in our history to exclude indigenous people from voting, to remove indigenous children from their families and to legislate in a range of other ways to the detriment of Aboriginal and Torres Strait Islander people. The socio-political ethos extant in 1901 is clearly at odds with where we are as a community now, not only in relation to Australia's first people but also in relation to other racial and ethnic groups.

Above: Dr Dash Newington and Professor Kate Leslie in "Recognise" T-shirts.

What changes are proposed?

In 1967, Australians voted to include Aboriginal and Torres Strait Islander people in the census and to include them in the clause that allows the parliament to make special laws with respect to any race. The referendum left unfinished business in relation to whether these laws could be used to discriminate against people on the basis of race; it did not repeal the clause that allowed people of any race to be precluded from voting and it failed to recognise the first people and their languages.

This leaves Australia as the only nation in the world with a constitution that still authorises discrimination on the basis of race. While the final model is yet to be decided, the Expert Panel on Constitutional Recognition of Indigenous Australians made recommendations along the following lines:

- That section 25 (which allows people of any race to be disqualified from voting) be repealed.
- That section 51 (xxvi) (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.

"The lack of acknowledgement of a people's existence in a country's constitution has a major impact on their sense of identity, value within the community and perpetuates discrimination and prejudice which further erodes the hope of indigenous people."

- That a new section 116A be inserted prohibiting racial discrimination (which is only ensured by legislation), without precluding the making of laws or measures for the purpose of overcoming disadvantage, ameliorating the effects of past discrimination, or protecting the cultures, languages or heritage of any group.
- That a new section 127A be inserted recognising that Aboriginal and Torres Strait Islander languages are the original Australian languages.

Will the referendum succeed?

Although referenda have a poor record of success in Australia, more than 90 per cent of voters supported the referendum on indigenous issues in 1967.

The current referendum has multi-party support in parliament, which established a Joint Select Committee on Constitutional Recognition of Aboriginal and Torres Strait Islander Peoples to plan a successful process.

The referendum also has the support of indigenous groups and support among the general population is continuing to grow, largely through the efforts of organisations such as Recognise (Facebook: Recognise; Twitter: @RecogniseAU).

However, widespread lack of understanding about our constitution persists, which is significant, as research has shown that people who do not understand referendum issues tend to vote no whereas people who do understand the issues are empowered to make an informed choice. We encourage Fellows and trainees who are eligible to vote in the referendum to familiarise themselves with the relevant clauses of the constitution and the principles behind the inclusion of Aboriginal and Torres Strait Islander peoples and their languages in Australia's founding document.

Conclusions

Aboriginal and Torres Strait Islander culture has endured frontier wars, dispossession, dislocation and family disruption to remain the longest enduring culture on Earth. However, Australia's first people do not enjoy the same health status and life expectancy as other people in Australia. We believe constitutional recognition represents one of the vital steps in our quest to "close the gap" on health outcomes, to effect reconciliation between indigenous and non-indigenous Australians, and ensure a future for all our nation's people built upon tolerance and mutual respect.

Professor Kate Leslie, Past ANZCA President

Dr Dash Newington, member, ANZCA Indigenous Health Committee

Dr Rod Mitchell, Chair, ANZCA Indigenous Health Committee

Recommended reading:

Broome R. Aboriginal Australians: a history since 1788. Crows Nest: Allen & Unwin, 2010.

The Australian Constitution. Accessed at www.aph.gov.au/About_Parliament/Senate/Powers_practice_n_procedures/~/media/AC79BBA0B87A4906A6D71ACCEEF10535.ashx

Davis M and Williams G. Everything you need to know about the referendum to recognise Indigenous Australians. Sydney: NewSouth Publishing, 2015.

Pearson N. A Rightful Place: Race, recognition and a more complete commonwealth. Melbourne: Black Inc., 2014.

www.recognise.org.au: the website of Recognise – a people's movement which is part of Reconciliation Australia.

www.lowitja.org.au: the website of the Lowitja Institute - Australian's national institute for Aboriginal and Torres Strait Islander health research.

Reference:

1. Commonwealth of Australia. Recognising Aboriginal and Torres Strait Islander Peoples in the Constitution: Report of the Expert Panel. Canberra: Commonwealth of Australia, 2012. Accessed on March 6, 2015 at www.recognise.org.au/wp-content/uploads/shared/uploads/assets/3446_FaHCSIA_ICR_report_text_Bookmarked_PDF_12_Jan_v4.pdf.

What would you do?

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

When performance is questioned

The standards of practice of anaesthetists in Australia and New Zealand are among the highest in the world. Our excellent training program produces practitioners who are very skilled; our highly developed continuing professional development standard and program enables practitioners to maintain and improve their skills.

It is not surprising then that despite patient co-morbidities and advancing age of patients the incidence of major complications is relatively low. What is surprising is the number of reports received from our medical and nursing colleagues about perceived clinical underperformance. Occasionally these concerns relate to competence but mainly they are about performance, a much broader aspect of our practice than competence.

Consider the following scenario

You work with a dental surgeon regularly but while on leave another colleague covers the list. When you return, the concerned surgeon seeks a debrief after an incident in which a fit, healthy patient in their early 50s is transferred to recovery room (PACU) after uneventful dental procedure under anaesthesia.

As the anaesthetist was about to induce the next patient, an experienced recovery nurse informed the anaesthetist that the previous patient was difficult to rouse and had a pulse rate below 40. The anaesthetist indicated there was no concern, did not suggest treatment and proceeded with the induction. Shortly afterwards, the alarm was sounded and another anaesthetist attended the patient, who responded rapidly to treatment without suffering adverse sequelae.

Vaso-vagal episodes are not uncommon. Bradycardia of itself may not be a major issue and it is reported that the resting heart rate of tennis player Bjorn Borg was so slow that he had frequent escape beats. Bradycardia in a patient who is difficult to rouse is another matter.

What would you do in this case?

PS53 *Statement on the Handover Responsibilities of the Anaesthetist* clearly outlines the responsibility and accountability of the anaesthetist. It also states that the anaesthetist must be readily available (item 4.4) to deal with any unexpected problems.

PS57 *Statement on Duties of Specialist Anaesthetists* lists the range of duties including those of supervising post-anaesthesia care units.

One of the first questions to arise is whether this is a matter of poor judgment. This is unlikely to be an issue of incompetence in that the practitioner, no doubt, would be quite capable of managing bradycardia and delayed emergence. However, the practitioner's performance in such a scenario warrants consideration.

It is easy to cast blame! Without making excuses could there be another perspective?

Communication is a common and recurrent theme underlying many of the problems that arise (so I am informed by my partner). We are well aware of the need for clear communication when conversing with our teams. However, communication is a two-way street. Active listening forms part of effective communication. I have been informed that I have two ears and one mouth and that ratio should be representative of my modes of communication.

Apart from reflex actions, all other actions require decisions to be made with a view to determining the need for action and then the sequence of actions to achieve the desired outcome. Simple "control theory" states that the fundamental components involve receptors, processing unit and effectors. Signals are received by the receptors and then delivered to the processing unit where they are integrated to produce an effect/action. One of the obvious contributors to this process is the quality of signals into the receptor as well as its sensitivity (readiness/ability to absorb input).

Was the signal strength in this case sufficient to induce appropriate action? Was the statement made by the PACU nurse of appropriate assertiveness? This is in no way intended to diminish the role and responsibility of the anaesthetist. It is presented to highlight the fact that non-technical skills are significant contributors to performance. Appropriately graded levels of assertiveness are valuable contributors to the decision-making process.

In the above scenario, it is interesting to contemplate the impact of a delay of a few minutes to review the patient in PACU. The benefits include the ability to assess the situation, avert a possible disaster and prevent escalation. Another benefit would be to provide support to our nursing colleagues. Any perceived negatives resulting from delays might be excellent opportunities to strengthen team relationships and cohesiveness with concomitant benefits in patient care and outcomes.

A significant component of clinical performance is practitioner attitudes and behaviour. The recently developed ANZCA document *Supporting Anaesthetists' Professionalism and Performance – A guide for clinicians* provides a basis as well as examples of good and poor behaviour, which should assist fellows and trainees striving to attain peak performance.

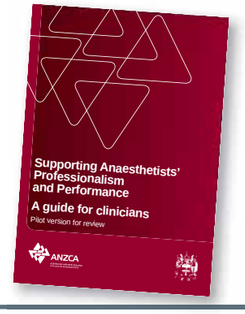
Dr Peter Roessler
ANZCA Director of Professional Affairs, Policy

Supporting your professionalism and performance

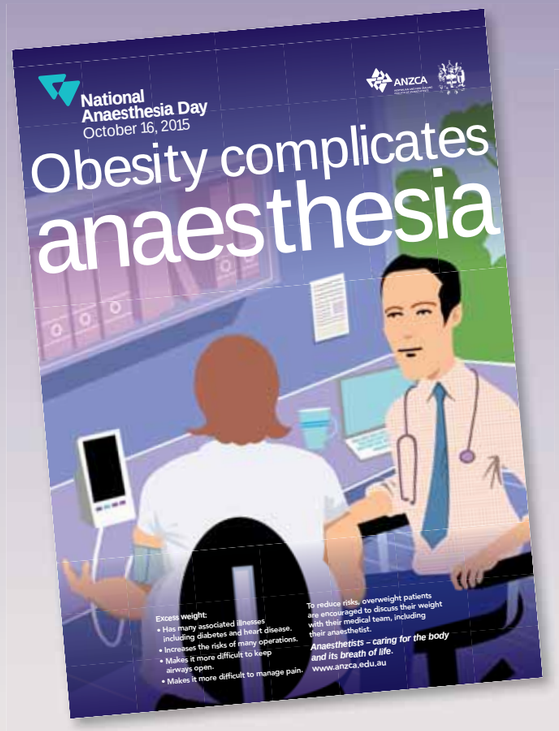
Supporting Anaesthetists' Professionalism and Performance: A guide for clinicians

Launched at the 2015 ANZCA Annual Scientific Meeting in Adelaide, this guide provides a framework for understanding professionalism and performance as it applies to the practice of anaesthesia.

It has been released as a pilot for 12 months and is available for review and comment. See www.anzca.edu.au/resources/professional-documents.



Obesity's big impact on anaesthesia



Save the date – Friday October 16, 2015

What are you doing on National Anaesthesia Day? Contact communications@anzca.edu.au for posters and other material.

Every anaesthetist knows how much of an impact obesity has on patients.

This year, the theme of National Anaesthesia Day is "Obesity complicates anaesthesia" and the aim is to encourage patients to talk to their medical team, including their anaesthetist, about how they can reduce their risks.

Key messages to patients will be that excess weight:

- Has many associated diseases, including diabetes and heart disease.
- Increases the risks of many operations.
- Makes it more difficult to keep airways open.
- Makes it more difficult to manage pain.
- Can lead to serious post-operative complications.

In September, ANZCA will again be sending kits to hospitals on its database. These will contain posters and other promotional materials, including the "Who is your anaesthetist (an-ees-the-tist)?" flyer.

All heads of anaesthesia departments in Australia and New Zealand have been contacted to encourage them to become involved – booking foyer space needs to be done well in advance at some hospitals.

The College is keen to hear from individuals who might be interested in celebrating National Anaesthesia Day. Please email: **communications@anzca.edu.au**.

Last year the focus was on the importance of giving up smoking before an anaesthetic and many hospitals celebrated the day. Anaesthetists at Auckland hospitals strongly embraced the day with staffed booths displaying equipment, mannequins, posters, balloons and information leaflets. People also were able to have a go at ventilating "patients" and using ultrasound. New Zealand Health Minister Dr Jonathon Coleman visited the display at Auckland City Hospital.

Dubbo Hospital set up a foyer display where patients could talk about smoking and its perioperative implications and staff gave demonstrations on giving an anaesthetic. Later, hospital staff held a symposium about the history of anaesthesia and held a quiz, followed by a dinner.

The College will again run a media campaign, issuing media releases to print, television and radio.

Last year's media coverage included three television reports (two in Australia and one in New Zealand), more than 700 online mentions and more than 100 radio reports.

Clea Hincks
ANZCA General Manager, Communications

Rising to the challenge

>ANZCA trainee Meg Walmsley was thrown into a medical emergency when the devastating Nepalese earthquake triggered an avalanche at the Everest Base Camp where she worked as a volunteer.

"I inhaled enough snow and ice during the avalanche blast to cause a cough that was severe and prolonged enough to damage intercostal muscles."

>Everest Base Camp

Mount Everest Base Camp is located in Nepal at an altitude of 5400m. It is remote, taking 10 days to trek from the nearest airport at Lukla.

In the climbing season of 2015, Everest Base Camp was home to approximately 1200 people. Of these, about 400 were foreign climbers. The environment is harsh, with the steep, rocky and icy ground covered in hundreds of tents each year.

Low barometric pressure at this altitude results in lower alveolar and arterial oxygen pressures meaning oxygen saturations are typically 80-85 per cent.

>Everest ER

There is one main medical facility at Everest Base Camp, known as Everest ER. This clinic operates out of a tent, which is put up every year on the glacier at Everest Base Camp. Yaks and porters transport medical supplies in.

Everest ER is a non-profit organisation staffed by volunteer doctors. Funds derived from the care provided to western climbers are used to subsidise minimal-cost healthcare for the Sherpas and Nepalese working at Everest Base Camp.

During 2015, I worked as a volunteer doctor at Everest ER, along with Dr Rachel Tullet, an emergency medicine trainee based in New Zealand.

>Earthquake and avalanche

Just before midday on April 25, a 7.8 magnitude earthquake struck Nepal. This triggered a massive avalanche from Pumori, one of the mountains surrounding the base camp. The avalanche swept across part of the camp, causing widespread damage.

I was working in the clinic tent at the time of the earthquake, assessing a sick Sherpa. After the earthquake, a massive blast of wind followed by a blast of ice and snow hit the clinic. This tore the sturdy tent fabric, twisted the tent poles and blasted the medicines out of their drawers. Equipment was strewn everywhere and the tent filled with snow and other debris. Our kitchen, dining and personal sleeping tents were obliterated.

I crouched inside the clinic with my patient and his brother while waves of snow and ice washed over us. Luckily I received no serious injury.

Minutes after the avalanche hit, patients started arriving at the clinic. Seriously injured patients, who were stretchered to our snow-filled clinic, quickly followed the walking wounded.

Luckily, a number of experienced mountain guides, Sherpas and climbers, who happened to have medical training, also began to arrive. They volunteered their expertise, resources and support.

>Clinic organisation and field hospital set up

Initially Rachel medically triaged patients outside our tent, splinting fractures and relocating limbs. I managed the most critically injured inside the tent. These included patients with pelvic and long bone fractures, as well as chest and abdominal injures.

It soon became apparent we would be unable to treat everyone in our destroyed clinic so patients and equipment were moved to an undamaged part of base camp, where we converted dining and supply tents belonging to climbing teams into makeshift field hospitals. Different tents were used for head injuries, critical injuries and walking-wounded patients. Those who couldn't walk were carried by stretcher over the icy and rocky ground for about 30 minutes to reach the new camp.

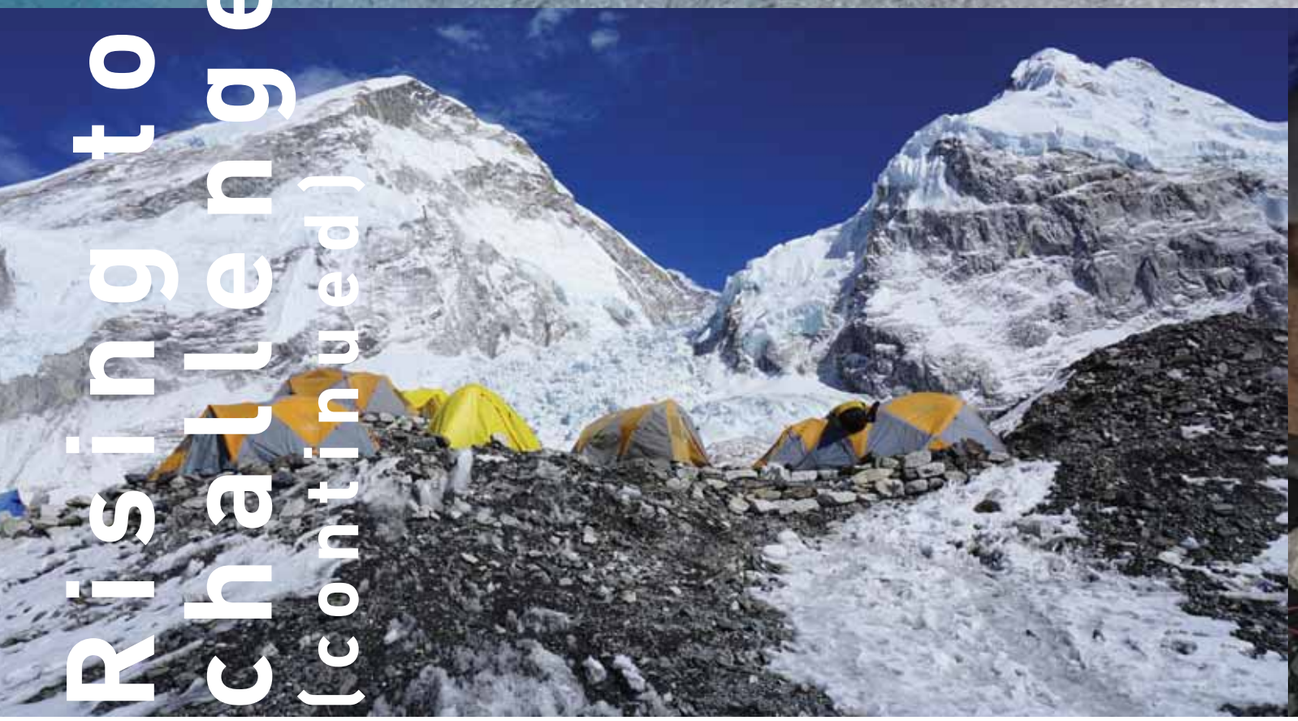
>Injuries

The injuries were typical of those caused by blast-force trauma. In total, approximately 80 people required medical assistance with the injuries ranging from minor to critical.

(continued next page)

Clockwise from top left: Everest ER clinic before the avalanche; ER clinic after the avalanche. The clinic poles bent and the canvas was torn off. Note that the yellow and orange tents initially behind the clinic, as well as the brown and orange tents; Inside the clinic – this was taken during our initial set up; Dr Meg Walmsley with Mt Everest behind; Even before the avalanche, some days were more difficult than others.

Rising to the challenge (continued)



Nine patients suffered serious head injury; 15 had other critical injuries including pelvic fractures, long bone fractures, compound fractures and rib fractures with suspected underlying lung injuries. Many had multiple injuries. More than 50 patients suffered from lacerations, abrasions, soft-tissue injuries and minor fractures. One patient vomited after having a limb relocated, aspirated and had a laryngospam requiring a short period of bag-mask ventilation.

Sadly, 17 people died in the avalanche; most died immediately as a result of massive trauma from the blast force.

Evacuation

Fortunately, on April 26, a day after the avalanche, the weather was clear enough for helicopter evacuation.

Patients were evacuated in order of injury severity and initially flown to Pheriche, a village located on the Everest trekking circuit, where a small medical clinic is run by the Himalayan Rescue Association and staffed by volunteer western doctors.

Helicopters in Nepal have neither medical equipment nor medical staff, so I flew with some of the sicker patients to Pheriche to assist the three doctors working there. Together, we reassessed and continued the management of almost 80 patients. These patients were then evacuated to Kathmandu.

I returned to base camp for a further five days to continue running our clinic and to try to salvage our medical and personal supplies. Mount Everest was soon closed, with no teams attempting to summit.

Challenges and hardships

Being faced with multiple patients with multiple injuries is challenging at the best of times. I was working in a tent, had minimal patient monitoring, the temperature was below freezing, and at times I needed to use my head torch for light.

Many patients were wet and cold after being covered in snow. We did our best to put them in dry sleeping bags and ensure they had a mat to protect them from the cold ground. Sherpa staff constantly boiled water so we could use drink bottles as hot-water bottles.

Our IV fluids were frozen due to the cold outside temperatures and these were placed in tubs of hot water to defrost. We had a limited supply of strong analgesia (five x 15mg vials of morphine and 10 x 100mg vials pethidine) to give to severely injured patients. This was made more difficult because we didn't know when evacuation would be possible.

I was awake for about 30 hours throughout the ordeal and didn't have time to salvage my personal gear (or change clothes) for three days. I inhaled enough snow and ice during the avalanche blast to cause a cough severe and prolonged enough to damage intercostal muscles.

Despite these hardships and challenges, I feel fortunate to have worked with an amazing team of people who helped us care for our patients. I worked with doctors from seven other countries, who came to the clinic after the avalanche to volunteer their expertise, skills and medical equipment.

A number of climbers and Sherpas with no medical experience helped to both stretcher and care for patients – feeding them, giving simple analgesia (and even holding the occasional pee bottle!)

I worked with climbing teams and mountain guides, who gave their resources, manpower, supplies, food, tents and endless kindness and support. It would not have been possible to manage this disaster without these people.

For further information and donations: www.everester.org or www.himalayanrescue.org

Dr Meg Walmsley,
ANZCA trainee

Above from left: Personal sleeping tents (before the avalanche); Salvaging medical supplies – the remains of ear pieces, gloves, medications and papers; After the avalanche – this site previously was filled with sleeping, kitchen and dining tents of a climbing team.

"I was working in a tent, had minimal patient monitoring, the temperature was below freezing, and at times I needed to use my head torch as a light source."

"After the earthquake, a massive blast of wind followed by a blast of ice and snow hit the clinic … and blasted the medicines out of their drawers."

Joining the world response to the Nepal disaster

"At this early stage there were estimated to be up to 200 patients with spinal cord injury and up to 1000 with complex orthopaedic injuries."

>It's after midnight when I crawl into a two-man tent on the lawns of the Australian embassy in Kathmandu.

Everyone's been talking about the unease of frequent after-shocks following the 7.8 magnitude earthquake that has caused devastation in the land-locked mountainous country of Nepal. Not many people have felt confident to sleep in buildings in this city and it's now five days since the onset of the disaster.

I was asked with 12 hours' notice to fly from Darwin to Kathmandu with a joint Department of Foreign Affairs and Trade (DFAT) and military delegation to make an assessment of the need to send in an Australian Medical Assistance Team (AUSMAT) to Nepal. It was just 48 hours after the earthquake that we prepared to depart.

I met with Dr Andy Robertson, a public health physician from the WA Department of Health. Having both trained as advanced team leaders and in needs assessment with AUSMAT, we travelled down to Amberley airbase in south-east Queensland to join the DFAT and Australian Defence Force teams aboard an enormous C-17 Globemaster.

Two of these impressive aircraft would take our delegation, along with many pallets of Australian government aid in the form of tarpaulins, blankets, hygiene kits and water purification tablets. It was a 10-hour flight to Bangkok where we stayed the night before our onward journey to destination Kathmandu.

As always following a disaster, information was scarce and frequently changing. We knew that Kathmandu airport was straining under the activity of so many aircraft trying to get landing slots to bring in aid and assistance personnel from all around the world. By the time we arrived, news came our way that the Nepalese were requesting no more foreign medical teams.

Our first two days were spent meeting with Nepalese Ministry of Health and Population (MoHP) staff who were managing the disaster, United Nations (UN) staff from the various agencies responding as well as many of the foreign non-government organisations (NGOs) that were doing what they could to assist.

More than 120 foreign medical teams (FMTs) had already arrived and registered with the Nepalese MoHP under the recently implemented World Health Organization (WHO) standard for FMTs. Many were deploying to the most affected districts to replace and supplement damaged health infrastructure.

It was quickly determined there really was no need for an additional response from the AUSMAT. We did realise, however, that while acute trauma needs had been largely addressed by incredibly busy Nepalese hospitals, there was little in the way of rehabilitation services that were being co-ordinated.

Over the next week we worked with some of the key NGOs such as Handicap International, as well as UN agencies International Office of Migration (IOM) and WHO to assist the MoHP to develop a strategic plan for early rehabilitation of affected patients. This would work on taking the heavy patient load from the main Kathmandu Hospitals and link people up with rehabilitation services in the non-government facilities and foreign NGOs, assisting them to receive care closer to their home district.

At this early stage there were estimated to be up to 200 patients with spinal cord injury and up to 1000 with complex orthopaedic injuries that would need assistance. Many if not most, had lost family members as well as their homes in the devastation of the earthquake.

After facilitating the first meeting of all the stakeholders involved and writing up the proposal, we handed over the co-ordination role to the UK Emergency Medical Team, who had arrived earlier and were set up for weeks to months of work in conjunction with the Nepalese MoHP.

There hadn't been any need for my clinical anaesthesia skills but the non-technical skills of communication, collaboration and advocacy developed in anaesthesia training and practice had a good work out.

Dr Brian Spain, FANZCA
Director of Anaesthesia, Royal Darwin Hospital
Team Leader, AUSMAT

Above from left: Australian Aid off-loading the aircraft in Kathmandu; Australian Aid on pallet inside C17, with Dr Brian Spain and Dr Andy Robertson; Rehabilitation meeting, Dr Brian Spain, Dr Bachchu KC, Medical Director Rehabilitation Sub-cluster, Director Health Emergency Operations Centre, Kathmandu, Nepal Dr Andy Robertson, Director Disaster Management Unit, Deputy Chief Medical Officer, WA Dept of Health; Dr Brian Spain on the ground at Kathmandu Airport, with RAAF C17 in background.

Safety news

Anaesthesia and infants, toddlers and preschool children

In recent years, Australian and New Zealand and international researchers have been studying the effects of anaesthesia on the developing brain.

Animal studies have shown there can be long-term, possibly permanent, adverse effects of anaesthetic and sedative medications on the developing brain. These effects may include changes to behaviour, learning and memory.

Studies in children have provided mixed results with some indicating that similar deficits may occur and others finding no evidence for a deficit at all. This prevents anaesthetists from being able to conclude that harmful effects were due to the anaesthesia or to other factors, including surgery, hospitalisation, or pre-existing conditions. It also is not possible to conclude the ages at which children may be vulnerable.

A number of prospective human studies aim to clarify the issue. A recent statement by SmartTots (www.smarttots.org/resources/consensus.html), which funds paediatric anaesthesia research, suggests giving consideration to postponing surgery that can be reasonably delayed. However, it would appear that a single and brief anaesthetic exposure seems "safe" (Hansen TG. Anesthesia-related neurotoxicity and the developing animal brain is not a significant problem in children. Paediatric Anesthesia. 2015;25(1):65–72. http://onlinelibrary.wiley.com/doi/10.1111/pan.12548/full) and many factors impact neurocognitive outcome.

Each year, millions of infants, toddlers and preschool children undergo anaesthesia for essential surgery. For the vast majority of these, the risks of not having surgery far outweigh the potential and as yet unproven risks that may be associated with any detrimental effects of anaesthesia on the developing brain.

Parents and caregivers of infants, toddlers and preschool children should be recommended to talk to their anaesthetist about the risks, benefits, and timing of procedures requiring anaesthetics and sedative drugs. Most paediatric anaesthesia experts believe there is, as yet, no clear indication to alter practice and certainly no need to postpone or cancel urgent surgery.

