

# ANZCA BULLETIN

**Working together:  
Anaesthetists  
and surgeons  
join forces  
in Singapore**

**POISE-2 and ENIGMA-II:  
Results of two major trials**

**New face of ANZCA Council:  
Meet the councillors**


**Exam results:  
Our successful candidates**







**26** Your new council  
In our “About ANZCA”  
series, we introduce  
the new ANZCA  
Council. We list all the  
new committee chairs.



**16** CPD tips  
A number of private practitioners have  
developed innovative ways of evaluating  
their practices to meet CPD requirements.

**32** Singapore success  
Nearly 2400 ANZCA  
delegates attended  
the Singapore annual  
scientific meeting held  
jointly with the Royal  
Australasian College  
of Surgeons.



#### **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.

**Medical editor:** Dr Rowan Thomas

**Editor:** Clea Hincks

**Art direction and design:**  
Christian Langstone

**Production editor:** Liane Reynolds

**Advertising manager:** Vivienne Forbes

**Sub editor:** Kylie Miller

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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](mailto:communications@anzca.edu.au)  
[www.anzca.edu.au](http://www.anzca.edu.au)

Faculty of Pain Medicine  
Telephone +61 3 8517 5337  
[painmed@anzca.edu.au](mailto:painmed@anzca.edu.au)  
[www.fpm.anzca.edu.au](http://www.fpm.anzca.edu.au)

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**24** Foundation board members  
The Anaesthesia and Pain Medicine Board of Governors now has six members.

**20** Two major trials  
The results of the POISE-2 and ENIGMA-II trials were announced at the Singapore ASM.



**30** Surgical bus delivers  
New Zealand Fellow Dr Malcolm Stuart has spent much of his career on a mobile surgical unit serving those in some of the country's more remote locations.



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# President's message



On May 9, the final day of the hugely successful ANZCA annual scientific meeting in Singapore, I was deeply honoured to take over the presidency of ANZCA from Lindy Roberts. The last joint Royal Australasian College of Surgeons/ ANZCA meeting was in 1992. This time, joined by our Faculty of Pain Medicine, our theme was “Working together for our patients” – and there were certainly many opportunities for attendees across all three disciplines to share, contribute and learn together in the iconic destination of Singapore.

In the past two years, ANZCA has launched an extensively revised and innovative curriculum; a five-year strategic plan (as has the Faculty of Pain Medicine); a revised and contemporary continuing professional development (CPD) program that better reflects the underlying principle of revalidation, of being a good doctor and practicing safely and ethically; and, in response to concerns about workforce, a Workforce Action Plan and our first Graduate Outcomes Survey.

The purpose of the strategic plan is to clearly define the direction of our College; the ANZCA Council needs to set priorities so its decisions and actions and College resources remain aligned to it. Direction may need to be adjusted as the environment changes – it is therefore vital for our College to be in touch with changes in the medico-political scene, the fiscal environment and the workplace.

I cannot emphasise enough how important it is for all Fellows and trainees to respond to surveys so that our College can make appropriate and relevant responses.

This year, the College will be repeating its ANZCA Fellowship Survey, last performed in 2010, and another Graduate Outcomes Survey. Last year's Graduate Outcomes Survey had a response rate of 47 per cent – although that is considered good by market research standards, it means we only know what half our new Fellows are experiencing. An annual graduate outcomes survey will allow the College to build on previous years' data and map the progress of each year's cohort over time. The fellowship survey can provide us with data about what is happening at the other end, as Fellows approach retirement age.

Elsewhere in this issue of the *Bulletin*, I have written an article about ANZCA's new council introducing our five new councillors. There will be further changes this year when Professor Barry Baker, Executive Director of Professional Affairs and Dean of Education, retires in July and Dr Frank Maloney retires from council life later in the year. I hope by reading this, the fellowship will gain a deeper understanding of council's role and responsibilities as a guide when voting in council elections.

The Australian and New Zealand governments have handed down their budgets (see page 14). There have been increases to health funding in

New Zealand with Vote Health (the health system's major source of funding) increasing to \$NZ15.6 billion with \$NZ1.8 billion for new initiatives. There are many important decisions affecting health in Australia: The boost to medical research via the Medical Research Future Fund, with \$200 million for dementia, and a focus on chronic disease is most welcome, and hopefully anaesthesia and pain medicine researchers will have access to some of this funding. Funding for the Personally Controlled Electronic Health Record (PCEHR) is also to be continued, although its future is not necessarily assured. However, Health Workforce Australia (HWA) will be abolished and subsumed into the Department of Health, and the Australian Commission on Safety and Quality in Health Care is also to be subsumed into a newly created Health Productivity and Performance Commission. The impact of co-funding for GP visits may have a negative impact on the health of the chronically ill.

ANZCA will be closely monitoring the changes produced by these developments.

The future of NMTAN, (the National Medical Training Advisory Network) is still unclear – this network has been working to find ways to nationally co-ordinate medical workforce needs for Australia, by assessing the capacity for and distribution of medical training against projections about population demographics and the burden of chronic disease.

