ANZCA BULLETIN

Museum refresh: Minister opens ANZCA's new knowledge centre

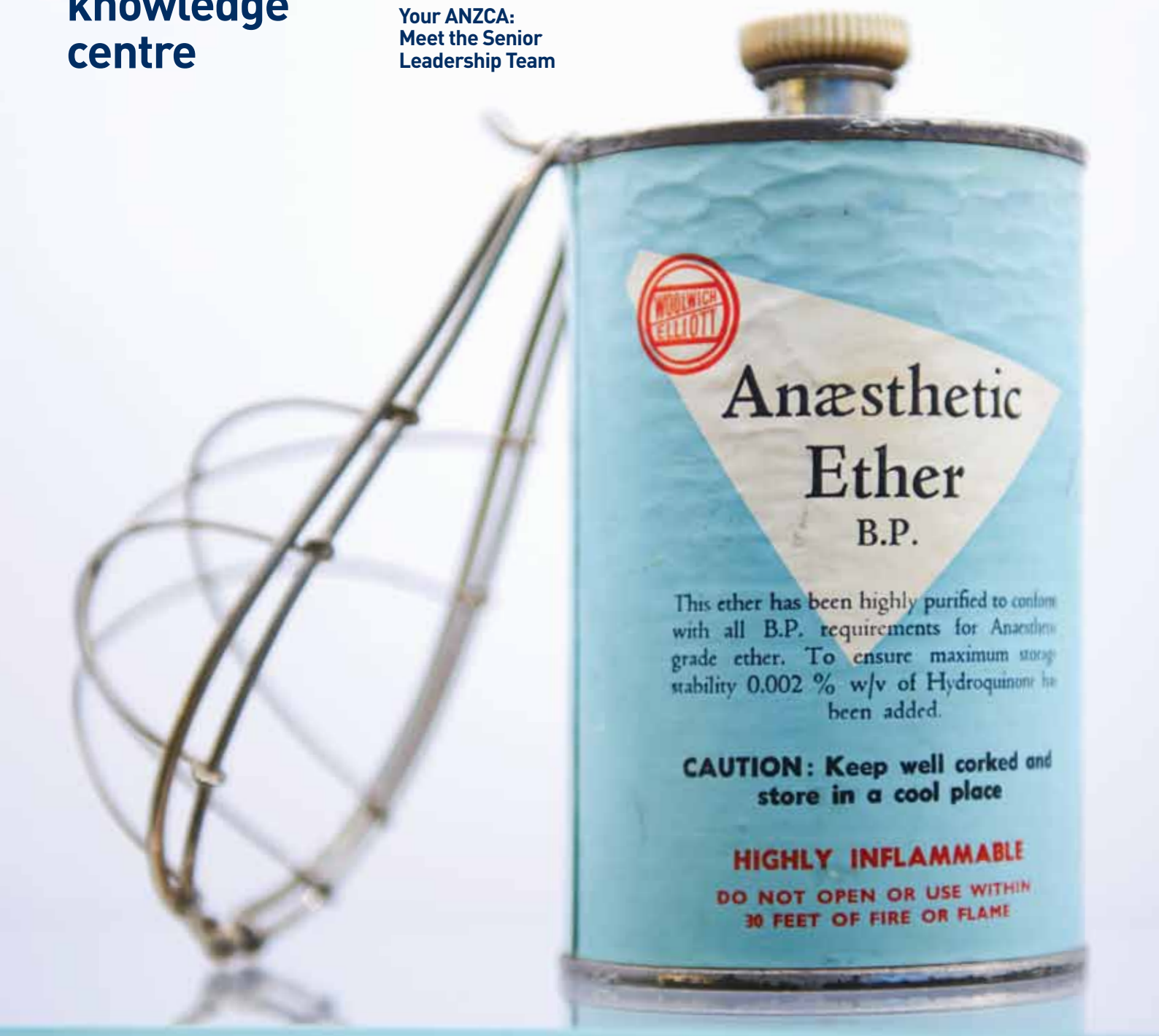
Connect, share, learn: Our new online learning system, Networks

Managing pain: Course expands into Manila

Your ANZCA: Meet the Senior Leadership Team

ANZCA
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

FPM
FACULTY OF PAIN MEDICINE ANZCA



ANZCA Bulletin

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

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Medical editor: Dr Rowan Thomas

Editor: Clea Hincks

Art direction and design: Christian Langstone

Production editor: Liane Reynolds

Advertising manager: Vivienne Forbes

Sub-editors: Kylie Miller, Jane Willson

Submitting letters and other material

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Contacts

ANZCA
630 St Kilda Road, Melbourne
Victoria 3004, Australia
Telephone +61 3 9510 6299
Facsimile +61 3 9510 6786
communications@anzca.edu.au
www.anzca.edu.au

Faculty of Pain Medicine
Telephone +61 3 8517 5337
painmed@anzca.edu.au
www.fpm.anzca.edu.au

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President's message

Survey season

We are now in the process of analysing two very important surveys – the ANZCA Fellowship Survey and the Graduate Outcomes Survey of new Fellows within three years of graduation.

Surveys are vital for ensuring our College serves its members to the best of its ability. They give direct feedback on the quality of your College's performance across many of its functions and whether these are meeting your needs. They guide our decision-making – where we focus our resources, how we communicate and, importantly, how we advocate on behalf of the College. The Australian Medical Council (AMC), which accredits all the medical colleges, requires that graduate outcomes data is produced.

I hope if you are one of ANZCA's 900 new Fellows who received the Graduate Outcomes Survey that you participated. ANZCA can only advocate with government and jurisdictions on your behalf and make appropriate responses if the College has a full and accurate picture of the distribution of the workforce and what problems are being encountered.

Watch out in the December *Bulletin* for the results of both these surveys.

Speaking of surveys, in June, 250 Fellows were also randomly selected for audit of continuing professional development (CPD) compliance – I was one of those Fellows.

The CPD audit is also an AMC requirement and demonstrates not only compliance but also the range of activities undertaken by Fellows. Proof for every activity entered is not required, just for the minimum points to meet the requirements.

The Medical Board of Australia is also randomly auditing medical practitioners for compliance with one of the four "mandatory registration standards". These include checks on practitioners' criminal history, evidence of CPD activities, recency of practice and evidence of professional indemnity insurance. The Australian Health Practitioner Regulation Agency (AHPRA) itself is undergoing a review as part of the planned (slightly late) three-year review of the National Registration and Accreditation Scheme under which it was established in 2010.

Doctors' health

ANZCA and the Royal Australian and New Zealand College of Psychiatrists (RANZCP) have set up a working party to review the scientific literature and overseas experience from doctors' health programs regarding propofol misuse in the profession. Rob Fry, an Auckland anaesthetist, has recently surveyed anaesthetic departments in Australia and New Zealand to determine the incidence of substance abuse in anaesthesia personnel over the past 10 years. Figures for the private sector, however, are not available except anecdotally. It is hoped that the working group can develop an evidence-based, consistent approach for the profession to detect and manage this emerging, serious, potentially fatal problem.

ANZCA has also participated in an AMA/beyondblue roundtable called in response to meeting the recommendations of the report detailing the results of the National Mental Health Survey of Doctors and Medical Students released in October last year (see www.beyondblue.org.au/resources/health-professionals). I recommend that you read this report. It discusses not only the prevalence of problems, including burnout, but also barriers to seeking help, "negative coping strategies" and stigmatising attitudes from colleagues. The roundtable will focus on resources and strategies for junior doctors. It was frequently acknowledged at the roundtable that the Welfare of Anaesthetists Special Interest Group was a leader in this area compared with other colleges and societies.

Museum improvements

Recently the College's Geoffrey Kaye Museum of Anaesthetic History was officially reopened by the Victorian Minister for Health, the Hon David Davis, MLC. The Geoffrey Kaye Museum of Anaesthetic History is a central feature of the refurbished ANZCA knowledge centre within the historic Ulimaroa building.

The museum complements the resources of ANZCA's library and archives and the newly appointed Fellows room. I encourage all Fellows – both local and those visiting Victoria – to visit the museum, which is a great gift from our forebears that will benefit many generations of anaesthetists in the future (full report – page 26).

National Anaesthesia Day

I wish to remind everyone about National Anaesthesia Day on October 16 (see page 20). The theme is smoking cessation with the message "Stop smoking before your anaesthetic" and coincides with the formal release of an updated *PS12: Guidelines on Smoking as Related to the Perioperative Period*.

National Anaesthesia Day kits will be sent to hospitals in the lead-up to October 16, which is the anniversary of the day in 1846 that ether anaesthesia was first demonstrated in Boston, Massachusetts.

This is an important health advocacy role for anaesthetists and we can influence our administrators, surgical bookings staff, and the surgeons we work with to implement the necessary strategies in a timely manner. Importantly, National Anaesthesia Day is also an opportunity to explain to the public the crucial role anaesthetists play in healthcare, both through face-to-face interactions and via a College-run media campaign.

ANZCA has recently endorsed *The New Zealand Guidelines for Helping People to Stop Smoking* that provide healthcare workers with advice they can use when dealing with people who smoke. The guidelines, published by the New Zealand Ministry of Health, are based on a recent review of the effectiveness and affordability of stop-smoking interventions. A range of supporting resources is also available.

Next year's National Anaesthesia Day theme will be obesity, a major public health issue in Australia and New Zealand and of great concern to all anaesthetists every day. "Being overweight is becoming normal as the majority of our adult population is overweight or obese", commented the UK's Chief Medical Officer in her 2014 annual report.

In Australia, obesity has been announced as a national health priority. I recommend an excellent document, *Tackling Obesity*, a position statement published by the NZ Medical Association in May (www.nzma.org.nz).

Dr Genevieve Goulding
ANZCA President

Chief executive officer's message

Technology improvements

As the year progresses, we continue to improve our systems and processes at the College to ensure we provide the best service possible for our Fellows and trainees.

These activities follow our Information Management and Information Technology (IM/IT) Roadmap so that our technology-driven projects are prioritised and carried out efficiently.

A recent project resulted in great improvements to the training portfolio system where we enhanced the multi-source feedback component.

Multi-source feedback, one of the four workplace-based assessments in the revised curriculum, is a critical part of the training portfolio system as it broadens the sources of feedback on everyday clinical care from anaesthetists and others who have had a direct experience with the trainee.

These new enhancements will significantly reduce the workload of ANZCA training supervisors who have been manually processing hard-copy forms. Until the enhancements, the supervisor would have to collect the forms and complete a summary, a time-consuming process that involved numerical scoring and insertion of comments.

The introduction of the online multi-source feedback process will have the forms distributed, completed and analysed via the training portfolio system with the supervisor of training ultimately receiving summary information that is already populated.

Work on the continuing professional development portfolio system is ongoing, in particular around the auditing process.

This system has also recently been updated to allow participants to record the recognition code for emergency response activities. Participants who have recorded an emergency response activity previously will have had a transitional code entered into their portfolio. This recognition code signifies that the course has been recognised as suitable by ANZCA.

The system now also generates a certificate of compliance upon participants meeting the triennial requirements.

Networks launch

The College has also just launched Networks, an exciting new online learning and collaboration management system that will allow ANZCA and FPM Fellows and trainees to connect, share and learn in a simple, engaging and accessible way.

There are four streams in Networks, which is customised to each user. Anaesthesia learning provides Fellows and trainees with quality educational resources, such as ANZCA podcasts and teaching and learning cases, in one place.

The communities stream offers online spaces for groups of Fellows and trainees, including ANZCA committees, sub-committees and working groups. It is a collaborative environment that, for example, allows the sharing of meeting documents.

Pain medicine learning provides users with access to the FPM podcast series. Resources now in development include the new Better Pain Management online education system for healthcare professionals.

The personal and professional learning section of Networks supports and facilitates the ongoing development of skills, knowledge and behaviours across a range of subject areas. The first resource available is the online Foundation Teacher Course.

See page 33 for further information.

Preserving our history

On September 19, the Victorian Minister for Health, David Davis, opened our newly refurbished Geoffrey Kaye Museum of Anaesthetic History, which is recognised as one of the best anaesthesia museums in the world. It is an important asset that preserves our history for all. I encourage local Fellows and trainees and visitors to Melbourne to come to the College and see the museum, now housed in our new cultural centre in the historic Ulimaroa building on St Kilda Road.

As part of the Ulimaroa refurbishments, we have a newly appointed room set aside especially for Fellows visiting the College. The ANZCA Library has also been moved and updated. The history sections of the ANZCA website are also being improved to coincide with these activities and one of the highlights is an interview with the late Dr Geoffrey Kaye, who founded the museum, conducted by ANZCA's honorary archivist, Dr John Paull.

I would like to thank our honorary curator, Dr Christine Ball, for all her input into this project. For more information, please see pages 26-29.

Our staff

During many of my interactions with Fellows who are not directly involved with the College, I sometimes find there is not always a strong understanding of the many and varied activities undertaken by staff within the College.

When Dr Genevieve Goulding became president in May, she suggested that a useful way of explaining some of these activities would be to have a feature about our staff in the *Bulletin*.

On pages 34-38, we explain our organisational structure and describe the roles of each unit at the College. I hope it gives a better understanding of what your College does.

Ms Linda Sorrell
Chief Executive Officer, ANZCA

Bravery award for Christchurch anaesthetist

In a Special Honours List released on June 23, ANZCA Fellow Dr Bryce Curran, a Christchurch anaesthetist, was awarded the New Zealand Bravery Decoration for the part he played in operating on and saving the life of a man trapped in a building that had collapsed in the 6.3 magnitude earthquake that struck Christchurch on February 22, 2011 (see *ANZCA Bulletin*, March 2011). Australian urologist Dr Lydia Johns-Putra, who was in Christchurch at a conference, received the same award for her part in the rescue.

A firefighter and police officer made up the team of four who carried out a double amputation on Brian Coker who was trapped under concrete. They all worked in a confined, unstable, dark space with the constant threat of aftershocks and with minimal equipment (a Leatherman knife and hacksaw, with morphine and ketamine as anaesthetic) to amputate the legs of and to free Mr Coker, who has since gone on to compete in the New York marathon on a hand cycle.

Clockwise from top: Dr Bryce Curran; Dr Lydia Johns-Putra; the collapsed Pyne Gould Corporation building. Photos courtesy of The Press, *Christchurch.*

ANZCA and FPM in the news

Patients put at risk of addiction

Julia Medew

Too many Australians are being sent home from hospital with large amounts of powerful painkillers, putting them and others at risk of addiction and unintentional overdose, doctors say.

There are also fears careless prescribing by hospital staff is fuelling the thriving black market for prescription opioids in Victoria, where about 300 people die from medication overdoses each year – more than the state's road toll.

Myles Conroy, a pain clinician at Geelong Hospital, said a study of 334 patients' at his hospital in 2011 revealed scores were being sent home after surgery with either too

revealed that about one third of people requiring opioids for their pain on the day before their discharge had them ceased when they went home. This also occurred for three-quarters of the patients on anti-inflammatory drugs

Snapshot

Limiting damage from starch drips in Australia

While the rest of the world has been exposed to starch drips for about 40 years, they were only licensed in Australia in 2007.

This was because Australian physicians primarily used the blood protein, albumin, to bulk up

and dialysis and no clinical benefit.

These two studies were instrumental in regulatory bodies restricting the use of starch drips around the world.

Myburgh says there has been a change in practice in Australia intensive care units over the past decade.

The use of albumin has remained

Professor John Myburgh was awarded an AO on Monday for his contributi to intensive care medicine.

a landmark trial to verify if this maize-based starch drip was safe sick patients in intensive care.

It began in 2009, was over by 2 and published in 2012. It showed t starch drip conferred no clinical benefit but was associated with a increased risk of harm.

Among intensive care patients who receive starch there was a 6 cent relative increase of death an per cent relative risk of requiring

Award icing on cake for medical trainee at NWRH

By ADAM LANGENBERG

FOR the first time the prestigious Beatrice Price has been awarded to a Tasmania-based trainee at the North West Regional Hospital.

hospital," he said.

"They've got 20 people over there to study together and pick each other's brain, while there were only two of us completing the exam in Burnie."

Mr Mahoney estimated he

Anaesthetists push to ban pholcodine amid anaphylaxis fears

ANAESTHETISTS have renewed calls to ban sales of a widely used cough suppressant in Australia, owing to fears the medication could cause anaphylactic reactions during some surgeries.

The Australian and New Zealand Anaesthetic Allergy Group said that patients who had taken pholcodine were at increased risk of anaphylactic reactions to neuromuscular blocking agents as a result of becoming sensitised to a shared allergen.

The group has called for Australian regulators to follow the lead of the US and some European countries, and either withdraw the medication – which it argues has "unproven efficacy" – from the market or at least make it prescription-only.

"We think that pholcodine puts people's lives at risk needlessly, so if we can get this taken off the over-the-counter market, then we can potentially save lives," said Dr Michael Rose, chair of the Australian and New Zealand Anaesthetic Allergy Group.

Studies suggest that it can take two years for potentially cross-reactive IgE antibody levels to normalise after pholcodine use, Dr Rose wrote in an editorial in *Australian Prescriber*.

The allergy group approached the TGA in 2010 with concerns about pholcodine, which is found in 56 over-the-counter cough mixtures and lozenges.

The group now plans to step up its campaign in restricting the use of the medication.

However, a TGA spokesperson said the regulator had reviewed the issue of pholcodine and anaphylaxis, and concluded there was "insufficient evidence to support the association at this stage".

The spokesperson noted the E Medicines Agency had also come extensive analysis of the issue an same conclusion in 2012.

Steve Scarff, director of regular scientific affairs at the Australian Industry, also stood by the safety pholcodine.

"The EMA and the TGA have a approach – that is that the benef pholcodine continue to outweigh said.

Australian Prescriber 2014; 37:74-

Brain power 'at risk' after anaesthesia

DOCTORS are regularly failing to recognise bouts of delirium after patients undergo anaesthesia, an intensive care physician warns.

Yahya Shehabi will tell an Australian and New Zealand College of Anaesthetists meeting in Sydney today that disordered and erratic thoughts, behavioural changes and self-harm go unrecognised despite potentially signalling other health problems.

Prof Shehabi said awareness of post-anaesthetic delirium was "a newcomer to critical care" and better tools were needed to treat it, given its association with an increased risk of cognitive decline, accelerated dementia and death.

Post-operative delirium occurs in one in five patients. An episode can last hours to days.

"For every day delirium occurs, there is 35 days of impaired cognitive and executive function – people are unable to go back to their normal work," he said. "Post-operative delirium ... heralds the onset of acute brain dysfunction."

Since June, ANZCA and FPM have featured in television, radio, print and online media reports reaching a combined cumulative audience of more than 650,000 people.

Highlights included a report on ABC's 7.30 program about chronic pain, featuring former FPM Dean, Associate Professor Brendan Moore, and a series of interviews with Professor Yahya Shehabi who spoke at a continuing medical education meeting on the long-term effects of post-anaesthetic delirium.

In this period, the Communications unit prepared and distributed seven media releases on topics of interest presented at special interest group meetings and ANZCA workshops, as well as matters of relevance to the anaesthesia community.

The Communications team also organised, facilitated and attended media training for the new ANZCA President Dr Genevieve Goulding and ANZCA Vice-President Associate Professor David Scott, as well as the new FPM Dean Professor Ted Shipton and Vice-Dean, Dr Chris Hayes. The new Quality and Safety Committee Chair, Dr Phillipa Hore also participated. The day-long session prepared the group for a variety of media speaking opportunities and explained the basics of how to prepare and highlight key messages when dealing with the media, what to expect in interviews, reputation management and the value and potential pitfalls of interacting with journalists.

Media releases distributed by the ANZCA media team since the last *Bulletin*:

June 9: Obesity increases risks after surgery.

June 20: Delirium after anaesthesia can lead to dementia, meeting hears.

July 3: Getting back to basics: easing pain with paracetamol in the emergency ward.

July 18: Australia's foreign medical aid second to none.

July 24: Protecting patients from chronic pain – how anaesthetists can help.

August 7: Australian patients help find the key to good health after anaesthesia.

August 17: Allergic reactions to common hospital antiseptic rising, meeting hears.

Ebru Yaman
Media Manager, ANZCA

This year ANZCA has featured in:
- **More than 80 print reports.**
- **More than 160 radio reports.**
- **41 television reports.**
- **More than 400 online stories.**

Letters to the editor


Letter to the editor

Desflurane – far from ideal

More can be done

I would like to endorse the letter by Dr Catherine Hellier ("Desflurane – far from ideal", *ANZCA Bulletin*, March 2014).

I would further advocate that anaesthetists can, and should be, doing much more to mitigate climate change than just abandoning the use of nitrous oxide and desflurane.

As a group of doctors who are in unique position of really having "lives in our hands" on a daily basis it behoves us to take a leadership role in determining the future of our planet.

This task is so immense that some will find it too confronting a concept to even consider. The editorial "Climate change: how soon is now?" in *The Lancet* (volume 383 May 17, 2014:1693) and it's associated links are excellent summaries of the state of play concerning these issues.

Anaesthetists can take steps towards mitigating climate change as both individuals and as a powerful medical group. Alteration in clinical practice to reduce environmental harm is simple to do. Supporting, facilitating and promoting more sustainable hospitals can empower staff and be remarkably simple to achieve. Recycling PVC, plastics and metals from operating suites significantly reduces landfill volumes and pleases hospital administrators when this adds up to tens of thousands of dollars in waste removal savings per annum.

As members of representative and governing bodies such as ANZCA, the Australian Society of Anaesthetists and the Australian Medical Association we should be asking where the significant financial resources and endowment funds of these organisations are being invested. It is inherently wrong to be profiting from investment portfolios based on any carbon-burning industry. We should be actively divesting these significant funds from banks and financial institutions that continue to invest heavily in companies that directly contribute to climate change and making it very clear to these groups exactly why this divestment is occurring.

Dr Wilga Kottek, FANZCA
Frankston Anaesthetic Service, Victoria


Letter to the editor

Reply to Desflurane and climate change

Climate evidence convincing

It is unfortunate and surprising that the *ANZCA Bulletin* has followed the trend of popular media to publish the minority opinions of climate change deniers ("Reply to Desflurane and climate change", *ANZCA Bulletin* June 2014). The evidence for global warming is extensive and convincing. The Intergovernmental Panel on Climate Change[1], the American Association for the Advancement of Science[2], the National Oceanic and Atmospheric Administration[3], the CSIRO[4], the World Health Organization[5], among other scientific bodies, agree that it is virtually certain our planet's climate is warming due to greenhouse gas emissions.

Climate change is one of the greatest threats to global health and the health of future generations, as Dr Hellier stated (*ANZCA Bulletin*, March 2014). A recent editorial and comment in the *British Medical Journal*[6] and *The Lancet*[7] have this year asked health professionals to be prepared for the impacts of climate change, particularly on vulnerable populations. Food insecurity, population migrations and destabilising extreme weather events will have lasting effects on global health.

Climate change is happening here and now, the time for debate is long past. As a professional body of doctors, we have a responsibility to act in creating awareness, influencing governments and working towards mitigating its effects. We certainly need to be unified in speaking up for the science.

Dr Liz Bashford, FANZCA
Deans Marsh, Victoria

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7. Climate change and health. 2014 Woodward A. et al. The Lancet Apr 5: 1185-9.

Time to act on climate change

We reply not to the comments by Dr Greg Smith ("Reply to Desflurane and climate change" *ANZCA Bulletin* June 2014) in regard to his denial of anthropogenic climate change, but to the editors and ask why such views find their way into the *ANZCA Bulletin*?

To publish comments that have no mainstream scientific basis and are in complete denial of one of the biggest health challenges we are facing is inappropriate. We would not publish a denial of AIDS being caused by a virus or that smoking does not cause cancer, despite some "scientific" research claiming just that.

The vast majority of institutions with expertise agree on the urgency to act on man-made climate change now. They include CSIRO, the Bureau of Meteorology, NASA, National Oceanic and Atmospheric Administration (NOAA) and Australian Academy of Sciences and of course the Intergovernmental Panel on Climate Change (IPCC), a body made up of 209 lead authors, 50 review editors and 600 contributing authors from 40 countries. To doubt this organisation is akin to doubting ANZCA being able to educate and advise on common side effects of general anaesthesia. Ninety-seven per cent of climate scientists agree on anthropogenic climate change taking place right now.

Internationally, and in Australia, our medical institutions are calling on doctors to take urgent and transformative action.