Dr Phillipa Hore, FANZCA, Chair, ANZCA Safety and Quality Committee

Dr Peter Roessler, FANZCA, ANZCA Director of Professional Affairs, Policy

Inadequate anaesthetic services

All anaesthetists are advised to read a New Zealand Health & Disability Commissioner report released on April 20, says NZ Safety & Quality Officer, Dr Geoff Laney.

The report concerns post-operative complications that resulted in a 15-year-old boy dying after uneventful surgery for appendicitis. A significant element covered is the clinical aspect of negative pressure pulmonary oedema said to be associated with the episode of laryngospasm, the latter of which is not uncommon.

The findings include that the anaesthetist failed to provide post-operative anaesthetic services with reasonable care and skill, including failing to sufficiently investigate the reason for the patient's high oxygen requirement, not consulting about a discharge to the children's ward rather than CCU and not keeping adequate records. The findings also were critical of nursing staff and district health board procedures. The report is available at www.hdc.org.nz/decisions--case-notes/commissioner%27s-decisions/2015/13hdc00482

Codeine use prompts alert

There are renewed safety concerns regarding the use of codeine for post-operative pain management, particularly in children. These follow new reports of respiratory depression and deaths.

The US Food and Drug Administration (FDA), the European Medicines Agency (EMA) and the United Kingdom Medicines and Healthcare Products Regulatory Agency (MHRA) have issued new guidelines and the Australian Therapeutic Goods Administration is reviewing the issue.

Codeine is widely available in Australian in combination with paracetamol and NSAIDs in both prescription and non-prescription quantities. The analgesic efficacy of codeine comes from its metabolism into morphine by cytochrome P450, which is highly variable.

Some patients will convert little and receive little analgesia while "ultra-rapid metabolisers" will convert more codeine to morphine and are at risk of morphine toxicity, including respiratory depression.

Updated guidance from FDA, EMA and MHRA

The EMA and MHRA have contraindicated codeine for all children under 12 years and for children up to 18 years for pain relief after tonsillectomy and/or adenoidectomy for obstructive sleep apnoea. The FDA has contraindicated codeine in children under 18 undergoing tonsillectomy and/or adenoidectomy for any indication.

Alert on fast metabolisers

Advances in pharmacogenetics have led to the finding that there are some genetic variants known as ultra-rapid metabolisers. People with this type of single nucleotide polymorphism metabolise various substances, including codeine, at such a rapid rate that the excretory mechanisms cannot keep pace. This can result in rising levels of active metabolites and toxicity. Beware of codeine in both paediatrics and adults.

If using codeine for children aged 12-18, use the lowest effective dose, use "as required" rather than regularly and treat for a maximum of three days.

Codeine is not recommended in any child with compromised respiratory function. The efficacy of codeine is not significantly better than paracetamol or ibuprofen.

NSAID after tonsillectomy

Codeine has retained a residual place in paediatric pain management due to the contraindication of ibuprofen after tonsillectomy due to concerns regarding bleeding and paracetamol alone being insufficient analgesia.

Surgical guidelines now advocate the use of ibuprofen, which is supported by a recent Cochrane Review concluding that there was no evidence for withholding NSAIDs after tonsillectomy.

The combination of paracetamol and ibuprofen is sufficient analgesia for many patients.

Supplementation is more safely achieved with tramadol or oxycodone, which may still produce respiratory depression but whose dosing is more predictable as they do not require metabolism for their efficacy.

Dr Chris Holmes, FANZCA, Cabrini Hospital and Royal Children's Hospitals, Victoria

Dr Chantal McNally, FANZCA, Cabrini Hospital, Victoria

Safety news (continued)

M&M meetings: can we do better?

Morbidity and mortality (M&M) meetings serve both educational and quality assurance purposes and are considered a core activity for anaesthesia departments[1]. Attendance at M&M meetings is required for trainees in the ANZCA curriculum and encouraged for consultants through continuing professional development[2,3]. However, their effectiveness and utility is not often closely examined. Our aim was to enhance these elements by considering the following questions:

- Are they an effective educational forum for participants?
- Can we make them more effective?
- How should we structure them to be most effective?

We investigated these and other questions in a regional teaching hospital in NSW through a prospective observational study of our departmental M&M meetings.

The NSW Health Department produced guidelines for the structure and content of M&M meetings in its Clinician's Toolkit (see table below)[4]. We assessed three separate M&M meetings in relation to their concordance with this recognised patient safety framework, as well as exploring participants' opinions regarding the effectiveness of these meetings as an educational activity. A total of 73 anonymous surveys were collected from participants and three questionnaires completed from an objective observer present at each meeting.

Seventy five per cent of respondents felt that M&M meetings served both a quality assurance and an educational purpose. Our M&M meetings conformed to the following core quality assurance components:

- Meetings were held regularly.
- Cases were presented in timely manner.
- Meetings were conducted in structured format.
- Staff of different levels of seniority attended meetings.

However, they failed to conform to other aspects, including insufficient regular review of routine clinical indicators and inadequate follow through or feedback on actions generated at previous meetings. Multidisciplinary attendance was minimal. While the observer felt discussion was not focused on blame of individuals in any of the meetings studied, only 26 per cent of respondents felt meetings were "always" a blame-free environment with 63 per cent indicating they were "sometimes" so.

Regarding the educational role, almost all participants felt the meetings were either always or sometimes a useful educational experience. The vast majority stated they had learnt something at each meeting (96 per cent in meeting one, 86 per cent in meeting two, and 95 per cent in meeting three). Furthermore, a large number reported they planned to change their future practice based on what was learnt at the meeting (100 per cent of residents, 87 per cent of registrars and 56 per cent of consultants).

Where to from here? We were able to identify areas for improvement to increase the effectiveness of our meetings for both quality assurance and educational purposes. While our particular findings are not generalisable to other anaesthesia departments, a similar evaluation in other departments would likely identify aspects of the M&M meeting that would improve its value. A robust M&M meeting can improve both patient safety and educational value at a local level.
A copy of our observer and participant questionnaires are available from the authors.

Dr Sara Arcioni, registrar, Wollongong Hospital, NSW

Dr Natalie Smith, FANZCA, senior staff specialist, Wollongong Hospital, NSW

References:

1. ANZCA PS58. Guidelines on Quality Assurance in Anaesthesia, 2012.
2. ANZCA curriculum 2013, AR_CL_1.16, AR_MG 1.2.
3. www.anzca.edu.au/fellows/continuing-professional-development/breakdown-of-cpd-activities/morbidity-mortality-meetings.html.
4. NSW Health Department, 2001, The Clinician's Toolkit for improving patient care, NSW Health Department, Sydney NSW.

Table contents reflect section 2.5 of The Clinician's Toolkit for improving patient care, NSW Health

Objectives of M&M meetings	
1. To critically analyse the circumstances that surrounded the outcomes of care provided by a multidisciplinary group of clinicians. These outcomes should include all deaths, serious morbidity and significant aspects of regular clinical practice.	Discussions should be used for educative purposes and must not involve apportioning blame to individuals.
2. To make recommendations for improving the processes of care given to this group of patients.	Discussions should focus on measures that can be recommended or implemented to prevent a similar incident or adverse outcome. These findings should be disseminated to relevant departments.
3. To initiate action on these recommendations and to oversee the progress of these actions.	A brief report should be compiled after each meeting, which identifies the actions that must be taken as a result of the discussions and review. If there are no recommendations for action, that should be so recorded.
Recommendations for conduct of M&M meetings	If action cannot be taken at the clinical level, a report should be sent to the facility or area quality council identifying the issues that should be addressed at that level.
Morbidity and mortality meetings should be considered to be a "core" activity for all clinicians.	All action items should be placed on the agenda for the next meeting.
All meetings should be multidisciplinary, including clinicians, technicians and managers involved in the care of that group of patients.	Feedback must always occur.
All levels of staff involved in the care of these patients – both junior and senior – should be involved.	M&Ms should not be used only to review the "exotic" cases that may be of greater interest to clinicians. M&Ms provide an ideal forum for the regular review of the clinical indicators that are relevant to that specialty or field of practice.
Meetings should be held on a regular basis and at least once a month.	Everyone who is associated with the care that is being reviewed should have the opportunity to report.
All deaths should be identified and, if appropriate, should include deaths that occurred outside of the acute care setting.	Case review should be conducted in a timely manner so that it is within recent memory of the people involved in the case.
Focus should be placed on identifying issues related to the processes or systems of care that led to the death or incident and not on the individuals who provided the care.	

Safety alerts

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

1. Propofol adverse events.
2. HeartWare Ventricular Assist System.
3. Recall: ResMed devices that use Adaptive Servo-Ventilation therapy.
4. Bard – Broviac Central Venous Catheters.
5. Access to Thiopentone and tranexamic acid.
6. Neurotoxicity in children (see article on page 26).
7. Suxamethonium supply interruption resolved.
8. Guidance on reprocessing of ERCP endoscopes linked to the superbug outbreak.

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

Adverse events

webAIRS news

The analysis of data relating to airway obstruction was presented at the 2015 ANZCA Annual Scientific Meeting in Adelaide.

There were four cases where a throat pack obstructed the airway, three were retained throat packs and in one case the surgeon accidentally dislodged the endotracheal tube with the throat pack still in place.

It was suggested during the presentation that the throat pack be added to the surgical swab count. In addition to the swab count, it was suggested a visual cue could act as a reminder to the anaesthetist such as, but not limited to, a label in a prominent part of the anaesthetic circuit.

There were nine instances where chewing gum was a potential hazard in association with anaesthesia. In four of the nine cases, the patient was anaesthetised prior to the discovery of the gum and in three cases the gum was removed in recovery. There was a similar case where a patient was anaesthetised after having concealed chewing tobacco in their mouth.

There was a single case where a coin had been ingested and resulted in tracheal compression during a procedure to remove the coin. Lastly, there were two cases that involved broken dentures. One resulted in airway obstruction and the other was a potential hazard.

Data also were presented relating to aspiration.

Aspiration Outcome	Count
Not reported	1
Potential Hazard	5
Near Miss	20
Harm	51
Severe Harm	6
Death	1
Total	**84**

Aspiration of gastric contents has been known as an important potentially avoidable cause of anaesthesia-related morbidity and mortality since Mendelson's article was published in 1946[1]. It is still an important cause of adverse outcomes as was noted in the *Safety of Anaesthesia* report (2009-11)[2] as well as the most recent VCCAMM report[3]. In common with these recent reports, webAIRS data confirms it is not only in high-risk cases where this adverse event occurs, as many happened during relatively minor cases such as upper endoscopy, colonoscopy and short duration cases where a laryngeal mask airway was used.

Fortunately, most of the cases reported to webAIRS had a satisfactory final outcome, however in the current webAIRS analysis, 8.3 per cent suffered serious consequences, including one death and six with serious harm. Fifty-one (60.7 per cent) of the reports were associated with some harm as well as 26 (31 per cent) that were assumed to have no harm. This latter group included one case that was not coded, five reported as a potential hazard and 20 reported as a near miss. A detailed analysis of the webAIRS data is being done and an article summarising the results will be prepared.

Program improvements

A new version of the registration program was released in February 2015. The update included enabling individual registration (without linking to a site) and a new simplified ethics approval process.

Firstly, regarding individual registration, previously users had to link their registration to a site. In the new registration program, individual registration is the default process and effective immediately.

When membership is confirmed, users can link to an existing site or register a new site (for example, hospital, day surgery or private practice). Linking to a site is optional and users can still report incidents and obtain CPD credits as an individual.

If users are registered both as an individual and at one or more sites, they can choose to either report each incident as an individual or direct it to one of the registered sites they are linked to. If existing users are only linked to a site, they can add individual membership to their existing username by logging in, selecting the "Register" tab and following the "Register as an individual" option.

The second important update to the registration process relates to ethics approval. In March 2014, the National Health and Medical Research Council released a document relating to ethical considerations for quality assurance activities[4].

It is no longer always necessary to obtain formal ethics approval for quality-assurance activities if a project meets the ethics considerations relating to the collection and use of the data. The webAIRS project has obtained formal ethics approval at multiple sites and is certain the data collected, and the way in which it is handled, meets the new ethical requirements.

When registering a new site, members may choose between agreeing to the ethics considerations online or making a new, low-risk ethics application. If your hospital has an ethics committee, it is worth discussing the ethics requirements with your committee to address any local concerns. However, individuals, private practice and smaller sites may wish to accept the findings of an ethics committee in their state. The latter may be performed online using the webAIRS website.

Finally, if any member wishes to assist with the analysis of the webAIRS data, please contact the medical director for further information.

For more information email anztadc@anzca.edu.au.

To register, visit www.anztadc.net and click the registration link on the top right hand side. View a demonstration at www.anztadc.net/Demo/IncidentTabbed.aspx

Dr Martin Culwick, FANZCA, Medical Director, webAIRS

Dr Heather Reynolds, Data Analyst, webAIRS

Dr Suraj Shanmugam, MBBS

Dr Peter Casey, MBBS

References:

1. Mendelson C.L., The aspiration of stomach contents into the lungs during obstetric anesthesia. Amer. J. Obstet. Gynecol. 52:191-205 1946.
2. Safety of Anaesthesia. A Review of anaesthesia related mortality reporting in Australia and New Zealand 2009-2011. Edited by Associate Professor Larry McNichol.
3. Victorian Consultative Committee on Anaesthetic Mortality and Morbidity (VCCAMM) Annual Report 2007. Associate Professor Larry McNichol. Chairman VCCAMM.
4. Ethical Considerations in Quality Assurance and Evaluation Activities. National Health and Medical Research Council. March 2014. (Available for download from the NHMRC website).

Professional documents – update

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

Professional documents are also referred to by government and other bodies 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.

- *PS08 Statement on the Assistant for the Anaesthetist* has been released for a twelve month pilot phase. Along with a name change from Recommendations to Statement, a key change to PS08 is that rather than prescribing curriculum content, PS08 is now based on a core set of competencies that all assistants to the anaesthetist are expected to demonstrate, be assessed on, and maintain, irrespective of training pathway.
- A definitive version of *A02 Policy on Endorsement of Externally Developed Guidelines* has been released following a close of pilot review. Minor amendments were made to reflect internal organisational changes and to clarify approval processes for draft versions of external documents.
- The Faculty of Pain Medicine has recently released *PM10 Statement on "Medicinal Cannabis" with particular reference to its use in the management of patients with chronic non-cancer pain*.

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.

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 and clinical pharmacology / Katzung, Bertram G [ed]; Trevor, Anthony J. [ed]. -- 13th ed -- New York: McGraw-Hill, 2015. Also available for loan

Clinical pediatric anesthesia / Goldschneider, Kenneth [ed]; Davidson, Andrew [ed]; Wittkugel, Eric [ed]; Skinner, Adam [ed]. -- 1st ed -- Oxford: Oxford, 2012.

Critical care ultrasonography / Levitov, Alexander; Mayo, Paul H; Slonim, Anthony D. -- 2nd ed -- New York: McGraw-Hill Medical, 2014.

Handbook of pediatric anesthesia / Houck, Philipp J. [ed]; Haché, Manon [ed]; Sun, Lena S. [ed]. -- 1st ed -- New York: McGraw-Hill Education, 2015.

Obstetric anesthesia / Santos, Alan C [ed]; Epstein, Jonathan N [ed]; Chaudhuri, Kallol [ed]. -- 1st ed -- New York: McGraw-Hill Education, 2015.

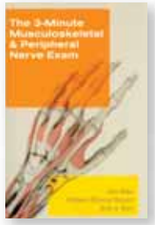
Principles of critical care / Hall, Jesse B [ed]; Schmidt, Gregory A [ed]; Kress, John P [ed]. -- 4th ed -- New York: McGraw-Hill, 2015.

Rang and Dale's pharmacology / Rang, H.P.; Ritter, J.M.; Flower, R.J.;Henderson, G. -- 8th ed -- Edinburgh: Elsevier Churchill Livingstone, 2015. Also available for loan

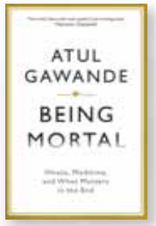
Training in anaesthesia: the essential curriculum / Spoors, Catherine [ed]; Kliff, Kevin [ed]. -- 1st ed -- Oxford: Oxford University Press, 2010.

New books for loan

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

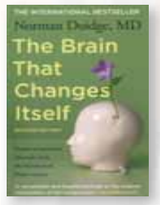


The 3-minute musculoskeletal and peripheral nerve exam: Three-minute musculoskeletal and peripheral nerve exam / Miller,Alan; DiCuccio Heckert, Kimberly; Davis, Brian A. -- 1st ed. -- New York: Demos Medical, 2009.

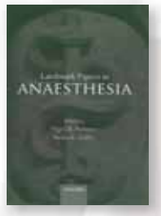


Being mortal: illness, medicine and what matters in the end / Gawande, Atul. -- 1st ed. -- London: Profile Books, 2014.

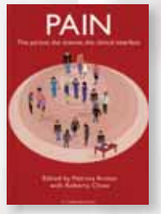
The brain's way of healing: stories of remarkable recoveries and discoveries / Doidge, Norman. -- St Ives: Allen Lane, 2015.



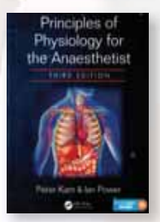
The brain that changes itself: stories of personal triumph from the frontiers of brain science / Doidge, Norman. -- Rev. ed. -- Brunswick: Scribe Publications, 2010.



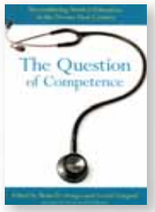
Landmark papers in anaesthesia / Nigel R. Webster [ed]; Helen F. Galley [ed]. --1st ed -- Oxford: Oxford University Press, 2013.



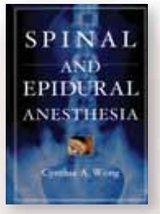
Pain: the person, the science, the clinical interface / Armati, Patricia [ed]; Chow, Roberta [ed]. -- 1st ed. -- Melbourne: IP Communications, 2015.



Principles of physiology for the anaesthetist / Kam, Peter; Power, Ian. -- 3rd ed -- Boca Raton, Fl.: CRC Press, 2015.



The question of competence: reconsidering medical education in the 21st century -- 2nd ed, 2014.



Spinal and epidural anesthesia / Wong, Cynthia. -- 1st ed -- New York: McGraw-Hill Medical, 2007.

Westmead anaesthetic manual / Padley, Anthony P. -- 4th ed -- North Ryde, NSW: McGraw-Hill, 2015.

Wilful blindness: why we ignore the obvious at our peril / Heffernan, Margaret. --1st ed -- London: Simon and Schuster, 2011.

ANZCA Library 24/7 – anytime, anywhere

The ANZCA 2015 Annual Scientific Meeting (ASM) in Adelaide provided a great opportunity for Fellows and trainees to visit the ANZCA stand in the healthcare industry area and learn more about the library services and resources. While many were aware of the large collection of specialist medical journals available through the College, nearly every attendee took something new away with them – whether it was access to the online textbooks and high quality procedural videos or finding out more about the expert services offered by the library staff; each nugget of knowledge usually accompanied by a free pen from one of the many publishers who provide products to the library.

The strongest message to attendees was that regardless of their location or time of day, the ANZCA Library is available online to all Fellows and trainees, 24 hours a day, seven days a week.

AusDI – Australian drug information

A popular resource discovered by Fellows visiting the ANZCA stand at the ASM was the AusDI database. AusDI delivers rapid access to Australia's most comprehensive and up-to-date database of independent drug monographs, pharmaceutical company production information, consumer medicine information, product summaries, drug product images and interactions and safety monographs in one single resource. AusDI now responds to your device, providing consistent access across mobile, tablet and desktop.

The drug interactions module and product identifier module were of particular interest. Many Fellows deal with patients who use a number of medications and struggle to recall the name of the drugs, but may remember the colour and shape.

ECRI Top 10 patient safety concerns for healthcare organisations

Patient safety is a top priority for every healthcare organisation, but knowing where to direct initiatives can be daunting. To help organisations decide where to focus their efforts, ECRI Institute has compiled its second annual list of the Top 10 Patient Safety Concerns for Healthcare Organisations. The top 10 concerns include many issues relevant across all care settings, such as:

- Ensuring data integrity.
- Managing care coordination events involving medication reconciliation.
- Performing independent double checks.
- Preventing opioid-related adverse events.
- Preventing medication errors related to pounds and kilograms.

New in the library (continued)

ECRI updated guidance: Handling latex sensitivity in workers and patients

Latex sensitivity has been a concern for patients and healthcare workers for several decades. Most healthcare organisations have policies and procedures to identify potentially sensitive patients and healthcare workers and take appropriate precautions. Most facilities routinely provide non-latex alternatives, especially gloves, and remind patients to tell their caregivers if they have an allergy to latex. Despite this awareness, however, latex exposures and allergic reactions continue to occur. Latex Sensitivity, newly updated on the ORRM members' website, discusses allergic responses to latex, individuals who are at risk for latex sensitivity, and strategies to minimise the risk of adverse reactions to latex among patients and healthcare workers.

Contact the library to obtain any ECRI publications.

Latest anaesthesia and pain medicine research

All articles can be sourced in full text from the library's online journal list: www.anzca.edu.au/resources/library/journals

Straube S, Derry S, Straube C, Moore RA. Vitamin D for the treatment of chronic painful conditions in adults. Cochrane Database Syst Rev. 2015;5:CD007771.

2014 Postgraduate educational issue: Advances in trauma care. Br J Anaesth. 2014;113(2).

Anesthestic care for abdominal surgery. Anesthesiol Clin. 2015;33(1).

Telemedicine in the ICU. Crit Care Clin. 2015;31(5):187-378.

Kim HC, Lee YH, Kim E, Oh EA, Jeon YT, Park HP. Comparison of the endotracheal tube cuff pressure between a tapered-versus a cylindrical-shaped cuff after changing from the supine to the lateral flank position. Can J Anaesth. 2015 Apr 17.

Stevanovic A, Rossaint R, Fritz HG, Froeba G, Heine J, Puehringer FK, et al. Airway reactions and emergence times in general laryngeal mask airway anaesthesia: A meta-analysis. Eur J Anaesthesiol. 2015;32(2):106-116.

Christelis N, Wallace S, Sage CE, Babitu U, Liew S, Dugal J, et al. An enhanced recovery after surgery program for hip and knee arthroplasty. Med J Aust. 2015 Apr 20;202(7):363-368.

Choo EK, Ranney ML, Chan TM, Trueger NS, Walsh AE, Tegtmeyer K, et al. Twitter as a tool for communication and knowledge exchange in academic medicine: A guide for skeptics and novices. Med Teach. 2015;37(5):411-416.

Larach MG, Brandom BW, Allen GC, Gronert GA, Lehman EB. Malignant hyperthermia deaths related to inadequate temperature monitoring, 2007-2012: A report from the North American Malignant Hyperthermia Registry of the Malignant Hyperthermia Association of the United States. Anesth Analg. 2014;119(6):1359-1366.

Aurini L, White PF. Anesthesia for the elderly outpatient. Curr Opin Anaesthesiol. 2014;27(6):563-575.

Nunnally ME, O'Connor MF, Kordylewski H, Westlake B, Dutton RP. The incidence and risk factors for perioperative cardiac arrest observed in the National Anesthesia Clinical Outcomes Registry. Anesth Analg. 2015;20(2):364-370.

Agarwala AV, Firth PG, Albrecht MA, Warren L, Musch G. An electronic checklist improves transfer and retention of critical information at intraoperative handoff of care. Anesth Analg. 2015;120(1):96-104.

Miner JR, Moore JC, Austad EJ, Plummer D, Hubbard L, Gray RO. Randomized, double-blinded, clinical trial of propofol, 1:1 propofol/ketamine, and 4:1 propofol/ketamine for deep procedural sedation in the emergency department. Ann Emerg Med. 2015;65(5):479-488 e472.

Terkawi AS, Durieux ME, Gottschalk A, Brenin D, Tiouririne M. Effect of intravenous lidocaine on postoperative recovery of patients undergoing mastectomy: A double-blind, placebo-controlled randomized trial. Reg Anesth Pain Med. 2014;39(6):472-477.

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

CPD update

CPD review

Feedback received from the 2014 ANZCA Fellowship Survey indicated participants are experiencing difficulty with the ANZCA Continuing Professional Development (CPD) program. ANZCA has commenced an evaluation of the current program, and invites feedback on further improvements envisaged following its revision in 2013 and roll-out last year.

In relation to the CPD portfolio and the program content, we are reviewing the educational priorities, our approach to meeting the requirements of the regulatory authorities and how well the program meets the needs of all users. For example, should emergency responses and essential areas for knowledge maintenance be extended? What changes have occurred in relation to community expectations and expectations around recertification, and how can we facilitate ease of use for time-poor specialist practitioners?

The review should be completed by the end of this year and we would really value your comments and suggestions to help guide changes and enhancements.

Provisional fellowship trainees

Provisional Fellows (trainees in their final year) are reminded that they are enrolled in the CPD program and must meet the specific CPD requirements of the curriculum.

CPD credits can be claimed for many of the activities that they have completed as part of training, including, for example, multi-source feedback in the practice evaluation category for 20 credits per activity.

More clinical audit resources to be developed

Six additional sample audit templates are in the development stage for the practice evaluation category. The first two will be available by the end of June and the others in the subsequent months. These will be added to the *CPD Program Handbook* and the ANZCA website as soon as we have finished "proofing" them.

This will be added to the six templates available now. The most popular audit in the group is the PONV prophylaxis clinical audit guide. We hope that the new topics will be widely applicable for many practitioners. We are working on audits covering chronic medication use, difficult airway equipment, the management of insulin dependent diabetics against hospital guidelines, management of pre-operative anaemia and PONV incidence. One of the new templates will be designed specifically for FPM Fellows.

If anyone has ideas for a topic, or an existing audit that has could be included, we would welcome your input – please contact cpd@anzca.edu.au and VanessaB@adhb.govt.nz.

Pending activities

Annual scientific meeting (ASM) activities are being added to CPD portfolios this month and should be completed by the end of June. Please keep a lookout for this in the "pending activities" section of your portfolio. Once it has been loaded (this is done by the ANZCA staff) all that is needed is for you to confirm/edit your attendance, and it will automatically (magically) appear in your activities and dashboard.

Once again, thank you to those who have provided valuable feedback and suggestions so far, and to the CPD Committee members, the audit sub-group members, and the ANZCA staff for their continued hard work.

Dr Vanessa Beavis
Chair, CPD Committee

CPD tips

Journal club

Anaesthetists based around the Mona Vale Hospital in Sydney have established a journal club, which meets every three months to discuss and critically appraise scientific papers. These meetings are separate from regular departmental meetings and are held away from the hospital. Attendance is recorded and minutes kept.

In order to claim the activity in their CPD portfolio under "journal reading" in the Knowledge and Skills category, each participant receives a copy of the attendance record to be kept as evidence. The activity attracts one credit per hour (maximum cap of 10 credits per year).

Dr Nigel Theaker, FANZCA
Mona Vale, NSW

EMBRACING CHANGE IN ADELAIDE

A total of 1729 ANZCA and FPM delegates and exhibitors attended the 2015 ANZCA Annual Scientific Meeting in Adelaide, "The changing face of anaesthesia and pain medicine". They enjoyed four plenary sessions, 60 concurrent sessions, 52 workshops, 50 small group discussions, 37 moderated e-Poster sessions and 36 e-Poster sessions. We also welcomed 149 ANZCA Fellows and 17 FPM Fellows to the fellowship of their College and Faculty.

A WONDERFUL FOUR DAYS

Wow, what an exhilarating ride for four days!