I bring to the presidency a background of more than 20 years as a clinical anaesthetist with experience in both the public and private sector, time on the councils of both the Australian Society of Anaesthetists and ANZCA, and a long-standing commitment to patient safety, professionalism, welfare and wellbeing issues and medical education, for both training and continuing medical education.

I am extremely grateful to all the Fellows and trainees who contribute selflessly to ANZCA and FPM's activities on committees, as examiners and trainers, for our trainees, our patients, for overseas aid and for our indigenous people, and of course the ANZCA staff working in our eight regional and national offices, who help us make it happen. Thank you all and I hope to meet as many of you as I can over the next two years.

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**Dr Genevieve Goulding**  
ANZCA President



# Chief executive officer's message



## Connect share and learn – ANZCA's new tool for learning and collaboration

In coming months, the College will start to launch a tool that takes online learning and collaboration to new levels in this digital age.

The learning and collaboration management system (LCMS) – with a branding and philosophy of “connect, share, learn” – will expand and improve on the College's educational offerings, including podcasts, webinars and online courses designed to allow Fellows and trainees to undertake training and continuing professional development activities.

It will also streamline online committee and working group work, replacing the e-communities with a vastly improved collaborative system.

The LCMS is being developed in line with our strategic priority to build community and engagement. It will be available to individual Fellows and trainees as well as the ANZCA Council, committees, working groups and project groups. Individuals with specific roles or needs can use the system to develop discussion forums or online blogs to communicate and share ideas or resources.

We are using the term “learning and collaboration management system” rather than the industry standard “learning management system” (LMS) because the system has significant collaborative potential for ANZCA and FPM.

Collaboration is a strong feature of ANZCA's Foundation Teacher Course, which is run online twice a year. The course allows participants to follow online modules and interact online with each other then implement new teaching techniques at work. Participants bring their findings back to the online course to share with others.

The second iteration of the course will run in the LCMS in the second half of the year. The course includes audio and visual presentations, videos, online quizzes and assessments, discussion forums and real-time webinars. The system allows participants to talk to each other and talk to the Education unit's learning and development facilitator using the computer's microphone and webcam. We plan for the new system to allow a greater implementation of the Foundation Teacher Course and other online courses in our digital future.

The Education, Training and Assessment Development Committee is overseeing other online resources to be available on the LCMS this year, including online trainee orientation and support resources, supervisor orientation support resources and a new primary examination support resource.

The FPM Curriculum Revision Project's Teaching and Learning Expert Panel is overseeing development of new online learning resources, including videos and webinars to support the Faculty's revised curriculum. This will allow FPM

trainees to access FPM-endorsed resources throughout training, and allow them to collaborate when geography and time pressures might otherwise prevent face-to-face interaction.

The LCMS will improve on ANZCA's expanding library of podcasts, webinars and online courses (see [www.anzca.edu.au/resources/learning](http://www.anzca.edu.au/resources/learning)) which have proved popular and effective for Fellows and trainees experiencing workforce pressures and limited study budgets that prevent them from travelling to national and international meetings.

An LCMS training strategy will be completed soon so ANZCA and FPM can benefit from the many tools available to help meet our strategic aims of delivering a world-class training program, providing a professional development framework that supports the ongoing development of skills and expertise, enhances services to Fellows and trainees and strengthens connections between all parts of the College structure.

## Farewell to Barry Baker

In August, ANZCA farewells one of its elder statesmen, Professor Barry Baker, from the roles of dean of education and executive director of professional affairs.

Formerly the Nuffield Professor of Anaesthetics, University of Sydney and chairman, Department of Anaesthetics, Royal Prince Alfred Hospital, Camperdown, Sydney, Barry is also a former dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons.

He has been involved in College activities for many years, including when ANZCA became a College in its own right in 1992. Then, he was instrumental in creating the College coat of arms. Perhaps his crowning glory was the lead role he played over many years in revising the ANZCA curriculum, which came into effect in 2013. His work has just been recognised in the Queen's birthday honours, where he was awarded an AM.

While Barry is stepping back from College activities we are fortunate not to lose his expertise entirely. He has agreed to be part of the College's History and Heritage Expert Reference Panel, which I chair. This means the College can continue to benefit from his knowledge of history, one of Barry's great passions.

Former ANZCA president Dr Leona Wilson will fill the role of executive director of professional affairs.

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**Ms Linda Sorrell**  
Chief Executive Officer, ANZCA

# Acknowledging Dr Lindy Roberts



It is my great pleasure to acknowledge immediate past president Dr Lindy Roberts for her work as the leader of our College from May 2012 to May 2014.

Lindy's presidency has been marked by diligence, great attention to detail, an emphasis on good process and an enormous amount of travel back and forth across the Nullarbor! She has had a personal and visible leadership style, attending committee, educational and other meetings in every Australian region, as well as New Zealand, Hong Kong, Malaysia and Singapore. She has made great efforts to listen attentively to the concerns of Fellows and trainees, to gain an understanding of their perspective and to provide answers to their questions. Under Lindy's leadership the following have been achieved:

- ANZCA's Strategic Plan for 2013-2017 has been developed and rolled out.
- All council and other committee agendas are structured around the strategic plan to ensure it is at the forefront of all our activities and endeavours so we stay on track.
- ANZCA's innovative revised curriculum has been launched.
- Terms of reference for all ANZCA committees and roles have been rolled out – this has given greater clarity to committee chairs and members.
- The work commenced by Kate Leslie to clarify and strengthen the relationship between ANZCA and the Board of the Faculty of Pain Medicine has continued.