We should welcome a healthy expression of opinion if perhaps reducing our use of Desflurane ("Desflurane – far from ideal" *ANZCA Bulletin*, March 2014) does help bring about urgent and necessary change. It is time to act on the strategies we consider effective and appropriate as doctors and anaesthetists to deal with the urgent and serious threat of climate change. We owe this to our future generations. Based on our best scientific consensus, this is not a hoax. If it were, well then we would have created a better world "for nothing" and simply acted on the best available evidence at the time.

Dr Ingo Weber, FANZCA, FRACGP
Lyell McEwin Hospital, SA

Dr Forbes McGain, FANZCA, FCICM
Western Health, Victoria

Editor's note: The references on a letter by Dr Greg Smith ("Reply to Desfluraen and climate change, *ANZCA Bulletin*, June 2014) were inadvertently omitted in the production process. We apologise to Dr Smith and include them here: Costello A, Abbas M, Allen A et al. Managing the health effects of climate change. The Lancet. 2009 Vol 373. Issue 9676, 1693-1733; Professor Robert M. Carter, Climate: The Counter Consensus, 2010, Stacey International, page 71; Dr Paul Reiter, Global Warming and Vector Borne Disease; Is warmer sicker? Found at www.cei.org/gencon/014,01520.cfm; and www.petitionproject.org/

The full letter can be found on the ANZCA website via www.anzca.edu.au/communications/anzca-bulletin

Time for the "tele-conference"

The recent use of an iPad app at the Singapore ANZCA ASM enhanced "question time" at sessions markedly and the organising committee is to be applauded for its introduction.

It did make me think, however, that with this final piece of the technological puzzle, there really was actually no need for me to actually be in Singapore at all. Most of the conference, from a learning perspective, could be undertaken from home. All talks and PBLDs could be streamed live via the internet, with coded access to paying "tele-attendees" (wherever in the world they happen to be) providing questions via an iPad app.

With concerns about costs, both to ourselves and to taxpayers, as well as the carbon footprint associated with travelling from one part of Australasia to another, it makes sense for our society and College to provide a "tele-attendance" option for each meeting.

This is not to say the conference is dead – there's much to be gained from hands-on experiences such as workshops and the benefits of relaxed socialising but a "tele-conference attendance" should be offered as an option in all future meetings as soon as possible.

Dr Chris Jones, FANZCA
Sydney

Surveys update

Two key College surveys – the ANZCA Graduate Outcomes Survey of new Fellows and the larger ANZCA Fellowship Survey – have reached the analysis stage.

The College received a strong response to its ANZCA Fellowship Survey and the results, which are being analysed by strategic market research consultancy Acuity Research & Insights, will assist the ANZCA Council, committees and staff in addressing the strategic direction of our College.

Acuity is also in the process of analysing the results of the annual Graduate Outcomes Survey, which was sent to 900 new Fellows (within three years of graduation) in July. This is the second time ANZCA has run the survey of new Fellows and the results will assist ANZCA's decision-making in relation to younger Fellows as well as interactions with government and other decision makers on workforce issues. The results of both surveys will appear in the December *Bulletin*.

What would you do?

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

Drug handling: Why perception matters

Ever seen one of those movies where there is a painting on the wall and a pair of eyes follows your every move? Scary!

Actually, minus the painting, pairs of eyes observe many of the things we do in theatre. It is interesting to ponder how we are perceived by the owners of those eyes, especially these days with all the rules and regulations, and mandatory reporting.

There is an adage, "if you want to know what an anaesthetist is like, ask the nursing staff". With the number of nursing staff in the theatre it is not surprising that there will be at least one pair of eyes observing our actions and behaviours at any given time. They see a lot! They are quick to pick up on any irregularities, which not infrequently get reported because of the conceivable implications, but also because of mandatory reporting requirements and the potential consequences of failure to do so.

Years ago, anaesthetists were expected to provide and transport ampoules of drugs from one location to another, and the carry-over acceptability of transporting drugs in this way appears to be lingering among some practitioners. While this practice may be quite innocent, it presents an opportunity to bypass the strict controls, governed by the drugs and poisons legislation. The jurisdictional authorities view any form of drug handling that bypasses strict controls as a very serious offence. So, how would our nursing colleagues perceive and respond to ampoules of drugs being removed from theatre?

There have been several instances where anaesthetists have had to endure harrowing experiences as a result of being reported for such activities. The purpose of presenting the following is not only to stimulate consideration of "What would you do?" but also to encourage consideration of "How would you feel?"

Each case involved the anaesthetist being reported to the hospital administration, resulting in the immediate withdrawal of privileges pending the outcome of investigations. As the act of transporting drugs was innocently or at least naively performed, each of the anaesthetists was devastated by the implications that their actions were deemed illegal and unprofessional. The assumption of guilt and impropriety was clearly evident and the ensuing investigation provoked for the practitioners a range of understandable emotions, including disbelief that they had done anything wrong.

These sorts of cases raise the question of how we are seen by others. The way we are perceived by others is particularly important, especially when it comes to the interpretations of our actions by nurses and others with whom we work. They can't read our minds or see into the future and consequently are driven to act on the basis of observations as opposed to our intentions. A heightened awareness of this perspective may be helpful in directing our actions and in particular, our communication.

The practice of transporting drugs between hospitals is clearly, under current regulations, a breach of the controls in place. What about between buildings within a single hospital, or even between suites in the same building? While there are means of achieving this with strict documentation, signing of relevant drug dispensing ledgers and communication with relevant staff, it courts danger in view of the different ways in which our actions may be perceived. Any departure in expected behaviour can easily be misinterpreted, raising questions about our professionalism and result in consequences that may impact on our health and well-being.

While the approach of *PS51 Guidelines For The Safe Administration Of Injectable Drugs In Anaesthesia* is from a safety perspective, it does address the issue of recording drug administration and the ability to reconcile those drugs.

Item 2.3 states that "Anaesthetists should have a comprehensive understanding of the systems and processes involved in drug prescription and administration". This includes the appreciation of the need to be able to reconcile each drug with each patient if required.

In anaesthesia we are good at performing risk assessments to guide our management. Maybe the way we handle drugs should also be subjected to a similarly rigorous risk assessment to then guide our drug handling procedures.

Dr Peter Roessler
ANZCA Director of Professional Affairs (Policy)

Professional documents – update

The professional documents of ANZCA and FPM are an important resource for promoting the quality and safety of patient care for those undergoing anaesthesia for surgical and other procedures, and for patients with pain. They provide guidance to trainees and Fellows on standards of anaesthetic and pain medicine practice, define policies, and serve other purposes that the College deems appropriate.

Professional documents are also referred to by government and other bodies, particularly with regard to accreditation of healthcare facilities.

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

A revised version of *PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures* is now available. This document seeks to support uniform standards for high quality and safe administration of procedural sedation and/or analgesia by all appropriately qualified health practitioners in Australia and New Zealand.

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.

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FACULTY OF PAIN MEDICINE ANZCA

From words to science: A brilliant career

Few people have made a more significant contribution to ANZCA and the preceding Faculty of Anaesthetists than Professor Barry Baker, who retired in August. ANZCA President, Dr Genevieve Goulding, pays tribute.

Barry Baker was raised in Queensland and obtained his undergraduate degree, MBBS, from the University of Queensland (UQ) in 1963. In his student years, Barry was co-editor of the university's literary magazine, *Galmahra*, and editor of the UQ medical school's journal, *Trephine*.

His residency years were spent in Brisbane with rural teams in general practice in Mundubbera and Southport. He completed his anaesthesia training in Brisbane and obtained fellowship of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons in 1968. In the same year, after crossing Russia on the trans-Siberian railway and flying from Leningrad to London for the exam, he was awarded fellowship of the Faculty of Anaesthetists of the Royal College of Anaesthetists.

He then completed a doctor of philosophy at Magdalen College, Oxford in 1971 for his thesis, *The physiology of artificial ventilation*.

He returned to Australia in 1972 to take up a post as reader in anaesthesia at the department of surgery, UQ, and the Royal Brisbane Hospital, where he remained until 1975. This was the first full-time academic appointment in anaesthesia in Queensland. His duties included being in charge of the intensive care unit. Barry initiated an undergraduate course in anaesthesia, resuscitation and intensive care and also was responsible for overseeing postgraduate training in anaesthesia and intensive care.

In 1975, a section of intensive care was established within the Faculty of Anaesthetists, RACS, and Barry Baker was appointed its inaugural chair, a position he held until 1977. He remained on the executive of the section until 1988.

Also in 1975, he took up the post of foundation professor of anaesthesia and of intensive care at the University of Otago on New Zealand's South Island, where he remained until 1992. This was the first chair in anaesthesia or intensive care in New Zealand.

Honours

1993 Admitted to the Court of Honour, RACS.

1994 ANZCA's Orton Medal, the College's highest award, given for distinguished service to anaesthesia.

1996 Awarded the Australian Society of Anaesthetist's Ben Barry Medal in recognition of an outstanding contribution to the society's journal, *Anaesthesia and Intensive Care*. The journal was established in 1972, and Barry has been on the editorial board from 1975 to this day.

1997 Awarded the prestigious ANZCA Douglas Joseph Professorship award for research in low flow and closed circuit anaesthesia.

2014 Awarded an AM, in the general division, in the Queen's birthday honours, for significant service to medicine, particularly to cardiovascular anaesthesia, to medical education, and to professional medical organisations.

The years in Dunedin were busy ones. Barry was the director of anaesthesia, on the Otago Hospital board as well as foundation director of the intensive care unit. Apart from his obligations to the faculty and its section of intensive care, the medical school, his clinical work, research and his young family, Barry undertook various faculty appointments, including being elected to the Board of the Faculty of Anaesthetists in 1980, the education officer from 1980-1988 and chairman of the Workforce Committee from 1985-1986. In 1987 he became vice-dean. He was acting dean for six months, while Robin Smallwood was sick, and then dean when Robin died in September.

From 1987-1990, Barry served as the Dean of the Faculty of Anaesthetists and on the RACS Council and executive committee (1986-1990), and also on the research committee.

This was an important time in the history of anaesthesia in Australia and New Zealand.

Barry was dean at the time of the negotiation of separation of the anaesthetists and intensive care specialists from RACS through the formation of an independent college.

He was a primary examiner in physiology for the Faculty from 1976-1991. However, he has also examined for the final exam as well as intensive care. There would be very few other Fellows who have examined in all three areas.

In 1991 ANZCA was incorporated – the journey towards the formation of a college of anaesthetists had begun!

In the same year, Douglas Joseph (Dean of the Faculty from 1980-1982) died and the bequest was established.

ANZCA was founded on February 7, 1992 and in 1993, the Faculty of Intensive Care was founded.

In 1993, the College's armorial bearings were granted. Barry was deeply involved in its design.

From 1989-1995, Barry was chair of the Education Standards Sub-Committee of the Committee of Presidents of Medical Colleges (CPMC).

In the same year that ANZCA was founded, Barry left Dunedin and became the Nuffield Professor of Anaesthetics at the University of Sydney, based at the Royal Prince Alfred Hospital (RPA) and he remained in that position until 2005. He was chair of the University of Sydney Ethics Committee from 1998-2000.

Barry retired from clinical anaesthesia in 2005, an important year as the RPA celebrated its 75th jubilee. He wrote a book, *Australia's First Anaesthetic Department, 75 years at the RPA* to commemorate the event.

In 2006, he was appointed as an ANZCA Director of Professional Affairs (DPA). He became the Executive Director of Professional Affairs in 2009, which placed him on the council's executive committee as well as attending council.

In 2010, he was appointed ANZCA's dean of education, and he led the Curriculum Redesign Steering Group, which was tasked with revising ANZCA's curriculum and providing oversight of not only its creation but also its implementation in 2013.

Barry also has a long-standing interest in the history of anaesthesia, and is a member of ANZCA's History and Heritage Expert Reference Panel. In 2012, he delivered the inaugural Pugh Day lecture in Launceston to commemorate the 165th anniversary of the first administration of an anaesthetic in Australia by Dr William Russ Pugh in Tasmania in 1847.

He has more than 200 publications in academic and scientific literature on anaesthesia, physiological and historical topics. He has presented at meetings in Australia, New Zealand and elsewhere overseas on many occasions on a diverse range of subjects. In the 2001 edition of *Australasian Anaesthesia*, Barry wrote "The Ageing Anaesthetist", a landmark article in this region that focused attention on the latter stages of an anaesthetist's career.

Quite apart from this prolific career, Barry spends time with his family – his wife Jane (also an anaesthetist), children Merinda, Alex and Matthew and four grandchildren. He is extremely fit and does challenging bushwalks, kayaks on Sydney Harbour and enjoys art, concert music and the theatre. He and Jane have travelled extensively.

Professor Barry Baker has had a long and distinguished medical career – the status of our specialty and that of intensive care have been shaped by his energy, passion, boundless enthusiasm and keen intellect.

ANZCA, and before it, the Faculty, has benefited enormously from his many years of dedication.

We are deeply grateful for his service, wisdom, guidance and vision.

New awards

Two new awards, to be funded in alternate years by the earnings of a generous donation from Professor Barry Baker, were announced at an ANZCA Council dinner in July.

The Joan Sheales Staff Education Award and the Provisional/New Fellow Research Award were announced at the dinner to farewell Professor Baker, who was retiring from his roles as Dean of Education and Executive Director of Professional Affairs, Professor Barry Baker.

The dinner was also an opportunity to thank Professor Kate Leslie, Dr Kerry Brandis, Dr Michelle Mulligan, Associate Professor Brendan Moore and Dr Gabe Snyder who left the ANZCA Council in May.

Listen to an interview with Dr Barry Baker on the College Conversations CD with this edition of the *ANZCA Bulletin*.

From left: Professor Barry Baker at July's ANZCA Council dinner; guests at the dinner; Professor Kate Leslie, who was farewelled from council at the dinner, with President Dr Genevieve Goulding, Vice-President Associate Professor David Scott, and former presidents Dr Leona Wilson and Dr Lindy Roberts; speeches at the farewell dinner.

Future uncertain for specialist training program

Australia

The Specialist Training Program is now a mature and stable part of the College. The Commonwealth Department of Health has been supporting the provision of specialist training arrangements in rural and outer metropolitan areas since 1997, but future funding is not assured.

There is an allocation in the budget to resource the Specialist Training Program beyond next year – but there is no funding agreement with the Government yet.

The funding agreement between the College and the Federal Government is due to expire in December next year. As a result, there have been no new positions released for the 2015 training year. The 2014-15 Health Portfolio Budget statements lists the continuation of 900 specialist training program positions across the 2016 and 2017 academic years. There is no indication of an increase in numbers but it is encouraging that there is an allocation of resources to the program within the health portfolio beyond next year.

Specialist Training Manager Donna Fahie and I will meet shortly with department representatives to advocate for continuation of the program after 2015.

The College recently assisted the Australian National Audit Office in a performance audit of the administration of the specialist training program by the Department of Health. As part of the audit, a number of specialist training program-funded hospitals were asked to share their perspective on how the program's funding has helped them in providing increased training opportunities, as well as any other matters relating to its operation. We would like to thank those sites that volunteered their time to be involved.

Further information on the specialist training program can be found at: www.anzca.edu.au/training/specialist-training-program. Enquiries relating to STP, including the above projects, can be directed to Donna Fahie (manager, STP) on +61 3 9093 4953 or stp@anzca.edu.au.

New Zealand

Parliament adjourned for the final time in this term on July 31, with political parties launching their election campaigns for the September 20 national election. Minister of Health, the Hon Tony Ryall, is retiring from politics at this election. In anticipation of a new health minister, ANZCA has been working with the Council of Medical Colleges in New Zealand to develop a briefing for the incoming minister. ANZCA's section of the briefing will highlight key work areas and priorities for the College.

PHARMAC has developed and consulted on its proposed approach for managing hospital medical devices nationally, and will eventually move to full management of hospital medical devices (including assessment and prioritisation). This will be a gradual process over several years. PHARMAC will continue to consult and seek feedback from the sector as this work develops and as PHARMAC takes over more categories of medical devices. Currently, PHARMAC has national contracts in place for wound care products, sutures and laparoscopic equipment, and is working on interventional cardiology and orthopaedic devices.

The Perioperative Nurses College, part of the New Zealand Nurses Organisation, has developed a draft *Knowledge and Skills Framework for the Registered Nurse Assistant to the Anaesthetist*. It has also announced that in early 2015, the Auckland University of Technology will pilot a Registered Nurse Assistant to the Anaesthetist Course as part of its postgraduate nursing program. Dr Nigel Robertson (ANZCA NZ National Committee Chair), Ms Heather Ann Moodie (GM NZ) and Ms Virginia Lintott (Policy Adviser NZ) were scheduled to meet with representatives from the Perioperative Nurses College and the Auckland University of Technology in early August, to discuss the importance of aligning with ANZCA's professional documents such as *PS08 Recommendations on the Assistant for the Anaesthetist*, among other issues.

Health Workforce New Zealand (HWNZ) is continuing its work to improve the information available to help medical students and doctors in prevocational training with career planning. The College has recently provided information to HWNZ about the ANZCA and Faculty of Pain Medicine training programs. HWNZ is also keen for colleges to work with it and district health boards to build data on workforce trends to help determine the number of training places required for the different specialties.

Submissions

ANZCA continues to advocate on behalf of Fellows and trainees, providing submissions to government and health stakeholders in a variety of areas. ANZCA has recently made submissions and/or representations to:

Australia:

- Australian Commission on Safety and Quality in Health Care on training and competency requirements for recognising and responding to clinical deterioration in acute care.
- Australian Medical Council on the accreditation of the Royal Australasian College of Physicians.

(continued next page)

- Community Affairs Legislation Committee and the Senate Standing Committees on Community Affairs on the Inquiry into the Health Workforce Australia (Abolition) Bill 2014.
- Health Workforce Australia on:
  - Expanded Scope of Practice, Advance Practice in Endoscopy Nursing Project.
  - Geographic Distribution: Medical Workforce Project.
- Medical Board of Australia on:
  - Core Registration Standards.
  - Limited Registration Standards.
- National Blood Authority on the Patient Blood Management Guideline: Module 5 – Obstetrics and Maternity.
- Pharmaceutical Benefits Advisory Committee and Department of Health on the generic modified-release oxycodone preparations and tamper resistance.
- Royal Australian and New Zealand College of Radiologists on the imaging guidelines and decision support tools.
- Standards Australia on the Reprocessing of reusable medical devices in health service organisations (AS/NZS 4187:2003).
- Victorian Department of Health on the Medical Planning Education Group Topic: International Health Professionals Victoria review.

New Zealand:

- Ministry of Health NZ, confirming ANZCA's endorsement of the *New Zealand Guidelines for Helping People to Stop Smoking*.
- PHARMAC on:
  - PHARMAC's proposed approach for managing hospital medical devices.
  - Feedback on requests from DHB hospitals for PHARMAC to list glucose 4% sodium chloride 0.18% solution on the Pharmaceutical Schedule.
  - Proposals on:
    - wound care products by W M Bamford & Co Ltd.
    - ferric carboxymaltose.
    - preoperative carbohydrate 0.5 kcal/ml oral feed.
    - erythropoietin.
- Perioperative Nurses College on its draft *Knowledge and Skills Framework for the Registered Nurse Assistant to the Anaesthetist*.
- Post Anaesthesia Nurses of New Zealand on its draft *Professional Framework and Practice Standards* for Post Anaesthesia Care Unit nurses

A selection of ANZCA's submissions, including the accreditation submission to the Australian Medical Council and submissions developed by the New Zealand National Committee can be accessed via: www.anzca.edu.au/communications/submissions.

Jonathon Kruger
General Manager, Policy, ANZCA

National Anaesthesia Day – October 16

Get involved!

National Anaesthesia Day
October 16, 2014

Smoking and the perioperative period – what our guidelines say

Tobacco use is the single greatest preventable cause of death and disease in Australia and New Zealand.

At least half of all smokers will eventually die as a result of their smoking according to conservative estimates. About 15,500 deaths in Australia and 5000 in New Zealand are attributable to tobacco each year.

Smokers are at increased risk of perioperative respiratory, cardiac and wound-related complications.

However, smoking cessation before surgery has been shown to improve surgical outcomes. Although there is some controversy about optimal timing of smoking cessation there is agreement that quitting for longer is best.

Seize the opportunity – the anaesthetist and advocacy

The perioperative period represents a "teachable moment" when many smokers quit or attempt to quit smoking, sometimes permanently.

The Smoking Cessation Taskforce of the American Society of Anesthesiologists developed a simple three-point cessation strategy (A-A-R = Ask, Advise, Refer). This involves always asking patients about their smoking status (even when known), advising them of the perioperative risks and referring them to locally available smoking cessation support.

See *PS12: Guidelines on Smoking as Related to the Perioperative Period* for more information.

It's never too late to stop smoking

- Quitting smoking for one day will lower carboxy-haemoglobin and nicotine levels and could be expected to improve tissue oxygen delivery.
- Quitting smoking for as little as three weeks has been shown to improve wound healing.
- Quitting smoking for six to eight weeks results in sputum volumes that are not increased compared to non-smokers, and improved pulmonary function.
- Immune function is significantly recovered by six months after quitting smoking.

From *PS12: Guidelines on Smoking as Related to the Perioperative Period* (see www.anzca.edu.au/resources/professional-documents).

Dr Claire Armstrong at Tamworth Rural Referral Hospital on National Anaesthesia Day last year.

Auckland anaesthetists embrace National Anaesthesia Day

Auckland anaesthetists are taking a hands-on approach to demonstrating their craft on National Anaesthesia Day, which aims to increase public understanding of anaesthesia.

On October 16, the anaesthetists will use three airways mannequins to show lung function, blocking the airways of one with gauze so the public can feel the difference between manually ventilating a clear airway and one that is typical of a smoker.

"People will be able to compare a normal lung with the problematic lungs of smokers," said Dr Chang Kim, who is co-ordinating National Anaesthesia Day activities for the Auckland District Health Board (ADHB) at Auckland City Hospital (including National Women's and Starship Children's hospitals) and the Greenlane Surgical Centre.

"We're trying to get them interested through a hands-on approach rather than setting up static information."

This year's theme for National Anaesthesia Day is "Stop smoking before your anaesthetic – every day makes a difference". It coincides with the formal release of the College's *PS12: Guidelines on Smoking as Related to the Perioperative Period*, which is now being piloted (see www.anzca.edu.au/resources/professional-documents).

The focus will be on the dangers of smoking and anaesthesia, and how anaesthetists can play a role in helping patients stop smoking.

ANZCA has contacted all hospitals to encourage them to get involved and will send National Anaesthesia Day kits, including posters and balloons, to all hospitals at least a fortnight before October 16. Patient information sheets will be available online for hospitals to download and use.

As well as face-to-face interactions between anaesthetists and patients, ANZCA will run a media campaign about the importance of quitting smoking before surgery and more generally about the critical role anaesthetists play in a safe healthcare system.

Dr Kim has several other activities planned for October 16 including:

- Setting up a booth staffed with anaesthetists, trainees and anaesthetic technicians in the Auckland City Hospital foyer and displaying the National Anaesthesia Day poster, balloons and other information.
- Displaying posters and balloons in anaesthesia departments, lifts and other parts of the hospital.
- Creating a continuously running slide show.
- Using a "sim-man" display to demonstrate anaesthesia.
- Using mannequin heads with airways and lung to demonstrate airway devices and ventilation.
- Displaying an anaesthesia machine and other anaesthetic equipment.
- Using computers to display patient information available on the ANZCA website (www.anzca.edu.au/patients).

What hospitals can do

- Set up a foyer display using collateral being sent by the College (posters, balloons) and have staff available to answer questions from the public.
- Run demonstrations using mannequins and other equipment, especially if it can demonstrate the negative effects of smoking (for example, lung function).
- Display the National Anaesthesia Day poster throughout the hospital and/or in consulting rooms.
- Print and distribute ANZCA's web-based patient information sheets (www.anzca.edu.au/patients/information-sheets) and other collateral (www.anzca.edu.au/patients/information-sheets).

For more information or support, please contact communications@anzca.edu.au.

Coincidentally, National Anaesthesia Day falls in the same month that the group ADHB Smoke-free is running "Stoptober", a campaign to encourage patients to quit smoking. They will have a booth near the one staffed by anaesthetists.

This booth will have a carbon monoxide breathalyser that allows people to assess their own breathing and compare it with smokers, as well as spirometry and peak expiratory flow meter testing to demonstrate lung function.