If someone had told me three years ago what a buzz organising the 2015 ANZCA ASM would be I wouldn't have believed them – but now I know! It has been an absolute blast (but that doesn't mean I necessarily want to do it again!).

Three years ago I decided to step forward and take up the role of convenor for the 2015 ASM. I had a vision and thanks to my amazing Regional Organising Committee (ROC) and ANZCA events team, my vision became not only a reality, but exceeded all my wildest dreams.

Our theme was "The changing face of anaesthesia and pain medicine". This represented not only our change in meeting format – a full four-day meeting – but also our appreciation of the way our profession is evolving and the changing culture of our patients.

The Adelaide Convention Centre unveiled its fabulous new redevelopment just in time for our ASM, which also coincidentally adopted the changing face theme. The new convention centre is modern and spacious and offers fabulous floor-to-ceiling views of the River Torrens and the spectacular new Adelaide Oval – views that greeted our delegates every day along with the unseasonal warm dry weather.

Our scientific program set out to make us think outside the square – we had talks not only from anaesthetists, but also from surgeons, physicians, scientists and other allied health professionals. It was diverse and exciting, covering a range of innovative and traditional topics. The only complaint I heard was that delegates didn't know which session to go to – always a nice dilemma to have, at least from a ROC point of view!

With the advent of the Virtual ASM introduced in Singapore last year, this dilemma does not loom as large as previous years as delegates can watch all the sessions they were unable to physically attend, and do so at their leisure.

One of the highlights was definitely the series of sessions devoted to the centenary of ANZACs – the history of anaesthesia and medicine for military campaigns was comprehensively covered and included the latest teachings from Afghanistan. As an ex-military anaesthetist myself, I found these sessions particularly interesting.

The workshops and small group discussions were extremely well subscribed and covered a wide range of topics. We also introduced many workshops designed to cater for the emergency response requirement of our continuing professional development program.

Our invited speakers were excellent and enthusiastically threw themselves into our program – both scientific and social! They brought different opinions from other parts of the globe and new ideas to ponder, all adding to our changing face theme.

Socially, our program was just as strong and inviting. The College Ceremony was held in the plenary hall of the convention centre where about 170 new Fellows were presented in front of family and friends and delegates.

It was a particularly moving ceremony as the family of Jennifer Best, who passed away recently, took to the stage on her behalf to receive her fellowship from Dr Genevieve Goulding. Gillian Hicks, this year, gave the oration, with the title "You only live twice" – a particularly moving and inspirational speech. She also expressed her immense gratitude to our profession for giving her a second chance at life.

Following the ceremony, we moved to the magnificent Art Gallery of South Australia where we were treated to a walk through the Elder Wing while listening to the most sublime harpist with an angelic voice en route to the Elysium Fields on the floor below. Guests were treated to a feast of South Australian food and wine and were able to celebrate in fantastic style!

We continued on the South Australian wine theme at the HCI Reception where we were lucky to have five wineries showcasing their wines for delegates and trade to enjoy. It was here that the 2016 ASM was launched with some spectacular moves form the Maori dance troupe, who joined us for their launch. We were even treated to a rendition of the world famous hakka!

The final social event was the gala dinner – this year our theme was an "Anaesthetic odyssey". Guests entered through inflatable tunnels into a room lit up like a galaxy with planets and stars all around. The entertainment stunned, the food and wine was amazing and the dance floor was full from the moment Blackjack started playing! There were many with sore heads and feet the following morning!

And so the meeting came to a close, finishing with a lively session between the audience and our invited speakers. And it was all over.

Despite massive nerves at 8am on the Saturday morning, the meeting went extremely well – thanks in no small part to the fantastic ANZCA events team who ensured there were no bumps in the road. I also must express my heartfelt thanks to my ROC who have also worked extremely hard to provide delegates with a program that is still being talked about today.

To all the other contributors, no matter how big or small, I also say thank you as without your contribution our ASM would not have been the success it has been.

And so finally a huge thank you to all who came to the meeting. I hope you had an interesting and educationally rewarding experience and that you had as much fun as I did.

To those of you who kindly stayed at home to ensure continuing provision of anaesthetic services – I thank you also. I now look forward to getting back to doing the job I love and when not working; putting my feet up, relaxing and spending time with my husband and labradors.

Dr Aileen Craig
ASM Convenor

SOMETHING FOR EVERYONE

We were delighted to have held the ANZCA ASM 2015 in Adelaide this year, under the roof of the newly built Adelaide Convention Centre on the beautiful South Bank, overlooking the Torrens Lake with views of the magnificent Adelaide Oval.

Background

There has been considerable mention of "perioperative medicine" in the literature recently, so the committee felt that the theme of the meeting, "The changing face of anaesthesia and pain medicine" should reflect this. To that end the keynote speakers and much of the program was dedicated to this topic.

We also elected to change the format of the meeting, by reducing it to four days, changing the post-Gala Dinner plenary to a later time (for obvious reasons!) and paying particular attention to those workshops that enable us to fulfill our continuing medical education requirements.

Keynote speakers

The ANZCA ASM Visitor was Professor Rupert Pearse from London who is an intensivist and influential researcher in all things perioperative. He opened the meeting with the Ellis Gillespie Lecture entitled "Perioperative medicine: The Future of anaesthesia", which was a thought-provoking address, during which he suggested that the UK college should, perhaps, be renamed the Royal College of Perioperativists! The FPM ASM Visitor Professor Irene Tracey, who discussed her groundbreaking work in using fMRI to image anaesthesia and analgesia, joined him in the opening plenary. One of the best plenaries I have had the pleasure of attending!

The Australasian Visitor was Professor Tomas Corcoran from Perth, who delivered the Mary Burnell Lecture "Perioperative inflammation and patient outcomes: Is anaesthesia an innocent bystander?" Clearly we're not! Here Professor Corcoran demonstrated the importance of inflammation and its effect on patient outcome over the longer term and described his current vital research to address this issue.

The ANZCA SA Visitor was Professor Rob Sneyd, who is Professor of Anaesthesia at Plymouth University and Dean of the Medical School. He delivered the SA Visitor's Lecture "Old habits die hard: What should we change and when?" This was another great lecture where we were encouraged to carefully analyse our practice, not just to better improve patient care, but to also develop a financial responsibility for the health service in which we work.

The final keynote address was from the Organising Committee's Visitor, Associate Professor Greg Crosby from Boston, called "The aging face of anaesthesia and pain medicine". This was a talk as interesting and as amusing as the title suggested, where we were encouraged to look critically at, not just the aging population, but to recognise our aging workforce and how best to look after ourselves so we can look after our patients. Frailty, porn and a graph to remember! Just brilliant.

Scientific program

We were delighted that so many anaesthetists from Adelaide and interstate came to share their knowledge and expertise. Every speaker has a passion for their specialty and a desire to share their understanding of how best to care for their patients. Without them there would be no conference.

We were also pleased that so many scientists and non-anaesthetists came to speak at the conference. This, to me, highlighted the importance of understanding how scientific research affects our practice and how a multidisciplinary approach to perioperative medicine and a desire, on both sides, to keep the channels of communication open can only ever improve outcomes.

Workshops, small group discussions and e-Posters

Dr Rob Young, Dr Merv Atkinson, Dr Kirsten McCullough and Dr Kaushik Saha developed an astonishing program, which catered to all the needs of the delegates attending the conference.

Almost all workshops were fully subscribed and all of the "emergency" workshops were filled within days of being advertised. The small group discussions (SGDs) were almost entirely filled and the feedback from both facilitators and delegates was that it was a worthwhile and enjoyable experience.

This is a true testament to the care, consideration and effort afforded by these four dedicated individuals.

We also had some really good, and evocative, submissions for poster presentation this year.

The winners deserve another mention: The Gilbert Brown Prize won by Dr Dean Bunbury, the Trainee Academic Prize won by Dr Paul Slocombe, the ASM 2015 Open e-Poster Prize was won by Dr Bernadette Wilks and the ASM 2015 Trainee e-Poster Prize was won by Dr Erin Bourke.

New technology

The Virtual ASM, in its second year, was a triumph, enabling delegates to watch those sessions they didn't want to miss online – and they are still available.

Twitter – well, the ASM has got me tweeting now! I think that's a good thing, although it does pervade "normal" social interactions! The best tweet of the conference for me was after the mathematical modelling session on the final day. It read #IthinkIbrokemybrain and #excusememybrainisfull! Thanks @mattnz and good luck next year!

ANZCA Events team

What a truly inspirational department. It has been a real pleasure to work with the team at the College. Driven, enthusiastic and dedicated are only three of the 1000 superlatives I have to describe them. Thank you very much.

I believe it was a truly educational, provocative and entertaining conference. It was a pleasure to be part of ANZCA ASM 2015.

Dr Nathan Davis
Scientific Convener

The late Dr Jen Best acknowledged

A particularly poignant moment at the College Ceremony was the presentation acknowledging the late Dr Jen Best, who was awarded FANZCA just 11 days before she died of cancer aged 31 on December 19, 2014. (See page 86 of the March 2015 edition of the *ANZCA Bulletin* for her obituary.)

Following the presentation of the FANZCAs, Dr Best's father, Peter Best, and sister Nicola Best, were invited onto the stage to present on her behalf. Her mother, Trish Best, also attended the ceremony. Many of those who had just presented and others in the audience stood in acknowledgement of the courage and determination Dr Best showed to achieve FANZCA despite knowing she had terminal cancer.

Fellows afterwards commented that her inclusion in the ceremony in this way and the acknowledgement made them proud to be part of the College.

PAIN PROGRAM WELL RECIEVED

The Faculty's annual scientific meeting (ASM) program and the preceding FPM Refresher Course Day, were a great success and a tribute to the hard work of the organising committee members Dr Penny Briscoe, Dr Roelof Van Wijk, Professor Andrew Somogyi, Dr Dilip Kapur, Dr Matthew Green, Dr Robyn Campbell and Dr Susan Evans.

On the opening day of the ASM, the FPM ASM Visitor Professor Irene Tracey, Nuffield Professor of Anaesthetic Science and Director of Oxford University Centre for Functional Magnetic Resonance Imaging of the Brain delivered the Michael Cousins Lecture in the opening plenary.

Professor Tracey presented her work on using brain imaging techniques to explore analgesic mechanisms, specifically how analgesics switch off part of the pain system to produce analgesic effects. Her work is also showing that the "person" part of the brain can have a powerful effect on the analgesia produced by drugs and that patients' expectations can have a marked effect on outcomes.

Professor Tracey is also undertaking work on how anaesthetics turn the brain off and produce the various levels of unconsciousness, trying to identify individual biomarkers to individualise anaesthetic. Her plenary was very well received by both anaesthetists and pain Fellows.

Professor Tracey's other presentations at the ASM included assessing patients' pre-existing vulnerability to developing chronic pain from acute event, as well as exploring the brain mechanisms of the placebo effect.

The FPM South Australian Visitor Dr David Lussier, Director Geriatric Pain Clinic, McGill University Health Centre, Montreal, Canada, presented the second plenary "Management of the Elderly – Pain and Drugs, What You Need to Know".

Dr Lussier gave a comprehensive review of the multiple co-morbidities and medication issues in the elderly patient with persisting pain (which is an increasing problem world-wide).

He outlined his experience and pharmacological research supporting his choices in medication for the elderly. Again this was another session highly relevant to both anaesthetists and pain Fellows. Dr Lussier's other contributions to the ASM included the issues of driving as they related to the elderly patient, and analgesic medication effects on driving.

The FPM Dean's Prize was won by Dr Preeti Krishnan for her paper "An Audit of Intrathecal Infusion Gases with Subcutaneous Port in the Management of Severe Pain in Patients with Cancer".

The best "Free Paper" was awarded to Dr Luke Arthur for his presentation titled "Sixty Thousand Plus Years and Twelve Papers: A Systematic Review of Pain Assessment, Experience and Management in Aboriginal Australian People".

Media coverage of both the Refresher Course Day and the pain medicine component of the ASM was widespread and included media releases and interviews from Professor Ted Shipton, Dean of the Faculty of Pain Medicine, along with the international speakers, Professor Irene Tracey and Dr David Lussier.

The overall feedback from attendees was that the program was of great interest and high standard and enjoyed by all.

Dr Gary Clothier
FPM Scientific Convenor

ANZAC COMMEMORATION

This year marks the centenary of the fateful landing of the ANZACs at Gallipoli. The occasion was commemorated recently at the ASM with a series of special lectures.

The speakers, many in uniform, addressed the subject of military anaesthesia over the last 100 years. The topics were fascinating, ranging from the first colloid, gum acacia, developed during World War I, to the advances in aeromedical evacuation.

Everyone there will remember the moving and powerful presentation by Dr Alex Douglas. The benign title, "My path to anaesthesia", did not prepare the audience as Dr Douglas bravely related her experiences in Rwanda. As the Medical Officer in Command at the Casualty Clearing Station at Kibeho, she was confronted by extreme violence, incomprehensible genocide and threats to her personal safety. Her calm but emotional presentation left no doubts about the horrors of war and its lasting impact.

The College continues to honour all our past and serving military personnel in an exhibition at the Geoffrey Kaye Museum of Anaesthetic History. The exhibition, *Trailblazers & Peacekeepers: Honouring the ANZAC Spirit*, takes place over three platforms. Onsite, there is a physical exhibition highlighting the personal stories of doctors in combat. A companion book and online exhibition launched at the ASM have also been produced.

The museum had its own booth at the ASM, displaying the online exhibition on a large screen, with surplus army rifle boxes housing copies of the book and a large photographic backdrop featuring a World War I nurse, preparing an injured soldier for anaesthesia.

The online exhibition stretches from the Boer War through to present day Afghanistan, along with a number of peacekeeping missions and emergency relief operations. This falls well outside the usual scope for ANZAC commemoration, but the "war to end all wars" failed to fulfil its promise and anaesthetists and pain specialists are still regularly called on to tend the sick and wounded in difficult circumstances.

Rupert Hornabrook, Australia's first full time anaesthetist, was a Boer War veteran. His medals and personal memoirs are featured in the online exhibition and have been loaned to the museum by the Hornabrook family (see page 71 for more detail).

New Zealand's first Dean of the Faculty of Anaesthetists, John William Watt OBE, was a veteran of World War II. Watt cut short his house surgeon year to enlist in the New Zealand Army Medical Corps. He served in Egypt, Italy and Japan with the 6th New Zealand General Hospital.

The exhibition is greatly enhanced by the contributions of current serving defence personnel and by stories drawn from living memory. Many Fellows of the College have generously offered personal glimpses into the difficulties, frustrations and rewards that come with experience in a conflict zone - whether the situation is man-made, such as the Rwanda genocide, or natural disaster, such as the Boxing Day Tsunami.

Monica Cronin
Curator, Geoffrey Kaye Museum of Anaesthetic History

MORE INFORMATION

The online exhibition can be accessed via the ANZCA museum webpage or at http://anzca.online-exhibition.net/trailblazers/.

Copies of the book are available for purchase. Please contact the museum for more information.

The physical exhibition will be on display until May 2016. To arrange a viewing, please call +61 3 8517 5309 or email museum@anzca.edu.au.

RAISING OUR PROFILE

Media

More than 35 media interviews with keynote speakers and other Fellows of ANZCA and FPM were generated during and after the 2015 annual scientific meeting (ASM) and the FPM Refresher Course Day (RCD).

This resulted in about 550 media reports in print, radio, television and online, according to ANZCA's media monitoring service, iSentia. This reached a potential combined, cumulative audience of an estimated 25.5 million people. Four media releases were generated.

Topics that generated the most interest included the FPM submission to the Therapeutic Goods Administration calling for the restriction on the sale of over-the-counter codeine products, the benefits and risks of driving among the elderly, and the call for a national taskforce devoted to research into paediatric obesity.

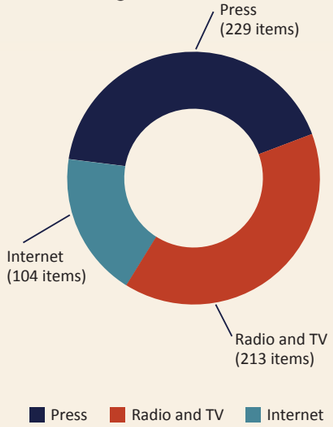
This year, analysis undertaken by iSentia provides a more comprehensive and accurate analysis of the College's media reach, including all syndicated radio, television and print reports.

The research shows ANZCA ASM interviews appeared in 213 radio and television items – Channel 9 ran two separate reports on calls to ban codeine, driving and the elderly and Channel 10 prepared a story on driving and the elderly. These reports ran on several bulletins throughout the day they appeared and ran in most states and territories.

Highlights from radio include high-rating stations 3AW, Triple M, ABC 774 and 702, as well as many regional stations (TV and radio).

Online, media releases and independent reports appeared on 104 websites, including *Australian Doctor*, Ninemsn, Yahoo and all major newspaper websites. The ASM and the RCD received most coverage in print, with 229 items appearing in hard copies of News Corp, Fairfax and independent publications ranging from the *Sydney Morning Herald*, *The Age*, *Sun-Herald*, *Herald Sun*, *The Australian*, the *Adelaide Advertiser*, *The Sunday Age* and dozens of regional newspapers including the *Illawarra Mercury*, the *Border Mail* and the *Townsville Bulletin*.

Media coverage



Fellows and trainees kept in the know

Delegates at the meeting and Fellows and trainees unable to attend the ASM were kept informed through five ASM e-newsletters distributed on the Friday before the ASM following the Refresher Course Day and on each day of the meeting.

Each e-newsletter had links to photos from the meeting, media updates and interviews with keynote speakers and links to audio visual recordings of their plenary lectures, as well as interviews with College leaders and others.

The e-newsletters, video interviews, photo galleries and media coverage can be found at http://asm.anzca.edu.au/2015-anzca-asm/.

Clea Hincks
General Manager, Communications

#ASM15Adl in the Twittersphere

The Adelaide 2015 Regional Organising Committee and the ANZCA Communications team decided to increase the presence of the 2015 ASM in social media and developed the hashtag #ASM15Adl for individuals to share their thoughts and keep up to date on Twitter. From the first tweet by @ANZCA on September 22, 2014, inviting people to submit abstracts for the ASM, momentum picked up.

To promote the use of #ASM15Adl, Dr Jo Sutherland (@josutherland50), anaesthetist and amateur tweeter, presented a pre-conference workshop on the use of Twitter. She described its benefits in propagating free medical education and having real-time discussion with individuals around the world. The room was alive with delegates, all with their electronic devices on and signing up to Twitter.

During the ASM, there were a total of 1,122 tweets from 219 participants, averaging 14 tweets per hour. Some tweeted about the inability to log on to the ASM wifi (@ANZCA responded with the correct password) and the swinging projector in the main hall. Many highlighted important messages from speakers, with some generating robust conversations online. Some of our invited speakers, Rupert Pearse (@rupert_pearse), Gill Hicks (@MADforPeace) and David Lussier (@LussiD), joined the Twitter conversation, as did sponsors Dräger (@DraegerNews), MDA National (@MDANational) and Intersurgical (@intersurgical). Even participants from outside the conference, including the Anaesthetic Group Ballarat (@Anaesthesia_AGB) contributed to the feed.

We look forward to seeing how Twitter is picked up in Auckland. See you in #ASM16NZ.

Dr Scott Ma FANZCA (@scruff888)
New Fellow councillor and amateur tweeter

PRIZES

Gilbert Brown Prize
Dr Dean Bunbury
"Epigenetic changes induced by morphine can affect opiate choice for cancer pain therapy"

Trainee Academic Prize
Dr Paul Slocombe
"A safety check prior to regional anaesthesia to prevent wrong sided blocks"

ASM 2015 Open ePoster Prize
Dr Bernadette Wilks
"A balance between trust and autonomy: A qualitative study of women's operating theatre suite stress while undergoing breast cancer surgery"

ASM 2015 Trainee ePoster Prize
Dr Erin Bourke
"Cricothyroidotomy catheters: An investigation of mechanisms of failure and the effect of a novel intra-catheter stylet"

FPM Best Free Paper
Dr Luke Arthur
"60,000+ years and 12 papers: A systematic review of pain assessment, experience and management in Aboriginal Australian people"

FPM Dean's prize
Dr Preeti Ananda Krishnan
"An audit of intrathecal infusion catheter with subcutaneous port in the management of severe pain in patients with cancer"

KEYNOTE PRESENTATIONS

Ellis Gillespie Lecture
Professor Rupert Pearse, ANZCA ASM Visitor
"Perioperative medicine: The future of anaesthesia?"

Michael Cousins Lecture
Professor Irene Tracey, FPM ASM Visitor
"Imaging analgesia and anaesthesia"

Mary Burnell Lecture
Professor Tomás Corcoran, Australasian Visitor
"Perioperative inflammation and patient outcomes: Is anaesthesia an innocent bystander?"

FPM SA Visitor's Lecture
Dr David Lussier, FPM SA Visitor
"Management of the elderly – pain and drugs: What you need to know"

SA Visitor's Lecture
Professor Robert Sneyd, ANZCA SA Visitor
"Old habits die hard: What should we change and when?"

Organising Committee Visitor's Lecture
Associate Professor Gregory Crosby, Organising Committee Visitor

"The aging face of anaesthesia and pain medicine"

College Ceremony orator
Ms Gill Hicks

RELIVE THE ADELAIDE ASM!

See photos, news coverage, interviews and ASM E-newsletters at: http://asm.anzca.edu.au/2015-anzca-asm/

Australian and New Zealand College of Anaesthetists
Virtual ASM

http://asm.anzca.edu.au/virtual-asm/log-in

ANZCA President Dr Genevieve Goulding, second from left with former presidents Dr Leona Wilson, Dr Lindy Roberts and Professor Kate Leslie.

FORMER PRESIDENT AWARDED ORTON MEDAL

Professor Kate Leslie's contributions to the profession of anaesthesia are vast. Among her many achievements are extensive innovations within ANZCA, including her time as president (2010-12), wider roles within the Australian healthcare system, and an internationally recognised research record.

Kate Leslie was born in 1962 in Melbourne, the eldest of three daughters. She studied medicine at the University of Melbourne (1980-85) and undertook anaesthesia training in Melbourne (1987-1991) and in San Francisco (1992). She was admitted to fellowship of ANZCA in March 1993.

After another year in San Francisco, Professor Leslie returned to a full-time staff specialist appointment at the Royal Melbourne Hospital, where she is now head of research in the Department of Anaesthesia and Pain Management. Her clinical interests include anaesthesia for neurosurgery, colorectal and trauma surgery, and sedation for gastrointestinal endoscopy. She is an honorary professorial fellow in the Department of Pharmacology, the Anaesthesia Perioperative and Pain Medicine unit at the University of Melbourne, and honorary adjunct professor, Department of Epidemiology and Preventive Medicine, Monash University.

Professor Leslie's involvement in clinical research began after she passed her primary examination in 1988. She published several studies as a trainee, under the mentorship of Dr David Crankshaw, Dr Brendan Silbert and Dr Daniel Sessler. It was under Dr Sessler's guidance at the University of California, San Francisco, that she developed her interests in thermoregulation, depth of anaesthesia monitoring and awareness. In San Francisco, she also cemented her interests in neuroanaesthesia, food and wine – and skiing.

On her return to Australia, Professor Leslie completed an MD ("Aspects of propofol pharmacology" in 1998) and a master of epidemiology (2002). Since 1989, she has published 121 peer-reviewed papers and four book chapters. She has made more than 160 invited presentations at international, national and local meetings, including twice as the Australasian Visitor to the ANZCA Annual Scientific Meeting (ASM) in 2003 and 2006. She is on the editorial boards of *Anesthesia & Analgesia, Anesthesiology* and the *British Journal of Anaesthesia*. She has won the Australian Society of Anaesthetists (ASA)/Boots Young Investigator Award, the ASA Gilbert Troup Medal, the ANZCA Gilbert Brown Prize, the ANZCA Douglas Joseph Professorship and the Australian Medical Association (AMA) Woman in Medicine Award.

Professor Leslie first became involved with multi-centre research when she and Professor Paul Myles instigated the B-Aware trial, a 2500 patient multi-centre trial on awareness. Subsequent contributions include chief investigator of the ENIGMA-I (n = 2000), ENIGMA-II (n = 7000), POISE-1 (n = 8531), POISE-2 (n = 10000), Balanced (n = 6500), RELIEF (n = 2800) and PADDI (n = 8800) trials. She has been awarded more than $A10 million research funding with five National Health and Medical Research Council project grants (three as chief investigator A). Professor Leslie is currently the chair of the ANZCA Clinical Trials Network Executive.

Professor Leslie's involvement with the College began in 1994 with co-option as the "younger Fellow" on the ANZCA Victorian Regional Committee, on which she held numerous roles, including chair (2000-02). She was an ANZCA physiology examiner for six years (1999-2005), scientific convenor of the 2000 Melbourne ASM, and in 2002 was elected to the ANZCA Council.

On the ANZCA Council, Professor Leslie chaired numerous groups, most notably the Communications and Fellowship Affairs, Research, Training Accreditation, Investments, International Medical Graduate Specialist and Executive committees, and the Anaesthesia and Pain Medicine Foundation Board. She served as honorary treasurer, ASM officer, vice-president and then as the youngest ANZCA president (2010-12).

Among her many College achievements were her vision to engage our fellowship; leadership during the ANZCA curriculum redesign; instigation of the novice investigator research grants, the new Fellow on ANZCA Council, the Indigenous Affairs Committee and the Ray Hader Award for Compassion; and her commitment to overseas aid reflected in establishment of the Overseas Aid Committee and Lifebox fundraising at the 2012 ANZCA ASM.

Professor Leslie was a member of the Committee of Presidents of Medical Colleges (CPMC) during her ANZCA presidency and was elected by the college presidents to the position of CPMC chair (2011-13). She is the CPMC representative on the Specialist Education Accreditation Committee and the board of the Australian Medical Council, of which she is also a director. She is a member of the Scientific Affairs Committee of the World Federation of Societies of Anaesthesiologists, and chair of the Advisory Board of the Anaesthesia Perioperative and Pain Medicine Unit, Melbourne Medical School. She is a Fellow of the Australian Institute of Company Directors, recently completed a master of health services management, and also is an accomplished media performer, promoting our specialties and important multi-centre research to the community.

Outside medicine, Professor Leslie's interests remain skiing (at Mount Hotham and overseas), politics, food and wine, and spending time with her friends and family, in particular her mother Netta, sisters Elizabeth (an ANZCA Fellow) and Bronwen, and her nephew Patrick and niece Lucy.

Professor Leslie's accomplishments as a leader, an international researcher and, not least, her accomplishments on behalf of ANZCA, place her among the most outstanding contributors to anaesthesia, to medicine and to healthcare overall. The Robert Orton Medal celebrates her extraordinary achievements.

Based on the citation by Dr Lindy Roberts at the College Ceremony during the 2015 ANZCA Annual Scientific Meeting in Adelaide.

COLLEGE ACKNOWLEDGES A LEADER IN SAFETY AND QUALITY

Professor William (Bill) Ben Runciman is internationally recognised as a leader in quality and safety in healthcare, particularly in anaesthesia.

Professor Runciman was born on December 30, 1945 in South Africa and spent his childhood in various African nations. He studied science (BScMed 1965) and medicine (MBChB 1969) at the University of Witwatersrand. During university, he supported himself with roles as a bookmaker's clerk, barman, security guard, wine steward, car-park attendant and night nurse, among other occupations.