- ANZCA's continuing professional development standard has been revised and the program made more contemporary in its structure and functionality.
- Oversight of two highly successful annual scientific meetings – Melbourne in 2013 and this year's exciting event with the Royal Australasian College of Surgeons (RACS) in Singapore.
- ANZCA's Workforce Action Plan has been developed as the structure for the College's approach to a complex, evolving problem.
- ANZCA has continued its dialogue with colleges such as RACS and the College of Intensive Care Medicine, and also societies such as the Society for Paediatric Anaesthesia in New Zealand and Australia, Australian Society of Anaesthetists and New Zealand Society of Anaesthetists.
- ANZCA has contributed to intercollegiate discussions on revalidation, professionalism, medical education, and many government policy submissions in Australia and New Zealand.

Much has been done in a short space of time and Lindy has developed many processes that will be of great benefit to the council and its committees into the future.

So Lindy, on behalf of all Fellows, trainees and staff, we thank you for all your hard work, passion and commitment. We wish you well in the future, both professionally and personally.

**Dr Genevieve Goulding**  
ANZCA President



# Letter to the editor



## Reply to Desflurane and climate change

I would like to reply to Dr Catherine Hellier's letter to the editor in the March *ANZCA Bulletin*.

I would like to challenge her claim that "Climate change is the greatest health challenge facing us in the 21st century." This article she quotes gives no evidence for her statement. In fact it repeatedly says things like: "...rise in temperature, which will almost certainly have profound health and economic implications." Page 1564. That is, this is a guess!

"The IPCC states that the evidence for global warming is unequivocal and is believed to be due to human activity." Page 1698. Even the IPCC has dropped Michael Mann's infamous false Hockey Stick graph and reinserted the Medieval Warm Period 800-1300 A.D. This idea that CO<sub>2</sub> is a poison is nonsense. It is a nutrient. Plants cannot make sugars without it.

"About 80 per cent of CO<sub>2</sub> is caused by industrialisation." Page 1698. This is blatantly untrue. Professor Robert Carter says, "...99.55 per cent of the greenhouse effect has nothing to do with human carbon dioxide emissions."

"Rising temperatures will also affect the spread and transmission rates of vector-borne and rodent-borne diseases." Page 1702. Dr Paul Reiter's article says that malaria, dengue and yellow fever are not tropical diseases but of poverty.

Since about 2002, the Earth has started cooling again. Beware extrapolation! It is not science.

Finally, I would refer Dr Hellier to the Oregon Petition in which more than 30,000 people, 9029 with PhD degrees, put their names to the following statement: "There is no convincing scientific evidence that human release of carbon dioxide, methane or other greenhouse gasses is causing or will, in the foreseeable future, cause catastrophic heating of the Earth's atmosphere and disruption of the Earth's climate ... increases in atmospheric carbon dioxide produce many beneficial effects upon the natural plant and animal environments of the Earth."

**Dr Greg Smith, FANZCA**  
Queensland

## Website assists with medical care of indigenous patients



A new website brings together a collection of tools designed for medical specialists who care for Aboriginal and Torres Strait Islander communities and patients.

The Network for Indigenous Cultural and Health Education (NICHE) has created nicheportal, an initiative of the Australian specialist medical colleges.

ANZCA Indigenous Health Committee chair Dr Rodney Mitchell said the website hosted a range of resources, which would be relevant to all healthcare workers caring for Aboriginal and Torres Strait Islander patients. "We have been aiming to reduce the duplication of material and offer a large bank of resources in one central place," Dr Mitchell said.

The portal was an ongoing project and online tools would continue to be

added to it, he said. While many of the resources were available to the public, nicheportal would be most useful to medical practitioners including hospital interns, nurses, allied health staff and international medical graduates.

ANZCA has contributed a series of podcasts to the project, which each examine a different aspect of indigenous health. The website is overseen by ANZCA with the Royal Australasian College of Surgeons and has been funded by the Department of Health under the Rural Health Continuing Education Sub-program (RHCE) Stream One, which is managed by the Committee of Presidents of Medical Colleges. [www.nicheportal.org](http://www.nicheportal.org)

# Awards

## Queen's birthday honours



**Officer (AO) in the general division**  
**Professor John Alexander**  
**MYBURGH Sydney, NSW.** For distinguished service to medicine as an intensive and critical care practitioner, educator and researcher, and as an international innovator in patient management.



**Member (AM) in the general division**  
**Professor Arthur Barrington BAKER, NSW.** For significant service to medicine, particularly to cardiovascular anaesthesia, to medical education, and to professional medical organisations.



**Member (AM) in the general division**  
**Dr Felicity Helen HAWKER, Vic.** For significant service to intensive-care medicine, and to professional organisations.

## Woman in Medicine Award

Former ANZCA president Professor Kate Leslie has won the Australian Medical Association's prestigious Woman in Medicine Award.