National Anaesthesia Day is held on October 16, the anniversary of the day in 1846 that ether anaesthetic was first demonstrated in Boston, Massachusetts. Last year, ANZCA successfully re-launched National Anaesthesia Day; Fellows and trainees throughout Australia and New Zealand were involved in activities that generated widespread media coverage. A wrap-up of last year's National Anaesthesia Day activities can be found in the December 2013 edition of the *ANZCA Bulletin* (www.anzca.edu.au/communications/anzca-bulletin).

A 2013 Community Attitudes Survey commissioned by ANZCA found that, despite 96 per cent of people reporting experience of a general anaesthetic (personally or through a close family member), only 50 per cent were aware that all anaesthetists are doctors (of these, 41 per cent know they are doctors with the same training/qualifications as other specialists). Nearly one in 10 did not think anaesthetists are doctors and 49 per cent were unsure.

This year, the poster includes the line "Anaesthetists – caring for the body and its breath of life", inspired by the ANZCA coat of arms motto "Corpus curare spiritumque".

The poster and other promotional materials will be sent to hospitals in late September/early October. Heads of anaesthesia departments in Australia and New Zealand have been encouraged to nominate a co-ordinator for the day.

For further information please contact Ebru Yaman, ANZCA Media Manager via communications@anzca.edu.au or +61 3 8517 5303. In New Zealand, NZ Communications Manager, Susan Ewart, is available at communications@anzca.org.nz or +64 4 499 1213. See also www.anzca.edu.au/communications/national-anaesthesia-day.html

Clea Hincks,
General Manager Communications, ANZCA

ESSENTIAL PAIN MANAGEMENT COURSE EXPANDS TO MANILA:

BEYOND THE PAIN BARRIER

A STIGMA ATTACHED TO MORPHINE AND A GENERAL RELUCTANCE TO ACKNOWLEDGE AND BE TREATED FOR PAIN MAKES ITS MANAGEMENT ESPECIALLY DIFFICULT IN THE PHILIPPINES.

Pain is a global human experience, undiscriminating among individuals and transcending cultures. But the way pain is recognised, assessed and treated can vary wildly. When the Essential Pain Management (EPM) course was delivered for the first time in the Philippines in August, more than 50 healthcare professionals had the opportunity to discuss their understanding of patients presenting with pain, its various causes and treatments, and the barriers to pain control encountered under their health system.

EPM was designed in 2008 by ANZCA Fellows Professor Roger Goucke, from Western Australia, and Dr Wayne Morriss, from New Zealand, in response to a request from colleagues in Papua New Guinea (PNG) who wanted to support doctors and other health professionals in understanding and providing effective pain management. It was piloted in PNG in 2010 and has since been introduced to 32 countries. The three-day EPM course (see breakout), was developed as a straightforward and easy-to-deliver module of education where the basics of the physiology and psychology of pain are explained and explored. Interactive and group discussion-based, an important component of the model is to train participants to deliver the course themselves once they have completed it.

At first glance it may seem unlikely that a highly-trained workforce such as physicians, anaesthetists, nurses and other healthcare professionals need any explanation of the dynamics of the human pain experience. But participants at the course, held in Manila and drawn from the nation's population of 100 million, all agreed that pain was complex to treat in their hospitals and clinics and remained grossly misunderstood even among their colleagues.

Course participant Dr Maria Elena Oripapy, an anaesthetist from the rural province of Bohol, more than 1000 kilometres south-east of Manila, explained that addressing a patient's pain was generally regarded as secondary to their healthcare and treatment, when it was considered at all.

"One of the main problems with pain medicine management in the Philippines is among medical practitioners," Dr Oripapy said.

"Most people are unaware of how to manage pain – the doctors and the allied health workers as well as the patients themselves.

"They all think injury and illness is supposed to hurt, and that they are supposed to live with the pain – that is, you had an operation and if two years later, you are still experiencing some pain, that it is normal.

"You had an operation or you got sick and you are meant to have pain. That's how we think, that's how people in the Philippines think."

So much so, she has never had a cancer patient present before when the cancer is terminal.

Dr Oripapy said she herself may have continued to think this way but for the development of a severe spinal problem in her mother, whose pain reached such excruciating levels she was unable to move.

"Being a doctor, I thought I should be able to give her comfort, I owe that to my mother," she said.

"That's when I started to really see the importance of pain relief and that's when I started to get interested in pain, when my mother felt so much pain that I realised that we had to treat pain itself as well as the condition."

The right combination of paracetamol, tramadol and psychological support has her mother's pain under control today, but Dr Oripapy said she still sees too much suffering among others that can be alleviated with the right combination of therapies.

(continued next page)

This page from top: EPM Manila - day 3; Professor Roger Gouke.

WHAT IS ESSENTIAL PAIN MANAGEMENT?

Essential Pain Management is a three-day educational program developed to improve pain management worldwide by working with health workers at a local level. The course recognises pain is a global problem. It has many causes and is often a "hidden" problem.

EPM works with health professionals to improve pain knowledge, provide a simple framework for managing pain and address pain management barriers.

There is a need for EPM because pain is often poorly treated; improving knowledge and attitudes can lead to improved pain management, and simple and inexpensive treatments for pain can make a big difference to the lives of individuals and their families.

The program is cheap to run, interactive and encourages the early handover of teaching to local instructors. To date, courses have been run in parts of the Pacific, Mongolia and Rwanda, Bangladesh, throughout parts of Asia and Latin America.

There are two parts to the program – the EPM workshop and the EPM instructor workshop.

The EPM workshop is a one-day program of interactive lectures and group discussions. The workshop teaches a system for recognising, assessing and treating pain (Recognise, Assess, Treat: RAT) and addresses pain management barriers.

The EPM Instructor Workshop is a half-day program designed to provide participants with the knowledge and skills to become EPM instructors. This encourages co-operation between local health workers, and local instructors are more likely to understand specific local problems.

On day three, those participants who took part in the instructors' course teach the EPM workshop to a new group of participants with the support of the course supervisors.

The EPM program is designed for any health worker who comes in contact with patients who have pain.

Participants often include doctors, nurses, clinic workers, pharmacists and other health workers.

For more information see www.essentialpainmanagement.org.

ESSENTIAL PAIN MANAGEMENT COURSE EXPANDS TO MANILA:

BEYOND THE PAIN BARRIER

CONTINUED

"I manage my mother's pain and I would like that for everyone else too.

"All the time I see patients as well as their attending surgeons and they are not well educated about pain at all."

Professor Goucke said there were many low and middle-income countries where public health and social problems were so enormous that there was little opportunity to make a breakthrough in pain management. But there was opportunity in the Philippines, he told his class, for a small revolution in patient well-being.

"Our aim is to improve the understanding of pain. Pain is simply poorly understood.

"Pain management is possible and it is affordable. It is a matter of education."

The EPM program is based on the acronym RAT: Recognise, Assess and Treat.

The course outlines the basics of pain and then explores recognition of pain, ways to assess (including the pain scale) and treatment options, which participants are encouraged to discuss widely – from cognitive behavioural therapy, through to rest, ice compression and elevation (RICE) techniques and then more complex treatments including opioid and antineuropathic combinations.

The incoming President of the Pain Society of the Philippines, Dr Lilybeth Tanchoco, said this misunderstanding of the urgent need to better manage pain in her country was largely informed by cultural and religious factors, shared as widely among doctors as patients.

A dominantly Catholic and deeply religious nation, suffering was seen as atonement, a "cross that must be borne" and an experience through which a greater sense of holiness attained.

"We have to help people understand that in relieving pain you are not separating yourself from God," Dr Tanchoco said.

"That when you have a better quality of life you are more able to participate in your life, your family and your community, that there is no virtue in suffering."

Anaesthetist Dr Renato Maranan attended the course from Davao, south-east of Manila, which has a population of just 18,000. He said he found that many patients also simply didn't want to "complain" about their suffering, which made the most sympathetic doctor's job more challenging.

"Many are too shy, they expect they must just put up with what they are feeling," Dr Maranan said.

It is for this reason that a component of the course involves how to identify a person is in pain. That technique, as Professor Goucke teaches it, is as simple as asking the patient what they feel.

"If someone doesn't tell you they are in pain then how would you know?" Professor Goucke asked participants on the first of three days of EPM.

"Sometimes it is just a question of asking them.

"Pain is what the patient says hurts."

The message that pain can be invisible is reinforced, as is an explanation of the different sources of pain – nociceptive (obvious tissue injury or illness) pain and neuropathic pain, where tissue damage may not be obvious but the nervous system responds abnormally. Case studies are discussed among participants where they share their observations and patient stories.

A recurring topic of conversation and clear source of frustration were attitudes to effective and cheap sources of pain relief, especially morphine.

While morphine was generally accepted for use in cancer pain but a major barrier was the distribution of opioids throughout the country, its prescription and its dispensing. The oldest and possibly most readily recognised opioid, fear in the community about morphine's addictive quality runs high in the Philippines. Families and patients themselves will regularly outright refuse its administration.

"They think they will be addicted and leave hospital or recover as a drug addict," said dean of the Faculty of Medicine and Surgery at the University of Santo Tomas, Professor Jesus Valencia.

"There is a very big stigma attached to morphine. We need to change attitudes so people can understand that managed by your doctor under close supervision addiction is not the outcome of treatment."

Dr Luviminda (Luz) Kwong, president of the Pain Society of the Philippines, said doctors themselves were often reluctant to administer treatment and that education was key to breaking down this barrier.

"Generally there is enough access to the drugs, although it varies, but as big a problem is lack of training in pain management."

The EPM course, she said, covered the topic of pain in straightforward and easy to digest blocks of information.

"It can be understood by health care workers from surgeons to physiotherapists and by training people to return to their workplaces and teach their own staff what they have learned we can slowly change the attitudes."

Professor Mary Cardosa, an anaesthetist and specialist pain medicine physician from Kuala Lumpur, led the EPM course in Manila with Professor Goucke and Associate Professor Jocelyn Que, from the Faculty of Medicine and Surgery at the University of Santo Tomas, a teaching hospital in Manila.

They each reinforced the myriad reasons for treating pain, from humanitarian to long-term social and economic imperatives.

"A lot of people in hospitals think they know how to manage pain but it is still not well managed," Professor Cardosa said.

"We teach that pain is not just about short-term discomfort but also that untreated acute pain has long-term consequences, can cause adverse physiological changes and lead to chronic pain."

As the course starts participants are asked to fill in a short questionnaire to gauge their understanding of pain, with questions from "What is pain?" to how pain can be classified and what a simple analgesic is.

At the end of the course attendees are asked to fill in the same test. This allows a short-term measure of the success of the program.

Professor Goucke said he enjoyed seeing how well the course was received and how easily it could be adapted to a local environment – from Fiji to Mexico – no matter what the local language for pain was or what the cultural challenges were for its management.

"It's cheap to run, local professionals learn to teach the concepts to their colleagues so it is very efficient.

"And it works."

Ebru Yaman,
Media Manager, ANZCA

Below from left: Course participant Dr Maria Elena Oripapy; Professor Jocelyn Que, centre, one of the EPM instructors; Professor Mary Cardosa takes a session "What is pain?"; The University of Santo Tomas, a teaching hospital in Manila.

"WE HAVE TO HELP PEOPLE UNDERSTAND THAT IN RELIEVING PAIN YOU ARE NOT SEPARATING YOURSELF FROM GOD."

Geoffrey Kaye Museum of Anaesthetic History reopens within dedicated knowledge centre

ANZCA's historic Ulimaroa building has been transformed into a hub of information for use by Fellows and trainees.

With the refurbishment of the Fellows Room, the relocation of the Geoffrey Kaye Museum of Anaesthetic History and ANZCA Library, as well as newly painted meeting rooms within Ulimaroa, ANZCA Fellows now have ready access to a dedicated and fit-for-purpose knowledge centre.

To celebrate completion of the works and to mark the occasion, Victorian Health Minister Mr David Davis joined around 60 guests at ANZCA House and officially opened the Geoffrey Kaye Museum of Anaesthetic History on Friday, September 19.

Dr Genevieve Goulding, ANZCA President, Dr Chris Ball, ANZCA Honourary Curator, Dr John Paull, ANZCA Honourary Archivist and Dr Andrew Kennedy, Convenor, 2014 New Fellows Conference all presented on the evening.

The event included a traditional smoking ceremony and welcome to country, saw the handing over of a time capsule from the 2014 New Fellows Conference ("My Legacy") and showcased a new visual and oral history presentation about Dr Geoffrey Kaye. Most interesting and entertaining were Dr John Paull's stories of Dr Kaye's life, ranging from his professional achievements to his personal eccentricities.

A popular part of the evening was the opportunity to walk through the knowledge centre and view the new exhibition in the museum focusing on developments in anaesthesia and pain medicine and how this has improved patient outcomes and professional practice. People also were drawn to the newly installed ANZCA timeline, a feature of the corridor leading from ANZCA House and into Ulimaroa.

Guests were asked to record their experiences with, and thoughts on, the museum and this will form part of an exciting oral history project designed to engage Fellows in the life and times of the museum.

The Geoffrey Kaye Museum of Anaesthetic History

Dr Geoffrey Kaye formed the Museum of Anaesthetic Apparatus in 1935. He believed a museum of that type was essential to the development of future anaesthetists. By looking to the equipment and procedures of the past, trainee anaesthetists would be better placed to understand the requirements of the present and anticipate those of the future.

Almost 80 years later, the museum has undergone several name changes, finally settling on the Geoffrey Kaye Museum of Anaesthetic History in 1987. It has been relocated several times with its newest form being formally re-opened within the knowledge centre in Ulimaroa.

Located in front of ANZCA House in St Kilda Road, Melbourne, the Italianite building, Ulimaroa, served as the College's library until recently. Now, the Geoffrey Kaye Museum and ANZCA Library sit side by side and, with a newly refurbished Fellows Room, form the knowledge centre.

The former exhibition, "All in a Day's Work", has been replaced by a thematic progression through the development of anaesthesia, advances in pain medicine and technical developments, which have resulted in equipment and skills to create better experiences for patients and practitioners.

The museum pays homage to the innovators of World War I; the (predominantly) men who challenged accepted practice and technique to develop better ways of treating critically injured soldiers.

On loan from the Royal Australasian College of Surgeons museum is a facial reconstruction mask from that era. The soldier represented by the mask, Private George Nesbitt, received severe facial wounds from a gunshot injury. The type of injury complicated the administering of anaesthesia and this inspired Ivan Magill and Stanley Rowbotham to develop more efficient endotracheal tubes to allow the necessary surgeries to be performed. A variety of what have become known as "Magill's endotracheal tubes" are on display.

A display area has been dedicated to Dr Kaye, the man who started it all. This glass case links the museum and library and from either side offers a peek to the other collections. The museum side highlights his developmental interests and achievements; cheap, portable vaporisers for the Australian army during the World War II, sectioning anaesthesia equipment for study and his creative side, with a set of ley pewter candle sticks, constructed in his workshop. The library side showcases his eclectic taste in literature, from technical works through to a German version of Shakespeare.

The museum has been designed in a modular fashion so sections of the display can be removed and replaced with temporary exhibitions. This allows for swift changes in response to current areas of interest or popularity. Plans are underway for 2015 programming.

From left: ANZCA President, Dr Genevieve Goulding with Victorian Health Minister, Mr David Davis, officially opening the newly relocated Geoffrey Kaye Museum of Anaesthetic History; a view from inside the museum; artefacts on display in a cabinet.

Geoffrey Kaye Museum of Anaesthetic History reopens within dedicated knowledge centre (continued)

The ANZCA Library

The ANZCA Library is as popular as ever and is often described by Fellows as the "jewel in the crown" of the College. Relocation did nothing to stop the steady stream of queries, with more than 1800 requests from Fellows and trainees fulfilled by the library during this period. The library team was very proud to offer a continuous service during the relocation.

The library has assisted with a range of projects so far this year, from sourcing current and relevant articles required for the new edition of the *Acute Pain Management* book, to performing literature searches on topics such as anaesthesia for electroconvulsive therapy.

The relocation of the ANZCA Library collection into a new space allows Fellows and trainees ready access to current material when visiting the College. A display of new journals and books can be browsed and dedicated exam preparation and medical education collections have been developed.

The older books collected over the many years since the library was established as part of the Faculty of Anaesthetists have been retained and now fill the grand bookshelves of the newly appointed Fellows Room. Over the next few months, rare and significant books, such as the Geoffrey Kaye Collection, will be transferred to the museum.

While the new library space offers a place for research and study, the online presence of the library including journals, textbooks and databases continues to expand and improve, ensuring equal access for all Fellows and trainees across Australia and New Zealand.

As one satisfied customer stated: "It is a pleasure to use ANZCA Library in general and it is great to know that you work so hard to improve it when possible".

Fellows Room

The newly refurbished Fellows Room, located in one of the front rooms of Ulimaroa, offers Fellows and trainees a dedicated social, study or meeting space within the knowledge centre. The mood of the room reflects back to an earlier era with floor to ceiling bookcases in dark wood, plush curtaining and comfortable seating areas, all set off by the large bay windows that afford a relaxing view of the gardens.

The room is fitted with data and power points, offering the perfect intersection between the charm of yesteryear and modern convenience.

Memories and milestones

A brief history of ANZCA, and its preceding Faculty of Anaesthesia, Royal Australasian College of Surgeons has been created for the corridor leading from ANZCA House into Ulimaroa.

As well as describing the formation of ANZCA in 1992, the timeline includes a section on the birth of the Faculty of Pain Medicine and the development of intensive care medicine.

It describes the evolution of core College roles including our commitment to training, our role in maintaining standards, our dedication to safety, our commitment to research and how we recognise achievements. It also looks at our work in the community and the important role of overseas trained doctors.

My Legacy: 2014 new Fellows time capsule

Delegates at the 2014 New Fellows' Conference on Sentosa, Singapore, created a time capsule to be stored at the Geoffrey Kaye Museum of Anaesthetic History. The capsule contains advice from new Fellows to anaesthetists of the future, along with objects and photographs that represent their working lives today.

Dr Andrew Kennedy, convenor of the New Fellows Conference, and Dr Vicki Pentelow, the youngest Fellow for 2014, presented the capsule to the museum's Honorary Curator, Dr Christine Ball.

When the capsule is opened in 2039, the new Fellows who open it will find anaesthetists' working lives represented by a range of objects: A photograph of doctors marching in protest against government contracts; a picture of propofol in an infusion pump; a paediatric face mask smelling of bubblegum; a peripheral nerve stimulator; a security badge card with resuscitation guidelines; and two takeaway coffee cups.

One interesting item is a departmental phone list. The contributor included it because "...it symbolizes our increasing role as perioperative physicians, with our care extending well beyond the OR and recovery to far broader areas, in post op care, nurse and physician education and theatre co-ordination".

Thank you

The newly refurbished knowledge centre and in particular the relocation of the Geoffrey Kaye Museum of Anaesthetic History would not have been possible without the vision, determination and commitment of a number of people. While it is impossible to name everyone, ANZCA would like to acknowledge the following Fellows, Dr Christine Ball, Honorary Curator, Dr John Paull, Honorary Archivist and Dr Rod Westhorpe, former Honorary Curator, who each in their own way has ensured the museum remains an integral part of the College for past and present members. Thank you also to the hard working museum and facilities staff, contractors and the ANZCA Knowledge Resources team who worked tirelessly to ensure all was ready for the September 19 opening.

From left: A glass cabinet dedicated to the late Dr Geoffrey Kaye links the ANZCA Library with the Geoffrey Kaye Museum of Anaesthetic History; the updated library; the newly refurbished Fellows Room; a timeline outside the museum gives a brief history of the College and describes some of its core roles.

Networks opens new online opportunities

This month, the College is launching Networks, ANZCA's new online learning and collaboration management system.

Networks is an intuitive digital environment that allows ANZCA and FPM Fellows and trainees to connect, share and learn in a simple, engaging and accessible way.

What's available?

Networks will expand ANZCA's educational offerings, such as ANZCA and FPM podcasts, webinars and online courses, to allow Fellows and trainees to undertake training and continuing professional development activities online.

It will also modernise online committees, sub-committees and project group practices, replacing E-Communities with a vastly improved collaborative system.

There are four main streams:

- Anaesthesia learning (see opposite).
- Communities (see opposite).
- Pain medicine learning (see page 32).
- Personal and professional learning (see page 32).

ANZCA and FPM will benefit from the many tools available in Networks to meet our strategic aims of delivering a world-class training program, to provide a professional development framework that supports the ongoing development of skills and expertise to enhance services to Fellows and trainees and to strengthen connections within the College community.

Logging into Networks

Trainees and Fellows will be able to log in to Networks using their ANZCA website username and password. You can access Networks from the ANZCA of FPM website homepages using the quick links in the right-hand listing.

Networks is customised to each user

Each user will see their own homepage, customised to display all the Networks that the user has access to, for example, ANZCA podcasts within anaesthesia learning and committees in which they are involved.

Log out at the end of your session

It is good practice for all users to manually log out after they have finished each Networks session. This is particularly important if users are using a shared computer as others may be able to access course material or committee papers if the computer is left unattended.

Olly Jones, General Manager Education, ANZCA

Networks can be accessed via the ANZCA home page.

Each user has a customised homepage.

Anaesthesia learning

Anaesthesia learning provides Fellows and trainees with a wealth of quality educational resources they can readily access in one place.

Existing learning resources, such as ANZCA podcasts and teaching and learning cases, are now available in Networks. Please note these will shortly be removed from their previous location on the ANZCA website.

We are also expanding resources in this section, and will have a range of new educational resources available soon. More information on these is listed below.

- **Trainee orientation program and support resources**
  The introduction of the revised curriculum has been challenging for both new and transitioned trainees. These new supporting resources will offer simple, practical advice and tips for trainees in each training period, an overview of the important training milestones and advice on balancing work and life. The project group developing this resource is chaired by Dr Noam Winter, Co-Chair ANZCA Trainee Committee, Victoria.
- **Supervisor orientation program and support resources**
  Supervisors are vital to the training program, and these resources will provide support in a simple and accessible format. From tips on co-ordinating your team, providing support and education for team members, to advice on looking after yourself and trainees, the resource will offer a wealth of information and an online collaborative network for all supervisors to share their experiences. The project group developing this resource is chaired by Dr Emily Wilcox, Supervisor of Traning, NSW.
- **Primary examination preparation resource**
  This resource will provide insights into the exam process, useful tips for preparing for the exam and information about what happens on the day. It will include a series of mock vivas, advice from trainees that have undertaken the exam, and a view into the examiners' perspectives. To complement the resources we will also run two webinars each year for trainees from 2015. There is a project group developing this resource with representation from the Primary Examination Sub-Committee.

Olly Jones, General Manager Education, ANZCA

Communities

Communities in Networks will replace E-Communities on the ANZCA website. It provides an improved collaboration environment for groups including the ANZCA Council and FPM Board and their committees, sub-committees and project groups. Special interest groups will also be able to use Communities.

Committees are being migrated over in a phased approach with committee chairs and members being kept informed. Please note the following key points:

- ANZCA's committee support officers are the key point of contact for questions relating to specific committees.
- Up to two years of data will be migrated from E-Communities.
- You will only see committees of which you are a member.
- Individuals with specific roles or needs can also use Networks to develop discussion forums or online blogs to communicate and share ideas or resources.

A select group of committees were chosen to be involved with a pilot, to use Networks and provide feedback. The feedback has been positive, and we will continue with a phased approach for the remaining committees and groups.

"The way it's set out and the way it works, it's a lot easier than the old E-Communities system... it's very easy to move back and forward and the papers seem to pop up much more quickly..."

Dr Patrick Farrell, ANZCA Councillor, NSW

"Members found it easy to use, much faster to download (documents), loved the fact they could view the documents in the browser and could navigate easily. "

Belinda Hofmeyr, ANZCA Committee Support Officer

Elaine Jenkins, Manager Corporate Office, ANZCA

Networks opens new online opportunities (continued)

Pain medicine learning

Pain medicine learning provides Fellows and trainees with a range of pain medicine learning content.

Log in to access the FPM podcast series, which covers a broad range of topics relevant to pain medicine. These podcasts have been developed by specialists who are experts in their field. Please note these will shortly be removed from the FPM website.