Following junior doctor roles and a stint in the South African military, in 1973 Professor Runciman moved to Australia, taking up an anaesthesia training post at the Royal Adelaide Hospital. Fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons (FFARACS) followed in 1975. In addition, he gained fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons, Intensive Care (FARACS) in 1981, of the Royal College of Anaesthetists (RCoA) in 1983 and the Hong Kong College of Anaesthetists (HKCO) in 1983. He completed a PhD at Flinders University in 1985 for his thesis "The effects of general and spinal anaesthesia on regional blood flow and drug disposition in the sheep".

He began specialist practice in intensive care medicine in 1976 when he was appointed staff specialist in the intensive care unit at the Flinders Medical Centre. He was appointed senior staff specialist in 1979 and remained in that post until 1988. During this time he held academic positions at Flinders University and continued his research interests in cardiovascular physiology and pharmacology, and patient monitoring. He was a member of the ANZCA South Australian Regional Committee between 1988 and 1993.

In 1988 Professor Runciman was appointed foundation professor and head of the Department of Anaesthesia and Intensive Care, University of Adelaide and Royal Adelaide Hospital, a position he held until 2007.

During this time, his main research interest shifted to quality and safety in healthcare. With colleagues, he established the Anaesthesia Patient Safety Foundation and conceptualised and implemented the Australian Incident Monitoring Study (AIMS) project.

Among the many highlights of his work in quality and safety were his outstanding contributions to the landmark "Quality in Australian healthcare study" (published in the *Medical Journal of Australia* in 1995, one of the top 10 cited studies published in that journal) and the "CareTrack study", the first of its kind in Australia and only the second in the world, which tracked treatment in a group of 1000 patients over two years for 22 common conditions, representing more than 40 per cent of Australia's disease burden. This work was published to great acclaim in the *Medical Journal of Australia* in 2012.

During his research career, Professor Runciman has been awarded more than $30 million from 28 bodies, has supervised more than 50 postgraduate students and published more than 250 papers, reviews, book chapters and reports. He has the greatest total number of citations for *Anaesthesia and Intensive Care* and the most papers by any author for *Quality and Safety in Healthcare*. His work has had nearly 5000 citations tracked by the conservative tracking service SCOPUS. Known as a passionate and provocative speaker, he has delivered more than 600 invited lectures in over 40 countries.

Professor Runciman has served in numerous additional roles related to patient safety nationally and internationally. Between 1992 and 1998, he was health commissioner for South Australia and between 2004 and 2008 he was visiting professor, Centre for Clinical Governance Research in Health, Faculty of Medicine, University of New South Wales. He is currently Professor, Patient Safety and Healthcare Human Factors, in the School of Psychology Social Work and Social Policy, University of South Australia; Clinical Professor, Joanna Briggs Institute, Faculty of Health Science, the University of Adelaide; Research Fellow, Australian Institute of Health Innovation, University of New South Wales; and president of the Australian Patient Safety Foundation.

In addition, he is a member of the USA National Quality Forum Expert Panel for the Common Formats, the Research Methods group, WHO World Alliance for Patient Safety and the working group developing an International Classification for Patient Safety, WHO World Alliance for Patient Safety. He continues to teach at the University of Adelaide, Flinders University and the University of South Australia.

Professor Runciman was awarded the Gilbert Brown Prize in 1978, the Lennard Travers Professorship in 1982, the Royal Australasian College of Surgeons John Mitchell Crouch Fellowship in 1987 and Academic Enhancement Grant in 1989. More recently he was awarded the Sidney Sax Public Health Medal for outstanding achievement in and contribution to the development and improvement of the Australian healthcare system by the Australian Healthcare and Hospitals Association (2008) and the William Russ Pugh Award of the Australian Society of Anaesthetists for outstanding service to the specialty (2008).

Based on the citation by Professor Alan Merry at the College Ceremony during the 2015 ANZCA Annual Scientific Meeting in Adelaide.

CULTIVATING A CULTURE OF CHANGE IN ANAESTHESIA AND PAIN MEDICINE

As our population changes and expectations about healthcare change with it, anaesthetists and pain physicians need to transform the way the profession is heading.

With this in mind, we welcomed new Fellows from around Australia, New Zealand and south-east Asia to the picturesque surroundings of Mount Lofty House in the Adelaide Hills for the 2015 New Fellows Conference, "Cultivating a culture of change in anaesthesia and pain medicine". The program not only provided an opportunity for new Fellows to develop their leadership potential, but also develop the strength to encourage innovation and change in their regions.

The conference began with introductions and we asked delegates to answer the questions "What change has made the biggest impact in your life?" and "What do you think the biggest change will be in anaesthesia or pain medicine in the next decade?" The responses were wide and varied.

Family and relationships were a common theme, as well as professional achievements. As for the biggest change in our profession, there was discussion of technology, including electronic records, the progression of scientific knowledge, particularly in pain medicine and genetics, and our change in scope of practice, with perioperative medicine and role of the non-anaesthetist sedationist as examples. We proceeded to the renowned Sticky Rice Cooking School where delegates were introduced to Vietnamese cuisine by guest chef Yukiko Anschutz and cooked their dinner for the night.

After breaking the ice on Wednesday, the delegates shared more of themselves with each other in the Key-2-Me Process Communication Model workshop, facilitated by Dr Marion Andrew, chair of the Welfare of Anaesthetists Special Interest Group. Delegates were given an insight into how their personality determines their communication style and how stress and conflict can impact on their interactions with others. Delegates became more aware of why they struggle to talk to that "difficult" surgeon and have a greater appreciated for why trainees in difficulty react the way they do.

On Thursday afternoon, Jonathon Kruger, ANZCA's General Manager, Policy, facilitated an "Advocating for change" seminar. Jonathon emphasised the importance of determining the message, identifying stakeholders and developing an appropriate strategy to affect change. Delegates were given an opportunity to develop a campaign on a variety of topics, including nurse sedationists, pholcodine, pain medicine training in New Zealand and revalidation.

The day ended with most delegates heading up to the summit of Mount Lofty to watch the sun set on the day. Delegates had time to catch up over dinner and Dr Andrew Zacest, from the Faculty of Pain Medicine Board, spoke to them about the challenges he faces as a neurosurgeon and pain physician with managing change in his practice.

On the final day of the conference, general practitioner Dr Roger Sexton reminded delegates about the importance of personal health and wellbeing for professional wellbeing. He shared cases to demonstrate problems that doctors face when seeking healthcare. In the final session of the conference, Dr Sexton joined a panel with ANZCA President Dr Genevieve Goulding, ANZCA councillor Dr Rod Mitchell and Dr Marion Andrew to discuss experiences in change management.

The new Fellows had an opportunity to ask the panel questions and the dialogue was informative and robust. Questions were asked about the new ANZCA CPD standard, the separation of intensive care medicine and the public image of anaesthetists.

From all accounts, the 2015 NFC was a successful meeting and we thank the delegates, including Dr Goulding, Dr Mitchell and Dr Zacest, and our facilitators, Dr Andrew, Mr Kruger and Dr Sexton, for their involvement. A special thank you to Eleni Koronakos for her hard work in making the 2015 conference the success it was.

Our conference was designed to reinforce important skills for the future leaders of our profession to drive change in the face of a challenging environment: effective communication; advocacy; and personal care. We look forward to seeing how the new Fellows put into action what they have learnt.

Dr Scott Ma and **Dr Giresh Chandran**
2015 New Fellows Conference Co-Convenors

Clockwise from top left: The NFC delegates on the final day of the conference; Dr Joanna Coates, Dr Dale Kerr and Dr Genevieve Goulding; Dr Dan Ellyard and Dr May Leung at Sticky Rice Cooking School; Dr Hema Rajappa, Dr David Sommerfield, Dr Yan Wei Lee, Dr Bridget Effeney, Dr James Dalby-Ball, Dr Chao-Yuan Chen and Dr Pauline Wake.

Medics team with locals in cyclone response

"The role that many anaesthetists play on a daily basis ... lends itself well to working with others – often with conflicting priorities – in the disorder of a post-disaster environment."

Australian doctors team up with locals to provide disaster relief in Vanuatu.

Tropical Cyclone Pam is one of the most powerful storms ever recorded in the southern hemisphere.

In March 2015, it struck the Pacific nations of Tuvalu and Solomon Islands before tracking south and devastating Vanuatu. Representing the worst natural disaster in the island nation's history, Tropical Cyclone Pam damaged buildings, communications and infrastructure, and destroyed many crops in a country heavily reliant on small-scale and subsistence farming.

In response to an appeal for help, the Australian Government announced a package of aid, which included the deployment of an Australian medical assistance team (AusMAT) from Victoria and the Northern Territory. I was asked to take the role of medical team leader, which included helping to co-ordinate AusMAT's role, along with local health staff, Australian consular staff and representatives from Canberra.

I flew into Port Vila, the capital of Vanuatu, one day after the event. It was clear from the air there had been widespread wind damage to buildings, roads and trees. Forest giants were stripped bare, split apart and scattered like twigs, houses were flattened and boats had been swept onto beaches, with masts, decks and hulls in pieces.

Following the principles of humanitarian medicine, the role of any foreign medical team is to work along with local health providers to meet the needs of the affected population. The humanitarian response after the 2010 earthquake in Haiti taught the wider aid community the harm that poorly prepared and inadequately trained foreign medical teams can cause, both from poor practice and stripping resources from the local community. With this in mind, our first priorities were to contact the local Ministry of Health and Vila Central Hospital (VCH) staff, to form links at the health cluster set up in response to the disaster, and to establish what the healthcare needs were and how AusMAT could help.

One of the strengths of the AusMAT training program is that we invite key people from neighbouring countries in the Pacific to work with us in our courses, helping to build local resilience.

This proved invaluable in Vanuatu, with both the superintendent of Port Vila hospital, Dr Richard Leone, and senior surgeon, Dr Basil Leodoro, having been AusMAT-trained in Darwin. Not only were both aware of what AusMAT could offer, but Dr Leodoro was able to contact and keep us informed of the situation on the ground immediately pre and post-cyclone, enabling the team to be well prepared when the decision was made to deploy.

VCH staff had prepared for Pam's arrival by moving all inpatients into the recently built emergency wing of the hospital, which was more able to withstand gusts above 300 kilometres an hour. This resulted in patients and relatives sleeping on floors, in corridors, treatment and consultation rooms, the radiology department and even the pathology lab.

The main ward block was badly damaged and flooded, as was paediatric outpatients and other areas. The Neonatal Intensive Care Unit had to be moved into the pharmacy. Additionally, the significant rise in patients presenting with injuries from flying debris, or from searching through damaged housing, meant the emergency department was becoming overwhelmed.

Working with the AusMAT logistics team, we helped with the repair of the hospital, which allowed patients to return to the wards, clearing the emergency department to allow more efficient management. We also constructed temporary field hospital tents at VCH to help deal with the surge in wound clinic visits and facilitate the paediatric outpatients.

AusMAT medical staff were embedded in the VCH emergency department, maternity ward, surgical and paediatric departments in order to ensure service could be increased despite local staff shortages – after all, most of us would be reluctant to leave our family to go to work if the house had just been destroyed in a storm.

As communications with outer areas were established, it became clear that islands to the east and south of Vanuatu had borne the brunt of the storm.

One of the three main hospitals in the country, in Lenakel on the island of Tanna, suffered catastrophic damage, demolishing the operating theatre. As a result, many patients required transport several hundred kilometres to Port Vila for treatment.

Used to only a few ad hoc aeromedical transfers per year, the local system was not set up for movement of such significant numbers of patients. Working with Dr Leodoro and the Ministry of Health logistics department, AusMAT was able to co-ordinate and undertake aeromedical transfers from a number of outer islands, including critically ill and injured children, acute surgical emergencies and women with catastrophic obstetric complications, all with good outcomes.

As an anaesthetist, I had worked in austere environments and post-disaster deployments in the past, though this was my first experience as a team leader. My clinical input was limited to treating a small number of minor injuries and aeromedical retrieval.

However the role that many anaesthetists play on a daily basis, co-ordinating theatres and handling negotiations between surgical teams, ICU, nursing staff, physicians and other departments, lends itself well to working with others – often with conflicting priorities – in the disorder of a post-disaster environment.

Flexibility, working under pressure and a willingness and determination to find a solution are traits many anaesthetists possess, and ones we should encourage in those we are training.

Australia and New Zealand in general, and ANZCA specifically, have a history of providing support for low and middle-income countries, particularly in the Pacific region. By funding programs including the overseas aid scholarship, through developing educational tools, including Essential Pain Management, and by offering popular and respected courses, such as Real World Anaesthesia and the AusMAT Surgical and Anaesthetic course, ANZCA Fellows are contributing to increasing ongoing capability and resilience against disaster for our near neighbours.

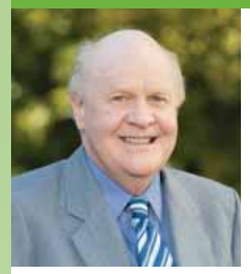
It is to be hoped, despite an age of austerity and increasing budgetary pressures, that Australia and New Zealand continue to recognise their fortunate position in the world, and maintain or indeed increase such support for those friends less privileged than ourselves.

Dr Dan Holmes, FANZCA
Specialist in Anaesthetics and Intensive Care, Royal Darwin Hospital

Clockwise from top left: Asbestos-laden damage to Vila Central Hospital; part of the AusMAT field hospital set up to support Vila Central Hospital; aeromedical retrieval of a patient severely injured in the cyclone; the busy paediatric outpatient clinic; damage to the operating theatre at Lenakel Hospital on Tanna; AusMAT field hospital wound clinic; Cyclone damage in Port Vila.

Faculty of Pain Medicine

Dean's message



Tackling the cost and suffering of chronic pain

The prevalence of chronic pain makes it a major health issue and a critical public health problem in Australia and New Zealand. Epidemiological studies in Australia have shown one in five Australians reported suffering from chronic pain[1]. In 2004, there were estimated to be 9.9 million workdays absent due to chronic pain annually in Australia, equating to a cost of $A1.4 billion per annum[2]. In 2007, about 3.2 million Australians (1.4 million males and 1.7 million females) were estimated to experience chronic pain[3]. The prevalence of chronic pain is projected to increase as Australia's population ages from around 3.2 million Australians in 2007 to five million by 2050[3]. A 2007 Access Economics report for the MBF Foundation (now Bupa Health Foundation) estimated the total cost of chronic pain at $A34.3 billion a year (or $A10,847 per person including $A7 billion in health care costs and $A11.7 billion in lost productivity)[3].

Chronic pain is Australia's third most costly health condition after cardiovascular diseases and musculoskeletal conditions. Among the most common diseases of care recipients are back problems (12 per cent), and arthritis and related disorders (10 per cent)[4].

Data from the 2006-07 New Zealand Health Survey showed one in six New Zealanders (16.9 per cent) suffers from chronic pain5. Forty-eight per cent of them used some form of medical treatment. There was an increased prevalence with age (from 8.6 per cent to 28.1 per cent)[5]. Chronic pain has become the third-biggest cause of illness-related disability for New Zealanders[6].

As the President of the Academy of Pain Physicians, Sean Mackey, recently commented: "Chronic pain is an astounding societal problem. Tackling this issue is a moral imperative, one that directs the cultural transformation in how we care for people in chronic pain, educate our providers, as well as in how we prevent and research pain"[7]. We must face up to these facts on cost and suffering in an increasing aging population, but what are we going to do about it?

Ensure access to pain services

The various elements of the health system need to work together. Multidisciplinary-based assessment and management of pain at a primary care level has been advanced by Faculty/Painaustralia initiatives sponsored by the Australian Government to support team medicine. The Faculty will continue to pursue these and other primary care initiatives. For example, a training pathway has been developed enabling general practitioners to become Fellows of the Faculty.

As a Faculty, we should lobby to improve the interfaces between community, primary, secondary and tertiary care, so when issues arise they are communicated and resolved quickly and effectively. Appropriate and timely access to pain services can be ensured through the development of health pathways in pain management. Health pathways can form the main source of assessment, management and referral information for general practice teams and other community healthcare providers to interact with secondary and tertiary services. Health pathways can help to improve the quality of care and reduce time spent waiting while supporting the delivery of more services closer to the community.

Our major pain management units should be encouraged to establish an outreach to rural clinics as well. Residencies in general practice and in family medicine should include relevant chronic pain medicine topics in their curricula and have supervised access to chronic pain patients in their specialty during residency training.

Targeting subacute (or acute persistent) pain

Every chronic pain was once acute. The transition of acute pain to pathological chronic pain is a complex and poorly understood process. Acute pain has a warning or protective function. However, poorly controlled and severe pain that occurs after surgery and trauma increases the risk of a chronic pain state. Biological, psychological, and social-environmental factors and the known polymorphisms in human genes are all involved in perpetuating the pain[8]. Our pain management units should expand their vision and target subacute (or acute persistent) pain. This offers the opportunity of secondary prevention of the destructive onset of chronic pain[9].

Professor Ted Shipton
Dean, Faculty of Pain Medicine

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News

Facing pain at the Refresher Course Day

The Refresher Course Day at the National Wine Centre of Australia on Friday May 1 attracted 174 delegates and strong support from the healthcare industry, with three major sponsors and two exhibitors present.

The program, "Facing pain", explored changes facing pain medicine with increasing research knowledge, society's concerns about driving while affected by medication, the ageing population, as well as "Facing our fear" regarding colleagues' mental illness, suicide and dealing with the aftermath.

The organising committee enacted a short play, The Dragon of Pain, to finish a very successful Refresher Course Day. The academic sessions were following by dinner at the award-winning Jolleys Boathouse Restaurant, including an entertaining after-dinner talk by Dr David Butler, co-author of the book Explain Pain and director of NOI group, titled "Dave's top 10 pain teaching tips".

Thanks to organising committee members Dr Penny Briscoe, Dr Roelof Van Wijk, Professor Andrew Somogyi, Dr Dilip Kapur, Dr Matthew Green, Dr Robyn Campbell and Dr Susan Evans for a very successful precursor to the pain medicine program at the annual scientific meeting (see page 42).

Dr Gary Clothier,
FPM Scientific Convenor

Above clockwise from top left: Delegates being welcomed to the Refresher Course Day at the National Wine Centre of Australia by FPM Dean Professor Ted Shipton; the organising committee enacting a short play "The Dragon of Pain"; Delegates looking forward to a session at the Refresher Course Day; Dr Gary Clothier with the FPM ASM Visitor, Professor Irene Tracey, and the FPM South Australia Visitor, Dr David Lussier; Faculty of Pain Medicine Dean Professor Ted Shipton congratulating the FPM Scientific Convenor Dr Gary Clothier.

Above right from top: FPM Dean Professor Ted Shipton with Dr Preeti Ananda Krishnan; Professor Shipton with Dr Luke Arthur.

Dean's Prize and Best Free Paper

This year's winner of the Dean's Prize, awarded at the Faculty of Pain Medicine's annual general meeting in May, was Dr Preeti Ananda Krishnan, an ANZCA trainee from South Australia, for her paper titled "An audit of intrathecal infusion catheter with subcutaneous port in the management of severe pain in patients with cancer".

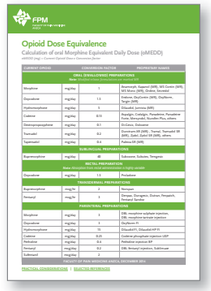
The Dean's Prize is awarded to the Fellow or trainee judged to have presented the most original pain medicine/pain research paper. Dr Krishnan was awarded a certificate and a grant of $1000 for educational or research purposes.

Dr Luke Arthur, also from South Australia, won the Best Free Paper Award, which is for original work judged to be the best contribution to the free papers session of the Faculty of Pain Medicine.

Dr Arthur won a certificate and a grant of $500 for educational or research purposes for his paper "60,000+ years and 12 papers: a systematic review of pain assessment, experience and management in Aboriginal Australian peoples". The Faculty free paper session is open to all registrants of the ANZCA and FPM annual scientific meeting.

News

Faculty publishes opioid dose equivalence table



An opioid dose equivalence table is now available on the Faculty of Pain Medicine website at www.fpm.anzca.edu.au/resources/professional-documents/OPIOID%20DOSE%20EQUIVALENCE.pdf.

The table is positioned with *PM01: Principles regarding the use of opioid analgesics in patients with chronic non-cancer pain*, which is being revised as a Faculty position statement. The Faculty also is developing a smart phone app to facilitate use of the dose equivalence table.

The table has been developed in recognition of a need to compare opioid doses used in clinical practice as part of the ePPOC (electronic Persistent Pain Outcomes Collaboration) data set. The FPM Research Committee spent six months developing the table, which was endorsed by the FPM Education Committee and FPM Board in October 2014.

The opioid dose equivalence table aims to meet a need in medical research and education where a consistent approach is required. Published literature varies in quoted morphine equivalent ratios, in some cases quite widely. The FPM table adds to the literature by providing evidence of a credible process of literature review by experts in the field.

The table includes commonly used opioids and routes of administration. Methadone, fentanyl lozenges and neuraxial opioids are excluded due to complex and variable pharmacokinetics.

Although the table was developed primarily for use in research and medical education, clinical application will inevitably follow. The "practical considerations" section provides brief information about clinical use and includes a warning that "administration of a calculated 'equivalent' dose of the replacement opioid may lead to overdosage".

It is anticipated that the FPM opioid dose equivalence table will be beneficial in research, education and clinical settings and provide a valuable, contemporary addition to the opioid conversion literature.

Dr Chris Hayes,
Vice-Dean, Faculty of Pain Medicine

Admission to fellowship of the Faculty of Pain Medicine

By examination:

Dr Ananthababu P Sadasivan, FRACS, NSW

Dr Chuan-Whei Lee, FANZCA, Victoria

Dr Sushama Deshpande, FANZCA, NSW

Dr Martine O'Neill, FANZCA, NSW

Dr Medhat Wahba, FANZCA, SA

Dr Jeremy Luke Brammer, FANZCA, Queensland

Dr Hasher Pallathu Kadavil, FANZCA, NSW

Dr Adeline Siu Yin Fong, FANZCA, WA

Dr Rosa Meng Chen Hou, FANZCA, Queensland

Dr Mark Joseph Heynes, FANZCA, Victoria

Dr Michael Edward Foss, FANZCA, NSW

Dr Kiran Gangappa Tippur, FCARCSI, Victoria

Dr Tze Chao Wee, FAFRM (RACP), Singapore

This takes the total number of Fellows admitted to 409.

FPM supervisor orientation and support resources

Access these resources in Networks under "Pain medicine learning/Supervisor orientation and support resources" via https://members.anzca.edu.au/networks/. Resources include the following topics:

- Training roles and responsibilities.
- Understanding the training requirements.
- Managing and supervising trainees.
- Welfare and mentoring.

These resources are possible thanks to the work of the FPM Supervisor Support Resources Working Group.

Trainees learn clinical skills

Twenty-nine trainees from Australia, New Zealand and Hong Kong gathered at ANZCA House in Melbourne on February 14 and 15 for the introductory clinical skills course, "So you want to be a specialist pain medicine physician? and other helpful hints". The course was a great success and a tribute to the hard work of convenors Dr Diarmuid McCoy and Dr Michael Vagg, who honed a great deal of the content through five years of convening the Geelong FPM Trainee Weekend, and of fellow presenters Dr Louise Brennan, Dr Meredith Craigie, Dr Melissa Viney, Mr Oliver Jones and Ms Laura Foley.

The program introduced trainees to the breadth and depth of pain medicine, from the connection between pain and philosophy to musculoskeletal examination. Dr Vagg also introduced trainees to the importance of considering sociopsychobiomedical factors when recording a pain-related history. The importance of being able to summarise the history in two or three sentences, thereby demonstrating a good understanding of the patient's presentation, was emphasised.

Dr Louise Brennan outlined the importance of communication, body language and safety in pain medicine practice. This session was well-received, with one trainee commenting that they had never before, in their medical career, heard such a talk. Other topics included the importance of accurate notes, letter-writing, legal implications of prescriptions and the exciting learning resources available within the College's online learning and collaboration system, Networks, and the ANZCA Library.

A particularly popular element of the course was an interview with a patient who has persistent pain. Trainees all agreed that the insights of the patient's story and the facilitated discussion provided a valuable learning experience. The patient kindly shared her experience of the session:

"It was an absolute pleasure. It was actually a great opportunity to reflect on what I have been through and how far I have come. I honestly can't thank you enough for creating the support network I have around me now and providing me with the education to move forward. I really hope your students found it insightful and if I have helped one person in the future have better post-surgical pain management care then it was all worth it... I am enjoying being chief pain mentor!"

In alignment with one of the key objectives of the course, feedback indicated that the opportunity to network with fellow trainees, FPM staff and Fellows was a highlight. The Faculty looks forward to providing another valuable program and opportunity for trainee interaction at the advanced clinical skills course on July 25 and 26.

A new era in pain medicine training

The first cohort of trainees has begun training under the revised FPM training program in Australia and New Zealand.

FPM Curriculum Redesign Project
Working together

"It was clear from the initial surveys that some trainees were commencing pain medicine training with inadequate background knowledge and one year was no longer enough time in structured training."

Dr Meredith Craigie, FANZCA, FFPMANZCA, Chair, Curriculum Redesign Project Steering Group

Pain medicine training comes of age

Pain medicine has evolved rapidly since the training program and curriculum were developed after the inception of the Faculty of Pain Medicine in 1998.

Educational theory and teaching techniques also have evolved, along with technological advances in online learning. The Faculty of Pain Medicine Board recognised a need to revise its training program, and a blueprinting process began in 2011, followed by surveys of stakeholders, especially trainees and new Fellows, who identified deficiencies in the program.

The extensive review led to a major change in the philosophical approach to pain medicine. The biopsychosocial framework has been redefined as sociopsychobiomedical, which recognises the importance and relevance of the psychological and social dimensions of the person with pain in addition to their somatic complaints. The other significant change has involved a change of assessment philosophy aimed at enhancing the trainee's learning experience.

It was clear from the initial surveys that some trainees were commencing pain medicine training with inadequate background knowledge and one year was no longer enough time in structured training. We sought to restructure the training program using the existing full two years of training time so new Fellows would feel confident to practice independently after completing the program.

The result is a restructured curriculum based on the CanMEDS framework with modified roles known as the Pain Medicine Roles in Practice, with explicit competencies under each role. The training program has a new spiral design, based around nine essential topic areas in the core training stage.

In the practice development stage, trainees have opportunities to develop a program tailored to their individual learning needs. Additional e-learning resources are provided centrally on Networks, plus two face-to-face workshops targeting clinical skills development. In addition, traditional workplace-based training will be enhanced using new workplace-based assessment (WBA) tools.

This year has been designated a transition year with opportunities for feedback to assist refinement of the curriculum, resources and program structure.

Early trainee feedback indicates a broadly positive reception of the redesigned program. More than 90 per cent of those surveyed have accessed the key documents, and engaged in the online learning.

The foundations of pain medicine examination achieved the goal of encouraging pre-reading around pain medicine topics. All trainees were successful, with 83 per cent spending more than 16 hours in preparation. However, the feedback indicates further refinement of the resources for this is required.

The supervisors of training (SOT) have participated in two workshops focused on understanding the revised program, enhancing feedback skills and supporting trainees with difficulties. Those surveyed generally supported the new program, but expressed concern about the time commitment required. New supervisor of training support resources are available on Networks and will be expanded over time.