The award recognises Professor Leslie's "outstanding contribution to improving the quality of care for patients in Australia and internationally, and her service to the medical profession".

The announcement was made at the AMA National Conference in Canberra in May. In presenting the award, then-AMA President Dr Steve Hambleton said: "Professor Leslie is a leader in every sense of the word."

He acknowledged Professor Leslie's contributions as ANZCA president and as the chair of the Committee of Presidents of Medical Colleges, her extensive research interests and her direct involvement in teaching the next generation of anaesthetists.

Professor Leslie is Head of Research at Royal Melbourne Hospital's Department of Anaesthesia and Pain Management. She has published more than 140 research papers and made more than 170 research presentations.





# Intensive care medicine book launched

*Below clockwise from left: Cover of Intensive care medicine in Australia; Dr Lindy Roberts speaks at the book launch; Dr Roberts (third from left) and Dr Ross Freebairn (end right) with members of Professor Phillips' family.*

A book that traces the development of intensive care medicine in Australia written by former ANZCA President, Professor Garry Phillips, AM, was launched on Friday April 11 at ANZCA House in Melbourne.

Dr Phillips began gathering material for *Intensive care medicine in Australia: Its origins and development* in the late 1960s. He says the origins of the specialty as we know it today can be traced back to World War II after which international medical networks had been re-established, and reconstruction of a damaged world had begun.

Professor Phillips was awarded the College's prestigious Robert Orton medal in 2005, the same year he was awarded the Order of Australia (AM) for his contributions to anaesthesia, intensive care and emergency medicine plus his teaching and community service.

The book was launched by then-ANZCA president, Dr Lindy Roberts and College of Intensive Care Medicine President, Dr Ross Freebairn. Professor Barry Baker also spoke at the launch.

**Copies of *Intensive care medicine in Australia: Its origins and development* can be purchased for \$24.95 plus postage. Please email [ceo@anzca.edu.au](mailto:ceo@anzca.edu.au).**



# Forthcoming ANZCA surveys

ANZCA will distribute an online Graduate Outcomes Survey to all new Fellows of the College starting in July and running for three weeks. This is in line with the College's efforts to address the training, practice and CPD needs of new Fellows, and to assist in our negotiations with relevant stakeholders in relation to workforce.

Following close on the heels of this survey, ANZCA will launch the Fellowship Survey in August. The results of this survey aim to assist the ANZCA Council in addressing the strategic direction of our College.

**Both surveys are crucial in informing key College decision-making.**

## Collecting workforce data via the Graduate Outcomes Survey

The results of the second annual Graduate Outcome Survey will be essential in shaping the framework by which the College engages with state and national governments on behalf of its new Fellows.

New Fellow councillor Dr Craig Coghlan is leading the July survey with assistance from outgoing new Fellow councillor Dr Gabe Snyder. Each is acutely aware of the workforce issues facing new specialist anaesthetists, particularly in metropolitan and rural areas of Australia.

High-quality data is essential to effectively negotiate workforce issues, and the College aims to substantially increase the 2013 survey response rate of 47 per cent.

Collecting quality data is one of three focuses of the College's workforce action plan. The other two are advocacy (ensuring the College has an effective voice in decisions by policy makers) and communication (ensuring Fellows and trainees understand College views and are aware of its workforce activities).

An article on the College's approach to workforce can be found in "Talking workforce", published in the December 2013 *ANZCA Bulletin*. The results of the 2013 Graduate Outcomes Survey can be found in the March 2014 *ANZCA Bulletin*. Both appear on the ANZCA website at [www.anzca.edu.au/communications/anzca-bulletin](http://www.anzca.edu.au/communications/anzca-bulletin).



## ANZCA Fellowship Survey to help guide College decisions

All Fellows of ANZCA and the FPM will be asked to complete the ANZCA Fellowship Survey in August when it is emailed and mailed to them.

This survey provides important information and allows the College to make informed decisions about where it should focus attention. It also will allow the College to measure progress since the last survey in 2010.

While the 2010 ANZCA Fellowship Survey showed the College was performing well in a number of areas, with high overall levels of Fellows' satisfaction with the College, it also identified issues that needed addressing.

The survey results prompted a restructure of the ANZCA website in 2011 to more prominently display areas identified as being of high importance to Fellows – quality and safety, professional documents, education (learning), training, the ANZCA Library and publications, and communications.

The development of a continuing professional development (CPD) data entry system for use on mobile devices was a direct result of Fellows' feedback, as was the redesign of the CPD web pages.

A comprehensive account of the College's response to the 2010 ANZCA Fellowship Survey can be found in the March 2014 edition of the *ANZCA Bulletin*. The original results can be found in the December 2010 *Bulletin*. Both articles can be found at [www.anzca.edu.au/communications/anzca-bulletin](http://www.anzca.edu.au/communications/anzca-bulletin).