We also are expanding the learning resources in this section. Resources in development include:

- **Nine FPM e-learning modules to complement the revised curriculum**
  These comprise self-directed modules, a case study and self-assessed quiz relating to the essential topic areas of the 2015 curriculum. The modules provide an entry point into the essential topic areas throughout the core training stage, and give trainees the opportunity to integrate the FPM Roles in Practice as they relate to a selection of learning outcomes drawn from the curriculum.
- **Better Pain Management**
  FPM has developed an engaging interactive online education program for healthcare professionals caring for patients with persistent pain. The program, called Better Pain Management, comprises six one-hour education modules, and will launch soon (see page 50).

Helen Morris, General Manager, Faculty of Pain Medicine

Personal and professional learning

This section of Networks helps to support and facilitate the ongoing development of skills, knowledge and behaviours across a range of subject areas.

The first resource available is the online Foundation Teacher Course (see opposite). This course exposes participants to a structure for planning, teaching and learning and provides an opportunity to experience approaches for teaching and supervision in a clinical environment.

One cohort of participants is now enrolled and their initial experience of the course and Networks has been very positive. Feedback included comments on the short orientation videos provided, ease of navigation, comprehensive introduction to the course and a wide range of tools available. See over the page for more information on the Foundation Teacher Course.

The future creation and expansion of Networks will be an exciting challenge for authors, designers and facilitators. As a collaborative and interactive space adhering to the principles of adult learning, we encourage Fellows and trainees to support their own learning journey with the opportunity of developing their own Networks and resources.

Olly Jones, General Manager Education, ANZCA

Foundation Teacher Course teaches the teachers

The Foundation Teacher Course has been running since 2010. The course is underpinned by adult learning principles and designed to support self-directed, motivated and committed participants with facilitator support and a model of formative feedback.

It consists of eight modules:

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

The course is offered online and face-to-face, and the outcomes are identical for both.

Here is feedback from a past participant:

"This course helped immensely with giving me tools to plan and deliver effective teaching, not only in the theatre environment, but in the simulator and in more formal environments."
Dr KA

Online course format

In 2012 the first online Foundation teacher course was launched as a pilot, with six participants. The course continues to evolve and is now offered to 15 participants twice a year, with further expansion planned.

The course participants view short presentations, usually a maximum of 20 minutes, and access reading material and other resources. They then complete workplace activities, which are structured to support the application of theory into practice. Participants initially complete three course components: the orientation; the introduction; and the first module of the course, Planning effective learning and teaching. Once they have completed the activities for the first module and provided feedback, they can access the remaining seven modules and plan their learning journey. The expectation is each module will be completed in two weeks.

A typical journey through a module might involve:

- Viewing the overall structure of a module.
- Reviewing the activities planned for the module.
- Watching the online presentation.
- Completing activities in the workplace.

An example of a workplace activity is planning a learning and teaching experience using principles learned. The participant can then share this with the group in a discussion for feedback and comment.

Within the course there is a range of learning tools being used in a variety of ways, including online presentations, discussions, reading resources, quizzes, videos and more. The course offers a webinar each month with the course facilitator to enable participants to engage in real time about the learning material and their experiences.

"Writing the learning plan allowed for application of new knowledge."
Dr HT

If you are interested in registering your interest in the Foundation teacher course in 2015 in either the face-to-face or online format, please email education@anzca.edu.au. We will contact you with details on how to register towards the end of November 2014.

Maurice Hennessy, Learning and Development Facilitator, ANZCA

Employee support keeps the College on track

Much work goes on behind the scenes at ANZCA. This article is about our College staff and their role in keeping the College focused on its strategic priorities.

While the contributions of Fellows and trainees are crucial to ANZCA's success as a leading medical college in Australia and New Zealand, the staff could be considered the glue that holds the College together.

ANZCA has a strong team of skilled and dedicated staff led by a senior leadership team made up of our general managers, our deputy chief executive officer, Carolyn Handley, and me. Also a key part of ANZCA is the team of directors of professional affairs (DPAs), experienced clinicians led by former ANZCA president Dr Leona Wilson, who provide advice on College functions that require input from Fellows. FPM also has a director of professional affairs, Professor Milton Cohen.

ANZCA has employees in Melbourne, New Zealand and offices in the Australian regions. To recognise outstanding achievements of individuals and teams, we introduced a Staff Recognition Program last year.

The activities of some units, such as Training and Assessments and Fellowship Affairs, are visible to Fellows and trainees. Just as important are the behind-the-scenes teams, such as Human Resources and Finance, which keep the College functioning efficiently.

Our staff ensure the core roles of the College are undertaken as seamlessly as possible – running the training program (including exams, hospital accreditation, managing trainee records and international medical graduate specialist assessments), running the continuing professional development program, running educational activities for supervisors, producing podcasts and webinars for Fellows and trainees, providing a comprehensive library, maintaining the highest standards in quality and safety through the development of professional documents and the dissemination of safety alerts.

Our events team has years of experience in running events – the ANZCA annual scientific meeting and other events, including meetings for special interest groups, FPM and the ANZCA Trials Group. Our regional staff also are involved in running meetings, exams and other activities. Another important role is raising money to support research.

ANZCA staff also play a key role in advocacy by working with Fellows on submissions to government and non-government organisations in Australia and New Zealand and raising the profile of our specialties through the media and via mechanisms such as the ANZCA website and National Anaesthesia Day. Community development in the areas of indigenous health and overseas aid is another important role.

To ensure a clear understanding of what individuals and teams do in the College and improve our interaction with Fellows, trainees and other stakeholders, we are developing service charters for each ANZCA unit.

Everything the College does is guided by the ANZCA Strategic Plan 2013-2017 (see www.anzca.edu.au/about-anzca/our-college) and its priorities to:

- Advance standards through training, education, accreditation and research.
- Build engagement, ownership and unity.
- Develop and maintain strong external relationships.
- Ensure ANZCA is a sustainable organisation.

The operational activities of the College are mapped each year in the ANZCA-wide business plan, which is structured around the strategic priorities (each of these has four objectives).

Cascading off the ANZCA-wide business plan are individual unit business plans, which also are structured around ANZCA's strategic priorities and objectives, and are considered during the budgeting process.

FPM is slightly different, in that it has its own FPM Strategic Plan 2013-2017 with three priorities: To build fellowship and the Faculty; to build the curriculum and knowledge; and to build advocacy and access. It can be found at www.fpm.anzca.edu.au/about-fpm/structure-and-governance. While FPM activities feed into the ANZCA business plan, the FPM unit plan is based on the FPM strategic plan.

Our relatively new Strategic Project Office and Technology unit ensures the strategic priorities of ANZCA are captured and prioritised in our Information Management and Information Technology (IM/IT) Roadmap.

Together, ANZCA staff ensure the College moves forward, with its mission, vision and strategic priorities guiding all that we do.

Linda Sorrell
CEO, ANZCA

ANZCA's Senior Leadership Team (clockwise from bottom left): Lee-Anne Pollard (Training and Assessments), Warren O'Harae (Australian regions), Clea Hincks (Communications), Olly Jones (Education), Jenny Lethbridge (Human Resources), Rob Packer (Anaesthesia and Pain Medicine Foundation), Jan Sharrock (Fellowship Affairs), Helen Morris (FPM), Vicki Russell (Strategic Project Office and Technology), Galina Fidler (Finance), Jonathon Kruger (Policy), Heather Ann Moodie (New Zealand National Office), Linda Sorrell (Chief Executive Officer), Carolyn Handley (Deputy Chief Executive Officer).

ANZCA's leadership

Chief Executive Officer – Linda Sorrell

ceo@anzca.edu.au

ANZCA's Chief Executive Officer is Linda Sorrell who has several direct reports in her Department of the CEO including the general managers of Fellowship Affairs, Communications, the Strategic Project Office and Technology, the Anaesthesia and Pain Medicine Foundation, Policy, Human Resources, the New Zealand National Office, Finance and the Faculty of Pain Medicine office. The executive director of professional affairs also reports to Ms Sorrell.

Deputy Chief Executive Officer – Carolyn Handley

The Deputy Chief Executive Officer is Carolyn Handley, who is also the head of the Training and Education Department. Her direct reports are the general managers of Education, Training and Assessments and Australian regions.

Professional Affairs

Executive Director – Dr Leona Wilson

DPAs@anzca.edu.au

The Professional Affairs unit is made up of clinicians who provide advice on specific areas that require input from Fellows. The Executive Director of Professional Affairs is Dr Leona Wilson. Other members who report to Dr Wilson are Dr Peter Roessler (DPA, Policy), Dr Steuart Henderson (DPA, Assessor), Dr Vaughan Laurenson (DPA, Assessor), Dr Michelle Mulligan (DPA, Deputy Assessor), Dr Nicole Phillips (DPA, Annual Scientific Meetings) and our Dean of Education, Dr Ian Graham.

Professor Milton Cohen is the DPA, FPM.

ANZCA's full corporate structure can be seen on page 38.

Employee support keeps the College on track (continued)

Who does what at ANZCA?

ANAESTHESIA AND PAIN MEDICINE FOUNDATION
General Manager – Rob Packer
foundation@anzca.edu.au
www.anzca.edu.au/fellows/foundation

The Anaesthesia and Pain Medicine Foundation raises funds to support medical research and education programs conducted by ANZCA and FPM Fellows and staff in Australia, New Zealand and internationally. It administers the research grants program and supports the College's international projects and activities.

COMMUNICATIONS
General Manager – Clea Hincks
communications@anzca.edu.au
www.anzca.edu.au/communications

The Communications team produces key ANZCA publications including the *ANZCA Bulletin* and e-newsletters and advises and supports other ANZCA units in their communications with Fellows and trainees through professionally edited and designed College collateral. Communications manages ANZCA website content and helps raise community awareness of ANZCA, FPM, anaesthesia and pain medicine through the media by promoting scientific meetings, research and other activities. Communications co-ordinates National Anaesthesia Day on October 16 each year.

EDUCATION
General Manager – Olly Jones
education@anzca.edu.au
www.anzca.edu.au/resources/learning

The Education unit is responsible for the delivery, development and ongoing quality improvement of education activities of the College. It develops e-Learning resources for ANZCA and FPM trainees and Fellows, delivers the Foundation Teacher Course designed to help Fellows and provisional Fellows in their training activities. The Education unit played a major role in developing the 2013 revised ANZCA curriculum, the 2014 ANZCA Continuing Professional Development Program, the FPM curriculum revision project and the implementation of Networks, the College's new learning and collaboration management system.

FACULTY OF PAIN MEDICINE
General Manager – Helen Morris
fpm@anzca.edu.au
www.fpm.anzca.edu.au

The Faculty of Pain Medicine unit supports all Faculty activities. Primarily it contributes to the delivery of the training program, the accreditation of training units, the delivery of a continuing medical education program that supports ongoing development of skills and expertise, the development of research and education projects, the delivery of Faculty communications and the development of resources for use by Faculty Fellows and trainees.

FELLOWSHIP AFFAIRS
General Manager – Jan Sharrock
- Events
- Quality and Safety
- Knowledge resources

fellowship.affairs@anzca.edu.au
www.anzca.edu.au/fellows

The Fellowship Affairs unit provides professional development support for Fellows. It offers events support (in particular the ANZCA Annual Scientific Meeting and special interest group events), support for quality and safety activities and knowledge resources, including the ANZCA Library, the Geoffrey Kaye Museum of Anaesthetic History and the ANZCA archives. It supports the Fellowship Affairs and Quality and Safety committees. Fellowship Affairs recently co-ordinated the ANZCA Fellowship Survey and the Graduate Outcomes Survey and ran a very successful annual scientific meeting in Singapore.

FINANCE
General Manager – Galina Fidler
finance@anzca.edu.au

The Finance unit manages the financial affairs of the College. It focuses on the production and use of information to meet College accounting needs, compliance (government and other regulatory bodies), management and control (to meet organisational objectives), strategy and risks (to inform the development and implementation of strategy and manage financial risk) and funding (identifying sources of funding for organisational activities).

HUMAN RESOURCES
General Manager – Jenny Lethbridge
hr@anzca.edu.au

The Human Resources team provides strategic and operational human resources leadership to encourage best practice in the management of staff to enable them to achieve their potential, personally and professionally. This includes employee relations, industrial relations, recruitment and selection, learning and development, payroll and health and safety activities.

NEW ZEALAND NATIONAL OFFICE
General Manager – Heather Ann Moodie
anzca@anzca.org.nz
www.anzca.org.nz

The New Zealand National Office manages New Zealand-based activities of the College and ensures ANZCA is represented at New Zealand government and non-government agencies, such as the Ministry of Health, Health Workforce New Zealand and the Medical Council of New Zealand.

POLICY
General Manager – Jonathon Kruger
policy@anzca.edu.au
www.anzca.edu.au/communications/submissions
www.anzca.edu.au/training/specialist-training-program
www.anzca.edu.au/resources/professional-documents
www.anzca.edu.au/fellows/overseas-aid

The Policy unit has an advocacy role, managing relationships and developing submissions for government and non-government bodies, including the Australian Medical Council and the Medical Council of New Zealand. The unit manages the Specialist Training Program, which funds training in settings beyond traditional public teaching hospitals. It also co-ordinates College professional documents and internal policies, such as intellectual property. The unit supports the Overseas Aid Committee and the Indigenous Health Committee.

AUSTRALIAN REGIONS
General Manager – Warren O'Harae
regional@anzca.edu.au
www.anzca.edu.au/about-anzca/council-committees-and-representatives

The regional operations team provides local support for Fellows and trainees in Queensland, New South Wales, the Australian Capital Territory, Victoria, Tasmania, South Australia/Northern Territory and Western Australia. Each regional office supports ANZCA and FPM committees, courses, events and examinations.

STRATEGIC PROJECT OFFICE AND TECHNOLOGY
General Manager – Vicki Russell
strategicprojectoffice@anzca.edu.au

The strategic project office manages projects in line with the strategic priorities of ANZCA. It has developed the Information Management and Information Technology (IM/IT) Roadmap, which prioritises ANZCA's technology-driven projects and manages the technological environment that enables College staff, Fellows and trainees to access information using the most efficient hardware and software. Recent projects include the development of the continuing professional development portfolio system and the training portfolio system.

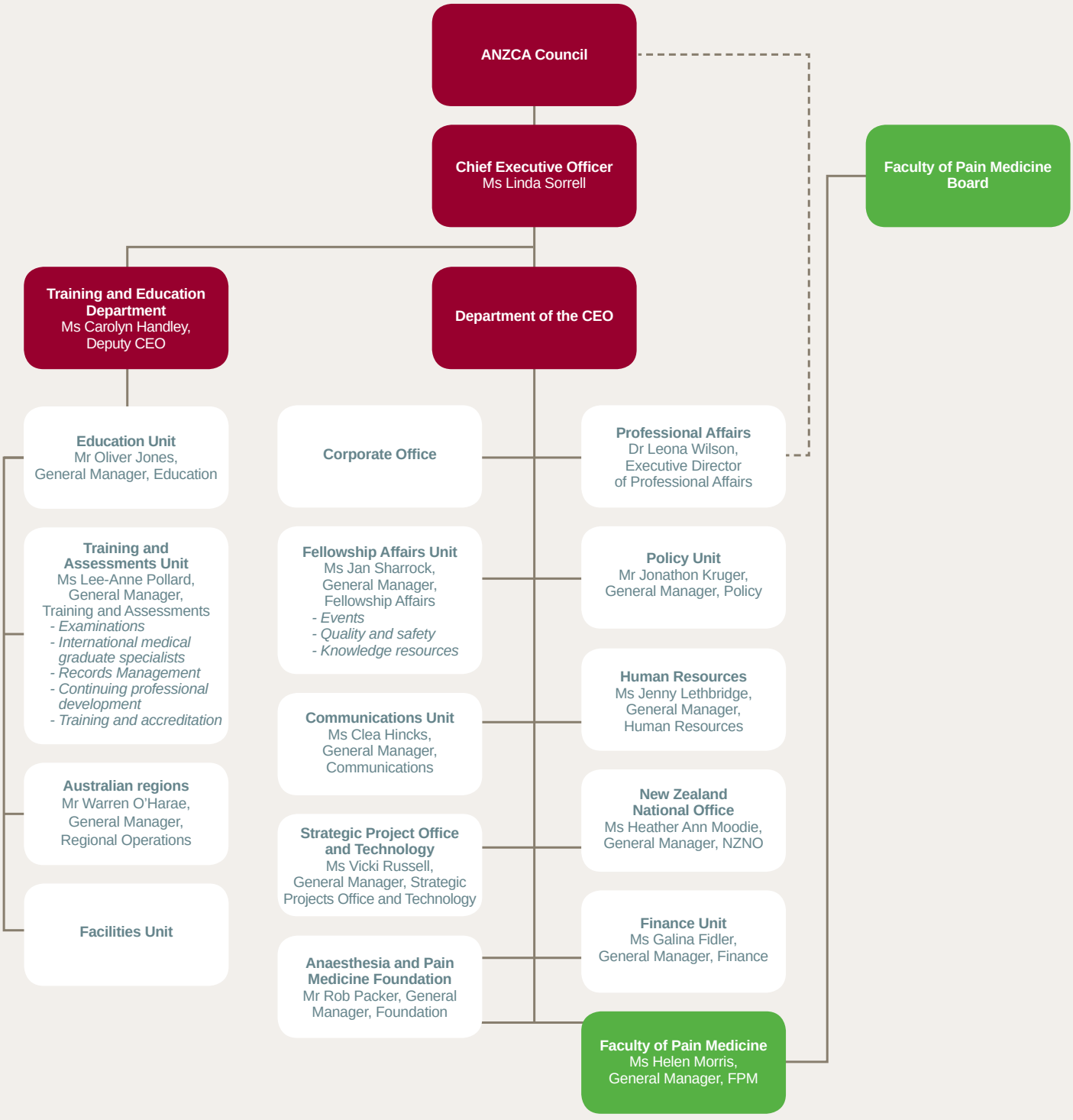
TRAINING AND ASSESSMENTS
General Manager – Lee-Anne Pollard
- Examinations
- International medical graduate specialists
- Records management
- Continuing professional development
- Training and accreditation

training@anzca.edu.au
www.anzca.edu.au/training

The Training and Assessments unit manages the systems that support the anaesthesia training program. This includes accreditation of departments for training, examinations, the international medical graduate specialist accreditation process, the online system that records training against the curriculum, and support for these functions.

Employee support keeps the College on track (continued)

ANZCA organisation chart



to Russia with Love

A doctors' orchestra that travelled to St Petersburg to play music in the grand State Capella Hall discovered a destination rich in culture, contrast and history.

White Nights in St Petersburg is the time of the midnight summer sun, when dusk turns to dawn and the city doesn't sleep. Every night there is opera, ballet and music at the renowned Mariinsky Theatre or the Grand Philharmonic Hall. The White Nights festival is also the time for a huge celebration for students graduating from high school. More than a million people gather in Palace Square watching fireworks and the Scarlet Sails celebration on the banks of the Neva River.

Melbourne has had a sister city relationship with St Petersburg, previously Leningrad, for 25 years. To celebrate this association, a Melbourne-based doctors' orchestra, called Corpus Medicorum, recently travelled to St Petersburg to play in the State Capella Hall.

The orchestra is mostly made up of medical practitioners who play their instruments to a professional standard, but it was also joined by a few lawyers and professional musicians. The result was a concert of an extremely high standard, matched with enthusiasm, intelligence, wit and energy. The performance was followed the next day by a charity ball at the Rose Pavilion in Pavlovsk Palace in aid of Advita, a Russian organisation that provides support for the families and children with haematological diseases requiring bone marrow transplants. The program for the concert and the charity ball was called "To Russia with Love".

We had time between rehearsals to discover much about the colourful and sometimes gruesome history of this relatively young city. Founded in 1703, St Petersburg has been home to famous composers, writers, tsars and the 1917 revolution. Beautiful churches and cathedrals punctuate the city skyline and there are many extravagant palaces in the surrounding areas of the town. We had a private viewing of the Hermitage and the Faberge egg exhibition. The Church of the Savior on Spilled Blood was astonishing.

We spent one day visiting hospitals. I went to the Federal Almazov Medical Research Centre, a hospital on the outskirts of St Petersburg. On the way to the hospital I saw a different city to the tourist centre. Many of the people living in St Petersburg are very poor and live in small, cold and dirty high-rise buildings in need of repair.

The hospital, on the other hand, had a modern, airy design and was built recently. The research labs were equipped with the latest technology for genetic analysis and manipulation. There were 30 ICU beds, each equipped with a stack of eight B. Braun pumps and the latest Datex ventilator. My guide was a recent anaesthetic graduate. Her first rotation after medical school in 2009 was anaesthesia. She graduated as an anaesthetic specialist in 2011. While she works as an anaesthetist at another hospital, the specialty she practices at the Almazov Centre is haematology, for which she will be sitting the final exams this year. She told me that most young medical practitioners work at two hospitals and have two or more specialist qualifications. The wages are not high and a single hospital is only allowed to employ each doctor for a maximum of 36 hours a week. Working in two hospitals allows doctors to double their income.

She said that over the past 10 years, a lot of money has gone into some hospitals, including the Almazov, but it has not been evenly distributed.

Other doctors in the orchestra visited hospitals that were poorly equipped; where major thoracic operations were performed on patients with end-stage cancer simply because radiotherapy equipment was not accessible.

Most health care is free, but there are some surprising exceptions. IVF is available free to anyone in a "normal" relationship any number of times, but freezing embryos costs around $US200. Patients choose to undergo egg harvest multiple times at no cost, rather than store eggs, to minimise the number of procedures!

The hospital I visited had an advanced electronic medical record system, but legislation dictates that after each update the page has to be printed and placed in a physical folder. The advanced genetic research tools at the Almazov Medical Research Centre often lie idle for lack of project funding.

"It is a cultural ideal to do one thing, and do it well."

One morning a small group of orchestra members were invited to meet with senior government officials at the Smolny Institute. The palatial building at Smolny was once a finishing school for the daughters of nobility, then during the revolution, the headquarters of Lenin. Today it is the region's government house.

Evgeny Grigoriev, the chairman of the committee for external relations, spoke with polite sincerity about the virtues of music and medicine, how these attributes can rise above political difficulties and pave the way for economic collaboration. Our accompanying Australian diplomats responded that political difficulties should not exist at all. We used the meeting to encourage and invite further experience exchange.

An orchestra of doctors was unusual in Russia. In fact, amateur orchestras are almost unheard of. One explanation I heard was that Russian people are poor and need to work many hours to feed their families. "Lifestyle" activities such as music performance are not possible for non-professional musicians. Another explanation could be that it is a cultural ideal to do just one thing, and do it well.

The bureaucracy in Russia is challenging to navigate. A foreigner needs first to obtain an "invitation" to then apply for a visa. The invitation amounts to eight pages of detail that is completed by the hotel or friend, inviting the visitor. Once in the country, a visitor must register his/her arrival within 48 hours. There are fines if a tourist is caught not carrying a passport. Artwork and musical instruments can be confiscated by customs on departure. We all carried documentation that we owned the instruments and that we brought them with us into the country.

We were only in Russia for a couple of weeks, but the memories of the wealth, the people, the art and the power of the country will last a lifetime.

Dr Rowan Thomas, FANZCA
St Vincents Hospital, Victoria

Clockwise from left: The Church of the Savior on Spilled Blood, St Petersburg; Panorama Kapella during the concert; Dr Rowan Thomas (centre) during rehearsal with conductor Keith Crellin; An ICU bed with pumps and ventilator in the Almazov Medical Centre.

Why ANZCA needs a direct line to you

When the College issues safety warnings, it needs to be confident its intended targets will get the message.

In the 1960s science fiction series *Lost in Space*, one of the characters was a robot that was frequently heard heralding imminent danger with the alert "Warning! Warning!" This function served to protect the humans from harm. But those that were out of earshot or distracted may not have been alerted and consequently were exposed to danger. This series was a futuristic one that looked to the role of robots, but interestingly did not foresee communication beyond auditory alarms.

Fifty years later modern technology has the ability of global communication including both auditory and visual means through computers and mobile devices. But there is still no guarantee that the warnings are received. What is needed is a process that achieves the ability to issue an alert and ensure that it is received by its intended target.

This is the challenge that ANZCA is attempting to take on. Safety alerts come to the College's Quality and Safety Committee, which filters and captures those relevant to our specialty. The information is then disseminated to Fellows and trainees by varying means, including an SMS safety alert system that allows urgent safety alerts to be sent immediately to Quality and Safety Committee members and quality and safety officers in each Australian region and New Zealand. These officers then disseminate the information locally.