Many Faculty Fellows have drawn on their extensive knowledge of and experience in pain medicine to make valuable contributions at all stages of the redesign process, including authoring the curriculum and designing the new workshops and e-learning resources.

The 2015 training program aims to ensure trainees continue to benefit from the breadth of experience within our fellowship. Trainees are therefore required to obtain feedback through workplace-based assessments from numerous assessors, not only their supervisor of training, throughout their training. We appreciate the participation of our Fellows in this important learning activity.

"Regardless of your background learning, to manage someone with chronic pain, and the psychosocial distress that accompanies it, is challenging to say the least."

Dr Harry Eeman, FAFRM(RACP), FFPMANZCA New Fellow Representative Curriculum Redesign Steering Group

Program suits trainees

It doesn't take long to realise that pain medicine is a whole new ball game.

Regardless of your background learning, to manage someone with chronic pain, and the psychosocial distress that accompanies it, is challenging to say the least. In the good old days of not-long-ago, one learnt skills by observing senior clinicians and through lots of ad hoc reading. These skills and knowledge would be tested over three gruelling days of examinations at the end of a busy year. Anecdotally speaking, many survived the exams, but did not feel confident to establish independent practice as a specialist pain medicine physician.

Thankfully, the Faculty has changed its approach to teaching this complex area of medicine. The real world experience of patient interaction in multidisciplinary clinics continues, but is supplemented by online, guided learning. Experts have carefully created the learning modules and students learn through an interactive process. Information is distilled from many resources and is up-to-the-minute.

As far as I'm aware there is no other teaching program like it. In terms of practical performance, workplace-based assessments ensure that Fellows receive regular feedback on their performance and grow as clinicians.

The training time has been extended by a year to ensure knowledge acquisition meets clinical experience. The aim is to produce well-rounded clinicians who can confidently manage complex patients via a multidisciplinary team; this cannot possibly be learnt in one year.

The extra year also allows Fellows to "spread their wings", in terms of developing skills in their area of interest. For example, one can choose to learn about addiction medicine, psychiatric medicine, procedural interventions, paediatric pain management, rehabilitation medicine and so forth. As long as it is relevant to pain medicine (and logistics allow) the only limit is your imagination. Few training programs offer this kind of flexibility and exposure.

I encourage everyone to make the most of this new learning experience and contribute feedback so the program continues to improve.

A new era in pain medicine training (continued)

FPM Curriculum Redesign Project
Working together

"The role of the clinical teacher may have been undervalued in the past, but not in this program."

Professor Milton Cohen, FRACP, FFPMANZCA Deputy Chair, Curriculum Redesign Steering Group

Program better for supervisors

As the 2015 curriculum and program roll out, it may be worth recalling why the Faculty has gone through this extensive process of revision.

By the end of the first decade of the Faculty's work, it was realised that not only was there too much for trainees to learn in one year of structured training, but supervisors of training were facing a huge task in simultaneously preparing their trainees for the major summative assessment event (the Faculty examination) and trying to develop their clinical performance in the workplace.

The focus of the new program is the learner and learning. This cannot be achieved without clinical teachers – and supervisors of training in particular.

The role of the clinical teacher may have been undervalued in the past, but not in this program. The curriculum prioritises skills as much as knowledge, clinical engagement over pills and procedures, and performance in practice above examinations. This change in emphasis and, in time, culture is dependent on specialist pain medicine physicians who want to help develop the discipline of pain medicine through teaching.

From a supervisor of training point of view, the demands – and potential rewards – of the new program are to implement the array of workplace-based assessments (WBAs) and to take advantage of the support for clinical teachers offered through the Faculty and ANZCA.

Workplace-based assessments are demanding for both trainees and supervisors of training. They are similar in principle to those used in the new ANZCA curriculum, but have been modified to accommodate different skills.

They include:

- Clinical skills assessment.
- Management plan assessment.
- Case-based discussion.
- Professional presentation.
- Multi-source feedback.

These are primarily formative to identify areas the trainee needs to develop. It falls to the supervisor of training (and trainee) to enlist colleagues to allocate the time required to these activities, as outlined in the handbook (and on the Faculty website).

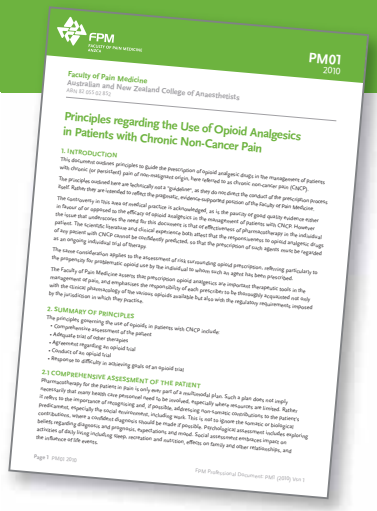
The assessment forms have been constructed to indicate the domains of assessment, with detailed descriptions of the three levels of performance, to be as user-friendly for the assessor as useful for the trainee. Supervisors of training are encouraged to help their colleagues to become familiar with these assessments, which will greatly ease the task of completing the quarterly in-training assessments (and assist in their own continuing professional development!)

The other side of the coin is support for supervisors of training. Much work by the FPM Supervisor Support Resources Working Group has gone into providing a set of resources (accessible via Networks, under "Pain medicine learning", open the "Supervisor orientation and support resources network"), that include five broad headings:

- Getting started.
- Training roles and responsibilities.
- Understanding the training requirements.
- Managing and supervising trainees.
- Welfare and mentoring.

These resources are impressively comprehensive, including a module on "Developing your skills as a supervisor", and are backed up by opportunities to develop skills (at the annual scientific meeting and spring meeting), as well as by the supervisor of supervisors of training, the ANZCA Education Unit, the Faculty office, and colleagues.

Faculty urges caution over cannabis use


FPM
PM01
2010
Faculty of Pain Medicine
Australian and New Zealand College of Anaesthetists
Principles regarding the Use of Opioid Analgesics in Patients with Chronic Non-Cancer Pain
1. INTRODUCTION
2. SUMMARY OF PRINCIPLES
2.1 COMPREHENSIVE ASSESSMENT OF THE PATIENT

There is little evidence cannaboids are effective in most chronic non-cancer pain cases.

With increasing talk about trials of medicinal cannabis in NSW, Victoria and Queensland, and apparent ministerial endorsement, a bill before the Senate and ongoing media chatter, the Faculty has taken the opportunity to look carefully at the possible role of cannabinoids in the management of patients with chronic non-cancer pain.

The stance taken by the Faculty has surprised, if not angered, some but has been supported by the broad fellowship, if not also other medical groups.

In summary, the Faculty focuses on the use of cannabinoids in chronic non-cancer pain and does not endorse that practice until a clear therapeutic role for them is identified in the clinical scientific literature.

This position stands on two main pillars; firstly, that calls for the liberalisation of the availability of cannabinoids as medicines are based more on anecdote than on sound clinical science and, secondly, that in Australia and New Zealand there is no need for greater availability of medicines for patients with chronic non-cancer pain.

It would have been naive for the Faculty not to acknowledge the reality of the widespread, uncontrolled and unlawful use of cannabis preparations in the Australian and New Zealand communities, noting that it is primarily for recreational purposes. Being outside its professional brief, the Faculty does not take a stance on the issue of decriminalisation of personal use of such cannabis preparations.

"There is major concern that society at large, regulatory authorities in particular and the medical profession as a whole, do not go down the same path that has led to the current problems with opioids."

However the science – or the lack thereof – suggests the populist call for greater availability of cannabinoids in the context of chronic non-cancer pain should be resisted. In fact, with the possible exception of pain and spasticity in multiple sclerosis, there is little evidence for the effectiveness of cannabinoids in chronic non-cancer pain situations, whether or not the pain attracts the descriptor "neuropathic".

Other major concerns are the adverse event profile in cannabis users, especially young people, including impaired respiratory function, psychotic symptoms and disorders and cognitive impairment, and the emphasis in chronic non-cancer pain away from polypharmacy towards active engagement of patients in multimodal management programs.

A further factor informing the Faculty's view is the experience with opioids in the management of such patients, which is characterised by lack of data on long term effectiveness on the one hand and increased problematic use and harms on the other.

There is major concern that society at large, regulatory authorities in particular and the medical profession as a whole, do not go down the same path that has led to the problems with opioids.

In coming to its view, which has been communicated to the Senate committee reviewing the bill, the Faculty has asserted the principle that substances intended for therapeutic purposes be fully characterised chemically, pharmacologically and toxicologically, which cannot be said for most cannabinoids available.

The complexity of patients with chronic non-cancer pain renders the performance of trials of any medication very difficult. Nonetheless, the Faculty believes that before they can be endorsed, cannabinoids must be subjected to nationally co-ordinated trials, conducted by highly credentialed persons and within strict parameters.

The Faculty statement and supporting documentation can be found www.fpm.anzca.edu.au/resources/professional-documents.

Professor Milton Cohen
Director of Professional Affairs, FPM

Anaesthesia-led perioperative medicine

"We need to increase our footprint in the pre-op and post-op period more, or we are going to go the way of the dinosaurs" – Mark Warner, past president, American Society of Anesthesiologists

You have done an all-day orthopaedic list where the first two of the three patients have significant co-morbidity. At the end of the day you play your role in the perioperative medicine collaborative, discussing the patients' care plans bedside in the ward with the consultant surgeon, the junior medical staff, nursing staff, physiotherapist, and a consultant and registrar from general medicine. I have recently done this; it is very rewarding. Greater anaesthesia presence and influence in preoperative assessment and post-operative care is one way for ANZCA Fellows and trainees to not only avoid extinction but, in the words of Australian Society of Anaesthetists keynote speaker Jason Hwang, to "adapt, survive and prosper".

I define perioperative medicine as collaboratively managing patient and operative risks before, during, and after surgery to provide patient-centred, clinically effective and cost-effective care. In Australia and New Zealand we have increasingly sophisticated and effective preoperative assessment services and high-quality intraoperative care. In addition to enhancing preoperative risk management, the greatest future gains are probably in post-operative care. The five main domains of post-operative care are: surgical-site management, general medicine (adapted to the post-operative period), pain medicine, resuscitation and rehabilitation.

Of the four principal medical specialties involved in post-operative care (anaesthesia, surgery, intensive care and internal medicine) no one craft group is skilled in all five domains, something all should acknowledge. Therefore, in contemporary practice optimal individualised patient care, including the post-operative period, is through a team approach: we play a team sport and the team includes a number of medical and allied health disciplines.

The Royal College of Anaesthetists (RCoA) calls it the "perioperative medical team" (PMT; rcoa.ac.uk/perioperativemedicine) while the American Society of Anesthesiologists calls it the "perioperative surgical home" (PSH or PoSH; asahq.org/psh).

The fundamental argument of these bodies is that collaborative perioperative medicine, with anaesthesia leading across the patient journey, will be both clinically effective and cost effective. Another part of this approach is a paradigm shift outlined by the RCoA, which is well supported by ANZCA research: "Traditionally, the care of patients undergoing major surgery has been tailored to the operation itself and the index disease being treated by the procedure. However, the majority of complications, which occur after surgery are not due to technical errors or failures by the surgical team, but are medical complications such as pneumonia or myocardial infarction. The prevention and treatment of these medical complications requires a broader approach than we currently take to the care of the surgical patient."

The RCoA also makes the insightful comment that: "Surgeons are increasingly diversified in their technical expertise, whilst care of acute and long-term medical disease is ever more sophisticated. It is no longer realistic to expect surgeons to have an in-depth knowledge of recent advances in the management of patients with complex needs, who develop acute medical problems." I would add that many of our physician colleagues who practice perioperative medicine, often in private practice, might have limited skills in wound management, pain medicine, resuscitation and rehabilitation. As someone who works within a university medical school and a large public hospital, it is readily apparent that many physicians have very limited understanding of contemporary anaesthesia practice. We should remind ourselves, and medical colleagues, that the ANZCA Clinical Fundamentals we bring to the perioperative medicine collaborative are: 1) General anaesthesia and sedation; 2) Airway management; 3) Regional and local anaesthesia; 4) Perioperative medicine; 5) Pain medicine; 6) Resuscitation, trauma and crisis management; and 7) Safety and quality in anaesthetic practice. All ANZCA trainees are assessed in all these fundamentals, ICU colleagues in some, while our physician and surgeon colleagues have limited training at best.

My opening scenario above is the latest of several projects looking at this kind of collaboration and I have a few thoughts. Important components are consultant leadership with both shared decision making and shared authority. To start a perioperative program means you have to "find friends" in other disciplines, to quote Dr Kain from the UC Irvine Medical Centre program. Start small (one surgical unit or ward), but remember one hurdle is that ward nursing staff may see the surgeons as "their" doctors. One way to gain nursing staff acceptance of multidisciplinary management is that other collaborators must have a strong ward presence. The acute pain service is often the main anaesthesia ward presence and should be an integral part of the collective.

However, we need more evidence through clinical trials to establish the clinical and cost effectiveness of perioperative medicine models. These models can include the sort of collaborative I described earlier. Other enhanced care may include anaesthesia-led overnight recovery for patients with risk profiles that lie between high dependency unit and ward care. A higher risk patient who has been stable after good overnight management may have a much better trajectory than a patient undermanaged on the wards. The ANZCA Clinical Trials Network is considering trials to examine this type of intervention.

Ongoing discussions include: how does anaesthesia best thrive in a time of expanding perioperative medicine? How do we provide fulfilling careers for Fellows and trainees over the next 30 years and beyond? There will be ANZCA Fellows who will embrace pre and post-operative care with vigour and those who will want to concentrate on operative care, with many in between. There are a number of forums for these discussions including ANZCA, Australian Society of Anaesthetists meetings and Perioperative Medicine SIG meetings. Long term we need to consider the evolution of formal qualifications including the excellent masters programs available. I wonder if a Faculty of Perioperative Medicine within ANZCA may help us guide the way, but important aspects will include appropriate additional training and collaboration with other Colleges, particularly the College of Intensive Care Medicine, the Royal Australasian College of Surgeons and the Royal Australasian College of Physicians.

Professor David Story
Professor and Chair of Anaesthesia
Head of Anaesthesia, Perioperative and Pain Medicine Unit
Melbourne Medical School, The University of Melbourne

Inaugural Obstetric Intensive Care Symposium

On February 21, nearly 200 delegates from Australia and New Zealand met in Adelaide for the inaugural Obstetric Intensive Care Symposium. The meeting was convened by the Department of Critical Care at the Women's and Children's Hospital and strongly supported by many from the Women's and Babies Division of the hospital.

The goal of the symposium was to create a forum for clinical teams involved in the care of the critically ill obstetric patient and to promote education and research in this select population of patients.

The symposium covered a range of contemporary topics on the high-risk obstetric patient with speakers from anaesthesia, critical care, obstetrics, midwifery and nursing. The academic program ended with a discussion, "where to from here".

The event, partly sponsored by SonoSite Fujifilm, included invaluable participation from the Australian College of Critical Care Nurses, BloodSafe, Donate Life, and the National Perinatal Depression Initiative.

The next Obstetric Intensive Care Conference will be February 26-27. Please contact Dr Ranjan Joshi, Ranjan.Joshi@health.sa.gov.au or Paul Knudsen (RN), Paul.Knudsen@health.sa.gov.au for more information.

Welfare… just the realm of the touchy feely brigade?

I've always been a practical, matter-of-fact sort of person. I used to be a doctor in the military and have had my share of instructions to "just get on with it". Training is said to build resilience and character – in many ways it does. My military experience enhanced my confidence and helped me to be organised and efficient, which are fabulous traits for an anaesthetist. It also resulted in personal challenges that ensured I needed to dig deep on the resilience front. I've been described as assertive and direct by many and am not necessarily who you think of when you think "welfare officer".

You'd be right. It seems an odd choice given my personality, but I consider it an inspired one. I offer a different perspective and believe anyone and everyone should be interested in this area. We work in a stressful environment with potentially life and death decisions that can impact our patients, our colleagues and ourselves.

I joined the Welfare Special Interest Group (SIG) by default. I'd been a Fellow at the Royal Children's Hospital in Melbourne with another Fellow, Dr Kushlani Stevenson, who was very interested in welfare. We became friends and her enthusiasm for this area was infectious. Once I'd moved back to Tasmania, she proposed me as a potential Tasmanian representative on the SIG committee.

I've subsequently become the welfare officer in the anaesthetic department at Royal Hobart Hospital (RHH). Prior to this, I initiated a Hobart Women in Anaesthesia Group to promote wellbeing, connections and provide support and friendship. We have regular social events and I've received positive feedback from the participants.

On establishing the welfare officer role, I was given a number of tasks. The first was to get a feel for the resources we had available. It became apparent that as a state we are very under-resourced in this area with ad hoc and reactionary plans. Collating information for the SIG helped me to highlight the need for improvement. A mentoring program has been developed for our trainees at RHH, however Fellow welfare is a work in progress.

My interest in welfare has allowed me to encourage a state meeting to consider the less clinical challenges and issues faced by anaesthetists. We are hosting our winter meeting for 2015 at Freycinet titled "The human face of anaesthesia". The objective is to highlight the importance of issues regarding Fellow welfare. Who hasn't been stressed by conflicting communication styles in the operating room? The "Key 2Me" workshop hosted by Dr Marion Andrew, chair of the Welfare SIG, will provide a taste of process-communication modelling.

So whether you are a sceptic, a touchy feely person or a realist/pragmatist like me, I think we all have a role in the welfare of anaesthetists. Who knows, you might save someone's career or life?

Dr Jenny Plummer, FANZCA
Royal Hobart Hospital, Tasmania

The invited speakers and delegates in this photo are all Air Force reservists and have been deployed overseas to places like Iraq, East Timor, Afghanistan, Solomon Islands, Bougainville PNG and the Middle East.

From left: Group Captain Andrew Pearce; Wing Commander Bruce Paix; Group captain Allan MacKillop; Wing Commander Kylie Hall; Wing Commander Marcus Skinner; Squadron Leader Gareth Lyttle; Wing Commander Michael Corkeron; Wing Commander Alex Douglas; Squadron Leader Sandy Donald.

Successful trauma meeting

More than 80 delegates attended the second combined Trauma and ACCUTE special interest group meeting in Adelaide, "Circulation in trauma: From roadside to bedside", that preceded the 2015 ANZCA Annual Scientific Meeting. More than 80 delegates attended.

Speakers included Dr Barry Schyma from Changi Hospital in Singapore; Associate Professor Susan Neuhaus from Adelaide; Associate Professor Andrew Pearce, Clinical Director of Training and Education at MedSTAR in South Australia; Dr Stefan Mazur, Chief Medical Officer for the South Australian Ambulance Service and Associate Professor David Roxby, Head of Pathology Transfusion Services for South Australia.

The flow of the meeting and quality of lectures were excellent. Highlights included lectures on early tissue damage and coagulopathy at the scene, through current practice at the cutting edge of in pre-hospital care, to current best practice and "damage control" principles in radiology, resuscitation and surgery. There was debate around the uses of point-of-care testing in trauma and comparisons between targeted treatment of coagulopathy with factor and fibrinogen concentrates and the more generalised approach of "1:1:1".

Many speakers also challenged entrenched views that are no longer applicable, including the adage of the CT scanner being seen as the "doughnut of death". There was also discussion of how trauma systems should allow different specialties to work together for the patient, and issues in trauma care facing regional and remote hospitals in Australia.

This year the meeting also offered an emergency response major haemorrhage component through a lecture delivered by Dr Clare Hayes-Bradley and number of small group discussions led by SIG members and invited speakers.

Dr Jamin Mulvey, Co-convenor and Chair, ACCUTE SIG, Dr John Moloney, Co-convenor and Chair, Trauma SIG, Dr Dan Holmes, Co-convenor, Dr James French, Co-convenor

Foundation news

Below from left: Ms Kate Spargo, Professor Kate Leslie and Ms Linda Sorrell; ANZCA President Dr Genevieve Goulding; Professor Alan Merry and Dr Peter Lowe.

Foundation cocktail reception

The foundation held a cocktail reception for supporters and friends at Adelaide's Playford hotel on the evening of Sunday May 3. Over enjoying drinks and canapés, guests heard inspiring short presentations from ANZCA Clinical Trials Network chair Professor Kate Leslie, Research Committee chair Professor Alan Merry, Board of Governors chair Kate Spargo and Foundation Committee chair Dr Lindy Roberts.

Guests heard about the consistent growth in funding available for Fellows' research projects and the need to continue to increase funding to meet the growth in demand from Fellows seeking support for important new research.

Speakers also highlighted the significant increase in national and global peer-review and recognition of research outcomes being produced by both experienced and emerging new ANZCA investigators, and impacts on clinical practice from related clinical trials.

Research grant applications for 2016

The 2015 grant funding round for projects commencing in 2016 has been highly competitive, with a large number of applications submitted. The College received applications for two novice investigator grants, two academic enhancement grants, three simulation/education grants and 39 project grants.

The Research Committee and the Anaesthesia and Pain Medicine Foundation office are now matching appropriately qualified reviewers to grants and thanks Fellows who have volunteered to review grant applications. High-quality reviews are fundamental to a robust assessment process and are crucial to maintaining the highest standards of research.

Applicants are encouraged to familiarise themselves with the review process, including feedback to applicants and decision criteria. Information can be found in the research section of the ANZCA website, under the Fellows tab.

The committee and the foundation thank all Fellows who submitted applications in this round, and acknowledges the significant amount of work involved.

The foundation at the annual scientific meeting

The Anaesthesia and Pain Medicine Foundation had a strong presence at the annual scientific meeting in Adelaide in May, culminating in the announcement of several new ongoing research awards during the Gilbert Brown Prize plenary session.

Session moderator Professor Alan Merry announced the Russell Cole Memorial ANZCA Research Award, the Robin Smallwood Bequest, the ANZCA Melbourne Anaesthesia Research Award, the Joan Sheales Staff Education award and the Provisional/New Fellow Research Award to the large plenary audience.

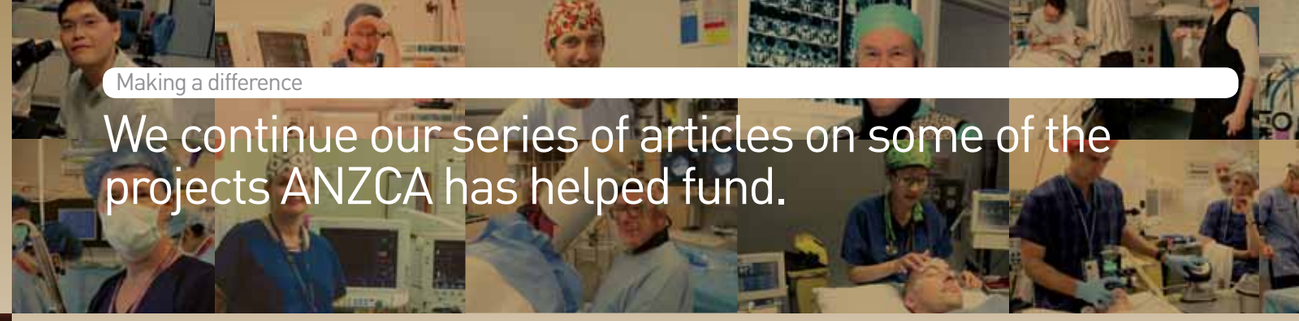
Professor Merry thanked the Cole family, the Smallwood family, Professor Barry Baker and Dr Peter Lowe for their generosity and vision in providing for the establishment of the awards last year. He also acknowledged the benefaction of the late Dr John Boyd Craig, which has been an inspiration to many foundation donors, and the long-term sponsorship of the pain medicine program by Pfizer Australia, a founding and continuing sponsor since 2007.

End-of-tax year research excellence appeal

The foundation is running its Excellence in Anaesthesia and Pain Medicine Research Appeal again. If you have not yet done so, please consider making a tax-deductible donation; it is an excellent way to direct government support towards Fellows' excellent research in the specialties.

The foundation thanks its donors and supporters for an encouraging year last year and a strong start to 2015.

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**



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

Researchers study cancer anaesthesia

A team is investigating whether different anaesthetic techniques can help prevent cancer recurring after surgery.

While cancer anaesthesia is a relatively new specialty, there is a growing consensus that anaesthesia used in cancer surgery could play a role in minimising the likelihood of cancer recurrence following surgery, according to ANZCA Fellow Dr Jonathan Hiller.

Dr Hiller's research, supported by ANZCA's Anaesthesia and Pain Medicine Foundation, recognises that lymph flow, associated with the spread of cancer, may increase during surgery.

It is important to improve understanding of the behaviour of lymphatics during surgery and whether anaesthetic techniques can minimise the spread of tumour cells during cancer treatment, Dr Hiller said.

"Recent scientific evidence from the Peter MacCallum Cancer Centre has shown that cancers associated with high rates of recurrence release hormones that increase the flow in lymphatic vessels," Dr Hillier said.

"These hormones are released in greater amounts during the time of surgery."

The behaviour of lymphatics under spinal and epidural anaesthesia has never been studied in humans.

But with the support of the foundation, researchers from the Department of Anaesthetics, Radiation Oncology and Diagnostic Imaging at the Peter MacCallum Cancer Centre will investigate whether anaesthetic techniques can minimise lymphatic flow and therefore the spread of tumour cells at the time of cancer resection.

The investigators hope to build on the knowledge of the lymphatic system and research methods that inhibit these hormones increasing lymphatic flow.

"The potential implications of this research are far reaching and may modify the anaesthetic techniques for all forms of cancer surgery in an attempt to reduce patients' perioperative morbidity and reduce their long-term risk of cancer recurrence," Dr Hillier said.

"It is the hypothesis that is currently being tested, and is a growing area of research."

To date, there are five large international clinical studies examining whether the method and means of anaesthesia used during tumour removal could reduce the incidence of cancer recurrence. These trials involve breast, colon and lung cancer resection surgery.

"When we remove a tumour, we are aware that there is an unavoidable spread of hundreds of residual cancer cells at the same time – sometimes straight into the patient's bloodstream.

"The way we administer anaesthesia carries the potential to boost the body's ability to resist cancer recurrence."

Dr Hiller said anaesthesia represented a "hit" to a patient's immune system. In the case of cancer surgery, this becomes a "double hit" because surgery often follows a period where a patient's immune system is weakened by pre-operative chemotherapy and the physiological strain of the cancer itself.

Beyond delivering a safe anaesthetic, anaesthetists had an important role in optimising patients prior to surgery and reducing the incidence of post-operative complications so patients recovered quickly and could return to their intended oncologic therapy.

"Ten years ago we hadn't even thought about it – how the lymphatic and immune system (the body's natural way of fighting infection) responds to anaesthesia – and now we are looking at the effect anaesthetic interventions can have on the body's ability to fight cancer."

Ebru Yaman
Media Manager, ANZCA

Supporting research for a safer future

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

The ANZCA Research Committee was established by the College to promote investigation and high-quality research in anaesthesia, pain medicine and related sciences and branches of medicine. Many of the advances in healthcare in Australia and New Zealand that are crucial to the safety and wellbeing of patients in acute care and life-threatening situations owe their origin to pioneering research undertaken by ANZCA and FPM Fellows. In many cases, these exploratory studies have paved the way for successful multi-centre clinical trials, which have gone on to receive large National Health and Medical Research Council (NHMRC) and Health Research Council (HRC) grants and led to significant improvements in local and international clinical practice.
The Research Committee is comprised of anaesthetists and pain medicine specialists from Australia, New Zealand, Hong Kong and the UK with extensive backgrounds in, and involvement with, research in their fields of speciality.