**Dr Rowan Thomas**  
Chair, Fellowship Affairs Committee



# ANZCA and FPM in the news



## Surgery link to dementia, memory loss

**Study** Over 65s at particular risk  
**Alan Blom**  
 A study of 65-year-olds and older found that those who had surgery were more likely to be admitted to hospital for dementia or memory loss than those who had not. The study, published in the journal *Journal of Neurology, Neurosurgery and Psychiatry*, found that the risk of dementia or memory loss was 1.5 times higher in those who had surgery than in those who had not.

## Study clears air for use of happy gas

**SINGAPORE** — Anaesthetists and other health professionals are encouraged to use nitrous oxide, commonly known as 'happy gas', to help patients with pain and anxiety during surgery, according to a new study published in the *British Medical Journal*.

## Sleep best medicine

Anaesthetics may hold key to fighting tumours

**GRANT MCARTHUR**  
 ANAESTHETICS given to cancer patients may hold the key to fighting tumours, according to a study published in the *Journal of Clinical Investigation*. The study found that anaesthetics can help to stop cancer cells from spreading and may also help to kill them. The researchers found that anaesthetics can block the growth of cancer cells and may also help to kill them. The researchers found that anaesthetics can block the growth of cancer cells and may also help to kill them.

## Media releases distributed by the ANZCA media team since February:

- Virginia McMillan wins 2013 ANZCA Media Award for pain story (March 4).
- Anaesthesia and the newborn – more research needed (March 23).
- Aspirin before surgery – risks revealed (April 2).
- Nurses and anaesthesia – caution urged (April 14).
- Book explores intensive care in Australia (April 17).
- Chronic pain after surgery – who is at risk and how can it be prevented? (May 4).
- Laughing gas gets the all clear at last (May 6).
- Is it possible to fight cancer with anaesthesia? (May 7).
- Controlling pain key to healing war wounds (May 7).
- ANZCA welcomes new president Genevieve Goulding (May 8).
- ANZCA welcomes medical research investment (May 13).

**Ebru Yaman**  
 Media Manager, ANZCA

The three months to May 2014 was dominated by stories highlighting the significant and varied research investment of ANZCA, the Faculty of Pain Medicine and Fellows.

More than 600 reports across radio, print, online and television media have reached a combined cumulative audience of more than 7.5 million people (7,755,986).

Highlights include the annual scientific meeting in Singapore (see page 37), where strong stories on anaesthesia and pain medicine were reported across Australia and New Zealand.

The Communications unit has prepared and distributed 11 media releases and ANZCA and FPM Fellows were interviewed on topics including the use of aspirin in surgery (Professor Kate Leslie on the POISE-2 study), the federal budget (Associate Professor David Scott), obesity in pregnancy and post-surgical pain.

In all, more than 20 interviews were given to journalists by Fellows.

## Since February ANZCA has featured in:

- More than 400 online stories
- 71 print reports
- 40 television reports
- 155 radio reports

# What would you do?



ANZCA's professional documents aim to assist Fellows and trainees to provide a high standard of care to their patients. This is part of a series of articles that explain aspects of ANZCA's professional documents in practical terms.

## Perceived value – the importance of good patient communication

Consider the following scenario: You are anaesthetising for a list with expected rapid turnover but staggered admissions, and one of your patients informs you they are impressed with your assessment because with the last anaesthetist “all they did was literally say hello and charged a fee for that”.

The patient goes on to criticise your colleague and indicates they have refused to pay the fee for that visit. In reviewing the charts you notice the anaesthetist is someone you know.

### What would you do?

What would you do in regard to the discussion with your patient and what would you do in regard to discussing this with your colleague?

We are constantly being evaluated by the community, including patients, colleagues and peers. The image of anaesthetists has been somewhat obscured over time, in the perception “just another prick in the back of the hand”.

The role of anaesthetists as specialists in resuscitative medicine, pain medicine,

intensive care medicine and retrieval medicine, in addition to anaesthesia, has been largely unrecognised.

Recently anaesthetists have been promoted as perioperative physicians with a view to achieving greater recognition within the community and the value that we, as specialists, provide. The College actively supports and promotes anaesthesia, both publicly (through a pro-active media program and activities such as National Anaesthesia Day) and through its many roles, including training, education, research, health advocacy, and community and cultural involvement.

The enormous effort spent developing the revised ANZCA curriculum and the revised CPD standard and program ensures the high standard of anaesthesia continues to be recognised worldwide.

However, this can gradually unravel if mounting numbers of patients suffer adverse experiences and dissatisfaction with their practitioner. The most common complaints surrounding fees almost invariably drill down to dissatisfaction with service. Interestingly, they are rarely due to incompetence. By and large they relate to patients feeling “mistreated”, and the commonest stage for this complaint to arise is at the preoperative assessment. Patients describe being rushed and having very little contact with their anaesthetist,

during which a cursory visit – often perceived simply as “hello” and a brief introduction – is eventually followed by a fee. In this situation patients perceive no value for the service.

Given the constraints under which we work, brevity may be reasonable, however, the challenge is in avoiding the patient being aware of anything other than that they are the focus of attention at the time and that they are receiving genuine concern from their practitioner.

In considering how you might respond to a patient criticising a colleague the following ANZCA documents may be helpful.

*Code of Professional Conduct* with specific attention to section 5 – “Anaesthetists and professional relationships”.