Following is the process for alerting Fellows of safety issues:

1. ANZCA receives the information. Safety alerts come from a variety of sources, for example, the Therapeutic Goods Administration, via Quality and Safety Committee members and Fellows (for example, hospital pharmacy alerts).
2. ANZCA assesses the information. The Quality and Safety Committee (through its chair, deputy chair and/or community liaison portfolio officer) determines the urgency of the safety alert.
3. ANZCA alerts Fellows. The significance of the alert will determine whether it is sent to all Fellows directly, or whether it is filtered through the Australian regional and New Zealand committees via electronic means.

The recent propofol recall – in which contaminated batches were thought to be in circulation – highlighted a need to review the current process.

To improve ANZCA's safety alert process, a number of conflicting issues need to be considered including:

- ANZCA's responsibilities. Alerts come to the College via several pathways and while ANZCA is not the source of these alerts it does act as the conduit.
- How ANZCA receives the alerts. The College relies on external organisations to assess safety issues and their relevance to anaesthesia before they disseminate the information to ANZCA.
- How ANZCA assesses alerts. Does a set of assessment criteria need to be established?
- Responsibilities of Fellows. As professionals constantly seeking to achieve the highest standards in patient care it is up to us to monitor all sources for alerts that are relevant to our practice.
- ANZCA is not staffed 24/7. What happens to very high priority alerts that may arise out of hours?
- Are Fellows in private settings adequately catered for?
- If Fellows and trainees are emailed directly about all alerts there is the possibility of email overload.
- Alerts are disseminated via Twitter and RSS feeds but the number of practitioners with Twitter accounts is small, and there are those who prefer not to have social media accounts or RSS subscriptions.

Quality and safety is paramount and in recognition of this, the College, in reviewing the matter of safety alerts, will ensure that its role as a conduit is as comprehensive as technology permits, and offers appropriate access to Fellows.

Dr Peter Roessler
Communication and Liaison Portfolio
Quality and Safety Committee

What you can do

Make sure your details are up-to-date

Please ensure ANZCA has your current details by updating them via the MyANZCA portal – members.anzca.edu.au.

Help us to alert your colleagues

If you hear of a potential safety issue, please contact the College as soon as possible via qs@anzca.edu.au.

Where to find anaesthesia safety alerts

- The ANZCA website. All safety alerts are listed here - www.anzca.edu.au/fellows/quality-safety/safety-alerts (also see the "safety alerts" quick link on the ANZCA website homepage www.anzca.edu.au). High-level alerts are loaded onto the ANZCA homepage.
- *ANZCA E-Newsletter* (monthly) and *ANZCA Bulletin* (quarterly) in the Quality and Safety section.
- Via Twitter and RSS feeds (please see below).

Setting up RSS and Twitter

To set up an RSS feed please visit the following link www.anzca.edu.au/fellows/quality-safety/safety-alerts/safety-alerts/RSS and add the RSS link to your appropriate RSS reader.

Set up a Twitter account by visiting twitter.com and following the prompts. Once signed up, follow @anzca to receive safety alerts and other communications from the College.

Alerts

Hydroxyethyl starch – NZ review

Following concern last year about the increased risk of death and kidney problems in patients given medicines containing hydroxyethyl starch, Medsafe and the Medicines Adverse Reactions Committee (MARC) in New Zealand have reviewed the benefits and risks of harm with Voluven and Volulyte 6 per cent in different types of patients. Medsafe and MARC issued a statement on July 16 saying that they have concluded that the restrictions already in place for the use of these medicines are adequate to manage the known potential risks of harm. The full safety alert can be viewed here: medsafe.govt.nz/safety/EWS/2014/Hydroxyethyl-starch-solutions.asp

Shortage of Neo-Synephrine®

Medical and nursing staff have been advised of a supply shortage of Neo-Synephrine® 1 per cent injection (phenylephrine hydrochloride). The interruption to supply is due to an unexpected delay in manufacturing. Hospira expects to restore supply to Australia from February next year. There is no generic equivalent to Neo-Synephrine® in Australia. However, there is a Special Access Scheme (SAS) version of phenylephrine available should there be an urgent need. Usage of the SAS version requires completion of an SAS Category A form, and is supplied on an individual patient basis.

ECRI alerts

The information below is obtained via alerts from the ECRI Institute.

Safe-cut safety scalpels

Bard states there is the potential for an inadvertent scalpel stick injury involving scalpels in the Bard safe-cut safety scalpels contained in peripherally inserted central catheter and dialysis catheter kits. Bard has replaced the Bard-Parker safety scalpels with the above scalpels. Bard states that the new safety blades are pushed forward from within the handle and that users should be aware of the following two differences:

- Ensure that the open ended, diagonal end of the scalpel is pointed away from the hand/body when the blade is extended.
- The blade has a lock in both the fully open and fully closed position. After using, ensure that the blade "clicks" into the fully closed position.

Philips IntelliVue monitors

The Philips IntelliVue monitors using Covidien Nellcor OxiMax pulse oximetry may malfunction. The monitor may alarm and display a SpO_2 malfunction error message, and no SpO_2 reading would be displayed. This problem typically occurs at SpO_2 monitoring initiation if a SpO_2 sensor is plugged into a monitor that is already powered on. A fix is now available by contacting the Philips local representative.

Dr Peter Roessler
Communication and Liaison Portfolio
Quality and Safety Committee

Engaged use of checklist essential for patient safety

World Health Organization

One of the great risks in our profession – and it's a risk even with the World Health Organization surgical safety checklist – is that people get into the mindset of just going through the motions.

The checklist has been used in New Zealand hospitals since 2008, when Auckland Hospital was one of eight pilot sites for a study led by Dr Atul Gawande and Dr Alex Haynes that was published in the *New England Journal of Medicine* in 2009.

The study showed dramatic improvements in mortality and morbidity: the rate of any complication dropped from 11.0 per cent at baseline to 7.0 per cent after introduction of the checklist ($P<0.001$); and overall mortality dropped from 1.5 per cent to 0.8 per cent ($P=0.003$). New Zealand's results did not contribute as much to the improvements as the lower income countries but the results were convincing nevertheless. Comparable results have been shown in several subsequent studies.

I think many of us believe there is too much paperwork and bureaucracy in healthcare today. However, the checklist is not meant to be about ticking boxes, but about increasing communication and teamwork in the operating theatre at the same time as making sure a few basic things are correct.

In the US, the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) reports communication as the root cause in more than 75 per cent of operative and postoperative sentinel events. A particular aim of the checklist is to make it easier for anyone to speak up if they see something wrong happening.

New Zealand's Health Quality & Safety Commission is working to promote truly engaged use of the checklist in operating theatres, along with pre-list briefings and post-list debriefings.

With their established reputation for promoting patient safety, anaesthetists are particularly well placed to support this important initiative.

More information can be found at www.hqsc.govt.nz/our-programmes/reducing-perioperative-harm/.

Professor Alan Merry, ONZM
Chair of the Health Quality & Safety Commission
Head of the School of Medicine at the University of Auckland
ANZCA Councillor

An updated list of safety alerts is distributed in the first week of each month in the "Quality and safety" section of the *ANZCA E-Newsletter*. They can also be found on the ANZCA website: www.anzca.edu.au/fellows/quality-safety/safety-alerts

webAIRS news

Results of investigation into propofol contamination

ANZCA Fellows were advised of the suspected contamination of one brand of propofol in May 2014. webAIRS received this report, which commented on the initial shortages of propofol and some local consequences.

De-identified report submitted as an alert to webAIRS

Earlier in the year there were widespread reports of contamination of one particular brand of propofol that led to a withdrawal of that brand from the market. As there were insufficient supplies of alternate brands this lead to a shortage of propofol, which in turn lead to a shortage of thiopentone. At one stage at our hospital a German brand was supplied. This in itself was not a problem except that all the documentation was in German. Special approval was given by the Therapeutic Goods Administration to allow this to be marketed with a label on the outside of the box to confirm the contents. A German speaking member of our staff also confirmed the documentation.

The implication was that the propofol was contaminated at the point of manufacture.

The incident was originally reported as a case where the documentation was insufficient as it was not in English. But the first part of this report also raises the wider issue of the vulnerability of the supply chain for essential medications. Possible factors that might have created this situation are the quest for the cheapest supplier of generic medications and the just in time principle for maintaining stock levels along the supply chain. Looking first at the issue of selecting the cheapest supplier, there are potential benefits and risks of this approach. The economic benefit of competition is the potential reduction of costs of anaesthetic and other drugs and savings to healthcare providers. The disadvantages are that after a period of low prices, some manufacturers may cease production. If relatively few companies are manufacturing the drugs then prices might be manipulated upwards and if any of the major manufacturers cease production there might be an acute shortage. When one company ceased to supply propofol because of concerns regarding contamination, this produced an acute shortage in Australia in May. It was somewhat mitigated by the timing, which coincided with a large combined annual meeting of the Australian and New Zealand anaesthetists and surgeons. Elective surgery might have been fortuitously reduced during the initial crisis.

In addition to the production of the drug there were problems with the supply chain. Many hospitals and warehouses keep minimum stocks of all drugs. The hospital can thereby potentially make savings by avoiding a large amount of capital assets in the form of pharmaceutical drugs and losses due to the drugs going past their expiry date. The cost of holding the stock and the cost of expired stock are thereby transferred to the warehouse. Supply can be maintained using an efficient ordering system. This is colloquially know as a "just in time" system. However the warehouse might also use this methodology to reduce their costs and order from the manufacturer "just in time". However this approach also leads to low stocks levels of alternative suppliers of a drug and the potential for shortages. This will be more acute if the drug is withdrawn and therefore all stocks effectively expire at the same time. This will put acute pressure on the supply chain of alternative stocks.

De-identified webAIRS report

The company has complied with testing and it would appear that the product and the factory were free of contamination. The company has circulated all anaesthetists and hospitals with a letter to this effect. It would appear that there are no unopened ampoules that are proven to be contaminated. The implication is that the propofol was contaminated at the point of care. The company has stated that the cap on the brand affected is a dust cap and not a sterile seal. That the rubber stopper is clean but not sterile and that all rubber stoppers on vials should be swabbed with alcohol and allowed to dry before piercing the stopper. I believe many anaesthetists might believe that it is a sterile cap. This issue might be important for other stoppered ampoules, especially when the contents are added to infusions or injected into epidurals. The exception would be if the ampoule was within a sterile package such as many local anaesthetic ampoules. However, once the sterile seal is broken the dust cap is not guaranteed to maintain sterility.

Information regarding the testing of the propofol batches is available on the TGA website. A recall was promulgated on the TGA website on May 2 and last updated on July 7[1]. Manufacturer advice is also available on the TGA website[2]. Under the heading of aseptic technique, the product insert states that strict aseptic technique must always be maintained during handling. Propofol (brand name deleted) 1 per cent is for single use in one patient only. Propofol (brand name deleted) 1 per cent can support the growth of microorganisms as it is not an antimicrobially preserved product. There have been reports in which failure to use aseptic technique when handling propofol injection was associated with microbial contamination of the product and with fever, infection/sepsis, other life-threatening illness, and/or death. Accordingly, strict aseptic technique must be adhered to[2].

On July 7, the precautionary supply restriction was lifted[3].

Subsequent testing of the product indicated that although the contents were sterile, it was possible to culture organisms from some of the flip-off lids and rubber stoppers. This varied in the tests and batches from 0 to 12/80 vials. In the pooled testing this was as high as 15/18 pools involving 90 vials[3].

Lesson that might be learned

Institutions should consider rotating suppliers so that alternative supply chains are maintained. However in suggesting this approach the implications of regular changes to the presentation and labelling of the drug should also be considered as there might be possible implications for increasing the likelihood of drug errors. Healthcare providers and warehouses should consider improving the robustness and resilience of the supply chain.

The implication of the testing was that it appears likely – although it will be impossible to determine with certainty –that the contamination might have occurred at the point of care. In other words, that the rubber stoppers may have been accessed with inadequate aseptic technique. Presumably the rubber stopper of propofol and all other rubber stoppered vials should be swabbed with an alcohol wipe and allowed to dry before drawing up or infusing the contents. The use of break open glass vials may not be immune from this risk as shards of glass may enter the vial when the top is broken. Therefore the necks of glass vials should also be swabbed.

Conclusion – swab the top

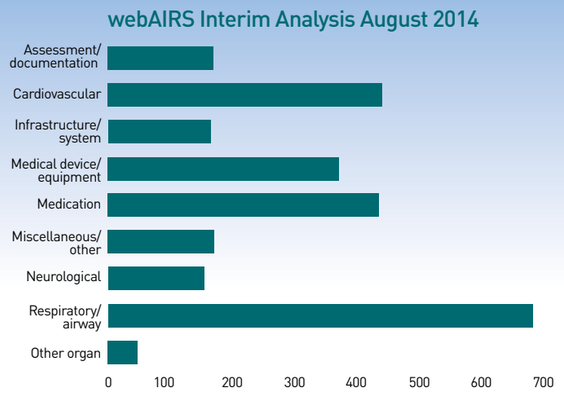
It is intended that this article will promote awareness of the importance of aseptic technique during all steps of the process of drug administration. As a secondary outcome, it is hoped that this article will promote ongoing discussion that will ultimately lead to improvements in patient safety in this area.

Adjunct Professor Martin Culwick, Medical Director ANZTADC
Dr Neville Gibbs, Chair ANZTADC

References:
1. www.tga.gov.au/safety/alerts-medicine-provive-mct-lct-140502.htm#.U-Q5NvmSyow
2. www.ebs.tga.gov.au/ebs/picmi/picmirepository.nsf/pdf?OpenAgent&id=CP-2012-PI-02953-1
3. www.tga.gov.au/safety/alerts-medicine-provive-mct-lct-140707.htm#.U-Q04_mSyox

For more information, please contact:
ANZTADC Administration
anztadc@anzca.edu.au
To register visit www.anztadc.net and click the registration link on the top right-hand side.
Demo at hwww.anztadc.net/Demo/IncidentTabbed.aspx
Mobile Demo at www.anztadc.net/demo/mobile.aspx

webAIRS data presented



A total of 2618 incidents have been submitted and preliminary analysis performed as of August 4. This analysis data has been used in presentations at the annual scientific meetings of the parent organisations of the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC). So far this year, webAIRS data has been presented at the AACA and ASURA combined 2014 meeting in Auckland, at the Airway Special Interest Group meeting and at the Australian and New Zealand College of Anaesthetists (ANZCA) Combined Scientific Meeting 2014 in Singapore. There will be further presentations this year including a session at the Australian Society of Anaesthetists, National Scientific Congress in October.

webAIRS
Anaesthetic Incident Reporting System from ANZTADC

Spring meeting a great success



The FPM Spring Meeting themed "Joining the dots: Links and transitions in pain management" was held from September 5-7 at the Fairmont Resort, Leura, in the Blue Mountains of NSW. The meeting was successful with 93 delegates registered and strong healthcare industry support.

The meeting featured international speaker Dr Stefan Friedrischsdorf from the US who presented on managing common but complex chronic pain disorders in children as well as the pharmacological and integrative management of neuropathic pain from a paediatric and adult perspective. The meeting also featured many local speakers, presenting on a range of topics including paediatric pain management, support for GPs managing pain, pain programs including novel online resources and transition back into the community and to adult services.

The meeting enjoyed successful media coverage. Dr Newman Harris was interviewed by radio 2SM and ABC Radio North Coast about the link between chronic pain and mental illness. He said depression and anxiety disorders and other mental health problems could not be extricated from the pain experienced, as each contributes to the genesis of the other and each makes the other worse. He also spoke about how pain medication can affect and be affected by anti-depressant medication.

Associate Professor Dr David Champion was interviewed by ABC radio's *The World Today* program and also by the *Sydney Morning Herald* about why doctors should look for a personal and family history of common recurrent pain disorders as well as iron deficiency, anxiety and depressive disorders – and a condition known as "restless legs syndrome" – in adults who present with chronic pain.

Above from left: Spring Meeting delegates at the Fairmont Resort; Convenor, Dr Matthew Crawford thanking international speaker, Dr Stefan Friedrichsdorf; Professor Ted Shipton welcoming delegates.

Above from left: Curriculum redesign project steering group members Penny McNair, Dr Cassandra Sparkes; Professor Ted Shipton, Dean of FPM; Dr Melissa Viney; Dr Chris Hayes; Dr Meredith Craigie; Professor Milton Cohen and Helen Morris.

Curriculum Redesign Project launch

The 2015 training program was officially launched by the Dean, Professor Ted Shipton, and Chair of the Curriculum Redesign Project Steering Group, Dr Meredith Craigie, at the Spring Meeting on September 6.

The launch was well attended and the new training program was well received by delegates. The considerable input of FPM Fellows in reaching this milestone is acknowledged and greatly appreciated.

The 2015 curriculum and a range of accompanying resources can be accessed via the FPM website, www.fpm.anzca.edu.au/training/2015-training-program. Two short introductory videos have been developed to outline the philosophy and structure of the 2015 FPM training program. These videos can also be accessed via the FPM website, www.fpm.anzca.edu.au/resources/learning/fpm-curriculum-redesign-project/.

Inquiries can be directed to fpm.crp@anzca.edu.au.

Simple accident leads to life of pain

Research and resources are desperately needed to ensure that fewer chronic pain patients are told to "go home and live with it".

Soula Mantalvanos was working in her graphic design studio seven years ago when the fitness ball (also known as a balance ball or exercise ball) she was sitting on in place of a chair unexpectedly burst beneath her. Ms Mantalvanos fell from a seated position onto the concrete floor, her sacropelvic region bearing the full force of the blunt fall.

Her husband Theo ran to her side. After the shock settled, she crawled to the carpeted area and her response was to laugh. The pair "had a good old laugh actually – it was such a silly accident," she remembers.

That unexpected and seemingly innocuous accident would determine the course of the rest of her life. Ms Mantalvanos expected to feel sore but better after a couple of days. But the pain continued, intensified and from that moment shaped her days, her nights, her relationships and her ability to work.

It took nearly five years of chasing answers, of tests and interventions, frustration, grief, and constant, unbearable pain to reach a diagnosis. The fall caused nerve damage in the pelvic area, very real but invisible on MRIs, examinations, X-rays and CT scans.

The diagnosis of pudendal neuralgia, arrived at after four and a half years, was the start of finding more effective treatment for her pain. Today, two and a half years after the diagnosis, Ms Mantalvanos's pain is better managed and she uses an electronic implant, which distracts signals of pain to her brain. She has also become a strong advocate for better recognition, treatment and management of chronic pain.

One in five people across Australia and New Zealand suffer from chronic pain, yet the condition remains little understood.

This message was the theme of the ANZCA Anaesthesia and Pain Medicine Foundation's "1 in 5" television campaign launched in July to spread awareness of chronic pain. The commercial can be seen at www.anzca.edu.au/fellows/foundation.

Ms Mantalvanos is one of the chronic pain patients who volunteered their services to appear in the commercial, which encourages the public to donate to research into chronic pain.

The Dean of ANZCA's Faculty of Pain Medicine, Professor Ted Shipton, said chronic pain had many causes and was a complex and debilitating condition that desperately needed more research.

"We need to keep finding better treatments and develop better understanding of the mechanisms at work in this condition – and for that we need more dedicated research."

Ms Mantalvanos agrees. She is also the subject of a short film, *The Hurting Strings*, which documents the effect chronic pain has had on her life (see www.pudendalnerve.com.au). She hopes the film and the television commercial will raise the profile of chronic pain in the community. She is also working with pain professionals in WA to produce a pain management program.

"It is still a primitive time in pain. Being told for four and a half years 'this is chronic pain ... go home and live with it, there's nothing that can be done' is brutal not to mention primitive."

Ebru Yaman
ANZCA Media Manger

Clockwise from left: Soula Mantalvanos in her studio; a still from the television campaign; self-portrait: Finalist in The Doug Moran Portrait Painting Prize 2014.

Trials know-how on the table at Palm Cove

Leaders and experts in trials research gathered recently for an opportunity to share and develop the best evidence to guide future practice plus an update on the hottest topics in the field.

That magical combination of sun, surf and science came together again for the sixth annual ANZCA Trials Group Strategic Research Workshop at the Sea Temple Resort in Palm Cove, Queensland on August 8-10.

The meeting continues to grow, with more than 100 investigators, co-ordinators and interested Fellows in attendance. While our primary aim is to develop proposals for large multi-centre trials, the format of the meeting provides for a fantastic update on all the hot topics in anaesthesia, perioperative and pain medicine. The informal atmosphere of the meeting also promotes networking among the participants, enabling emerging investigators and sites to get involved in established trials and also get advice on new ideas.

After the flight to Cairns, a quick taxi ride to Palm Cove and a dip in the ocean, the meeting opened with two workshops. Sofia Sidiropoulos (Melbourne), outgoing chair of the research co-ordinators special interest group, convened a workshop for co-ordinators and early career investigators on good clinical practice and recruitment and consent in preparation for starting a study. At the annual business meeting held at the end of this workshop, Jeanene Douglas (Newcastle) was elected the new chair of the group. Meanwhile, Professor Kate Leslie chaired a workshop for the trials group executive at which they finalised the strategic plan for the trials group for the period 2014-2017. The new vision for the trials group is: The ANZCA Trials Group will be a world leader in delivering high quality trial evidence that translates into safe and effective practice in anaesthesia, perioperative and pain medicine.

The formal part of the meeting opened with stimulating presentations from the two invited speakers. Professor Philip Clarke, a health economist from the School of Population and Global Health, University of Melbourne, spoke about measuring and valuing health outcomes. This was of particular interest given our new vision to ensure that our trials are translated into better outcomes for patients. Then Associate Professor Chris Frampton, a biostatistician from the University of Otago, spoke about data management and safety committees. These committees are established as independent bodies to oversee large trials, offering advice on progress and ensuring patient safety by viewing outcomes and adverse events. Later in the meeting, Professor Clarke spoke on embedding economic evaluations in all large studies and Associate Professor Frampton spoke on pitfalls in reporting of randomised controlled trials.

Next came a quick round-up of eight large trials in progress. Largely funded by national grants in Hong Kong, New Zealand and Australia, these trials plan to recruit more than 10,000 patients at more than 50 centres worldwide. Then the real fun began with the new proposal session. Ably chaired by Professor David Story (Melbourne), this session allows investigators 10 minutes to pitch a new idea and convince the audience of its merits – a bit like speed dating for researchers!

Ideas ranged from administration of fibrinogen concentrate in obstetric haemorrhage (Dr Joreline van der Westhuizen, NZ), through comparison of volatile anaesthetics and propofol for OSA patients (Dr Viraj Siriwardana, NSW) to intravenous iron for NOF patients (Dr Ed O'Loughlin, WA). Two proposals were considered in depth – Dr Ashley Webb's (Victoria) proposal on a quit pack for smokers and Dr Thomas Painter's (SA) proposal for a study on tranexamic acid during arthroplasty. All these proposals were graded by the participants, and investigators will receive detailed feedback from the executive. Finally, reports were received from pilot studies endorsed by the trials group.

Delegates enjoyed tropical-themed welcome drinks and barbecue on the opening night and the conference dinner at the Reef House, Palm Cove, on the second night. At the dinner, incoming ANZCA Trials Group Executive Chair, Professor Kate Leslie, thanked Sarah Chezan (ANZCA events), Karen Goulding (ANZCA Trials Group Co-ordinator), Anna Parker (Melbourne) and Sofia Sidiropoulos (Melbourne) for organising a fantastic meeting. She also took the opportunity to thank outgoing executive chair, Associate Professor Tim Short (NZ) for his leadership during his term. Associate Professor Short was successful in gaining a $NZ1 million grant for the Balanced Anaesthesia Study and engaging more than 10 centres in New Zealand in the trial.

The Trials Group Strategic Research Workshop brings together world leaders in anaesthesia, perioperative and pain medicine trials, emerging investigators from around the regions, trial co-ordinators and interested Fellows in a fantastic melting pot of ideas and enthusiasm. We are determined to move onward and upward in our quest for the best evidence to guide practice.

Professor Kate Leslie
Chair, ANZCA Trials Group

Above from left: Palm Cove; Professor Paul Myles, Professor Matthew Chan and Dr Tuong Phan; Professor Kate Leslie, Dr Ashley Webb and Associate Professor Chris Frampton; Delegates in a group discussion.