The Research Committee is responsible for developing policy on research issues for consideration by the ANZCA Council, and assessing applications for project grants, novice investigator grants, academic enhancement grants and the simulation/education grant. The committee awards the prestigious Lennard Travers and Douglas Joseph professorships. It mentors and counsels prospective applicants and provides constructive feedback to early-career novice investigators. The committee also advises the Anaesthesia and Pain Medicine Foundation Committee on research matters to support the foundation's fundraising efforts for research, and awards named research awards from foundation corporate sponsors and individual donors. The chair of the Research Committee is a member of the Anaesthesia and Pain Medicine Foundation Committee.

The chair of the Research Committee oversees and chairs the adjudication panel for the Gilbert Brown Prize session at the ANZCA annual scientific meeting. This prestigious prize is awarded to a Fellow of ANZCA or the Faculty of Pain Medicine who is an early-career researcher. The judging panel scores each candidate on several criteria, including the preparation of good quality audiovisual material, precise timing of the presentation, overall scientific merit of the project, the candidate's contribution and independence in executing the project, the presentation itself and performance in the discussion period.

Each year ANZCA Research Committee members read all grant applications received (an increasing number each year), select reviewers for each application on the basis of their expertise and relevance to the project, read the reviews, collate the information, act as spokespeople for each grant and make the final recommendations. The grant review process is rigorous, objective, merit-based and transparent. Conflicts of interest are recorded and members of the committee are excluded from consideration of any grants for which they have a conflict.

Many new internationally recognised anaesthesia and pain medicine researchers were first supported by seed grants for "proof of concept" studies. Such studies have played important roles in the development of clinical trials led by ANZCA investigators, which in turn led to the establishment of the ANZCA Clinical Trials Network (CTN) in 2003, a multi-national collaboration of anaesthesia and pain medicine researchers whose primary aim is to improve the evidence base of anaesthesia by developing and conducting high quality, multi-centre randomised controlled trials and related research. The ANZCA CTN Executive reports directly to the Research Committee and its membership includes a number of Research Committee members.

Studies the ANZCA Clinical Trials Network has co-ordinated or participated in have featured in world-leading peer-reviewed medical publications. In 2014, articles appeared in the prestigious *New England Journal of Medicine* and *The Lancet*.

- Myles P, Leslie K, Chan, M, Forbes A, Peyton P, Paech M et al. The safety of addition of nitrous oxide to general anaesthesia in at-risk patients having major non-cardiac surgery (ENIGMA-II): a randomised, single blinded trial. Lancet 2014; 384: 1446-54.
- Devereaux PJ, Mrkobrada M, Sessler DI, Leslie K, Alonso-Coello P, Kurz A et al. Aspirin in patients undergoing non-cardiac surgery. New Engl J Med 2014; 370: 1494-503.
- Devereaux PJ, Sessler DI, Leslie K, Kurz A, Mrkobrada M, Alonso-Coello P et al. Clonidine in patients undergoing non-cardiac surgery. New Engl J Med 2014; 370: 1504-513.

Professor Alan Merry,
Chair, ANZCA Research Committee

The ANZCA Research Committee Members:

- Chair, Professor Alan Merry (NZ)
- Deputy Chair, Associate Professor David A Scott (Vic)
- Faculty of Pain Medicine representative, Associate Professor Andrew Zacest (SA)
- Chair, ANZCA Clinical Trials Network Executive, Professor Kate Leslie (Vic)
- Community representative, Dr Angela Watt (Vic)
- Professor Matthew Chan (HK)
- Professor Andrew Klein (UK)
- Associate Professor Simon Mitchell (NZ)
- Professor Paul Myles (Vic)
- Professor Michael Paech (WA)
- Professor Anthony Quail (NSW)
- Professor Stephan Schug (WA)
- Associate Professor Timothy Short (NZ)
- Professor Philip Siddall (NSW)
- Professor David Story (Vic)
- Professor Bala Venkatesh (Qld)
- Associate Professor Jennifer Weller (NZ)
- Professor Andre van Zundert (Qld)
- Professor Britta Regli-Von Ungern-Sternberg (WA)
- ANZCA President (ex officio), Dr Genevieve Goulding (Qld)

The voice of the community

ANZCA has community representatives on several of its committees to help the College achieve transparency and consistency in its decision-making in pursuit of its mission "to serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine".

Community representatives come from many walks of life and their role is to provide a societal perspective on issues and ensure the committees recognise community concerns in their decision-making processes.

They do not represent specified constituencies rather they provide a public perspective. In New Zealand, the Panel for Vocational Registration has community representation to ensure that international medical graduate applicants have an appropriate understanding of community expectations of anaesthetists, and appreciate the cultural context in which they will be practising.

Community representatives first became part of the College landscape in 2002 when committees including the General Exams Committee (when the primary and final exam sub-committees reported into the GEC) and the Hospital Accreditation Committee (now TAC) had community representatives. The role was formalised further in 2010.

Helen Maxwell-Wright said she and other community representatives aimed to provide a skill set that ideally included management as well as health sector experience to complement Fellows' voluntary contributions. She said they should have the ability to form relevant questions and provide an external perspective for College committees and the Panel for Vocational Registration.

Professor Alan Merry, the chair of the ANZCA Research Committee, said that the presence of Dr Angela Watt on his committee added an important extra safeguard to ensure the grant review process continued to be rigorous and transparent.

ANZCA has seven community representatives. They are:

- Angela Watt – Research Committee.
- Diana Aspinall – Education, Training and Assessment Management Committee; Trainee Scholarship Evaluation Sub-Committee.
- Helen Maxwell-Wright – International Medical Graduate Specialist (IMGS) Committee and interview panel; Safety and Quality Committee; DDG Cultural Competency.
- Isabelita McRae – IMGS interview panel.
- Sue Sherson – Training Accreditation Committee.
- Dorothy McLaren – Professional Affairs Executive Committee.
- Sue Driver – New Zealand Panel for Vocational Registration.

ANZCA values the contribution of community representatives and ensures that they have an equal voice on committees and have the necessary support, tools and education to fulfil their role.

The College's approach to community representation is outlined in the ANZCA Community Representation Policy here www.anzca.edu.au/resources/corporate-policies and an evaluation of community representation is undertaken biannually.

Australia's first full-time anaesthetist Rupert Hornabrook

In 1899, South Africa erupted into a war that had simmered beneath the surface for years.

The British colonists and the Dutch-Afrikaaner settlers, known as Boers, had shared an uneasy relationship throughout the 19th century. When war came, Australians quickly volunteered to do their bit for the empire. Australians already in South Africa also joined the ranks.

Rupert Hornabrook was working as health officer at the Johannesburg mines when war broke out. He enlisted with the Natal Volunteer Medical Staff, was attached to the Natal Mounted Rifles and commissioned with the rank of lieutenant, then promoted to captain. He transferred to the Royal Army Medical Corps in 1901.

Hornabrook was with the British Bellair Troop during the Battle of Tinta Inyoni. This defeat prompted a retreat to Ladysmith, placing the troops, and Hornabrook, within the siege zone. The siege of Ladysmith lasted 120 days.

Tales abound of Hornabrook's charm and wit during the Boer War. His personal notes and letters home tell little of his medical service, although he does refer to scouting the battlefields at the end of a conflict, looking for and tending to the wounded. It was during one of these exercises he saw some 25 Boers coming toward him. Unarmed and alone, he managed to convince the Boers they were surrounded, relieved them of their weapons and escorted them to camp as prisoners.

Hearing Hornabrook had been wounded during the siege, the Boers are said to have sent an emissary bearing a missive and a case of whiskey. The missive is believed to have been an apology, of sorts, for wounding him and an assurance it happened without malice.

For his service during the Boer War, he received the Queen's South Africa Award with the clasps Elangslaagte and Defence of Ladysmith; the only Australian to have received both clasps.

At the end of the war, Hornabrook returned to Australia and transferred to the Australian Army Medical Corps with the rank of lieutenant. Again he was promoted to captain and left the service in 1908.

Melbourne General Hospital appointed Hornabrook as honorary consultant in anaesthesia in 1909 and there he became Australia's first full-time anaesthetist.

In 1914, at the outbreak of World War I, he enlisted in the Royal Navy and served on HMAS Australia for a year. In November 1916 he again joined the war effort, but this time with the Australian Army Medical Corps, holding the rank of major. The army released him to return to Melbourne to resume his anaesthetic practice in 1917.

Rupert Hornabrook's service medals and personal memoirs of his experiences during the Boer War are currently on display in the Geoffrey Kaye Museum of Anaesthetic History, loaned by grandchildren, Michael and Meg Hornabrook. The museum has been building a strong relationship with the Hornabrook family as we work towards a fuller understanding of the contribution Rupert Hornabrook made to anaesthesia.

Monica Cronin
Curator, Geoffrey Kaye Museum of Anaesthetic History

Hornabrook display on the right hand side of the Trailblazers exhibition in the Geoffrey Kaye Museum of Anaesthetic History; Meg Hornabrook delivering the medals and memoirs; Lieutenant Hornabrook, Natal Volunteer Medical Staff, mounted on a Boer pony that he captured at Elangslaagte, The Australasian, May 1900; Hornabrook's court mounted service medals from left: Queen's South Africa medal with clasps, the 1914-1915 Star, British War Medal, Victory Medal.

A short history of dental anaesthesia

General and intravenous (IV) anaesthesia techniques in dental surgeries have had a longish and somewhat chequered history, particularly concerning patient safety.[1, 2]

Dental surgeons have always wished to provide good analgesia and comfort for often anxious patients and the foundation role of dentistry in the birth of general anaesthesia in 1846 is well recognised. This was followed in Sydney by dental surgeon John Belisario[3], who shared his achievement on June 7, 1847, with that of medical officer/anaesthetist Dr William Russ Pugh[4], who used anaesthesia for surgery in Launceston the same day.

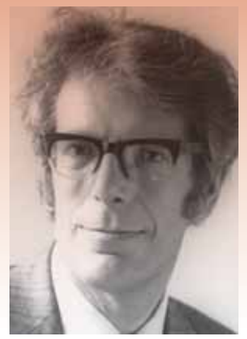
Eighteen eighty-four saw the birth of local anaesthetics[5], and the following decades saw notable clinical advances in anaesthesia, stimulated by various wars.

Pioneering British dentist Stanley Drummond Jackson (D-J), became concerned about the poor quality of the gaseous (nitrous oxide) dental anaesthesia being practised. In the 1930s he began to experiment with IV sedation anaesthesia for sitting-upright patients, publishing his IV hexobarbitone technique in 1952[6]. In 1957 he founded the Society for the Advancement of Anaesthesia in Dentistry (SAAD), which had increasing influence in the UK and beyond and support from prominent anaesthetists of the day [7]. Dental anaesthesia courses soon developed.

More recent clinical practices

In the 1950s and '60s, qualified anaesthetists began to include anaesthesia in dental surgeries as part of their regular practice and to administer gaseous general anaesthesia to patients sitting upright in the dental chair[1,2]. A prominent champion for addressing the safety concerns for such patients was the anaesthetist J. G. Bourne[1]. These techniques of brief general anaesthesia sometimes involved intentional hypoxic-inspired gas mixtures [for example, FiO2 of 10 per cent[2]] with associated rushed dental procedures. Not surprisingly, some mortality ensued[1, 8].

With the advent of "neuroleptanalgesic" drugs in 1959[9], intermittent IV sedation techniques continued to develop as alternatives to, or in combination with, inhaled anaesthetic gases. The intermittent IV methohexitone technique, by this time



"An older patient asked if he could watch during his general anaesthetic, and a dentist received an epidural injection for low back pain following the list!"

espoused and practised by D-J himself, 10 became increasingly common – along with the unease of many anaesthetists, especially when used by a "sole operator-anaesthetist"[11-13].

Progress with safety

At the height of the debate, a study addressing the physiological effects of IV methohexitone in sitting patients by anaesthetist and intensivist Dr Colin Wise and colleagues appeared in the British Medical Journal (BMJ) in 1969[14]. Its findings convincingly challenged the safety of intermittent IV methohexitone in sitting patients. Then to the surprise and concern of anaesthetists, D-J sued the BMJ and these authors for libel. The journal, supported in principle by the Royal College of Anaesthetists, refuted this as an attack upon freedom of the academic press and there followed in 1975 an expensive court case, culminating, after some 38 days, in D-J withdrawing his suit[6].

Over the next 40 years, with careful ongoing dental reports[8], with the advances in anaesthetic pharmacology and anaesthetic and dental equipment and techniques, and with increasing adoption of the supine position for dental procedures (particularly with any anaesthesia and sedation), SAAD and general anaesthesia techniques in dentistry continued until the present[15,16].

Nevertheless, as recently as the 1960s and '70s some experienced anaesthetists still believed full-scale endotracheal relaxant techniques were inappropriate in dental surgeries. Safety concerns included patient recovery facilities and the use of non-depolarising muscle relaxants in such settings[11, 13]. Medico-legal concerns also developed[17]. This was the situation facing anaesthetic practice in north Queensland in the early 1970s.

Some north Queensland experiences of 40 years ago

Dental health around this time was a concern for reasons including inadequate dental health insurance, the many visits required for restoration procedures and patient anxiety about awake dental surgery. Some people also still believed that "teeth" and "general health" were unrelated!

An Australian pioneer in anaesthesia in dental surgeries was Cairns-based consultant anaesthetist Dr Ron Thiel[18]. In Townsville, limited in-hospital dentistry using standard drills was happening under general anaesthesia, but many dentists were uncomfortable in the unfamiliar operating theatre environment. General practitioners provided some spontaneous ventilation anaesthesia services in dental surgeries.

Enter the high-speed dental drill

It may not always be appreciated how the "high-speed" dental drill with its air-turbine handpiece, invented by J P Walsh, in Wellington, in 1949[19] and its subsequent technical development, reduced the time taken and pain endured during restorative dentistry. This drill soon entered dental surgeries but not, initially, hospital operating theatres.

The Townsville Anaesthesia Group

The Townsville Anaesthesia Group (TAG), a group of qualified anaesthetists, appreciated that restorative dentistry during a single visit under general

"As recently as the 1960s and '70s some experienced anaesthetists still believed full-scale endotracheal relaxant techniques were inappropriate in dental surgeries."

anaesthesia, in patients with neglected dental health, could take hours. On safety grounds alone, this precluded use of a nasal or facemask, spontaneous ventilation general anaesthesia and/or intermittent IV sedation techniques.

The TAG anaesthetists were experienced with hospital and retrieval endotracheal relaxant anaesthesia with managed short recovery times. Despite expressions of concern[11-13], no firm evidence contraindicated such same-day techniques in supine patients within appropriately equipped dental surgeries and with at least two people – a qualified anaesthetist and an experienced dentist – present throughout[11,13].

After discussions with anaesthesia colleagues and dentists, including TAG's maxillo-facial surgical colleague and former dentist, Dr Sidney Roveda, in 1973 TAG began performing same-day, endotracheal relaxant anaesthesia services in selected dental surgeries.

Equipment and procedures

- An anaesthetic machine and monitor/defibrillator.
- An expanded "medical bag" packed with all anaesthesia needs.
- Procedures were morning sessions only. A trained anaesthetic nurse assisted.
- A pre-anaesthesia assessment clinic in the TAG rooms. Patients living remotely and who required same-day pre-operative assessments at the dental surgery had prior telephone screening.
- Healthy children, including some mentally disadvantaged patients, were managed.
- Cuffed naso-tracheal intubation, throat pack and non-depolarising muscle relaxant general anaesthesia (oxygen/N2O/low-dose halothane) with a circle breathing system and manual IPPV were used. Monitoring included radial pulse, sphygmomanometric blood pressure and "Lifepak" ECG. Pulse oximetry was soon added (no capnography at that time). Slow IV crystalloid infusions were common, especially in children, on hot days and/or for longer procedures
- The service extended to Home Hill, 100kms south of Townsville. Ultimately the program serviced six dental surgery locations.

Results

No documented records remain but, from memory, the program spanned 15 years from 1973 to 1987 during which around 1000 patients were managed. There was no mortality and no permanent morbidity. There were no serious intubation difficulties, nor serious allergic reactions. Prolonged recovery was conspicuous by its absence.

Post-procedure morbidity included a case of a post-operative nausea and vomiting with dehydration requiring hospital admission, and of a paediatric respiratory tract infection requiring antibiotics. There were several brief post-extubation episodes of unilateral middle ear pain, acute epistaxis, short-term post-operative nausea and vomiting, venepuncture haematoma and skin itching, all readily controlled.

Inevitably there were lighter moments. One patient reported a dental anaesthetic he had in 1935, aged seven years. One eight-year-old patient escaped into the street during a tumultuous gas induction! An older patient asked if he could watch during his general anaesthetic, and a dentist received an epidural injection for low back pain following the list!

Conclusion

These experiences confirmed at that time the safety and efficacy of endo-tracheal relaxant techniques in dental surgeries, in experienced anaesthesia and dental hands, even for prolonged dental procedures. Nowadays, such techniques in "remote" areas, including long-distance retrievals and some military situations[21, 22], are part of everyday acute anaesthesia practice.

Above from left: The late Dr Colin Wise, of Cardiff (courtesy of Dr Mark Wise and family); Dr Ron Thiel, 1934-2012; A 1976 Physio-Control "Lifepak 5" (reproduced with permission from the US National EMS Museum Foundation); CIG "Midget" anaesthesia machine (halothane vapouriser and circle system not shown).

Dr John Williamson, FANZCA
Melbourne

Acknowledgements:
The author is grateful for the advice, support and memories of his TAG colleagues Marcus Unwin, Peter Duff, Bill Tucker, Geoff Pryor, and of TAG's great friend and office supervisor, Margaret Caulfield. Sincere thanks also to Mrs Caulfield's predecessor, Jenny Morris. These two ladies set benchmarks for office excellence and efficiency in TAG, over many years. Thanks to Dr Doug Harnick (US) and Dr Paul Brown (UK), for reviewing the manuscript. Gratitude is expressed to the ANZCA Library staff, including Nathalie Cosmos and the archivist, Fraser Faithfull, for their prompt provision of historical articles and College documents. Thanks especially to Dr Shang Ng for helpful comments and to Dr Mark Wise, of Cardiff, UK.

(references on next page)

A short history of dental anaesthesia (continued)

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Call for universal access to safe, affordable anaesthesia and surgical care when needed

The 68th World Health Assembly has unanimously approved a resolution on "strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage".

ANZCA supported the resolution, passed in Geneva on May 22, in a letter to Australia's World Health Assembly representative Mr Martin Bowles, the Secretary of the Department of Health. The report leading to the resolution provided evidence of the global burden of surgical conditions, gaps in surgical and anaesthesia coverage and highlighted the importance of cost-effectiveness in surgery. The resolution also outlines appropriate actions at the country and World Health Organization secretariat level to address the challenges identified.

The ANZCA 2013-2017 Strategic Plan encapsulates the commitment to "Advocate for community development with a focus on indigenous health and overseas aid". This year there is a renewed, global push for universal access to safe, affordable anaesthesia and surgical care when needed.

On April 27, in the lead-up to the World Health Assembly, The Lancet Commission on Global Surgery released its report, "Global Surgery 2030: Evidence and solutions for achieving health, welfare, and economic development". The report lays out the case for the importance of supporting access to safe, affordable anaesthesia and surgical care when needed and presents a picture of the many barriers to care – geographic, organisational and economic – faced by people trying to access appropriate care in low- and middle-income countries. The report's key messages are outlined in the boxed section.

Dr Wayne Morriss, an ANZCA Fellow who is also the Chair, Education Committee of the World Federation of Societies of Anaesthesiologists, took part in a panel discussion on Human Resources for Global Surgery during the official launch of the Lancet Commission report in London. He briefly outlined the importance of training teachers and leaders, not just excellent clinicians. He also stressed the role of societies and colleges in promoting collaboration and advancing anaesthetic and surgical care.

Also released in 2015 was the third edition of *Essential Surgical Volume of Disease Control Priorities*. This publication focuses on the global burden of surgical disease including anaesthesia and perioperative medicine. The report finds that essential surgical procedures rank among the most cost-effective of all health interventions. Full provision of these essential procedures would avert about 1.5 million deaths per year, or 6-7 per cent of all avertable deaths in low- and middle-income countries.

2014 ANZCA Fellowship Survey

Twenty-two per cent of FANZCA respondents reported having provided clinical or educational support in a developing country.

The World Health Assembly resolution, backed by research identifying issues, setting targets, and defining measurements, will provide the platform needed to work towards system level improvements for surgical and anaesthesia care around the world. This presents an exciting opportunity for the 22 per cent of respondents to the 2014 ANZCA fellowship survey who identified they have previously provided clinical and/or educational support in developing countries.

For more information please see the ANZCA Overseas Aid webpage providing details on these, as well as ANZCA initiatives in support of improving anaesthesia care globally www.anzca.edu.au/fellows/community-development/overseas-aid.html.

Dr Michael Cooper
Chair, ANZCA Overseas Aid Committee
Adjunct Professor of Anaesthesia, School of Medicine and Health Sciences, University of Papua New Guinea

Below from left: Every year the World Health Assembly takes place in the Palais de Nations in Geneva. This photo is of the outside of the plenary hall of the Palais; Committee B at the World Health Assembly; Director General Dr Margaret Chan on day two of the WHA; Delegates attending the opening of the 68th WHA in the Palais des Nations, Geneva.

Photos provided by WHO/Violaine Martin.

"The Lancet Commission – Global Surgery 2030: evidence and solutions for achieving health, welfare, and economic development" has identified the following five key messages:

- Five billion people do not have access to safe, affordable surgical and anaesthesia care when needed.
- 143 million additional surgical procedures are needed in low- and middle-income countries (LMICs) each year to save lives and prevent disability (an increase from an estimated 313 million procedures per year).
- 33 million individuals face catastrophic health expenditure due to payment for surgery and anaesthesia care each year (plus another 48 million cases of catastrophic expenditure attributable to non-medical costs).
- Investing in surgical services in LMIC is affordable, saves lives and promotes economic growth.
- Surgery is an "indivisible, indispensable part of healthcare".

Successful candidates

Court of primary examiners.

Primary examination February/April 2015

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

AUSTRALIA

Australian Capital Territory
Christopher Brunsdon
Sophie Joy Klaassen
Jennifer Ruth Moran

New South Wales
David Fred D'Silva
Frank Benjamin Marroquin-Harris
Furqan Arshad
Kate Blatchford
David Boers
Samuel John Boyers
Jayasundara Mudalige Jayanath Sanjeewa De Alwis
Elyse Kate Farrow
Gordon Bernard Fowler
Melissa Alice Jamcotchian
Kanathiban Theepan Kathirgamanathan
Andrew William Marks
Michael Ian McCreery
Jonathan David Moore
Lachlan Andrew Nave
James Robert Padley
Peter Michael Henry Simmons
Sarah Rose Skidmore
Harshika Steele
Louisa Imogen Swain
Luke Tobin
Angela Walker
Claire Alexandra Wohlfahrt

Northern Territory
Andrew Martin

Queensland
Guy Oliver Amey
Tamsin Catherine Barratt
Tegan Nicole Burgess
Georgine M Cameron
Sally Chan
Cameron Scott Collard
Thomas R Druitt
Gemma K Duncan
Daniel James Foster
Alexander Edward Harding
Clementine Amelia Hartl
Shane Anthony Kamphuis
Way Siong Koh
Nihal Kumta
Lim Kiam Loong
Anna F Pietzsch
Karla Pungsornruk
Bethany Jane Reeve
Leah Rickards
Matthew Hugh Routley
Antony Richard Scanlan
Andrew Richard Souness
Charles Henry Williams

South Australia
Cheryl Sook Lai Chooi
Nicole Diakomichalis
Nicholas Colin Harrington
Munib Leong Kiani
Kritesh Kumar
Kylie Jayne Musgrave
Elena Clare Vowels

Tasmania
Musdiyana Ishak
Kaylee Anne Jordan
Adam Timothy Mitchell
Vasheya Naidoo
Chang Yang Yew

Victoria
Verna Melda Aykanat
Jin Jie Cheah
Ping Han Chia
Wen Hao Chiong
Abarna Nadia Devapalasundaram
Sarah Ann Donovan
Ned William Rudd Douglas
Patrick Dunne
Mari Kawamata
Klara Krivanek
Nicholas James Litzow
Andrew James MacKay
Timothy Michael Makar
Erin Belinda McCabe
Patrick Chee Fei Tan
Daniel Stuart Trevena
Jack Jia Wang
Derrick N Wong
Zi Yang

Western Australia
James Robert Anderson
Paras Malik
Bridgette Anne Mathews
Daniel Gerard O'Callaghan
Brooke Louise Rule

NEW ZEALAND

Lousia-Rose Bhanabhai
Tze Chow Chow
Daniel James Cochrane
Gihan Ganeshanantham
Mehreen Maqsood Farrow
Kate Ida Hudig
Timothy James Knowlman
Brian Ching-Hsueh Chen
Everard Christopher Lee
Agnieszka Renata Lettink
Chung Wei-Lyn
Lynette McGaughran
Thomas Morton Noonan
Nicholas James Port
Stephen John Roberts
Dilraj Singh Thind
Arihia Elizabeth Te Mare Waaka
Chwee Ling Yeat

Renton Prize

The Court of Examiners recommended that the Renton Prize for the half year ended June 30, 2015, be awarded to:
Frank Benjamin Marroquin-Harris, NSW
Kaylee Anne Jordan, Tas

Merit certificates

Merit certificates were awarded to:
Karla Pungsornruk, Qld
Timothy Michael Makar, Vic
Sarah Rose Skidmore, NSW
Gemma Katherine Duncan, Qld

Court of final examiners.