ANZCA professional document PS07: *Recommendations for the Pre-Anaesthesia Consultation* in which the principles are identified and guidelines provided.

If we observed a trainee perform a preoperative assessment, what would we advise them?

Finally, what can we do in our practice to improve a patient's experience, and what would this do to our perceived value?

**Dr Peter Roessler**, ANZCA's Director of Professional Affairs (Professional Documents)

## Professional documents – update



The professional documents of ANZCA and FPM are an important resource for promoting the quality and safety of patient care 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.

Queries or feedback regarding professional documents can be directed to [profdocs@anzca.edu.au](mailto:profdocs@anzca.edu.au).

The complete range of ANZCA professional documents is available via the ANZCA website, [www.anzca.edu.au/resources/professional-documents](http://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](http://www.fpm.anzca.edu.au/resources/professional-documents).



# A new federal government

## Australia

It has been an interesting time in Australian health policy with a great deal of speculation in the lead up to the government's inaugural budget. The Australian government's Commission of Audit was released on May 5 just a week prior to the 2014 budget announcement. ANZCA chief executive officer Linda Sorrell attended a closed federal budget briefing in Canberra on behalf of the College on May 13 and the College welcomed the government's unanticipated commitment to a \$20 billion dollar national research fund, which is estimated will effectively double the support for health research in the coming years.

The restructuring of health and education payments to the states was another unanticipated announcement and has created a wedge between the federal and state governments with estimates that \$80 billion dollars of funding is at risk. The health funding cuts would be comparatively small in the 2014-15 financial year but significantly escalating from 2018. State premiers have already announced that the failure to honour agreements such as the National Health Partnerships Agreement signed by the previous government will have immediate impacts on frontline services.

Announced as part of a number of measures to consolidate government and non-government agencies, Health Workforce Australia (HWA) will be integrated into the Department of Health (DOH). The College has been working with HWA since its inception in 2009 providing input into a range of workforce-related projects through providing data, submissions and representatives for working groups. The government has advised that HWA projects will be integrated into DOH. The College will continue its workforce engagement under the new structure with the ANZCA Workforce Action Plan.



## Specialist Training Program

An extensive evaluation of the Specialist Training Program (STP) commenced in January 2013 with the aim of furthering program development and assessing the ongoing success of the program. The purpose of the evaluation is to determine whether the STP overall is meeting program aims and to ensure that trainees are benefiting from rotating through STP posts. The evaluation is now complete and overall the feedback was positive, demonstrating that the program and the College are performing well in a number of areas. While the satisfaction ratings are pleasingly high, the results have assisted ANZCA to identify gaps and recommend strategies for streamlining data collection as well as drive changes to streamline administrative processes and improve relationships with STP hospital stakeholders.

The Rural Engagement Project also was recently completed as part of STP. Enhancing engagement of all trainees and Fellows is a key strategic priority for ANZCA, however rural and regionally based trainees and Fellows is a focus area for STP. We thank the management group who took the time to participate and provide strategic advice on the project and the trainees and Fellows who responded to the survey. The resulting strategy provides recommendations to improve the way ANZCA communicates with rural Fellows and trainees and engages with this group through online learning platforms.

Further information on the Specialist Training Program can be found at: [www.anzca.edu.au/training/specialist-training-program](http://www.anzca.edu.au/training/specialist-training-program). Inquiries 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](mailto:stp@anzca.edu.au).

## New Zealand

The New Zealand Government released its 2014-15 budget on May 15, showing a small return to surplus of around \$370 million. Funding for Vote: Health will increase to \$15.6 billion for the 2014-15 financial year. Over the next four years, \$1.8 billion will be available in health for new initiatives and to meet cost pressures and population growth (\$1.39 billion of this is new money, and \$412 million is from savings).

District health boards will have \$320 million available next year for extra services and to meet cost pressures. Specific new areas of spending over the next four years include an additional \$110 million to fund more elective surgery, \$90 million to extend free GP visits and prescriptions to children under 13 years old (increased from under six years old) and \$13.2 million for additional places at medical schools.

In March, the Council of Medical Colleges (CMC) facilitated a meeting with the Medical Council of New Zealand and Ministry of Health representatives to discuss developing a framework for assessing doctor competence. ANZCA will continue to work through CMC on this issue.



Other meetings have focused on issues with New Zealand’s medical workforce “pipeline”, which is experiencing various pressure points but particularly a lack of consultant positions for graduating trainees. This was discussed at a CMC forum in March and at a CMC-facilitated meeting between college representatives and Health Workforce New Zealand (HWNZ) director Dr Graeme Benny in May. HWNZ is keen to work with the colleges to establish better data on workforce trends, and to improve information available to medical students to assist with career planning.

ANZCA also participated in a meeting with the Ministry of Health on April 29, along with representatives from midwifery, obstetric and anaesthetic organisations, held to discuss a proposed extension to prescribing rights for midwives of the controlled drugs pethidine, fentanyl and morphine. If Cabinet approves the legislative amendment, the Midwifery Council will submit a scope of practice for gazetting. ANZCA would work with the Midwifery Council to assist with the development of practice guidelines.