2015 New Fellows Conference
Cultivating a culture of change in anaesthesia and pain medicine

Wednesday April 29 – Friday May 1, 2015
Mt Lofty House, Adelaide Hills, South Australia

Applications now open

Applications are invited from Fellows in all training regions for selection to attend the 2015 New Fellows Conference in the Adelaide Hills, South Australia. To be eligible, Fellows must be within five years of fellowship on Friday October 31, 2014 and attending the 2015 ANZCA Annual Scientific Meeting.

Selection will be undertaken by the regional and national committees and the Faculty of Pain Medicine.

The aim of the New Fellows Conference is to facilitate development of leadership and management capabilities in those identified as being significant future contributors to our profession and the College. Special emphasis is placed on fostering current and future leaders in anaesthesia and pain medicine, to encourage new Fellow engagement and strengthen relationships between new Fellows from different regions.

The 2015 New Fellows Conference is themed "Cultivating a culture of change in anaesthesia and pain medicine".

The College and Faculty will cover the costs of this conference; however the applicant is responsible for the cost of travelling to and from Adelaide and all fees associated with ASM registration and associated costs. This conference is strictly for Fellows; families are not permitted to attend.

Written applications, with accompanying curriculum vitae and the names of two referees, should be forwarded to the applicant's regional or national ANZCA committee, or the Faculty of Pain Medicine by Friday October 31, 2014. Successful applicants will be notified in early December.

For further information please contact:

Eleni Koronakos
Australian and New Zealand College of Anaesthetists
630 St Kilda Road, Melbourne VIC 3004 Australia
P: +61 3 9510 6299 F: +61 3 9510 6786
E: ekoronakos@anzca.edu.au

Change agents

One of the focuses of next year's New Fellows Conference will be empowering participants to inspire others.

Next year's New Fellows Conference will be held at Mount Lofty House in the Adelaide Hills from Wednesday April 29 to Friday May 1. The conference theme will be "Cultivating a culture of change in anaesthesia and pain medicine". As well as facilitating development of leadership and management capabilities in new Fellows identified as being significant future contributors to our profession and the College, the 2015 conference will encourage those new Fellows to seek opportunities for renewal and innovation and drive the process of change.

The process of change remains challenging and effective leaders are effective change agents who can inspire others within their organisation to implement change. The program for the conference has been designed to provide a welcoming environment for the new Fellows to interact and engage in activities related to change management that will be challenging and rewarding.

The Key 2 Me Process Communication Model® Seminar, facilitated by Dr Marion Andrew, will provide to new Fellows an introduction to a tool that develops a deeper understanding of individual behaviour under stress. New Fellows will begin to learn and understand the needs and motivations of themselves and others, and stay open and resilient, when change or difficulties present a challenge.

The "Advocating for change" workshop, to be facilitated by Jonathon Kruger (ANZCA General Manager, Policy) will provide practical steps involved in developing an effective advocacy strategy with reference to examples at various levels, including within both hospital departments and government. New Fellows will develop an understanding about policy, stakeholder engagement/ management and facilitating change.

The "Personal and career health" seminar, to be facilitated by Dr Roger Sexton, will provide an opportunity for delegates to investigate factors that affect personal and professional fitness. New Fellows will discuss stressors that are specific to the profession and develop strategies to minimise them.

We look forward to hosting you in the picturesque Adelaide Hills and presenting a thought-provoking and inspiring program so that we can cultivate a culture of change in anaesthesia and pain medicine.

Dr Scott Ma and Dr Giresh Chandran
Co-convenors, 2015 New Fellows Conference

Saving lives in Pakistan

Tasmanian-based anaesthetist Dr Colin Chilvers joined the humanitarian medical aid organisation Médecins Sans Frontières (Doctors Without Borders) in 2012. His first field placement was in Nigeria, where he worked as an anaesthetist in the Teme Trauma Hospital in Port Harcourt. In 2013, Dr Chilvers spent a month in Hangu, Pakistan, and recently returned to the town in June.

Like many doctors, I'd always thought I'd volunteer for Médecins Sans Frontières at some stage, but it wasn't until I met and talked with a Médecins Sans Frontières anaesthetist that I thought, "Maybe I could really do this".

I looked at the website and realised that I had the experience required and that the time commitment was manageable. It's a minimum six-week placement for anaesthetists, which means I'm able to keep my family life and normal career. My plan is to continue doing one field placement each year.

I have recently returned from my second assignment in Pakistan, where I was working at a hospital in Hangu. This hospital is in a fascinating cultural context, adjacent to Pakistan's North-West Tribal Areas and the highly conservative society that lives there. I saw many children with burns from domestic accidents and many obstetric emergencies. There is little antenatal care in the area and women often only get brought to hospital when they are in extreme difficulties with obstructed labour or haemorrhage.

Before this I worked as the anaesthetist at Teme Trauma Hospital in Port Harcourt. We operated on about 10 patients each day for injuries from road traffic accidents, gunshot wounds and machete attacks, so it was a busy hospital.

As an anaesthetist with Médecins Sans Frontières, surgical cases are mainly trauma and obstetrics, with some general type emergencies such as abscesses, appendicitis, etc. The surgery is quite rewarding to be involved with. Patients presenting near-death with penetrating trauma or a ruptured uterus, can be sitting up and happy within hours after surgery and resuscitation. There is unrivalled experience for young anaesthetists in the treatment of massive haemorrhage.

Ketamine is the most common anaesthetic for the frequent peripheral wounds and burns dressings, with spinals for caesareans and lower limb surgery, and general anaesthesia with intubation reserved for laparotomies and other bigger or unstable cases. Patients tend to be much younger than those in Australia. Obesity is not an issue. Limited investigations are available and there is no invasive monitoring, but this provides good experience in using clinical judgement – which we don't get to exercise properly in advanced health care settings in Australia.

Working in Pakistan also offered an opportunity to practice a more complete form of medicine. With often only a single surgeon and anaesthetist, both will closely manage patients from the emergency room, through to the operating theatre, and then in the ward post-operatively. Decision making is challenging; which casualty goes to theatre first, how much of your limited blood supply will you transfuse, if unlikely to be extubated post-op, should you even proceed?

An unusual phenomenon is that when the chips are down, Médecins Sans Frontières administrators and logisticians regularly appear by the bedside to offer support. This is in contrast to hospital bureaucracy in Australia, which seems increasingly adversarial to clinicians and reluctant to leave offices and computer screens.

An extremely high percentage of your day is spent doing the hands-on clinical work. One of the things I like most is that compared to work back home, you don't have to worry much about things such as meetings, reports, phone calls. You're freed up to put all your energy into clinical work. The anaesthetist's role on mission includes more than anaesthetising patients in the operating theatre. We assist in prioritisation and resuscitation of patients in the emergency room, day-to-day care of surgical ward patients, including pain management, and training local staff.

Field placements to one of the 60-plus countries in which Médecins Sans Frontières works offers a fascinating cultural experience. There are opportunities to interact with local people, staff and patients that no tourist could hope to access. There will be a small team of idealistic international staff who live and work closely together. Many of these have colourful backgrounds and will have worked in other interesting environments. Sharing the successes and duress of a field assignment creates a camaraderie that can't be found in normal life.

Last year Médecins Sans Frontières Australia sent 184 field workers from Australia and New Zealand to work in humanitarian crises around the world. One of the priority groups for recruitment is anaesthetists. Anaesthetists working with Médecins Sans Frontières support independent medical care to populations affected by conflicts, natural disasters, epidemics or healthcare exclusion. To work with Médecins Sans Frontières you need experience in general, paediatric, obstetric and trauma anaesthesia, while experience with intensive care, pain management and emergency medicine is highly valued. You also need to be a Fellow of ANZCA and available to commit to an assignment of six weeks minimum.

To learn more visit www.msf.org.au/join-our-team/who-we-need/anaesthetists.html

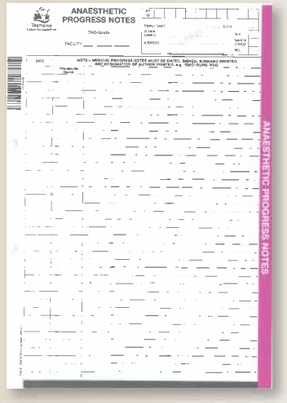
For me, the motivation to perform humanitarian anaesthetic work doesn't need to be one of pure altruism. I found professional satisfaction in successfully dealing with the challenges of anaesthesia in a limited resource setting. And, of course, personal satisfaction in being able to help save many lives.

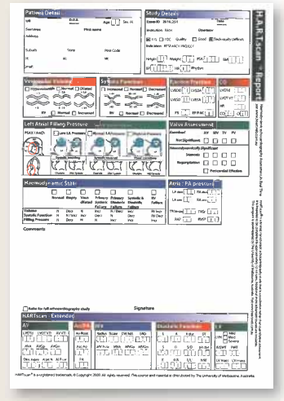
Dr Colin Chilvers, FANZCA
Tasmania

Listen to an interview with Dr Colin Chilvers on the College Conversations CD with this edition of the *ANZCA Bulletin*.

Above from left: Hangu Tehsil Headquarter Hospital, Pakistan; MSF implements "No weapon" policy inside Hangu Tehsil Headquarter Hospital; Australian anaesthetist Dr Colin Chilvers inside an operating theatre in the Hangu Tehsil Headquarters hospital in Pakistan; Dr Chilvers with Médecins Sans Frontières staff at the Hangu Tehsil Headquarters hospital in Pakistan.

Anaesthesia in the world of perioperative medicine





Dr Joanna Walsh considers how her field is evolving in the face of changes to the way patients undergoing surgery are assessed and cared for.

At some time during my registrar training, the department I had spent a large portion of time in changed from the Department of Anaesthesia to the Department of Anaesthesia and Perioperative Medicine.

I couldn't say exactly when this was but as I walked through those familiar departmental doors as a consultant, I wondered what underpinned the change? Had everyone in the department completed a masters of perioperative medicine in my recent absence?

This, of course, was not the case, but there are initiatives underpinning the department's new title and its decision to embrace the future of anaesthesia in the world of perioperative medicine.

In 2012, I read an editorial in the *British Journal of Anaesthesia* called "Perioperative Medicine: the future of anaesthesia?"[1]. I had fellowship exam blinkers on and further study in the field of perioperative medicine was not on my radar. But recently I re-read the editorial that declared perioperative medicine to be the future of anaesthesia if the specialty is to thrive.

The perioperative physician is defined in the editorial as a "qualified medical practitioner with an appropriate portfolio of competencies whose patient interaction is temporally defined by the index surgical admission". They argue that while the full scope of perioperative medicine is not yet clearly defined, it must "integrate the training, experience and organisation to link effectively with a range of hospital and community specialists from the surgeon to the general practitioner".

With this in mind, I wondered had the Department of Anaesthesia at the Royal Hobart Hospital (RHH) earned the right to call itself the Department of Anaesthesia and Perioperative Medicine? As I look around me, I think the answer is yes.

In 2014, the department introduced a perioperative registrar role, which is filled five days a week by a registrar in training. The registrar performs a number of duties including timely reviews of patients booked on to the emergency theatre booking system.

One of the most innovative areas of perioperative medicine at the RHH is the provision of perioperative ultrasound by anaesthetists. Dr David Canty, formerly of the RHH, has recently completed a doctorate of philosophy at the University of Tasmania and his thesis is on the impact of focused transthoracic echocardiography in anaesthesia and non-cardiac surgery. Dr Canty's initial work, undertaken at the RHH, demonstrated observational evidence that the use of focused transthoracic echocardiography changed anaesthetic (and surgical) management in patients with increased cardiac risk presenting for both elective and emergency non-cardiac surgery.[2]

Dr Canty's initial work in Hobart was the catalyst for the department's perioperative, anaesthetic-led, echocardiography service. Under the lead of Dr Simon Pitt and Dr Thomas Mohler, the department now provides ready access to transthoracic ultrasound performed by anaesthetists for anaesthetists.

If the role of perioperative medicine is to deliver the best possible pre, intra and postoperative care to meet the needs of patients undergoing surgery, it is imperative to be involved in quality perioperative outcome research. Indeed, our department's current and past involvement in international multicentre studies including POISE-2, RELIEF, and BALANCE trials, the International Surgical Outcome Study and METS demonstrates a burgeoning commitment to this role. Recently RHH was the second largest patient recruitment site in Australia and New Zealand for POISE-2. The results from this trial have implications for practice and therefore the next step is to translate the evidence into perioperative practice by updating guidelines and incorporating it into patient care. Similarly, we are expecting that the results from the other studies will also have a significant impact on perioperative medicine.

"To some degree we all practice perioperative medicine with variable enthusiasm."

To some degree we all practice perioperative medicine with variable enthusiasm. To remain abreast of practices in fields other than our own can prove difficult. However, the department hosts a fortnightly education session rostered into the working day.

Increasingly, in the setting of public healthcare, our patients present to us after long periods on waiting lists. This brings with it not only the pre-existing 20 per cent or more of the adult population with chronic pain and patients with pathology associated with pain awaiting surgery, but also the pain problems and risks from "waiting in pain". At presentation most have not undergone a specialist pain team review, which is generally restricted in our public system to those for whom no further operative intervention is possible.

While our specialist anaesthetist/pain physician and specialist nurse-led acute pain service does an exemplary job at managing these increasingly complex patients, in the past few years the department has developed a consult liaison specialist pain medicine physician position to manage those patients with an aberrant post-operative pain trajectory that frequently includes those with complex psychosocial and alcohol and drug-related issues. Dr Max Sarma provides this service and education and liaison with persistent pain and primary care services.

Whether you have taken an interest in the field of perioperative medicine or not, it is hard to argue against the *British Journal of Anaesthesia's* conclusion that "anaesthesia is best placed to drive the development of perioperative medicine" and "If we duck this challenge, others will not".

The Department of Anaesthesia and Perioperative Medicine at the RHH has taken up the challenge. We will continue to embrace it at the forthcoming ANZCA/ASA combined annual Tasmanian scientific meeting *Perioperative Medicine – Science to the Bedside* from February 20-22 next year.

Joint keynote speakers are doctors Daniel Sessler (Michael Cudahy professor and chair at the Cleveland Clinic) and Professor David Story (professor and chair of anaesthesia at the University of Melbourne). Other guest speakers will include Professor Kate Leslie (AMA Woman in Medicine Award 2014 Recipient), and Dr Maggie Wong (St Vincent's Hospital and the Royal Women's Hospital, Melbourne).

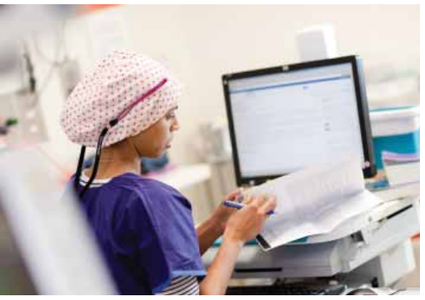
Dr Joanna Walsh, FANZCA
Royal Hobart Hospital, Tasmania

References:

1. Grocott MPW, Pearse RM. "Perioperative medicine: the future of anaesthesia?" *British Journal of Anaesthesia* 2012; 108 (5): 723-6.
2. Canty D, Royse CF. Audit of anaesthetist performed echocardiography on perioperative management and decisions for non-cardiac surgery. *British Journal of Anaesthesia* 2009; 103: 352-8.

From left: Royal Hobart Hospital, Tasmania; Dr Joanna Walsh in theatre; Dr Simon Pitt does a scan as part of the perioperative process at RHH; A form to record anaesthetic progress in the patient progress notes; A HART scan form.

College shines a spotlight on academic integrity



Anaesthesia trainees who don't accurately log the cases they complete are placing themselves at risk of legal action and potentially putting patients in danger.

Breaches of log requirements in the training portfolio system (TPS) also place them at risk of being disqualified from ANZCA's world-class anaesthesia training program.

Dr Natalie Smith, a senior staff specialist at Wollongong Hospital and chair of ANZCA's Medical Education Special Interest Group, said it was critical to the integrity of ANZCA's training program that trainees documented their experience accurately.

"There are several reasons that trainees might not complete their log requirements, and inaccurate entries are not always fraudulent," Dr Smith said. "Sometimes trainees reach their minimum numbers and then stop entering the cases they complete."

For example, a trainee might be required to complete 20 cases of a certain procedure to meet their volume of practice requirements, she said.

"If the trainee enters only 20 cases of X then we don't know whether they've just managed to get 20 cases of X or whether they've actually done 100 cases of X," Dr Smith said.

"The College monitors the curriculum to ensure it meets all of a specialist's training needs. If trainees don't indicate there is a problem – for example if there are too few or too many cases to be completed for their volume of practice requirements – then there is no imperative on the College to review the requirement."

While the level of inaccurate logging is difficult to establish, anecdotal evidence suggests the practice may be widespread.

Trainees offered various reasons for not logging cases, Dr Smith said, including the time it takes to enter data into the training portfolio system, the difficulty they can face in de-identifying cases, and a perception that it's not important or relevant to their education.

"There also is an element of fraudulent behaviour, but it is difficult to assess how widespread that is," Dr Smith said. "For example, when trainees are close to achieving the case numbers required, it is possible that some may be entering a couple of cases to reach the number they need to complete to move to the next stage of training."

The College recently dealt with a case in which a vigilant supervisor of training questioned a junior trainee after noticing the trainee had logged several very complex cases into their TPS. The supervisor realised a trainee at this early stage of training could not have completed the cases claimed.

"The supervisor of training talked to the trainee, who explained that they had been present when some of these cases were happening but not actually involved and thought they could log them, when that was not the case," Dr Smith said.

Trainees who are in doubt about what they can log should speak to their supervisor.

The College was working on ways to improve the training portfolio system, particularly when recording cases and procedures and in response to other trainee and supervisor feedback, ANZCA's Operations Manager, Records Management, Juliette Whittington, said.

Trainees struggling to meet training requirements that would allow them to progress to the next training period can seek dispensation from the College. For example, trainees are required to complete a certain number of thoracic epidurals, but the frequency with which the procedures are performed is low, so some trainees find it hard to reach the required number.

"If trainees are ready to progress to the next training period and they are short of a case or two, they can seek dispensation to do them in the next training period," Ms Whittington said. "There is flexibility in the system, you just have to follow a process."

Trainee requirements
Trainee requirements are covered in ANZCA's regulation 37 and the ANZCA Training Agreement. Both the regulation and the agreement require trainees to abide by ANZCA's Academic Integrity Policy (see www.anzca.edu.au/resources/corporate-policies)

Volume of practice requirements
Where trainees cannot meet volume of practice requirements due to regional variation in practice or lack of relevant cases, they can apply for an exemption to the director of professional affairs (DPA) assessor.

Dr Smith warned that trainees who falsely claim to have completed cases not only potentially place their patients at risk, they rob themselves of the quality education ANZCA's anaesthesia training program provides. They also are exposed to legal risk if anything goes wrong in their practice.

"Each year, our trainees sign an agreement saying they are acting in good faith and are behaving in a professional manner," Dr Smith said. "If they don't adhere to this then they are liable for any legal problems that arise."

ANZCA's Training Agreement includes a paragraph that says trainees agree to abide by a range of professional standards and codes, including ANZCA's new Academic Integrity Policy, and "to be honest, trustworthy and act with integrity at all times". It also points out that "plagiarism and academic misconduct, including fraudulent entry into the TPS" are violations of these standards.

The ANZCA Council approved the academic integrity policy in February. It sets the standard for professionalism and integrity required of all trainees and Fellows of the College.

"The College views integrity very highly as a professional value and trainees may not even realise their behaviour is academic dishonesty," Dr Smith said. "There is a whole spectrum and we are concerned about every level of behaviour on that spectrum."

For further information, please speak to your supervisor of training or contact the Records Management unit at training@anzca.edu.au.

Kylie Miller,
Sub-editor, ANZCA

Planning a break in your training

Interrupted training is not easy, but careful planning, confidence in your skills and support from your colleagues can help.

When Catherine Pease was pregnant with her first child, Alexandra, she had to think carefully about how she would continue her anaesthesia training.

Dr Pease, a 33-year-old trainee anaesthetist at St Vincent's Hospital in Melbourne, expects to meet all requirements of her training by the end of this year, though she is the first to admit it has taken great organisation and determination to achieve with a young child in tow.

"You do have to be pretty committed to see it through, it all takes good planning," she said.

Her experience is typical of many trainees who take time away from their studies, whether for family reasons, maternity leave or illness. Places on training programs can be difficult to secure and interruptions can take their toll.

"Trainees are generally employed on a 12-month basis so it can be difficult when people take leave because it creates gaps in the roster ... anaesthetists are quite a conscientious group and are mindful of how their absence might affect fellow trainees and their employer," Dr Pease said.

One of the greatest concerns for trainees, and for their supervisors, can be ensuring skills remain up-to-date when they interrupt their training. ANZCA allows 10 years for trainees to complete their anaesthesia studies. Dr Prani Shrivastava, chair of the ANZCA, Australian Society of Anaesthetists and New Zealand Society of Anaesthetists' Welfare of Anaesthetists Special Interest Group, said the exact number of trainees who interrupt their studies is not known, but reasons that might cause someone to disrupt their training include injury, illness, family concerns, domestic responsibilities and maternity leave.

"People take a break from their training for many reasons and it isn't always easy for them, but there are a number of elements that are important to the success of their return to anaesthesia," Dr Shrivastava said.

"One of the main issues that we hear is the sense of feeling unsupported on return to work, and some other trainees lack confidence when they come back to their studies and work because they feel they have been out of touch."

With so many demands around rostering and a gruelling training schedule to follow, Dr Shrivastava said supervisors were sometimes concerned that skills were diminished during the interruption.

"Things can change quickly ... educational officers sometimes have concerns about competence."

Nevertheless, part-time and interrupted training remained a "significant employment issue" in anaesthesia, she said. Employers were required to fill the position of an absent trainee during the interruption and finding a replacement with comparable skills could be problematic. For employees it created a sense of uncertainty and the pressure of "catching up".

Dr Pease said she had a relatively smooth path into maternity leave and was well supported by her department director - who facilitated her return to work in a part-time capacity - but knew it wasn't the case for everyone who interrupted their training.

"Being able to work meant I was able to return to work sooner than I might have otherwise, which enabled me to keep up my clinical skills and continue preparation for my Fellowship exams.

"But I know that it is a tricky time for employers who have to accommodate individual needs that arise for working parents."

Training rotations are usually allocated year by year and occasionally in blocks of four to six months at different hospitals. Depending on the timing of leave, a pregnant trainee can therefore encounter difficulties accessing paid maternity leave entitlement, Dr Pease said.

But she felt a "groundswell of change" was making the transition from full-time to part-time or interrupted training – and return – easier.

"Late 20s to early 30s is the prime time for many people starting families and now most of the medical schools are only taking graduates, so during your specialist training it certainly becomes an issue."

Dr Hema Rajappa, a paediatrican and pain specialist at John Hunter Hospital in Newcastle, NSW, interrupted her pain training in 2010 to have her second child.

She gained fellowship to the Faculty of Pain Medicine this year, and says whatever the reason for interrupted training, many concerns are applicable to all trainees.

"You worry that you aren't going to keep up with changes because changes happen all the time in our profession, even in just a couple of months. Supervisors of training change, even the rules of training can change; the schedule is a dynamic one, not static."

But Dr Rajappa has some advice for anyone who takes their training part-time or interrupts it.

"You have to look at the long term and not just the short-term picture," she said.

"You need honesty with self. You have to understand what your needs are and ask for support. You may not always be familiar with what is happening.

"Don't be backward in coming forward; be honest, know your learning needs and ask for time off.

"If you can keep your finger in the pie it is even better. Keep in touch online, at conferences. It's all very helpful for your return. Know where you're going, know your goals and be open to change. Things will change."

In an indication of this change – and recognising that anaesthetists and trainees may require extended leave – the Royal Melbourne Hospital has begun to offer the CRASH course (Critical care, Resuscitation and Airway Skills in High Fidelity Simulation) for anaesthetists who have taken a break.

The course was designed to make the return to work easier and recognises that leave can result in reduced levels of confidence, Dr Shrivastava said. It is based on the UK's Gas Again course, a refresher course for anaesthetists who have taken leave.

Awareness of your skills and confidence, and support from your colleagues are the most important things in returning to work," said Dr Shrivastava.

Ebru Yaman
Media Manager, ANZCA

Listen to an interview with Dr Pease on the College Conversations CD, available with this edition of the ANZCA Bulletin.