Final examination March/May 2015

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

AUSTRALIA

New South Wales
James Christopher Atkins
Sarah Louise Boyle
Phui-Leng (Lynn) Chan
Brenton Peter Coats
Sebastian John Corlette
Rebecca Jane Cregan
Douglas Joe Dong
Edward Kayesh Fairley
John-Paul Michael Favero
Dilan Srimantha Wijesinghe Kamalasena
Lucy Rebecca Kelly
Monika Kenig
Alfred Tanaka Mahumani
Caroline Clare McCombie
Rebecca Jade McNamara
Nathan Andrew Irvine Moore
Ashokkumar Murugesan
Andrew Mena Nikola
Adelene Su-Chen Ong
Florian Gustav Paturi
Neil Lawrence Pillinger
Liwei Ren
Bernard Roach
Jade Shandler
Peter Matthew Smith
Claire Heather Stewart
Lick Wei Tan
Niklas Ove Jaakko Tapper
Marcin Felix Teisseyre
James Robert Tester
Trylon Matthew Tsang
Lakshmi Nayana Vootakuru
Sean Wesley Wright
Mei-Ying Camille Yip
Lee Zimmer

Northern Territory
Dennis Gokcay

Queensland
Jodie Anne Beuth
Christopher Stephen Alexander Carter
Rebecca Elizabeth Christensen
Shaun Emmanuel De Cruz
Andrew Robin Growse
Lynton Ashley Hargrave
Adam John Hicks
Jade Danielle Jones
Jacqueline Lippiatt
Darrin Roderick Mckay
Anna Louise Milanovic
Mary Catherine O'Shea
Tegan Samantha Owen
Emilia Gisella Reece
Rochelle Leigh Ryan
Michael John Saba
Alastair James Scarr
Matthew Graham Schafer
Daniel Ashton Shorter
Tara Leigh Smith
Adam Suliman
Ryan Tsu-Kit Tan
Michael Gill Tetley
Pieter Weemaes
David Walter Wood
Christy Li-Ling Yeow

South Australia
Salam Adil Naeem Al-Khoury
Alexandra Alison Bull
Marni Calvert
Greg John Houghton
Eddie Khoo
Wai Munn Ng
Cristianne Lorimer Read
Jessica Joan Staker
Kristopher Alexander Nolan Usher
Laura Jane Willington

Tasmania
Pravin Dahal
Jack Douglas Madden
Joanne Darleena Samuel
Christopher James Wilde

Victoria
Eliza Jane Beasley
Jonathan Luke Begley
Matthew Thomas Blair
Julie Yin-Mei Chan
Stephanie Pei-Pei Chen
Peter John Commons
Ali Jilani Ayoob Coowar
Samuel Timothy Costello
Elizabeth Maree Coyle
Nancy Fammartino
Rafsan Halim
Andrew James Iliov
David Andrew John
Christopher Larnoch Johnson
Benjamin Kave
Matthew Wai-Kei Lee
Li-Ni Lin
Steven McGuigan
Siobhan Kirsty McGuinness
Anastasia Mellios
Bishoy Moussa
Justin Mark Nazareth
Sze Ying Ng
Verity Rachel Nicholson
Darragh Eoiw O'Brien
John Ozcan
Tuan Michael Pham
Annie Poon
Bronwyn Claire Scarr
Tessa Pamela Smith
Daniel Gunther Stanszus

(continued next page)

Successful candidates (continued)

Joshua Anthony Szental
Soon Yee Teoh
David Justin Tsang
Ida-Fong Ukor
Christine Kim Thu Vien
Andrea Pek Anne Yap
Vincent Andrew Kun-Sai Yuen

Western Australia
Matthew Peter Aldred
David Baguley
Bojan Bozic
Nathan Jon Curr
Galappathige Natasha Lekshika De Silva
John Michael Denton
Josef Marian Ferguson
Tamara Lee Garside
Catherine Elizabeth Goddard
Anna Karen Hayward
Rebecca Anne Kelly
Nirooshan Rooban
Rory Charles Walsh
Tamsyn Meredith Williams

NEW ZEALAND
Jacqueline Gwenda Blay
Andrew John Colls
Lizi Kate Edmonds
Duane John English
Hannah Mary Gibson-Lapsley
Erica Ting-Yi Hsu
Jennifer Ellen Hudson
Laura Michelle Khodaverdi
Ashlea Jane Meehan
Johanna Renate Pigou
Amy Dorothy Pollard
Alexander Peter Ames Reed
Emily Claire Rowbotham
Ryan James Kavanagh Salter
Daniel Brook Wood
Henry Heng-Yi Wu

HONG KONG
Febbie Pui-Wah Chung
Vivian Nga Man Lau
Etonia Yin Tung Pang
Kam-Sheung Poon

SINGAPORE
Hui-Jian John-Paul Lew
Selene Yan Ling Tan

IMGS examination March/May 2015

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

Mestiyage Saubagya Gunatilake, NSW
Hitesh Nischal, NSW
Raed El Yaman, Qld
Virendra Singh Yadav, SA
Asavari Krishna Bhagwat, Vic
Tobias Nientiedt, WA

Cecil Gray Prize

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended June 30, 2015, be awarded to:

Bronwyn Claire Scarr, Victoria

Merit certificates

Merit certificates were awarded to:

Galappathige Natasha Lekshika De Silva, WA
Lucy Rebecca Kelly, NSW
Siobhan Kirsty McGuinness, Vic
Jade Shandler, NSW

Responding to feedback: Preserving quality, simplifying the curriculum and managing your workload

ANZCA is committed to an evolving curriculum and training program that adapts to best meet the needs of all stakeholders through ongoing evaluation and improvement.

A Training Program Documents Review Working Group, chaired by Dr Damian Castanelli, who also chairs the Education, Training and Assessment Development Committee, has been reviewing all outcomes from the evaluation work conducted throughout 2014 and early 2015.

The review aims to ensure the curriculum is the right size and complexity, and presented in a format that is easy to access and understand.

The challenging task of transitioning trainees from the previous curriculum is almost complete, and a key focus now is to ensure the optimal quality of the training program, and to protect the workload of trainees and those delivering training.

The working group is reviewing the whole training program, with a focus on maximising the learning value of each activity.

Recommendations will be presented at the July ANZCA Council meeting and, if endorsed, will form the basis of a project to improve the training program and ensure supporting assets, such as the training portfolio system (TPS), are aligned with the program.

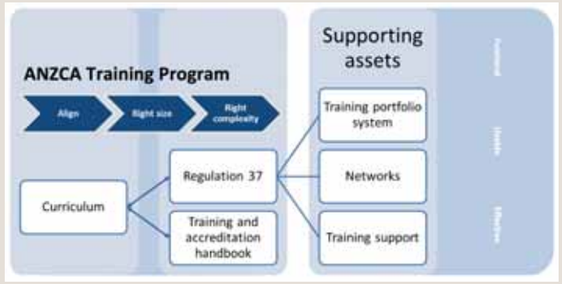
This is an extensive piece of work and will take time, but communication and opportunities for collaboration with trainees and Fellows will occur.

We thank all trainees and Fellows who have given evaluation feedback and to working group members who have accepted a challenging task.

Most importantly, we acknowledge the significant work involved in providing training in a challenging clinical environment. ANZCA Fellows and trainees are committed to providing the highest quality care to our patients and our work will ensure the curriculum and training program continue to support that aim.

Dr Damian Castanelli, Chair,
Education, Training and Assessment Development Committee

Olly Jones, General Manager,
Education



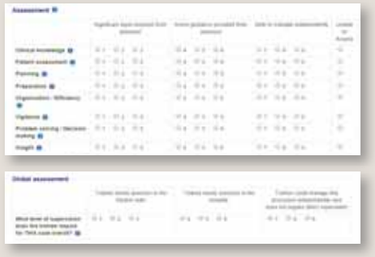
Interim enhancements – making core unit reviews easier

A new function in the training portfolio system is in the final stages of testing. The core unit review (CUR) will be tailored for each training period. Targets for each training period will be presented on the CUR form. Data showing trainee progress will pre-populate the CUR form throughout the training period. The function will make it very clear for supervisors of training to see where requirements are missing. Shortly, trainees will be able to see the CUR once the supervisor of training has created the draft so they can see how they are progressing against requirements.

Regular feedback and the run rate – the key to showing progression

The run rate traffic light will be removed as this indicator is not accurately reflecting the intent of the run rate. The run rate requirements still remain, as outlined in the curriculum. The run rate is a requirement of the curriculum, and trainees are required to meet the curriculum requirements to be awarded fellowship. The purpose of the run rate is to ensure trainees undertake workplace-based assessments (WBA) on a regular basis (that is a three-monthly basis) so they receive regular feedback to help improve their performance. This also generates information to inform regular clinical placement reviews. The value of regular feedback to trainees was confirmed in the evaluation data as one of the greatest improvements in the curriculum. However, there is still confusion about the purpose of WBAs, which assessments to do and when. A project group will be developing more resources for departments to use at their local meetings to learn more about the purpose of WBAs and how to do them. For now, trainees and WBA assessors should check WBA requirements in the curriculum, but be assured that the College is working to ensure the purpose and requirements for WBAs are made clearer for all involved.

Workplace-based assessment: What score do I give?



The independence scale rates a trainee's progress towards consultant performance.

You've watched your trainee and now you are going to discuss with them what you've seen and heard to help them make plans to improve. Before you do, you look at the form and think, "So, what score should I give?"

It can be a dilemma. There are lots of different aspects of the trainee's performance to consider. You are also figuring out what to say and how to say it, and with all the other things going on in the clinical environment, there isn't a lot of time. But a little background on how the scale is meant to work can help. While this article is aimed at consultants and provisional Fellows, trainees should also find it useful.

Judgment of trainee performance

Every day we make decisions about our trainees' capability and what we expect of them. Some of the judgments we make, based on what we know about them and the case at hand, might include:

- The introductory trainee: They should know enough to be an active helper.
- The junior registrar: Who you want to work with while they do the case.
- The registrar: You want to run through the plan with them before they go ahead while you are nearby.
- The senior registrar: You send off to do it themselves, confident they will call if required.

Trainees become progressively more independent as they develop. As supervisors, we use these judgments to give them increasing responsibility, both in recognition of their increasing capability, but also to provide opportunities for further development. Trainees make similar judgments of their own so generally there is a shared understanding of what is going on when decisions on supervision are made.

Independence scales

The independence scale in the workplace-based assessment (WBA) form aims to capture and apply this familiar judgment to help give trainees an indication of their progress. As they become more capable, trainees move from requiring "significant input" or help, to requiring "guidance", and then to "managing independently". In effect, the scale tracks development from helping you give the anaesthetic on the left-hand side, to being able to replace you as the consultant on the right-hand side.

There is no need with an independence scale to know what level the trainee is at in their training, as you do not need to compare them to anyone else or to your own idea of how trainees ought to perform. This should be simpler than our old scales, which did require that sort of judgment.

Because the standard of performance the trainee is aiming to perform at is consultant level, trainees will often get low scores in many aspects of performance. It might take time for consultants and trainees who have used our old scales to get used to using the full range of scores and seeing low scores where they are justified. Trainees know they have a lot to learn when they start out, or when they tackle a new clinical area or a new procedure, so it is usually easily explained. Consultants should be realistic and honest in their scoring and their judgment. How else will trainees know how they are performing or measure their improvement in performance with time?

Filling in the scores

When you complete the WBA form, you are being asked to rate the trainee's progress towards consultant performance in different aspects of the case. The reason for looking at different aspects of performance, rather than the whole performance, is to pinpoint discrete areas where improvement can be made. This helps make specific plans for what trainees can do differently in the future to improve – to move from left to right towards consultant performance.

In this way, deciding what scores to give can help with planning what you want to say to the trainee and how you want to say it, rather than getting in the way. When you think the trainee has room for improvement based on what you think is consultant-level performance, give a lower score. Then you know you and the trainee have something to discuss, and you can think about what to suggest the trainee can do differently to improve or challenge themselves.

Global assessment

After you score individual items, you are asked for an overall score based on the level of supervision you think your trainee needs. This is another independence scale – moving from close supervision on the left to independent practice on the right, and again there is no need to know the trainee's level of training. There are text anchors to help you with the increments, but as discussed with the individual items above, you are making a judgment about the trainee's progress toward consultant performance based on what you have observed.

Near the end of the form you are also asked to estimate the trainee's training level, based on your expectations of trainees, similar to the assessments we made with the old in-training assessment forms, as another piece of information for the trainee to use to monitor their progress.

Conclusion

Next time you think about what score to give, ask yourself how close the trainee's performance is to consultant level and then score accordingly on the one-to-nine scale. Make sure the score honestly reflects what you think based on what you have observed, recognising low scores can be appropriate and reflect how much the trainee is yet to learn. Aspects of performance where the scores are lower offer greater opportunities to improve and are the best areas to focus on in discussion with your trainee.

Dr Damian Castanelli
Chair, Education, Training and Assessment Development Committee

Results presented at the ASM

Research highlights

The ANZCA Clinical Trials Network (CTN) session at the 2015 Adelaide annual scientific meeting (ASM) attracted a large crowd eager to hear about the latest results from the NHMRC-funded and Anaesthesia and Pain Medicine Foundation-supported research.

Professor Paul Myles, the principal investigator of the ATACAS Trial, announced the results of the aspirin arm of the trial. Professor Matthew Chan and Professor Kate Leslie, chief investigators of the ENIGMA-II trial, presented the results of the chronic pain and one-year follow-up studies, respectively. We will summarise these results in the next edition of the *ANZCA Bulletin*.

Keys to successful patient recruitment

The CTN presented an interactive session at the ASM on keys to successful recruitment to a large group of study investigators and research co-ordinators.

Jonathon Shauder, from the Change Agent Network, inspired the audience with an interest-based relational approach to patient recruitment; Professor Paul Myles, from the Alfred in Melbourne, presented on how to design a feasible, randomised control trial; and Dr Thomas Painter, from the Royal Adelaide Hospital, presented evidence and practice of recruiting to randomised control trials.

The successful completion of large, multi-centre, randomised control trials, such as the ATACAS aspirin arm and ENIGMA II, continues to debunk myths around clinical practice. These trials, which provide definitive evidence to guide clinical practice and improve patient safety, could not have been possible without the commitment of investigators, research co-ordinators and thousands of patients, nationally and internationally.

Despite these co-ordinated efforts, Dr Tom Painter presented that thousands of eligible patients eligible for ANZCA trials were not recruited mainly due to physician or patient refusal. This represents missed opportunities for patients to be enrolled into clinical trials and for clinical trials to be completed faster.

The session finished with a panel of the three speakers, along with Associate Professor Lis Evered, Ms Sofia Sidiropoulos and Ms Sophie Wallace, who shared insights about recruitment. The consensus is that patient recruitment should be vision-focused by both researchers and patients.

With this in mind, recruitment should include discussions about the uncertainty in clinical practice and how patients' involvement really helps and how participant safety is the number one priority in clinical research.

PADDI trial update

The PADDI start-up meeting will be held on Saturday August 15 at the CTN Strategic Research Workshop in Sanctuary Cove, Queensland. We anticipate recruitment will begin in September.

New PADDI trial manager Ms Jaspreet Sidhu has been appointed at the ANZCA Clinical Trials Network office at Monash University. She has a background in clinical research, organ and tissue donation, quality and clinical governance and, most recently, in clinical quality and performance monitoring of the Victorian correctional health system. For more information about PADDI and to register your interest, visit www.anzca.edu.au/ctn.

CTN survey of research capability

Dozens of sites from around the ANZCA training regions have contributed to the success of landmark ANZCA trials such as the Master, B-aware and ENIGMA I and II trials.

The CTN aims to build on this success to strengthen research capacity, drive patient recruitment, and share resources and infrastructure with ANZCA-accredited sites to become sustainable in delivering research. We need to improve our support of emerging investigators and centres to advance our contribution to knowledge in our field.

To this end, the CTN Executive will be sending a survey to heads of departments to document the state of research capability so we can benchmark the effectiveness of our support strategies. Your contribution will provide vital baseline data and help identify investigators and sites with great potential that need more support. Thank you in advance for your contribution.

Survey Research Policy and application form

The CTN has revised its Survey Research Policy and application form to assist Fellows and trainees undertake survey research. Download the new policy and application form at www.anzca.edu.au/ctn. We thank Fellows and trainees who support their colleagues by participating in ANZCA-facilitated survey research.

New sites needed for clinical trials

The CTN is seeking new sites to join ANZCA multi-centre trials (PADDI, Balanced and RELIEF). For more information and to register your interest, visit www.anzca.edu.au/ctn.

Karen Goulding
ANZCA Clinical Trials Network Manager

Strategic Research Workshop

August 14-16
Sanctuary Cove, Qld

Registration and abstract submission for the 7th annual workshop are now open. This meeting will feature discussions on new research ideas, updates on clinical trials, a workshop for research co-ordinators and early career researchers, and keynote presentations on new methods in clinical trials, fraud and building a medical and scientific career.
There will be plenty of opportunities for social interactions with fellow researchers. Researchers are strongly encouraged to submit abstracts to present new research ideas to the CTN. For further information and to register, please visit: www.anzca.edu.au/fellows/Research/anzca-clinical-trials-network-events.html

Opposite page, clockwise from top left: Dr Genevieve Goulding, Professor Kate Leslie, Dr Lindy Roberts, Professor Alan Merry and Dr Kate Spargo; Dr Edmond O'Loughlin and Dr Thomas Painter; Associate Professor Philip Peyton, Associate Professor Tim Short and Professor Tomas Corcoran; Associate Professor John Rigg, Ms Jaspreet Sidhu and Professor David Story.

Death of David Sackett, the father of evidence-based medicine

David Sackett, who died in Canada recently, had a great influence on me and my co-investigators in the design and conduct of the Master Trial, published in *The Lancet* in 2002.

I first met David in early 1972 when I joined the Department of Anaesthesia at McMaster University in Ontario, Canada. David was appointed founding chairman of the new medical school's Department of Clinical Epidemiology and Biostatistics at just 32 years of age. On my return to Australia in 1981, Michael Davies (later an ANZCA president) and I often discussed the lack of quality evidence in relation to the question of regional block improving outcomes after surgery, a controversy enhanced by a publication in *Anesthesiology* in 1987.

Fortuitously, David came to Perth in 1988 and, at a social function to welcome him, I met Konrad Jamrozik, who subsequently joined me and helped recruit Brendan Silbert, Paul Myles and Philip Peyton to the cause of the Master Trial.

A key year in the evolution of the project was 1990 when I spent three months at Bowman Gray Medical School, North Carolina, on study leave. Here I wrote the first draft of a National Health & Medical Research Council application, which, after many subsequent iterations, was awarded more than $500,000 in November 1996. Visiting David Sackett in Canada and David Glass in New Hampshire, and receiving detailed constructive comments about this early draft in 1990, was critical to the success of the project.

After the trial was funded in 1996, the College asked our research team to arrange a Master Trial Symposium at the next four annual scientific meetings of ANZCA. We agreed these would have a common theme of "evidenced-based medicine", testament to the enormous influence of David's teachings on us all.

This is a link to David's obituary in the Toronto *Globe and Mail*: www.theglobeandmail.com/life/health-and-fitness/health/david-sackett-the-father-of-evidence-based-medicine/article24607930/

The subsequent success of the ANZCA Clinical Trials Network, in association with Monash University, can be directly attributed to his influence.

Associate Professor John Rigg, FANZCA
Perth, Western Australia

Be kind! Reminiscences of an old teacher and examiner

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

Kindness is a good attribute for any doctor to possess. It should be an essential one. I was stimulated to write about this after recent discussion in the media about bullying and stresses that some medical students and doctors may suffer, causing anxiety and depression, sometimes long lasting.

In classes where the teacher or lecturer belittles a student for not being able to answer a question, anxiety and hostility are increased. There are some teachers who believe that this approach spurs the student on so that they know the answers the next time. The problem is that many of these students will avoid such classes in future and will probably remember the teacher with disdain or hatred.

It can be alarming to a student to be asked a question point blank, without time to think. What happens? You have a sympathetic nervous response to such a situation and your mind goes blank! Good teachers ask the question first so that everyone can think about it, and then asks someone to answer.

Good tutors can quickly discern the confident, knowledgeable students who often want to lead the discussion most of the time, from the quiet, non-confident student. The latter may or may not have the knowledge but are not sure that they will answer correctly and want to avoid embarrassment. This group must be drawn into the discussion with relatively easy questions first, which will allow them to build their confidence if they answer correctly. On the other hand, the first group needs to be held back a bit to give the slower ones a chance.

Building confidence will help the quieter or less able ones in the long term and avoid the problems later in their lives.

Assessing people, whether at interview or by examination, can create stressful situations. The aim should be to make the interviewees comfortable so that they can perform well. Examinations, especially professional ones like the fellowship, on which so much depends, which are the culmination of much study, are very stressful for most people. The challenge for the examiner is to be able to pick the most stressed individuals and make them sufficiently relaxed that they can perform well enough to do themselves justice.

I remember one candidate who was so nervous that he clutched the edge of the table so tightly that his knuckles were white. I knew that I had to ask a very straightforward and easy question to give him a chance to get started.

Not all examiners can cope with unusual situations. One day I had a candidate who came in drunk, saying he had failed his physiology oral in the morning, had a liquid lunch and had come to say he would not attend this oral. He was persuaded to come in. What do you? Throw him out or try to encourage him so next time he might perform better? I asked if he had done any interesting cases lately. Yes, he had done one with hypotension using sodium nitroprusside. When I quizzed him about it he had a good knowledge of its pharmacology so I was able to encourage him not to give up so easily next time.

The important point to make is that if the candidate is obviously distressed try simplifying the question to give him/her a chance to recover. Treat them kindly and get the best out of them rather than nailing the coffin when they cannot answer something.

I observed unreasonable questions being asked to a reasonable candidate leading to unfair failure and another six months toiling over the books.

The other side of examinations and interviews is the occasional examiner's or interviewer's inability to assess the performance. Fortunately this was rare but it can occur. One clue is that the examiners' marks are often significantly divergent from their co-examiners.

I attended a workshop on oral exams where we were divided into groups of four – two examiners, a candidate and an observer. I was the latter and had occasion to write a very convoluted question down. When I showed it to the examiner afterwards he was horrified, especially when I told him it was one of his questions. It is important to make the questions short and clear.

Another point that came out of this session was the posture of the examiner. Leaning across the table towards the candidate can be quite threatening.

Finally, if a candidate is obviously not going to pass it may be helpful to ask useful questions and if the candidate cannot answer them tell him/her the answer. They will remember those things for many years thereafter. In this way their examination fee will not be entirely wasted!

Much has changed in the last 25 years but my basic premise still holds true; that a kindly, sympathetic approach to questioning will produce the best chance of a fair performance and result.

Dr Kester Brown, AM, FANZCA
Melbourne

New Zealand news

Clear communication wanted for end-of-life care

When it comes to aged and end-of-life care, there should be a greater emphasis on the wishes of patients. This was a key message at a forum headlined by one of the world's most respected and forward-thinking health communicators, American surgeon and writer Dr Atul Gawande, a professor in both the Department of Health Policy and Management at the Harvard School of Public Health and the Department of Surgery at Harvard Medical School.

New Zealand health professionals had a rare opportunity to hear and talk with Dr Gawande on May 18 when New Zealand's Health Quality & Safety Commission (HQSC) hosted the forum that focused on teamwork and communication, as well as aged and end-of-life care. The HQSC Chair, ANZCA and FPM Fellow and Councillor, Professor Alan Merry, chaired the forum.

Dr Gawande, author of bestsellers such as *The Checklist Manifesto: How to Get Things Right* and, most recently, *Being Mortal: Illness, Medicine,* and *What Matters in the End*, was the keynote speaker at the day-long forum for people working in the health and disability and aged care sectors. Last year, Dr Gawande gave the prestigious Reith Lectures for the BBC.

In *Being Mortal*, Dr Gawande argues for innovative approaches to aged and end-of-life care, and supports a greater emphasis on the wishes of patients and their families instead of being bound by inflexible medical and aged care systems.

Among those joining Dr Gawande for the forum were Professor Ian Civil, chair HQSC Perioperative Harm Programme; Professor Jonathon Gray, director of the Ko Awatea centre for health system innovation and improvement, Auckland; Dr Brian Ensor, director of palliative care at Wellington's Mary Potter Hospice; Dr Geoff Green, geriatrician and clinical head of the service for older people at Counties Manukau Health, Auckland; Dr Barry Snow, consultant neurologist at Auckland City Hospital; and Professor Ron Paterson, Faculty of Law, University of Auckland.

The audience of more tham 500 "who's who" in the New Zealand health system heard about ways to improve the patient's journey: the surgical safety checklist, Lifebox, crisis management checklist, collaboration versus competition, teamwork, patients' end-of-life priorities and goals, advanced care plans and the importance of communication that is clear and empathetic, closes the loop, and which allows speaking up and listening.

A large number of ANZCA Fellows attended with ANZCA's NZ National Committee being represented by Chair Dr Nigel Robertson, Safety & Quality Officer Dr Geoff Laney and NZ General Manager Heather Ann Moodie.

See www.hqsc.govt.nz for more about Dr Gawande and his presentations in New Zealand.

Nurse endoscopist model being considered

ANZCA and the NZ Society of Anaesthetists (NZSA) are continuing to work with Health Workforce New Zealand (HWNZ) on the model for nurse endoscopists, with a view to a national bowel screening program being rolled out.

A key issue is how conscious sedation will be delivered in a manner that aligns with *PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures*. Discussing the concept with HWNZ's Director Dr Graeme Benny and Group Manager Dr Ruth Anderson in March, NZNC Chair Dr Nigel Robertson highlighted the need for the patient experience to be the same or better than the current endoscopy service, and that patient safety had to be paramount.

HWNZ said nurse endoscopists would be fully trained to provide non-complex treatment and provided assurance that, in terms of sedation, there was a commitment to comply with ANZCA's professional standards. HWNZ also noted that fairly small numbers would go through the training program, resulting in only 10-15 per cent of the endoscopist workforce being nurse endoscopists.

These issues will be discussed in more depth with members of the working group for nurse endoscopist training, which includes anaesthetist Dr Emma Patrick, from Taranaki Base Hospital, as the ANZCA/NZSA representative.

Above from left: Morning panel of speakers, Professor Jonathan Gray, Dr Atul Gawande, Professor Alan Merry and Professor Ian Civil.

Nurse assistant course under way

The NZNC is continuing to work on and monitor developments regarding assistants to the anaesthetists – including nurse assistants and anaesthetic technicians.

Eight people are enrolled in the newly developed registered nurse assistant to the anaesthetist course, seven of whom are already working as assistants to the anaesthetist. The course is being run through the Auckland University of Technology (AUT). NZNC Chair Dr Nigel Robertson says the course workbook is of a very high standard, and anaesthetists have already been involved in the teaching component of the course.

In February, ANZCA representatives took part an AUT-facilitated a meeting about the future of the anaesthetic technicians' course. The NZ Society of Anaesthetic Technicians, the NZ Society of Anaesthetists and the Counties Manukau District Health Board were also represented. A major prompt for the meeting was concern that the current training program is unable to train enough technicians for the New Zealand workforce and there is a large reliance on UK-trained operating department practitioners (ODPs).

The issue of whether there should be a degree model or a shortened diploma model was discussed, with the suggestion that, as an interim measure, reducing the current diploma to two years would be desirable, as this is adequate time to train as a technician and would allow technicians to be trained more quickly to address the workforce shortfall. HWNZ has indicated to ANZCA that it is supportive of the apprenticeship-based model for technician training.

Applications for scholarship due soon

People intending to apply for the BWT Ritchie Scholarship this year should now be well down the track in terms of preparation.

These scholarships provide funding to assist advanced New Zealand-based anaesthesia trainees (or new Fellows) to gain overseas experience and bring it back to New Zealand. Those undertaking a pain medicine or intensive care fellowship, who already have FANZCA, can also apply.

While applications do not close until October 31, they need to include a proposal of how and where the scholarship will be used, including acceptance from the overseas institutions involved.

For further information, see www.anaesthesiaeducation.org.nz. As well as information on how to apply, this website includes reports from previous and current BWT Ritchie scholars that serve as a guide as to how the scholarships have been used.

Australian news

Queensland

Brisbane to host the next ANZCA ASM

The 2017 ANZCA Annual Scientific Meeting will be held at the Brisbane Convention and Exhibition Centre on May 12-16, 2017.

The opportunity to convene this world-class event was one that I accepted enthusiastically. Clearly the amount of work before us is significant, but a talented and experienced committee is braced to take the load. With the support of the College's well-honed ASM team, we will deliver a high-calibre event in our world class city.

Dr David Sturgess has been appointed as the Scientific Convenor. David shares his clinical time between anaesthesia and intensive care at the Royal Brisbane and Mater Hospitals. Since completing his PhD at The University of Queensland, his research interests have broadened beyond left ventricular diastolic dysfunction to include an array of projects and publications on aspects of perioperative care.

We are in the early stages of conference planning but are underway refining themes, generating shortlists for invited speakers, canvassing enthusiasm and planning workshops and small group discussions.