## 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:

- Pain Australia on the National Pain Strategy Evaluation.
- Automated External Defibrillator Deployment Registry on automated external defibrillator deployment.
- Australian Resuscitation Council on the clinical standards for resuscitation clinical practice and education.
- Medical Services Advisory Committee, Department of Health on local anaesthetic nerve blockade for post-surgical analgesia.
- Pharmaceutical Benefits Advisory Committee on the prescription of opioids.
- Australian Medical Council on the pre-employment structured clinical interview.
- The Treasury on restating and centralising the special conditions for tax concession entities.

- The Australian Commission on Safety and Quality in Health Care on:
  - Clinical care standards for antimicrobial stewardship and acute coronary syndrome.
  - National consensus statement: essential elements for safe and high-quality end-of-life care in acute hospitals.
  - National set of high-priority hospital complications.
  - Draft clinical care standard for stroke.

### New Zealand:

- Pharmac on:
  - Sugammadex.
  - Changes to the decision criteria for pharmaceutical funding.
- The Maternity Monitoring Group on the 2012 Guidelines for Consultation with Obstetric and Related Medical Services.
- The NZ House of Representatives on the Smoke-free Environments (Tobacco Plain Packaging) Amendment Bill.
- The Medical Council of New Zealand on advertising.
- The NZ Ministry of Health on proposed amendments to midwives’ and nurse practitioners’ prescribing of controlled drugs.

The 2014 ANZCA and FPM Accreditation Submission was also sent to the Australian Medical Council and the Medical Council of New Zealand.

ANZCA’s past submissions, including the College’s accreditation submission to the Australian Medical Council and significant submissions developed by the New Zealand National Committee can be accessed via: [www.anzca.edu.au/communications/submissions](http://www.anzca.edu.au/communications/submissions).

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### Jonathon Kruger

General Manager, Policy, ANZCA



# Fellows show initiative in evaluating their practice

## Private practitioners develop innovative ways to evaluate their practice to meet the requirements of ANZCA's revised CPD program.

In January, the College successfully launched the revised ANZCA Continuing Professional Development (CPD) Program and accompanying CPD portfolio system.

Designed in response to pressure from external regulatory bodies for colleges to strengthen their CPD standards, the revised program ensures all anaesthetists and specialist pain medicine physicians can unambiguously demonstrate their ability to practice at a specialist level.

It gives the community confidence in doctors' ongoing fitness to deliver the safest possible patient care.

The Chair of ANZCA's CPD Committee, Dr Vanessa Beavis, said the revised CPD program also pre-empted (for now) moves towards revalidation in Australia and New Zealand, and brings the college into line with other jurisdictions, which have experienced considerable tightening of CPD requirements.

Dr Beavis, who is director of perioperative services for Auckland District Health Board, said registered clinicians in New Zealand now undertake a compulsory audit of medical practice relevant to personal practice, and refer to CPD as part of recertification to renew their practising certificates.

"It is likely that regulatory authorities in Australia and New Zealand will significantly increase the requirements on Fellows and other CPD participants for re-registration," Dr Beavis said.

"The regulatory requirements include a greater emphasis on practice evaluation and a steady move towards revalidation – we believe revalidation is only a matter of time. By revising our CPD program, the College has proactively addressed these challenges."

ANZCA's revised CPD standard reflects contemporary developments in CPD with a dual focus on practice evaluation and traditional pure learning activities. While the CPD program always required practice evaluation (previously category 3 activities), there is a stronger focus on practitioners evaluating their own practice in the revised program so that there are now two mandatory practice evaluation activities which have been included.

"The standard now places a much greater emphasis on practice evaluation than on knowledge and skills acquisition," Dr Beavis said. "This is to help give participants an indication of how they practice in relation to their peers, so they can work on what needs to be improved if necessary, and consolidate or maintain their skills in the other areas."

Specialists must complete two groups of practice evaluation activities each triennium – two above-the-line or mandatory activities worth a total of 40 points, plus a range of below-the-line activities, approximately 10 hours a year, worth a total of 60 points.

Activities that evaluate an individual's own practice include clinical audits, multi-source feedback, patient experience surveys and peer review of practice. Participants are required to complete two of these activities each triennium, and can complete the same activity twice to satisfy this requirement.

All other practice evaluation activities are optional and include attendance at morbidity/mortality meetings, participation in case conferencing, accreditation inspections of hospitals or other training sites and medico-legal report writing.



## Case study 1



**Dr Ben Olesnicky**  
VMO anaesthetist: Royal North Shore Hospital, North Shore Private Hospital, The Mater Hospital, Dubbo Private Hospital.

The type of evaluation a specialist chose would largely depend on his or her practice.

“Private or hospital practitioners can easily do multi-source feedback if they work in one area regularly, because the staff and colleagues will have enough exposure to their practice to provide some feedback. This will apply to remote practice as well,” Dr Beavis said.

“Patient surveys may suit a private practitioner who works in many locations over the course of the week, since there will be a significant caseload for a survey. Someone may pick a week in which to send out a survey to all patients then repeat that again in years’ time, and get the two above-the-line activities in this way.