Above: Dr Catherine Pease and baby Alexandra.

Requirements for a scholar role activity audit

The scholar role activities were introduced in the 2013 ANZCA curriculum to replace module 11 and the formal project requirements. They offer greater flexibility and are designed to allow trainees to pursue a range of scholarly activity, including research, education or health administration. Completing them shows trainees have achieved skills in interpreting research and evidence.

What are we looking for when we assess an audit submitted as part of the SR Option-A activities?

The Scholar Role Sub-Committee is the College body overseeing the successful completion of the scholar role elements in the 2013 curriculum. Among its responsibilities is the formal assessment of the SR-A activity "Complete an audit and provide a written report for external assessment by the Scholar Role Sub-Committee"[1].

A recent review of our experience revealed we had received only four completed audits for review under Option-A to date. Unfortunately, most of these were fundamentally flawed and required substantial work before they could be considered of an acceptable standard.

This article outlines the requirements and aims to encourage trainees to seek appropriate advice and support before embarking on an audit. This is particularly so if the purpose is to submit the final report as an Option-A element.

In the UK, the National Institute for Clinical Excellence (NICE) defines audit as "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, process and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement in healthcare delivery"[2].

It is much more that asking a few questions about one's own practice, and should not be taken lightly. The relevant ANZCA document on the website provides guidelines[1]. The trainee should familiarise themselves with these requirements and discuss them with their local departmental scholar role tutor (DRST) as a first step in designing their audit. The topic and design of the audit should be approved by the DSRT before the audit commences, and the trainee may be required to confirm this at the time of assessment. We expect trainees to seek appropriate ethics approval for their audit activity.

We recommend audits be undertaken as a small group activity, preferably as a joint effort of both Fellows and trainees to ensure the job is thoroughly undertaken and that adequate resources can be maintained during the audit period. Most audits will take longer than a term or two and being in the right place for long enough can be a problem for a single trainee. Remember to maintain a record of each trainee's involvement so the appropriate people can later justify an application as a significant contributor. As a guide, we expect around 100 hours of work for each significant contributor.

Audits should have a structure that roughly conforms to the following stages: reviewing established criteria and reviewing any local data; planning data collection; making the ethics application; sampling; evaluating results against established criteria; planning an intervention; resampling; interpretation of second data set; writing the report. The report should be in the form outlined by SQUIRE[3], and should be at least 1500 words long. Useful audit templates can be obtained from the Royal College of Anaesthetists[4] and we thoroughly recommend this publication.

Dr Michael Bennett, FANZCA
Chair, Scholar Role Sub-Committee

References:
1. Scholar role training. www.anzca.edu.au/training/2013-training-program/scholar-role-training
2. Principles for best practice in clinical audit. NICE, London March 2002.
3. Standards for quality improvement reporting excellence. (www.squire-statement.org).
4. Raising the standard: A compendium of audit recipes for continuous quality improvement in anaesthesia. www.rcoa.ac.uk/document-store/audit-recipe-book-3rd-edition-2012

Multi-source feedback updates

The entire multi-source feedback (MsF) process can now be completed online, following improvements to the training portfolio system (TPS) made on August 29.

The MsF process enables trainees to gather feedback on their overall performance from multiple colleagues, allowing them to further develop in all areas of the ANZCA Roles in Practice.

The key benefits of the improvements are:

- Trainees can send requests for feedback and reminder emails to their nominated feedback providers via the TPS.
- Nominated feedback providers will receive an email request with a link to complete an online MsF feedback form.
- Responses completed online are automatically sent to the TPS and are viewable by the trainee's nominated supervisor of training.
- Data from the responses received is collated and auto-populated into the MsF summary form, for completion by the nominated supervisor of training.

If you need assistance with completing the multi-source feedback process please contact the College via **training@anzca.edu.au**.

Cobras, chloroform and consumption at the third Pugh Day lecture

The Honorary Curator of the Geoffrey Kaye Museum of Anaesthetic History, Dr Christine Ball, enthralled an audience of more than 80 people on June 15 as she delivered the third annual Pugh Day lecture with the somewhat bizarre title, "Cobras, chloroform and consumption – the life and times of Joseph T Clover". In the days preceding the lecture the title had generated puzzled comment in Launceston.

Not only did Dr Ball deliver a lecture with a great deal of extraordinary historical content, she entertained the audience with the tale of the cobra attacking its drunken keeper and many other curious and amusing anecdotes. Clover's remarkably productive life and ingenuity were highlighted in the lecture, as was his sad and untimely demise from consumption.

The president of the Launceston Historical Society, Ms Marion Sergant, introduced Dr Ball with the assurance that while the lecture was about anaesthesia, she could guarantee no one would sleep through it. And she proved correct.

Dr Ball's concluding comment, "Never trust a cobra" was greeted with applause and laughter.

The chair of the Launceston General Hospital Historical Committee, Dr John Morris, thanked Dr Ball for her wonderful address and the committee members who worked to publicise the meeting. He also thanked the Launceston General Hospital Department of Anaesthetics for supporting the event.

A display of Pugh's historical material in the meeting room related to his anaesthetic activities provided background to the Pugh Day celebration.

Dr Morris also thanked Dr Dan Huon, secretary of the Launceston General Hospital Anaesthetic Department and a qualified historian, and Dr John Paull, who had mounted a month-long public display of historical anaesthetic equipment with explanatory captions in five glass cases at the Launceston Public Library.

The fourth Pugh Day lecture will be held on June 21, 2015.

Dr John Paull, FANZCA
Launceston, Tasmania

From left: Dr Chris Ball and Marion Sergant; Pugh Day lecture audience.

New online books and new books for loan

New online books

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

Two new texts on general diagnostic and therapeutic medicine have been updated in the ClinicalKey collection of online books: Conn's Current Therapy 2014 and Ferri's Clinical Advisor 2015.

Core Topics in Vascular Anaesthesia / Moores, Carl [ed]; Nimmo, Alastair F [ed]. -- 1st ed --Cambridge: Cambridge University Press, 2012.

Non-operating Room Anesthesia / Weiss, Mark S. (Mark Steven) [ed]; Fleisher, Lee A. [ed]. -- Philadelphia, PA: Elsevier/Saunders, 2015.

New books for loan

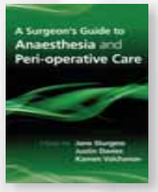
Books can be borrowed via the ANZCA Library catalogue: www.anzca.edu.au/resources/library/book-catalogue.html

Board Stiff TEE : Transesophageal Echocardiography / Gallagher, Christopher J.;Sciarra, John C.; Ginsberg, Steven. -- 2nd ed -- Philadelphia, PA: Saunders, 2013.

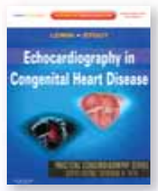
Equipment in Anaesthesia and Critical Care: a complete guide for the FRCA /Aston, Daniel; Rivers, Angus; Dharmadasa, Asela. -- 1st ed -- Banbury, UK: Scion Publishing Limited, 2014.

The Complete Recovery Room Book / Hatfield, Anthea. -- 5th ed, rev. --Oxford: Oxford University Press, 2014.

Copies kindly donated by the author to the library and New Zealand office.



A Surgeon's Guide to Anaesthesia and Peri-operative Care / Sturgess, Jane [ed]; Davies, Justin [ed]; Valchanov, Kamen [ed]. -- Cambridge: Cambridge University Press, 2014.



Echocardiography in Congenital Heart Disease / Lewin, Mark B. [ed]; Stout, Karen. [ed]. -- Philadelphia, PA: Elsevier/Saunders, 2012.

Free online journal on pre-hospital medicine and trauma

Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine (SJTREM) encompasses all aspects of the epidemiology, etiology, pathophysiology, diagnosis, treatment, rehabilitation and prevention of acute illnesses and trauma, resuscitation and emergency medicine, with particular interest in the multidisciplinary aspects of the chain of survival. Contributions focusing on education, training, implementation, as well as ethical and socio-economic aspects of trauma management are welcome. Recent articles include: "Quality improvement in pre-hospital critical care: increased value through research and publication".

Available online at: www.sjtrem.com/

Health Libraries can help manage information overload

Siemensma G. Managing information overload. Med J Aust. 2014;201(4):200-202.

"To the Editor": Gee's introduction to a recent issue of the *Journal* discussed the impact that the overwhelming growth of health information has on doctors. While it is true that doctors are an important mainstay of advice to patients, health librarians are an important resource to doctors. Health librarians are trained to acquire, organise and disseminate credible information resources that enable doctors to find the best evidence to support clinical decision making.

Read the full letter in the Medical Journal of Australia through the ANZCA Library: www.anzca.edu.au/resources/library/journals/

New ECRI safety publications

Operating Room Risk Management articles:

- "Recommendations for identifying, managing physician substance abuse"
- "Moderate sedation and analgesia analysis"
- "Safety in moderate sedation and analgesia"

Contact the library if you require access to the full articles: library@anzca.edu.au

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

Russell R, Lucas N. Obstetric anaesthesia guidelines. International Journal of Obstetric Anesthesia. 2014;23(2):101-105.

Vega RD, Roset R, Castarlenas E, Sanchez-Rodriguez E, Sole E, Miro J. Development and testing of painometer: A smartphone app to assess pain intensity. J Pain. 2014 May 19.

Laukkala T, Ranta S, Wennervirta J, Henriksson M, Suominen K, Hynynen M. Long-term psychosocial outcomes after intraoperative awareness with recall. Anesthesia & Analgesia. 2014;119(1):86-92.

Fang Q, Qian X, An J, Wen H, Cope DK, Williams JP. Higher dose dexamethasone increases early postoperative cognitive dysfunction. Journal of Neurosurgical Anesthesiology. 2014;26(3):220-225.

Garnier M, Bonnet F. Management of anesthetic emergencies and complications outside the operating room. Current Opinion in Anesthesiology. 2014;27(4): 437-441.

Spencer RJ, Chang PH, Guimaraes AR, Firth PG. The use of google glass for airway assessment and management. Pediatric Anesthesia. 2014;24(9):1009-1011.

Contact the ANZCA Library
www.anzca.edu.au/resources/library
Phone: +61 3 8517 5305
Fax: +61 3 8517 5381
Email: library@anzca.edu.au

Special Interest Group news

Doctors turn collective minds to pain

A winter meeting in Cairns proved another success for the Rural Special Interest Group, attracting a strong mix of delegates and speakers.

The Rural Special Interest Group held its seventh annual meeting at the Pullman Hotel in Cairns, Queensland from July 4-6. The meeting, which focused this year on "Pain – Proven Performers & Promising Pioneers", attracted solid numbers, with around 60 delegates, a good number of GP anaesthetists and strong support from trade displays.

The plenary sessions covered topics including the safe practice of regional anaesthesia, a review of current pain medications, persistent pain, and tips for challenging patients and specific procedures. The speakers were a mixture of Rural Special Interest Group members from New Zealand and Australia, along with invited speakers. These included a clinical psychologist, Alison Beeden, and pain specialist Matt Bryant, from Townsville, local anaesthetists Vesselin Petkov and Alex Cottle, as well as Kath Cooke, from Brisbane. Our keynote speaker was Tania Morris, a pain specialist from the Sunshine Coast. The presentations were all well researched and loaded with clinical tips, for which I thank all the speakers.

The meeting once again hosted an ultrasound for regional anaesthesia workshop run by Vesselin Petkov, Mike Haines, Willem Basson and Craig Mitchell, with support from Sonosite. We also held our first simulation sessions in the theatres at Cairns Base Hospital. Penny Strickland, Kenneth Gilpin and Rod Martin ran two emergency scenarios for small groups with the help of some local theatre staff.

We continue to host a poster session, with the prize going to doctors Ian McPhee and Stephen Naughtin for their poster on intrathecal morphine. We plan to run a poster competition next year and the posters can be on any topic but must be relevant to rural anaesthesia.

The social events were well attended with delegates able to meet old friends and network. The drinks reception on the first evening was held in the hotel and the dinner was held at Salt Restaurant in the marina. The outdoor setting gave us all a chance to appreciate winter in the tropics and some great food.

The meeting was a great success and I would like to acknowledge local support from the Cairns Base Hospital and, in particular, Heather MacDonald for finding some local speakers and Penny Strickland for arranging the simulation session.

I would also like to acknowledge the great support that Hannah Burnell has provided to the Rural Special Interest Group and its meetings over the past five years. In her role as special interest group coordinator she has been meticulous with the planning and a wonderful host for the meetings and we would like to wish her well as she takes up a new role with ANZCA.

The final business of the meeting was the Rural Special Interest Group AGM, where plans for next year's meeting were discussed. The meeting will be titled "ERAS – Every Rural Anaesthetists Should..." and will be held at Cradle Mountain in Tasmania from July 3-5.

Dr David Rowe
Convenor

Clockwise from left: Dr Craig Mitchell teaching an ultrasound workshop; Delegates participating in the simulation workshop; Conference delegates.

Recognising warning signs

Are you enthusiastic for long, difficult or complicated cases? Do you volunteer to work extra shifts or to do extra or late cases on a list? Are you over-anxious to givebreaks to your colleagues? Did you know that these are some of the warning signs of drug abuse, according the Association of Anaesthetists of Great Britain and Ireland (AAGBI)?

These attributes are also those which are generally valued by anaesthetists, which highlights how difficult it can be to recognise substance misuse amongst our colleagues. For more warning signs and for strategies on what to do when you suspect someone may have a substance abuse problem, I encourage you to read the Welfare of Anaesthetists Special Interest Group resource document *RD20 Substance Abuse 2013*. This and other resource documents can be found on the ANZCA website at www.anzca.edu.au/fellows/special-interest-groups/welfare-of-anaesthetists/introduction.html

Recommendations for future articles in the *Bulletin* are welcome. Please contact Kirsty O'Connor (koconnor@anzca.edu.au) or Dr Suzi Nou (Suzi.Nou@nh.org.au).

New Zealand news

Workforce – top topic at joint meeting

The changing nature of the anaesthesia workforce, with increasing competition for consultant positions especially in metropolitan hospitals, is shaping up to be the major issue for the New Zealand National Committee (NZNC) this year.

After the NZ Society of Anaesthetists (NZSA) and ANZCA had conveyed differing views to government of what was happening in the workforce and what needed to be done about it, there was robust discussion on this topic at the annual joint meeting between the NZNC and the NZSA Executive held on June 26.

The two groups agreed to form a small working group to gather authoritative data and to formulate recommendations to present to Health Workforce New Zealand (HWNZ) and the government on how the New Zealand anaesthesia workforce can be sustained to meet the health needs of New Zealanders. A joint statement of intent to this effect has been provided to HWNZ.

In undertaking this, the NZNC will work within the framework of the Anaesthesia Workforce Action Plan that ANZCA developed last year to address the changing employment situation for trainees and new Fellows in both Australia and New Zealand. It will also access the results of the College's annual Graduate Outcome Survey, which provides extremely useful data for helping to assess workforce trends.

The NZNC has also been working through the Council of Medical Colleges (CMC) and with HWNZ (including supplying data and information) to provide medical students and pre-vocational doctors with as accurate a picture as possible of the current and likely future workforce situation so that they can make their career choices accordingly.

Perioperative nurses as assistants to anaesthetists

Another continuing issue discussed at the joint meeting is the proposal by the Perioperative Nurses College (PNC) for an education pathway and assessment framework for registered nurses working as assistants to the anaesthetist, with the course to be provided by the Auckland University of Technology (AUT). This would be a separate course and qualification from that already in place for anaesthetic technicians.

In essence the NZNC's view, conveyed in submissions and at meetings with the PNC and the Ministry of Health, is that anaesthetists need to be confident that any assistant meets standardised, minimum requirements, irrespective of the training pathway to reach those standards. ANZCA has offered to provide anaesthetist input to assist PNC and AUT to develop a course that is fit for purpose and aligns with ANZCA's professional document *PS08 Recommendations on the Assistant to the Anaesthetist* (now under review).

September forum for clinical directors

On September 26, the NZNC is hosting a meeting in Wellington to update the clinical directors of New Zealand anaesthesia departments. This all-day meeting will provide a forum for discussion and information-sharing on common issues in anaesthesia practice and departmental management in New Zealand. It will include an update on ANZCA matters including what the NZNC is doing, Training Accreditation Committee changes and what they mean for a department, continuing professional development, the new curriculum and National Anaesthesia Day plans. There will be group discussions on the anaesthesia workforce, anaesthetic assistants and industrial challenges. The afternoon will include a workshop on the utility of system tools in healthcare.

Inaugural anaesthesia research workshop

Another innovation from NZNC this year is the inaugural ANZCA New Zealand Anaesthesia Research Workshop to be held at Auckland City Hospital on December 4, just before the Annual Registrar Meeting. The research day aims to provide specialists, trainees and research nurses with a guide on how to become involved with and develop quality research. It should also provide a stepping stone into the area for novices seeking guidance or assistance along with the opportunity to network with research peers.

This page: Joint meeting NZSA-NZNC. NZSA President Dr Ted Hughes (left) and NZNC Chair Dr Nigel Robertson chairing the annual joint meeting between the NZNC and NZSA Executive.

Opposite page from left: Dr Kathryn Hagen who recently reported on her BWT Ritchie Scholarship experience studying regional anaesthesia in Ireland this year; Dr Jane Torrie presenting at the regional meeting hosted by Palmerston North Hospital on August 1.

BWT Ritchie Scholarship applications close soon

Applications for this year's award of the BWT Ritchie Scholarship close on October 31, 2014. This scholarship enables New Zealand-based trainees to obtain experience in other countries, with the proviso that they bring that experience back to New Zealand.

The scholarship is open to anaesthesia, pain medicine and intensive care trainees who have passed their final examination for ANZCA fellowship and are eligible to proceed to training year five, or those who wish to undertake a further year of study outside New Zealand in the year following completion of their fellowship. It may be awarded for one further year, if appropriate. Candidates must be nominated and supported by their training departments.

For further information, including details on how to apply and reports from previous recipients, see www.anaesthesiaeducation.org.nz.

Nominations due for 2015 Visiting Lectureships

Nominations for the 2015 NZ Anaesthesia Visiting Lectureships close on September 30, 2014. This lectureship promotes the sharing of knowledge and experience by funding outstanding presentations to be made at regional hospitals around New Zealand.

A visiting lecturer should be an anaesthetist who will give a stimulating, informative and well-delivered presentation to colleagues and be willing to travel to two other centres in New Zealand to present their lecture/workshop. Nominations should be made by the head of department or practice with the consent of the nominee, using the form available at www.anaesthesiaeducation.org.nz.

Departments who wish to host a lecturer in 2014 should complete an expression of interest form, available on the same website, also by September 30.

This year's series of lectures got under way on August 1 with a continuation of last year's innovation of having two lecturers present jointly at a one-day regional symposium. This saw some 40 participants from Palmerston North, Wanganui, Hawke's Bay and Taranaki hospitals attend a highly interactive meeting at Palmerston North to hear from Dr Jane Torrie (Auckland) and Dr Nav Sidhu (North Shore).

Symposium organiser and one of those who initiated the regional meeting concept, Dr Nigel Waters says: "The idea behind combining rural hospitals from within the region is twofold: it supports regional collaboration and is an excellent way to get to know our colleagues from within the region. It is a cost efficient way for more of the secondary level hospitals to get exposure to experts in their field – both saving time (travel and presentation) for the presenters and dollars for the NZAEC."

Dr Sidhu's topic "CICO and the Surgical Airway: a personal account" used a case report to highlight issues and discuss the evidence surrounding emergency airway management with a particular focus on cricothyroidotomies.

"This presentation was 'eye opening' to say the least," Dr Waters says. "An intense 'ask the expert' session followed and made many of us rethink our ideas on cricothyroidotomies. It also reinforces why the Emergency Response section of the latest College CPD Program is so relevant."

Dr Torrie presented on perioperative team work behaviours – theory, research and practical application, to an audience representative of a theatre team with surgeons, anaesthetic technicians, and PACU and theatre nurses all present along with anaesthetists. There were also plenty of questions and discussion after this presentation.

Dr Colin Marsland (Wellington) will present in Hawke's Bay on November 14 on emergency transtracheal ventilation and bronchoscopic airway management. He will join Dr Torrie to present at another regional meeting being held in Rotorua on November 15, while Dr Sidhu will give his second presentation at Timaru on a date yet to be finalised.

Australian news

New South Wales

Anaesthetia – a change of mind?

The "Anaesthetia – a change of mind?" meeting was held at the Sydney Hilton on June 21. The meeting attracted anaesthetists from across Australia and New Zealand and was very well received. This conference raised the question "Is anaesthetics good for you, or can they be detrimental for your brain?"

Some of the topics that the keynote lectures covered were anaesthesia and the developing brain, brain monitoring, local anaesthetic toxicity revisited, perioperative delirium, optimising the orthogeriatric patient and minimising the harm in the elderly brain.

The problem-based learning discussions and workshops were a great success and addressed new techniques and equipment facilitated by expert presenters on the program.

We congratulate the NSW ACE committee, convenors and NSW ANZCA staff on the success of this event. Planning for next year is already under way.

Above from left: Dr Don Hannah, Dr Jordan Wood, Dr Tim Short, Associate Professor David Scott, Professor Yay Shehabi, Associate Professor Andrew Davidson, Dr Mary Hegarty.

Australian news (continued)

Queensland

Unassuming Fellows lauded for relief work efforts

A fully subscribed recent meeting in Queensland covered topics from war zones to endovascular work.

The 38th Annual ANZCA/ASA Queensland CME Conference was held on July 19 at the Brisbane Convention and Exhibition Centre. Entitled “Go Where and Do What?!?! – Anaesthesia in the Challenging Environment”, the meeting was fully subscribed and a great success.

Delegates were treated to inspiring tales of the exploits of some unassuming Fellows from Australia in relief work in disaster and war zones. Highlights included the sheer scale of the devastation in the Philippines after Typhoon Haiyan, as well as the demonstration of a handover during battle conditions in Kandahar. I, for one, was jealous of the description of “quiet” in the busy trauma bay.

We were also amazed to learn of some of the endovascular work being undertaken in the state of the art hybrid theatre at The Prince Charles Hospital in Brisbane, particularly the possibility of a same day Transcutaneous Aortic Valve Implantation (TAVI)!

The afternoon was occupied with workshops designed to help fellows meet the needs of the new CPD curriculum with respect to emergency response activities, and I think we all learned some valuable lessons about anaphylaxis, major haemorrhage or the can’t intubate, can’t oxygenate scenario.

Once again the facilities at the Brisbane Convention and Exhibition Centre were excellent. A big thanks goes to to Queensland events staff for their hard work, and also thanks to all our workshop facilitors, organisers and speakers for doing their part to ensure a high quality of education was delivered.

Dr David McCormack,
Chair CME Committee

Decision time for registrar training

Interviews have taken place for applicants to the Queensland-based training scheme.

The Queensland Anaesthesia Rotational Training Scheme (QARTS) interview process, undertaken in August, is an approved program accredited by ANZCA, and is a sponsored body providing advice to employing organisations in Queensland, northern New South Wales and Darwin. QARTS reports to anaesthetic directors, who represent the employing jurisdiction. It includes those Queensland hospitals, plus Lismore, Tweed and Darwin, which have been accredited for training by ANZCA and consist of four rotations, each managed by a rotational supervisor.

The annual process for the rotation, allocation and recommendation for registrar training is currently underway for the 2015 hospital education year. All applicants (both continuing registrars and newly applying candidates) were required to apply to QARTS in May in order to be considered for a training post from February 2015, and the interviews for newly applying candidates took place in August. The anaesthetic directors, QARTS committee, and other hospital representatives will then meet on August 29 to consider those applying to QARTS, as well as agree on the annual rotations of registrars presently on the training scheme.

Above from left: Panel discussion with moderator Dr David McCormack and guests Dr Andrew Fenton, Dr Mark Gibbs and Dr Sarvesh Natani; Delegates taking a break.

Final exam preparation

The Brisbane office held the second Final Exam Preparation Course for 2014 in July. The course welcomed 30 trainees who are in the last few weeks of prep for their final exam in August. Course convenor Sanjiv Sawhney filled the week-long program with high-quality exam focused sessions.

Participants experienced practice examinations under exam conditions and a range of informative, well presented and relevant talks to best prepare them for success in the final exam. Evaluation of course content, the presenters and the training facilities points out that participants felt the topics were covered in sufficient detail and met or exceeded their expectations.