We are looking forward to presenting an innovative, cutting edge program designed to inspire and challenge thought and practise in anaesthesia. There will be a full day dedicated to workshops to enable delegates to get hands on and efficiently complete mandatory CPD requirements. The social program will complement the themes of the conference and will be based in top notch and convenient river side venues proximate to the convention centre. The extra-curricular program will be bulging at the seams to allow our delegates to enjoy the glorious May weather: Brisbane at its best!

Your talents will be essential. We'll need your help to co-ordinate workshops and small group discussions, chair sessions and give talks. Fellows from Brisbane and beyond are strongly urged to contribute. This is our chance to showcase our city, our state and all the good work we do – so please get involved.

I look forward to updating you as plans are put in place, and welcome your contributions to what will be an outstanding ASM in 2017.

Dr Bridget Effeney, FANZCA MBBS BSc

Final Exam Preparation Course

The Final Exam Preparation Course was held at the ANZCA Queensland office on February 9. There were 35 participants, with 19 Queensland trainees, 13 interstate trainees and three trainees from Singapore.

Our next course will have a new convenor, with Dr Paul Lee Archer taking over from Dr Sanjiv Sawheny.

Western Australia

News from the west

The ANZCA/ASA Winter Scientific Meeting will be held on July 4, convened by the WA CME Committee with the title "Blood, sweat and TEG®s". Registrations are now open via the ANZCA website and are filling quickly.

The ANZCA and ASA Autumn Scientific Meeting was held on March 14, 2015 at the University Club at the University of Western Australia. One hundred and thirty two delegates attended as well as 60 anaesthetic technicians. This conference was well sponsored with 18 Health Corporate Industry in attendance.

Dr Ian McKenzie from the Royal Children's Hospital in Melbourne presented on muscle diseases, children and anaesthesia and also presented a workshop on case reviews on paediatric anaesthesia. Dr Andrew Davidson, also from Royal Children's Hospital, presented on awareness in TIVA, children and adults and presented a workshop on managing patients with awareness. Both workshops were very well received by the participants. This meeting also included a well attended ASA AGM presented by Dr Ralph Longhorn.

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.

The office has been busy promoting the college through career exhibitions. The Surgical Career Expo was held on May 1 at the Medina Hotel in Perth. We thank Dr Jay Bruce, Dr Natalie Akl and Dr Grace Ho for volunteering their time to attend and answer the many questions we received regarding the college's training program and entrance requirements. The Medical Career Expo was held at the Burswood on Swan on May 5 and we thank Dr Kevin Hartley, Dr James Anderson, Dr David Rawson and Dr Christine Ong for attending and providing demonstrations.

Clockwise from top left: Dr Andrew Davidson workshop; Dr Ian McKenzie presenting; Surgical Careers Expo; Medical Expo - Intubation.

Tasmania

Anaesthesia in the extreme

The 2015 Tasmanian ASM was a very successful meeting with a record attendance and received a lot of positive feedback. The planning for the 2016 Annual Scientific meeting is well underway with Professor Peter Slinger from Toronto General Hospital confirmed to be the keynote speaker. The meeting will be held at the Medical Science Precinct in Hobart from February 26-28 with the theme "Anaesthesia in the extreme". It is planned that the meeting will focus on thoracic anaesthesia and management of patients with severe lung disease. Other topics covered will be the management of "extreme" airways, anaesthesia in the elderly, hyperbaric medicine, and retrieval and altitude medicine. The convenor of the meeting, Dr Clare McArthur said that planning is going very well and is confident that this is yet another Tasmanian meeting not to be missed. It is anticipated that registrations will open late October.

Learn, relax and enjoy

Registrations for the Freycinet Winter Workshop are now open. This meeting is being held at the stunning Wine Glass Bay on August 29. With the theme "The human face of anaesthesia", registrants will explore this theme by attending one of the two morning concurrent workshops, which is followed by educational and entertaining presentations in the afternoon, with a dinner overlooking the Hazards, completing this fulfilling day.

Delegates have a choice of attending a Key 2 Me Process Communication Model Workshop or an Advanced Life Support Refresher Course (which fulfills College requirements). The convenor of the meeting, Dr Gregg Best explained that the meeting is held in an inspiring location and runs over one day, leaving Sunday to discover the beautiful beaches and mountains of the world renowned Freycinet National Park. Gregg encourages those wanting to attend to register and book their accommodation as soon as possible as workshops are limited to 20 positions each and accommodation will book out quickly. For more details and registration please go to: www.anzca.edu.au/about-anzca/council-committees-and-representatives/Committees/tas-regional-committee/tasmania-regional-events

Famous faces in Launceston

William Russ Pugh is famous for demonstrating anaesthesia for surgery for the first time in Australia. He did this on June 7, 1847, in Launceston, Tasmania.

In May, Dr Pugh received a totally unexpected but reassuring pat on the hand from the Prime Minister, Tony Abbott, and a hug from Andrew Nikolic, MHR, Liberal member for Bass. Mr Abbott was in Launceston to announce funding for the John L Grove rehabilitation unit at the Launceston General Hospital.

A month after this encounter, Dr Rod Westhorpe, AM, was scheduled to give the commemorative Pugh Day lecture at the Queen Victoria Museum and Art Gallery in Inveresk, Launceston.

Photo courtesy of The Examiner.

Australian Capital Territory

ACT Regional Committee

A reminder that the ACT Regional Committee members are:

Dr Andrew Hehir (Chair)
Dr Carmel McInerney (Deputy Chair)
Professor Thomas Bruessel (Elected Member)
Dr Natalie Marshall (Education Officer)
Dr Catherine Muggeridge (Safety and Quality Officer)
Dr Will Matthiesson (New Fellows representative)
Dr Mark Skacel (ASA ACT representative)
Dr Romil Jain (FPM representative)
Dr Ross Hanrahan (Trainee Committee Chair)
Ms Kym Buckley (ACT Regional Co-ordinator)

The committee can be contacted via act@anzca.edu.au or +61 2 6282 0524.

South Australia and Northern Territory

Anaesthesia and the bariatric patient

SA and NT Continuing Medical Education Meeting "Anaesthesia and the bariatric patient" was hosted by ANZCA/Australian Society of Anaesthetists on April 8 at the Women's and Children's Hospital. Upper gastrointestinal and general surgeon, Dr Jacob Chisholm, presentation on "Bariatric surgery, does it work?" demonstrated the difficulties for morbidly obese patients to lose weight and maintain long term weight loss through traditional methods such as diet, exercise, meal replacement programs and drugs. With obesity in Australia a significant problem and more than 65% of its population overweight with a BMI (Body Mass Index) of >30 and the mortality risk doubling once the BMI hits >35, the risks of bariatric surgery become less than the risk of remaining at that weight.

Long term morbidly obese patients risk developing diabetes, heart disease higher mortality from stroke as well as a poorer quality of life in general. Gastric bypass surgery has immediate effects on improving blood sugar control and control group studies have shown 30 per cent excess weight loss over 15 years, 48 per cent reduction of death due to MI and 38 per cent reduction in cancers. Other key findings include almost 100 per cent prevention of progression from impaired glucose tolerance to type 2 diabetes, "the evidence is clear that gastric bypass surgery does work"!

Dr Lynne Rainey, FANZCA, specialises in bariatric anaesthesia and presented "The bariatric patient, who makes me anxious?". Surprisingly it was not weight, co-morbidities or age that were at the top of the list but men's beards. The challenges of beards is what is hidden behind them such as short necks and big chins sitting on the anterior chest - this indicates possible airway restrictions and potential difficulties to manage the airway and ventilate, let alone the mask fitting!

Dr Rainey advised pre bariatric surgery endoscopies and physician reviews are key to reducing any anxieties about the patient and this type of surgery as well as her preferred patient positioning in theatre and its benefits for these procedures. The first CME meeting of the 2015 calendar was very well attended by 65 people and presentations were professionally recorded and distributed to remote South Australian and Northern Territory Anaesthesia hospital departments for their training and CPD purposes.

Above from left: Guest speaker Dr Lynne Rainey, FANZCA; Guest speaker Dr Jacob Chisholm, Gastrointestinal and General Surgeon.

New South Wales

Continuing medical education

The NSW FPM CME "Medical marijuana for chronic non-cancer pain – promise or pothole?" was held on May 28 to a full house of attendees. Our two speakers were Dr Alex Wodak and Professor Milton Cohen who provided stimulating and thought provoking approaches to the topic and the recent FPM position paper was presented and discussed. It was a meeting where politics, ethics, history, morals and science collided and the complexity of the issue was brought forth. It would be fair to say that a topic such as this does not lend itself to universal consensus (if so there would have been no need for the topic!) and indeed there were a variety of viewpoints presented on the night. It provided ample food for thought and an interest in following political and social developments in this area. This continued with a convivial dinner at our regular CME dinner haunt opposite the NSW ANZCA office in Crows Nest, Sydney.

Part Zero: An Induction to Anaesthesia takes off

The New South Wales Part Zero Course was held on February 28 at Royal Prince Alfred Hospital. As Convenor, it was wonderful to welcome around 60 junior doctors to the course. We were also glad to see many supporting partners and relatives join the afternoon. This year, attendees were treated to a range of important topics related to anaesthesia training and "life after training".

The early afternoon covered the role of the trainee committee and GASACT. Dr Donald Innes and Dr Simon Martel covered issues surrounding the training program, including the current structure and requirements of the "new" ANZCA program. Given his experienced role as a College examiner, Associate Professor Ross MacPherson presented a session on the Primary Exam. The course also included a session on trainee selection by Dr Fergus Davidson, career options by Dr Scott Fortey and perspectives from a regional centre by Dr Emma Bendall. Finally, presentations by Dr Ben Allard and Dr Gerri Khong highlighted the importance of mental health issues and work-life balance, given the challenges of specialty training. I am grateful to all my fellow speakers who made their time and effort to be available.

Additional thanks to Tina Papadopoulos and the New South Wales ANZCA office staff for their ongoing work.

I have thoroughly enjoyed my role as Committee Chair during 2013 and 2014. I wish the 2015 Committee well.

Dr Chetan Reddy, 2014 Chair,
ANZCA NSW Trainee Committee

Clockwise from top left: Dr Richard Morris presenting the Part II course; Dr Christine Velayuthen and Dr Emma Privet; Delegates at the conference; Dr Scott Fortey presenting at the Part 0 course.

Right from top: Dr Luke Bromilow at the Part II Refresher Course; Dr Arpit Srivastava at the course.

NSW Part II Refresher Course

The NSW Regional Committee again conducted a very successful Part II Refresher Course in Anaesthesia at Royal Prince Alfred Hospital from February 9-20.

The course enabled candidates sitting for the final fellowship examinations a greater understanding of anaesthesia. It included seminars, panel sessions, demonstrations, lecturers and informal tutorial. A highlight on the last day of the course was the anatomical workshop held at Department of Anatomy and Histology, University of Sydney, which enlists the help of seven lecturers in a hands-on workshop.

A special thanks to all the speakers who devoted a huge amount of time and effort in assisting the candidates to prepare for their final examinations, and especially to Dr Chris Wong.

Dr Boon Tock Lim 1938 – 2014

Dr Boon Tock Lim led a peripatetic life. Born in Singapore before the outbreak of World War II, he had some dim memory of that conflict and was part of the post-war generation that saw Singapore develop from a colonial outpost to the proud independent country we have today.

In a way, his own life parallels that of his city of birth. Having received a colonial education at St Andrew's school in Singapore, he had ambitions to seek further education overseas and that was how he came to study medicine in Hong Kong, where he met my mother, and that was how I came to be.

He was at school both a scholar and a sportsman, although I am not sure which took priority. He was head boy in his final year, and represented his school in badminton and hockey. He continued in his sporting endeavours at university, culminating with success at the inter-varsity games.

I have strong memories of my father studying and sitting successfully for his fellowship of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons, as it was then. His wanderlust not satisfied and Australia was at that time short on medical manpower. In 1974 he was offered a post in Darwin, which he thankfully declined, then was approached by Ron Davies, the Minister for Health in Western Australia at the time.

At one time he was the only full-time anaesthetist at Fremantle Hospital when the Department of Anaesthetist ran the intensive care unit as well. He had many late nights and, on one occasion, a very nasty aspiration pneumonitis, secondary to barium, despite the usual counter aspiration manoeuvres. The patient had massive dilatation of the stomach, which the radiologist had diagnosed as gastric perforation, when barium contrast (on plain film only, as it was then) could be seen pooling below the pelvic brim. The patient aspirated barium on induction and the outcome, as I recall, was fatal.

Nevertheless, he took to life in WA with gusto. He took part in the rural services and regularly took flight to the many scattered towns in WA to provide anaesthetic cover for the fly-in surgeons. On one occasion, he was in the unenviable position of having three patients simultaneously, as the anaesthetist in the other theatre took ill after anaesthetising a patient and had to be resuscitated. On another occasion, the occasion of my mother's birthday party, he was caught out in the north of WA as the surgeon had to be evacuated after suffering a mild heart attack. He had driven up and left his car there, which my father drove back. He made it to the party, but could hardly stay awake during the evening. Such was his dedication.

For many years, he volunteered his time and made many visits to Kiribati with his orthopaedic colleagues, as well as trips with Interplast to repair cleft lips and palates in developing countries. After his retirement from full-time work, he became bored, and spent a few years providing locum cover in Victoria and NSW. Even at this stage of his career he obviously enjoyed his work and often talked about his five tubes transfers while working at country locums – an IDC, ETT, arterial line, central line, and sometimes a chest tube. It was a pity the cost of medical indemnity became prohibitive, and he decided to forego his locum and charity work in anaesthesia.

I knew him as a father, and also as a friend, colleague and mentor. I also am an anaesthetist and, as an anaesthetist and doctor, my father gave his advice and time generously. His pre-operative visits must rank among the longest on record since he felt it his duty – I think it was an irresistible urge – to take down the life story of each patient. That was the kind of doctor he was; not only was he a very competent anaesthetist, but one to lend a patient ear. He was a kind and caring doctor.

He also was a kind and caring colleague. Wherever I have followed in my father's footsteps, people he had worked with, especially nurses and orderlies, remembered him fondly and asked after him even though he had retired more than 10 years earlier. He always had time for people and as we well know, time is indeed a most precious thing.

Dr Barry Lim, MBBS FANZCA

Emeritus Professor Martin Henriksson Holmdahl 1923 – 2015

Martin Holmdahl passed away at the age of 91 on March 11.

One of the giants of Nordic anaesthesia in the 1960s and '70s, Professor Holmdahl gained his medical degree at Uppsala University, perhaps Sweden's most famous university, in 1950, and gained a PhD in physiology. He then trained in England before taking up a position as head of anaesthesiology at the University Hospital in Uppsala in 1953.

Professor Holmdahl gained his doctorate by dissertation in 1956 and was appointed inaugural professor of anaesthesiology in 1965, heading the newly established department of anaesthesiology and intensive care at Uppsala University.

He was a world leader in studies in oxygen diffusion and was the Australian Society of Anaesthetists visitor in 1966. During his time in Melbourne, he visited the Queen Victoria Memorial Hospital and – as a very junior registrar – I was given the task of showing him around. I found him to have a most charming personality while being able to clearly pass on his considerable knowledge.

In 1970, I had the privilege of working in his department in Uppsala, which proved to be a defining experience. At this time, Professor Holmdahl was finishing his time as dean of medicine and became deputy vice-chancellor of Uppsala University. In 1978 he became vice chancellor.

Today the department he created has more than 300 staff and covers the disciplines of anaesthesiology, intensive care and pain treatment. The official obituary from Uppsala University says it best.

Vice-Chancellor Eva Åkesson has today, 11 March, received notice that Uppsala University's former Vice-Chancellor, professor emeritus of anesthesiology, jubilee doctor of medicine Martin H:son Holmdahl has passed away. The University Main Building will fly the flag on half-mast this afternoon and tomorrow, 12 March.

Martin H:son Holmdahl was born in 1923 in Gothenburg. He came to Uppsala to study medicine in the early 1940s. He earned his licentiate degree in medicine in 1950 and his doctoral degree in 1956. In 1965 he was inaugurated as professor of anesthesiology at Uppsala University. He was pro-dean and dean of the Faculty of Medicine 1966-1970. During the years 1970-1978 he was Uppsala University's Deputy Vice-Chancellor and later Vice-Chancellor 1978-1989. He was inspector of Göteborgs nation in Uppsala in the 1970s and 1980s.

"Uppsala University remembers Martin H:son Holmdahl with sincere gratitude for the faithfulness and loyalty with which he has served his Alma Mater: As a student, researcher, teacher and professor, in management positions, as Deputy Vice-Chancellor and as Vice-Chancellor. Through his life's work he has contributed to Uppsala University advancing its positions in a great number of areas. As emeritus he remained interested in and dedicated to the University's development, and was a great support to his former colleagues and his successors," says Vice-Chancellor Eva Åkesson.

Martin H:son Holmdahl was very committed to human rights issues. In 2003 the Martin H:son Holmdahl Scholarship was founded by the University for the furthering of human rights in celebration of his 80th birthday, and it has since been awarded annually.

– Anna Malmberg

Dr Peter Lowe, FANZCA
Melbourne

Dr Richard (Dick) Ewart Rawstron 1916 – 2014

With the death of Richard Rawstron, always known as Dick, at the grand old age of 98, it is fitting to remember his achievements as one of the first specialist anaesthetists. He gave his first anaesthetics in the open drop era, at a time when anaesthesia was not recognised as a specialty, and there was little in the way of instruction and education. He was the only New Zealander to pass the inaugural fellowship exam, was a pioneer in anaesthesia, intensive care, resuscitation and pain medicine, and made lasting contributions to anaesthesia.

Dick was born in Christchurch in 1916. He studied at Canterbury University before graduating from Otago Medical School in 1941. He did his house surgeon years at New Plymouth in the war years. At that time, house surgeons gave 95 per cent of all anaesthetics, with rudimentary instruction from more experienced house surgeons. His most commonly used anaesthetics were the open drop sequence of chloroform/ether, or ethyl chloride/ether, ethyl chloride alone (guillotine Ts & As) and spinal. He then did service in the Pacific as a medical officer with the RNZAF. In 1946, Dick became SHO at Waikato Hospital in Hamilton, and in 1947 at Sydney Women's Hospital where he gave anaesthetics.

In 1948, Dick set up general practice in Hamilton and was appointed visiting anaesthetist to Waikato Hospital. It was not until late 1949 that he used an anaesthetic machine frequently (thio, N2O/O2 /ether) vs. open ether, as prior to this time they were not available. This was the time of the introduction of muscle relaxants (curare) which Dick considered a major advance, as it was now possible to perform abdominal procedures without the need for deep ether or chloroform. However, curare did require skill in intubation and ventilation, which Dick found difficult to achieve using ether.

Dick decided to specialise in anaesthesia in 1953. By this stage, he could have presented his recorded list of 1450 anaesthetics to meet the requirements for a DA but felt the need for a comprehensive anaesthetic education. He spent 1954 as an anaesthetic registrar at Auckland, when Dr Eric Anson was director and, when on call, the registrar covered all four hospitals. As he was working in department with experienced specialist anaesthetists, Dick received valuable advice and instruction.

In 1955, Dick worked as a registrar at the Royal Children's Hospital in Melbourne, when inhalational cyclopropane follow by intubation and controlled ventilation was the preferred technique for neonatal emergencies. Dick was also involved with cardiac cases including the first cases involving hypothermia and cardiac standstill. He then worked at the Melbourne women's hospital where he used caudal and epidurals.

Dick passed the part I exam for the Diploma of Anaesthesia in January 1956 and the first final exam for FFARACS in May 1956, being one of six successful candidates and thus becoming FFARACS and FANZCA when the College was established.

Dick initially took up a specialist position at Waikato but was appointed Director of Anaesthesia at Palmerston North Hospital in 1957. As a condition of his appointment, he insisted on independence for the newly-formed department – previous anaesthetists had been either visiting GP anaesthetists or house surgeons working under the direction of surgeons.

Dick applied to the RACS Faculty of Anaesthesia (the College's forerunner) for registrar training in 1957 which was approved as long as he remained director. He established a two-week instruction course for house surgeons in anaesthesia, known as the diploma.

In 1960/61, feeling the need to further his training to keep up advances in anaesthesia, Dick did a fellowship in Ohio, gaining experience in regionals, cardiac arrest (Safar protocol), urology, obstetrics, paediatrics, neurosurgery, theatre recovery and intensive care.

Dick had a lifelong interest in resuscitation and established closed chest cardiac massage with a staff training system in 1961.

In 1962, he established an eight-bed recovery area for all post-op patients, although initially staffed only for regular hours. He also established a special care unit for recovery of out-of-hours patients, sick patients and cardiac arrest cases. A Radcliffe ventilator was used, and Dick had the staff well drilled in the use of the Wright respiromator, Radcliffe nomogram and Astrup interpolation technique. He successfully treated a number of tetanus and GBS patients. In 1964, this became the intensive care unit.

In 1963, Dick, together with Dr Caldwell and Dr Broad, set up an obstetric epidural service, and by 1965 25 per cent of caesareans had epidural anaesthesia.

Dick was an active member of the NZ Society of Anaesthetists and was its president in 1964/5.

He was active in research in a diverse range of topics and had many publications. He used mice to research the safe haemoglobin level for anaesthesia and surgery, finding that the critical level was 8.9gm/100mls, and by inference that a lower level was acceptable for humans because of scaling and their lower metabolic rate. He was awarded an MD for this work in 1973. He was invited to Germany on a DAAD fellowship in 1978, where he worked with Mesmer and others on haemodilution.

Dick became interested in pain, initially through the treatment of cancer pain. He spent six months in 1977 working in pain clinics in England, Germany and the USA, and initiated a pain clinic at Palmerston North in 1978.

Dick became interested in malignant hyperthermia in 1968 after a death under anaesthesia at another location in the town. Other members of the extended family died during anaesthesia in other centres in 1972 and 1976. From 1973, Dick worked towards setting up muscle biopsy in vitro testing for malignant hyperthermia together with Dr Ian Anderson of the Massey Veterinary School, who had expertise in porcine muscle biopsy testing, and Mr David Dunlop, who did the surgery. At the time IV dantrolene had been shown to be effective in treating anaesthetic-induced porcine MH and Dick was keen to have it available in the event of a triggering event. To this end, Dr Kolbe of Norwich Eaton made available IV dantrolene as part of clinical trials, after a rigorous evaluation of Dick's laboratory and the requisite approvals. The first biopsy was done in 1979 and this work has been continued at Palmerston North with the establishment of the national testing centre, and work on the molecular genetics.

Dick is remembered with affection by nurses and house surgeons who had instruction from him on cardiac arrest, obstetric anaesthesia, respiratory support and post-operative recovery. He was respected by surgeons who recognised that his advances in anaesthesia had enabled advances in surgery.

He is remembered by keen house surgeons as being willing to teach and impart his knowledge and would instruct in the use of a range of volatile agents by means of the copper kettle vaporiser, with calculation of inhaled concentration by knowledge of agent SVP, temperature and flows.

After the death of a colleague, continuing specialist shortages and a period of ill health, Dick retired in 1980. His departure left a huge gap at Palmerston North Hospital, leading to difficulties in providing paediatric anaesthesia and the College proposing to withdraw approval for training.

Dick took up the position of visiting anaesthetist to Horowhenua Hospital in 1982, which he continued until his full retirement in 1990.

In retirement, he wrote a number of books, including a contribution to the centennial history of Palmerston North Hospital in 1993, the history of nurse anaesthetists in WWI (who had been trained at Palmerston North Hospital) and notes on anaesthetics in New Zealand. He continued to work for Presbyterian Social Services and Rotary. He returned to Christchurch where he worked with the Pat Cotter Medical History Trust and, through Rotary, supported the Addis Ababa Fistula Hospital in Ethiopia. His wife Jessie, whom he married in 1955, died in 1999, and he is survived by three sons – Tony, Bill and Rob.

Dr Andrew Spiers, FANZCA
Palmerston North Hospital, New Zealand

Dr John Gordon Roberts 1942 – 2015

Dr John Roberts, a former editor of the journal *Anaesthesia and Intensive Care* and life member of the Australian Society of Anaesthetists, has died quietly at home aged 72.

John was born in North Sydney in 1942. His father was absent for three years on active service during World War II and his mother raised John in those early formative years. He attended school at Christian Brothers, Lewisham, where he was head prefect in his final year. With the help of a commonwealth scholarship, he studied medicine at Sydney University, graduating in 1966. It was during his first postgraduate year at St Vincent's Hospital that he met a nurse, Lyn, who would become his wife. It is alleged this meeting was prompted by the line, "Sister, you're going to have to give me a hand because I don't know anything about these patients". After 12 months of study, during which he married, John began anaesthesia training at St Vincent's Hospital, completing it in 1970 with fellowship of the then Faculty of Anaesthetists, later to become the Australian and New Zealand College of Anaesthetists (ANZCA).

John had already indicated his academic potential with his intellect and an ever-inquiring mind, so with Lyn and their first born son, James, the family moved to Oxford University in the UK, where he immersed himself in the academic environment of the time with animal studies of the physiological effects of beta blockers. This culminated in the award of DPhil in 1974. With the birth of their second son, David, the family made the difficult decision to decline offers of professorships in UK, preferring to return to Australia as a better place to bring up his family. Flinders Medical Centre (FMC) in SA was about to open when the family decided to move there in 1976. John spent the whole of his specialist anaesthesia career in full-time practice at FMC as a respected clinician, teacher, mentor and researcher. For 12 years, he was an ANZCA examiner for the primary examination. On several occasions, he was an invited speaker, teacher and examiner in South-East Asia.

One of John's major interests was his love of the English language, its grammar and the Latin derivation of words. This gave rise to many spirited discussions that always resulted in John having the last say; of course he was always correct. This passion also gave rise to his appointment as the editor of *Anaesthesia and Intensive Care*, a position he held for 15 years. His contribution and commitment in this challenging role was recognised by the Australian Society of Anaesthetists (ASA) in conferring him with life membership, an honour of which he was very proud.

During his career, John became one of the original owners and developers of the Fox Creek Winery in McLaren Vale. His scientific background and inquiring mind were again put to the test when he challenged the conventional viticultural methods used at the time.

John's experience with animals at Oxford was notable not only in his research, but also for the dogs that participated in his experiments. He cared for these animals, ensured their safety and found homes for them afterwards. This love of dogs gave rise to a lifelong interest. He and Lyn kept Rhodesian ridgebacks for many years and enjoyed the camaraderie with other owners. Again, John's mind resulted in him finding a cause and cure for a debilitating spina bifida-like illness that had been shortening the lives of the breed.

The latter part of John's career was interrupted by several illnesses, the most significant of which was his battle with depression. He appreciated the importance of awareness of this illness and the need to discuss it openly, so he agreed to share his personal experiences and struggles in a presentation at a major anaesthesia conference in Adelaide. This bold and selfless decision occurred at a time when there was little public knowledge of this largely hidden illness. In this regard, John was way ahead of his time.

Despite his medical problems, John loved a good party and was never happier than when he could engage friends and colleagues with stories and in-depth discussions about matters of the day. With his sharp mind and wit, it was a brave person who would try to contradict him.

He bore his final illness with fortitude and remained alert and lucid up to his final day. His wife Lyn, his sons, James and David, and four grandchildren survive him.

Richard Willis, FANZCA,
with assistance from John's family