During August, the Primary Lecture Program continues and the second round of primary and final practice vivas will begin. Thank you to all of the course presenters and mock examiners who volunteer their time to support Queensland trainees.

Primary exam preparation

The 2014 Primary Exam Preparation Course (PEPC) was held in Brisbane during June with 23 trainees registering to take part. During the two week long course, trainees heard from more than 30 of their peers, who presented a full and diverse program. The first day saw trainees dive head first into practice exam sessions for the short-answer questions and multi-choice question papers with course convenor Dr Tiffany Wilkes, staff specialist at Princess Alexandra Hospital in Brisbane.

This year’s course included new presenters and welcomed back doctors who have been supporting the course for many years. Feedback indicates that the course exceeded the expectations of participants, with most extremely satisfied with the program content. Overall, trainees evaluated the course as excellent or very good, with appreciation for a mix of didactic and interactive sessions.

We would like to thank Dr Wilkes for her time as PEPC course convenor and welcome Dr Bronwyn Thomas, who will take on the role next year.

Above: Dr Jason Howard presenting on regional anaesthesia to course participants

Tasmania

Perfect location for a weekend workshop

The rugged and beautiful Freycinet National Park at Coles Bay was again the location for the winter continuing medical education workshop on Saturday August 23. Located two and a half hours from both Hobart and Launceston, the Freycinet meeting provided an opportunity for quality learning in a unique and stunning part of Tasmania.

Participants were able to fulfill their ANZCA continuing professional development (CPD) requirements by attending an advance life support (ALS) refresher course in the morning, followed by a range of presentations in the afternoon. These included an update on the revised CPD program by Dr Vanessa Beavis, an appraisal of the latest workforce issues from Dr Richard Grutzner and a topical discussion by Dr Sara Bird on medico legal issues such as mandatory reporting obligations under federal law and anaesthetists’ obligations when dealing with impaired colleagues.

The ALS course included six workstations and provided opportunities for participants to gain hands-on knowledge and experience. Participants in the ANZCA CPD Program were able to claim this course as an emergency response activity in their CPD portfolio. Delegates greatly appreciated the small groups at each workstation as it allowed increased teaching time and plenty of hands-on practice.

Feedback by participants was overwhelmingly positive. Registrants were impressed not only by the location and venue but also by the quality of facilities and the overall organisation of the day. Many brought their families and stayed overnight to enjoy the natural surroundings on the Sunday. Another winter workshop is planned for 2015. A different, though equally stunning location, may be on the cards.

Clockwise fom top: Delegates in an afternoon presentation; Small groups allowed hands-on practice; Sunset at Freycinet Lodge.

South Australia and Northern Territory

In search of the magic bullet

The South Australian and Northern Territory Continuing Medical Education Meeting "POISE- 2 – the elusive magic bullet for perioperative ischemia" was hosted by ANZCA/Australian Society of Anaesthetists on May 21. The second continuing medical education for the year and the highest attendance to date (at 143) saw the Women's and Children's Hospital lecture theatre bursting at the seams with an additional 19 anaesthesia consultants and trainees video conferencing in from Darwin, Alice Springs and regional SA.

The guest presenter, Dr Tom Painter, FANZCA, is the principal investigator for POISE-2 research at the Royal Adelaide Hospital, as well as being the clinical senior lecturer at the University of Adelaide School of Medicine in the discipline of acute care medicine.

The POISE-2 study is a highly regarded international, multicentre, randomised controlled trial looking at the role of Asprin and Clonidine in perioperative morbidity. There was much anticipation for members to attend this presentation on such a highly regarded research project and attendees were not disappointed. Dr Painter was an outstanding speaker, receiving the highest commendations from his audience and remained post meeting to discuss the many questions and inquiries generated by his talk. With such high attendance numbers it was all hands on deck, so visiting ANZCA General Manager of Australian Regions, Warren O'Harae, was put to work on the registration desk signing in attendees, and valued the opportunity to meet many of the South Australian ANZCA Fellows and trainees.

Clockwise from top left: Guest speaker Dr Tom Painter, FANZCA, Principal investigator for POISE-2 research at the Royal Adelaide Hospital;

At the Part 0 course Dr Tristan Adams (new trainee), Dr U-Jun Koh (new trainee), Dr Alex Barratt (new trainee), Dr Louis Papilion (new trainee), Dr Samuel Willis (SANTRATS rotational supervisor), Dr Sam Lumb (SA/NT trainee committee chair), Dr Liz Chye (SA/NT Part 1 convenor) and Dr Christine Hildyard (SA NT education officer);

Dr Penny Briscoe and Dr Tony Davis.

Part 0 Course

The mid-year Part 0 course was held in the SA regional office in July. The new trainees entering the rotation were given informative presentations on trainee issues relating to the TPS, rotations, exams and workplace-based assessments. It was presented by SA/NT Trainee Committee chair, Dr Sam Lumb; education officer, Dr Christine Hildyard; rotational supervisor, Dr Sam Willis; and Part 1 convenor, Dr Liz Chye.

Spotlight on mental health

A Faculty of Pain Medicine continuing medical education meeting on "The mental health of the profession/what is the problem and what can be done" was held on July 28 in the SA premises. It was presented by Dr Tony Davis and Dr Jill Benson and was well received by all delegates. Before the meeting, Dr Penny Briscoe was acknowledged for her years of effective work within the Faculty of Pain Medicine and, in particular, for her contribution as Dean of the Faculty 2008-2010. A framed portrait was unveiled, to be hung in the committee room along with other distinguished South Australian contributors to the professional life of ANZCA and FPM.

Doctor endorses full transparency

Regional Anaesthesia Refresher's Continuing Medical Education evening meeting was held on July 30 at the Women's and Children's Hospital in Adelaide. Four local anaesthetic consultants provided an up-to-date summary on common regional anaesthetic techniques, dosing strategies and useful tips. Each speaker discussed clinical indications for blocking, anatomy and sonoanatomy and troubleshooting. Real-time ultrasound scanning demonstrations on a live patient were projected onto the large audio-visual screens for attendees to view, including those in Darwin, Alice Springs and Mount Gambier.

The SA and NT joint ANZCA/ASA Continuing Medical Education Committee express their gratitude to Dr Justin Porter, Dr Richard Church, Dr Jim Dennis and Dr Chen Wei Seong for their expertise and valued contribution to this education meeting. A special thank you to Dr Adam Badenoch, who "volunteered" to be our live patient, for his good humour at being scanned and exposing his insides in front of a live audience – many compliments were offered for the high quality, clear images his lean physique offered the observers and some fun was had while still learning invaluable anaesthetic techniques. Of the 130 attendees, 17 per cent were ANZCA trainees.

Clockwise from top left: Dr Jim Dennis demonstrating ultrasound guided lateral popliteal sciatic nerve blocks; Dr Justin Porter speaking on interscalene block "Going beyond the wall"; Dr Chen Wei Seong demonstrating an ultrasound femoral nerve block; Dr Richard Church demonstrating ultrasound on transversus abdominis plane block.

Australian Capital Territory

Registrars converge on Canberra Hospital

The inaugural ACT Registrars Workshop was held on Saturday August 30 in the theatre complex of The Canberra Hospital. Co-ordinated by Dr Candida Marane (chair, ACT Trainee Committee), Dr Jennifer Myers (Fellow, co-opted Trainee Committee member), and Dr Nathan Oates (Trainee Committee member), the workshop was centred around crisis and resource management, particularly focusing on the human factors involved in emergency responses. A variety of teaching approaches were used, including discussions, drills, lecture presentations, and high fidelity simulations.

Eighteen enthusiastic local registrars spent the afternoon rotating between four hour-long stations:

- An obstetric case-based discussion, run by Dr Lanie Stephens.
- Airway emergencies and drills, run by Dr Natalie Marshall.
- A high fidelity in-theatre simulation based around an anaphylaxis emergency, run by Dr Candida Marane, and
- A high fidelity trauma simulation based around a multi-trauma in ED, run by Dr Simon Robertson.

The day was thoroughly enjoyed by all, with both participants and faculty providing great feedback on the fantastic learning received. We would like to extend a special thanks to the 20 faculty members of The Canberra Hospital who dedicated their time, effort and expertise to ensure the success of this workshop.

Dr Candida Marane, Dr Jennifer Myers, and Dr Nathan Oates
(ACT ANZCA workshop co-ordinators)

Clockwise from top left: Workshop organisers Dr Candida Marane, Dr Nathan Oates, Dr Jennifer Myers; Airways workshop briefing by Dr Natalie Marshall; Anaphylaxis simulation; Trauma simulation.

Victoria

35th Annual ANZCA/ASA Combined CME Meeting

On Saturday July 26 we held the 35th Annual ANZCA/ASA Combined Continuing Medical Education Meeting at the Sofitel Melbourne on Collins. The theme of the meeting was ”Primum non nocere – How anaesthetists avoid harm”.

In the meeting we explored the issue of harm to our patients and to ourselves, which is unfortunately a part of our work. The meeting was well attended and generated forthright discussion. Issues of fluid management, pain and airway management helped us to aim for better care for our patients and the final session on propofol addiction and anaesthetist welfare helped us to reflect on the dangers around our practice.

Dr Mark Hurley
Convenor
CME officer
Victorian Regional Committee

Standing, from left: Dr Debra Devonshire (Chair VRC), Dr Mark Hurley (Honorary Secretary/CME Officer/Convenor of the Meeting), Dr Peter Seal (Co-Convenor and Chair ASA Victoria), Dr David Bramley (Deputy Chair VRC and Assistant CME Officer). Sitting from left: Dr Lisa Zuccherelli and Dr Kym Jenkins, guest speakers in the fourth session of the program.

Australian news (continued)

Victoria

University revives the EH Embley Memorial Medal

The University of Melbourne has revived the EH Embley Memorial Medal with generous support from the Victorian branch of the Australian Medical Association.

This medal is also awarded at Monash University and, consistent with the Monash guidelines, the University of Melbourne medal is awarded to the medical student who submits the best case report or essay in the areas of anaesthesia, perioperative or pain medicine.

The first of the revived medals was awarded to Ms Vanessa Weerasinghe Mudiyansalage, who is also in the first wave of final-year students in the new four-year postgraduate medical degree at the university. Vanessa wrote a case report on managing recurrent suxamethonium myalgia. Vanessa has had anaesthesia experience in both Australia and Sri Lanka, and has anaesthesia at the top of her list of career options.

As foundation Chair of Anaesthesia at the University of Melbourne, Professor David Story was pleased to revive the medal, which has been awarded intermittently over more than 80 years.

The Victorian Branch of the British Medical Association first awarded the medal in 1929 to recognise the achievements of Dr Edward Henry Embley (1861-1924). Dr Embley's life and career are described in a 1981 article by Geoffrey Kaye in the *Australian Dictionary of Biography*. As an anaesthetist at the (Royal) Melbourne hospital Dr Embley conducted physiology and cardiology experiments, published in the *British Medical Journal* in 1902, that demonstrated that death from chloroform was due to cardiac rather than pulmonary toxicity, the prevailing view at the time. Dr Embley's work enhanced patient safety through practice change, to quote Dr Kaye: "Henceforth, chloroform was to be given progressively, close watch upon the pulse and avoidance of surgical interference until anaesthesia was complete."

Above: Vanessa Weerasinghe Mudiyansalage with Chair of Anaesthesia at the University of Melbourne, Professor David Story.

Western Australia

View from the west

In WA, the focus recently has been on the challenges of respiratory disease, and smoking and surgery, ahead of the upcoming country conference in Bunker Bay.

The ANZCA/ASA winter scientific meeting was held on July 26; convened by Dr Michela Salvadore with the topic "updates on all things respiratory". It was chosen to encompass a variety of interesting talks on the issues and challenges we face when providing anaesthesia for patients with respiratory disease.

The new lectureship for this triennium is dedicated to Dr John Boyd Craig; Dr Ashley Webb was the plenary speaker and presented on smoking and surgery: an issue of titanic importance that was well received and appreciated by the audience.

With the recent changes in continuing professional development (CPD) requirements, the Continuing Medical Education (CME) committee has been working hard to provide sessions that are CPD approved. Dr Lindy Roberts clarified some of the issues relating to the changes by giving us an update on CPD during the late afternoon session. One hundred and twenty six delegates attended the winter meeting and thank you to those who have sent through feedback.

Primary exams were held on August 11 and final exams were held on August 22-23. We wish the trainees the best with their results.

The WARC met on August 5; we thank the committee for its continued support and attendance. The ASA Committee met on August 25 and the CME Committee will meet on September 1 to discuss the upcoming country conference at the Pullman Resort.

The country conference, scheduled for October 17-19 and convened by Dr Twain Russell and Dr Silke Brinkmann, will consider crises management, and is fully subscribed. Thank you to all the delegates who have registered for this exciting conference and we will see you in Bunker Bay!

Above from left: Dr Ashley Webb; Dr James Anderson and Dr Michela Salvadore. Photos courtesy of Dr Nigel Hamilton.

Dr Diana Tolhurst
1929-2014

Diana was born in Sydney in 1929, the eldest of three Furness girls. The sisters attended the girl's school Ascham. Diana moved on to university as soon as she finished high school, and considered it one of the best periods of her life. She followed her passions and moved into first year medicine, which consisted in those days of chemistry, physics, zoology and botany. She found physics particularly challenging because it was not a subject she studied at school. At the University of Sydney, she completed her medical course and then went on to become qualified both as a medical practitioner and then as an anaesthetist.

In the early 1950s, it was rare for a woman to become a medical specialist; certainly no woman from the Furness or Longworth families had previously undertaken a university degree. Di then moved to Melbourne, where she met a young Melbourne barrister, Van Tolhurst, while working at St Vincent's Hospital.

The couple were married in 1958 and had four children: Chris, Nick, Penny and Hugh. It was a curious coincidence that all of the Tolhurst children were hit by a car at sometime or other before they left school and, in fact, Diana herself was hit by a car. Suffice to say that few families did more to bring about the 40 kilometre speed zones in Melbourne than the Tolhursts. In 1980, Nick passed away and is forever remembered.

For some 32 years Di juggled running a household with a demanding part-time job as a specialist anaesthetist at the Footscray and District Hospital, later to become the Western Hospital in Footscray. She worked there until her late sixties and then ended her anaesthetic career at the Peter MacCallum Cancer Centre. She was especially keen on travel and, in particular, loved Scandinavia. The family had a lot of fun touring Sweden, Denmark, Norway and also at one stage they got lost in East Germany for 24 hours without a visa. They also had a long holiday in the US driving from Los Angeles to San Francisco and went on to visit Chicago and New York. Other interests were ballet and bridge – she was an astute card player at the Lyceum Club. These are passions that endured until the end of her life.

In Di's passing I have lost the last of my three friends from Footscray and District Hospital. As a junior resident, George Robinson, Betty Spinks and Diana Tolhurst each held an anaesthetic fellowship. In fact, these three were very close friends. They all passed the first inaugural fellowship examination and I wrote an article about them and the other successful candidates in the College Bulletin.

I later met up with this same trio in 1969 when I joined Footscray and District Hospital as a specialist anaesthetist. Diana and I shared Wednesday mornings. There were many a time when, much to our mutual benefit, we also shared the problems of a difficult anaesthetic. One of Di's academic achievements was to write an article on controlled respiration in neurosurgery. There is a letter in the file from Dr Cecil Gray, who was at that stage editor of the BJA and he commented that he was going to make some alterations because the paper was more suitable for a lecture than for publication. He redrafted the article and it was then published in the journal. This was an important change in the practice of anaesthesia; up until this time most neurosurgery anaesthesia had been with spontaneous ventilation.

I am grateful to both Chris and Penny Tolhurst, who kindly provided me with some detail that filled gaps in my knowledge about Diana's life, and allowed me to write this obituary about a very close friend.

Dr Ian Rechtman, FANZCA
Victoria

Dr Desmond Alexander McQuillan
1925-2014

Desmond (Des) McQuillan was born in Auckland, New Zealand, on August 19, 1925 and died in Auckland on March 28, 2014.

Des, who was an only child, attended Bayfield Primary School and Sacred Heart College, Auckland, where he excelled at cricket, rugby and tennis as well as academically. From his early teenage years, he decided to study medicine and completed his medical studies at Otago University's Medical School in Dunedin in 1950.

In December 1949 in Wellington he married Judith Foden, a home science graduate, whom he had met while at university.

After house surgeon years at Palmerston North Hospital (1950) and Wairau Hospital, Blenheim (1951), Des, as a consequence of Department of Health bursary bonding obligations, was given the choice of placement as a general practitioner in either Ruawai or Rawene in Northland. He chose Ruawai where he was the only doctor for a large area from south of Dargaville to Matakohe. He travelled many thousands of miles annually on the Kaipara District's notorious unsealed roads. At times, patient isolation meant rides on horseback or boat were required. After a few years, he acquired his own runabout boat to visit isolated patients and to experience catching the then well stocked Kaipara harbour fish resources. Concern for his patients having to travel out of the district for X-rays led to him acquiring and operating his own X-ray machine and plastering facilities.

As a sole practitioner servicing the local rural community during the peak baby boom years, obstetrics became a significant part of his practice. The two local maternity hospitals were in Te Kopuru and Paparoa. The quickest way to the hospital at Te Kopuru, just south of Dargaville, was by car ferry across the Northern Wairoa River. Night deliveries thus involved disturbing the local ferryman with whom he developed a great co-operative relationship. The opening of a new hospital in Dargaville saw Des kindle his interest in anaesthetics as he attended to a weekly afternoon theatre clinic. Throughout his time in Ruawai, he greatly appreciated the collegial support from professionals in Dargaville, especially Dr Maurice Matich to whom he entrusted his wife's obstetric care.

Des was a great GP, competent, kindly and well integrated into the local community. The large number of Maori families that he served were devoted to him.

After 13 years, Des, Judith and, by this time, their four children left Ruawai for Auckland where Des worked as an anaesthetics registrar at the Auckland Hospital Board's Auckland, National Women's, Greenlane and Middlemore hospitals. In 1965, he decided to further pursue his interest in anaesthetics, which required a shift for the family to the United Kingdom. While completing his specialty exams, he worked at hospitals in London and at Shotley Bridge Hospital in County Durham. During his time in the UK, Des was a very enthusiastic and eloquent spokesman for the beauty and charm of his homeland and encouraged others to visit, some of whom stayed in New Zealand.

On his return to New Zealand in 1967, Des' interest in obstetric anaesthesia led him to take up a position as a senior anaesthetist at National Women's Hospital (NWH), Auckland. These were the days of international renown for National Women's and Des' colleagues included Professors Liggins, Professor Liley and Professor Bonham.

In 1969, Auckland University offered a Diploma of Obstetrics and Des (who claimed he got the job of delivering many a baby because of the late arrival of the obstetrician) was one of the inaugural successful recipients. He later helped with the tutoring for this diploma.

His special interest was epidural anaesthesia for which he perfected the technique both left and right handed. Des and Dr Ian "Hutch" Hutchison popularised epidural anaesthesia for obstetrics at NWH to such an extent that the workload risked becoming unsustainable with the staffing level of the time. Hence he and Hutch also explored the possibilities of using a neuroleptic technique for pain relief in labour. Des continued with this research, trialling various drugs over the next few years, and in early 1976, he presented his findings to the World Conference in Anaesthesiology in Mexico.

Des became senior anaesthetist-in-charge at NWH in 1973 and continued in this position until August 1976, when at the age of 50 he suffered a stroke while at work in the NWH operating theatre. The resulting left-sided paralysis prevented him from working in anaesthetics again but he did return to some part-time GP work. Des was not one to complain but he did have a number of health setbacks in his life, including hepatitis during his matriculation year, meningitis (twice), pneumonia, broken vertebrae and a congenital kidney condition.

Des was a great human being as well as a doctor. He was what one would call a real Kiwi bloke with all the positive things that implied: simplicity, a strong sense of equality, openness, compassion for the underdog and the sick, and a humble, well concealed competence as a doctor. His well-stocked medical bag went with him everywhere. Even when holidaying at his favourite camping site at Tauranga Bay, Northland, he held a free daily clinic and responded to many emergencies. Outside medicine, he was involved with tennis, playing for Otago and Northland, rugby playing and coaching, and lawn bowls, spending time as the president of Auckland Bowling Club.

In his later years, grandchildren became a major interest and he was immensely proud of all their sporting and academic achievements. He was also very proud of discovering his Maori heritage in the early 1990s and took great pleasure in meeting his Maori relatives, attending the National Maori Tennis Championships with some of his grandchildren and visiting the marae in Northland, which ironically is very near Rawene where he had originally been offered a GP position. In retirement, he continued to follow the new trends in medicine, read the latest *ANZCA Bulletin* from cover to cover and took an interest in politics, which included putting a submission in for the review of New Zealand's proportional parliamentary system.

Des died on March 28, 2014 from a ruptured abdominal aortic aneurysm. Fully aware of the situation he was in over his last few hours, he remained the caring family patriarch. Des is survived by his wife Judith, children Janet, Michael, Helen and Linda, seven grandchildren and one great grandchild.

Written by family: Linda O'Rourke, Michael McQuillan, Helen Birse and Janet Sweeney, with contributions from Professor John Werry CNZM, Emeritus Professor of Psychiatry, University of Auckland Medical School, and Dr Glyn Richards, MBS, FRCA, FANZCA, FFPMANZCA, Auckland.

Dr Gisele Mouret 1968-2014

Gisele Marie-Louise Mouret was born at Royal North Shore Hospital in 1968, a hospital where she would both train as a medical student and where her own children would later be born.

Her parents had settled in Sydney's north after her father emigrated from Mazamet, France, schooling Gisele at St Ives North Public School and later Brigidine College. These early years were significant, with the formation of lifelong friendships demonstrating an intense and unwavering loyalty that defined much of Gisele's adult life.

With interests in human performance and fitness, Gisele studied physiotherapy at the University of Sydney 1987-1991. After a short period working as a graduate physiotherapist, she sought a new challenge for her passions and in 1996 entered the inaugural year of the University of Sydney's Graduate Medical Program.

While a medical student, Gisele's sense of loyalty and service prompted her to enlist in the Royal Australian Navy. After completing her internship and residency, Gisele completed officer training at the Royal Australian Naval College at HMAS Creswell. The coming years of RAN training and service offered challenge, adventure and personal sacrifice for her formative junior doctor years.

Her first operational posting was to HMAS Manoora as part of Operation Anode, with HMAS Manoora serving as a logistic and medical support base for the Australian-led RAMSI forces restoring law and order to the Solomon Islands. Gisele was then deployed to HMAS Adelaide in the North Arabian Gulf under Operation Catalyst, contributing to post-war reconstruction of Iraq. It was on this deployment that Gisele managed to deliver a baby on-ship – an experience she was adamant should only occur once in the career of a budding anaesthetist!

In 2004 Gisele was deployed to HMAS Kanimbla in Operation Sumatra Assist, the ADF response to the devastating Indian Ocean earthquake and tsunami. Following this she returned to HMAS Penguin in 2006 as the Officer in Charge of the Submarine and Underwater Medicine Unit (SUMU). Her interests and expertise in hyperbaric, diving and underwater medicine then led her to commence ANZCA training the following year as a proud St George Hospital anaesthesia trainee.

Gisele's interests and contributions to trainee well-being were evident in her active membership of regional training committees, continuing her career-long appreciation of welfare as an important issue for doctors and students of all levels. She had begun this interest even as a medical student, publishing and presenting widely on the management of stress in graduate medicine. Her loyalty and strong sense of justice made Gisele a formidable champion in any training matter.

After achieving fellowship in 2011, Gisele contributed as a visiting medical officer (VMO) at several northern Sydney anaesthesia departments, most notably to her training hospital, St George, where she is warmly remembered as a much liked and hard-working anaesthetist. She also continued as a Lieutenant Commander in the Royal Australian Naval Reserves.

As with all obstacles in her life, Gisele met health challenges with quiet, unwavering focus and determination. She never allowed her illness to define her life or her identity. Her persona was greater than any illness: a decorated naval officer, doctor, consultant anaesthetist, a mother and partner. A loyal and genuine friend to many, now deeply missed. From beginning to end, Gisele decided with discipline and dignity how she would live – a life defined by the discipline of her spirit and the genuineness of her character.

Gisele died on June 5, aged 45. She is survived by her partner Alison Potts and their two children, Blythe and Alexander.

Dr Daniel Jolley, FANZCA
Royal Darwin Hospital, Northern Territory