“A practice review could be done with a trusted colleague using a half-day slot when the surgeon is away and there is no list. Anaesthetists could use the opportunity to review a colleague, who will then return the favour. When completed, this would knock off both above-the-line activities for the whole triennium.

“Usual practice evaluation activities, such as morbidity/mortality meetings, case conferencing, webAIRS etc, would occur as they do now.”

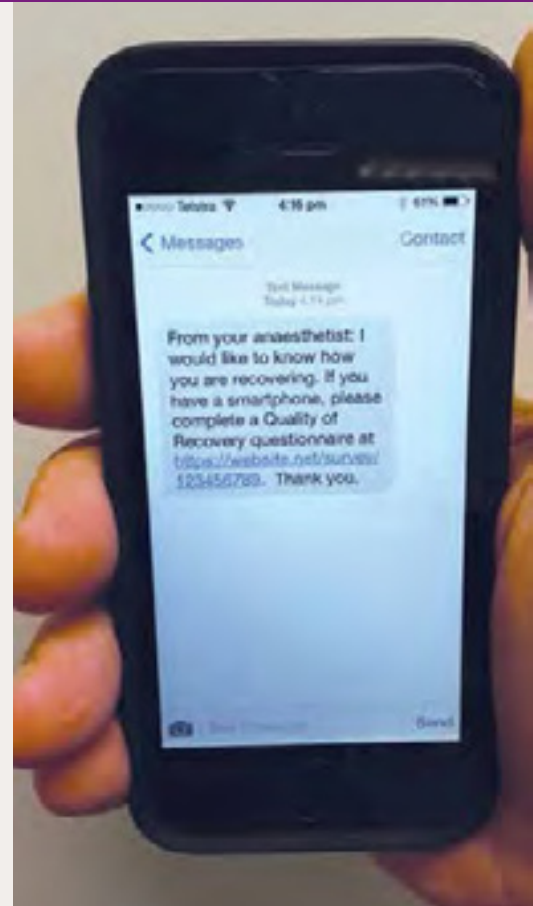
For further information about the 2014 ANZCA CPD Program and to log into individual CPD portfolios, go to [www.anzca.edu.au/fellows/continuing-professional-development](http://www.anzca.edu.au/fellows/continuing-professional-development).

There is a lot of information available on the College website, including tools, templates and podcasts, to show you how to undertake each activity.

The ANZCA CPD unit welcomes Fellows’ feedback. Please contact the CPD unit on +61 3 9510 6299 or [cpd@anzca.edu.au](mailto:cpd@anzca.edu.au).

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**Kylie Miller**  
ANZCA Communications



A specialist anaesthetist who splits his time between public and private work, Dr Ben Olesnicky provides anaesthesia for private neurosurgical and orthopaedic procedures and a variety of trauma and duty director work at Royal North Shore public hospital, four to six days a week. He also is a member of Macquarie Anaesthetic Group, a private group with 34 anaesthetists.

Dr Olesnicky has introduced ways to evaluate his practice in both domains using a range of techniques.

At Royal North Shore public hospital, he and a colleague produce monthly graphs of outcomes in the post-anaesthesia care unit, where each anaesthetist is compared against his or her colleagues and the department is compared to published standards.

The audit is based on a postoperative audit form created by Dr Mark Markou at Flinders Medical Centre in Adelaide

“The measured outcomes are designed to meet indicator-reporting requirements for hospital accreditation with Australian Council on Healthcare Standards,” he said. “The outcomes audited include PONV, pain, hypothermia and need for unplanned review of patients.”

In the ANZCA CPD program, this meets the criteria for “clinical audit of own practice or significant input into a group audit of practice”.

The specialists also receive regular feedback at department meetings and use it to change their practice, which means each can claim CPD credits under “review of patient care pathways”.

“Through our private group, we operate an SMS and web-based preoperative assessment and postoperative feedback form,” Dr Olesnicky said.

Each patient is identified from a theatre list in the days leading up to their surgery and is sent an SMS with a link asking them to fill out a preoperative questionnaire. After the surgery, patients receive another link to a questionnaire about their experiences, sent either by email or SMS.

“The postoperative questionnaire is based upon the published Quality of Recovery Score (QoR-9). The responses are sent directly to each anaesthetist’s email, or directly to a Google docs spread sheet, to allow for easy audit of data.”

The information is used as a patient experience survey and accrues category one CPD credits.

*(continued next page)*



## Fellows show initiative in evaluating their practice (continued)

### Case study 1 continued

While establishing the infrastructure and IT support wasn't easy and required an internally managed redesign of the group website to incorporate the questionnaire and SMS capabilities, Dr Olesnický said the cost to the practice was negligible – about \$16 a month plus the cost of sending SMS messages.

And it delivers other benefits.

"I have a 80-85 per cent reply rate on my preoperative evaluation forms and about a 60-65 per cent reply rate on

postoperative feedback forms," he said. "The feedback through patients of all ages is that they like the use of technology in this way and even though it is not at all individualised, that it feels somewhat personalised for them. It has become an important component of the patient-doctor relationship in my practice. It also provides for documented informed financial consent from the patient."

He also believes it offers important information for anaesthetists as a component of practice improvement

and generates an interest in research and quality assurance that can benefit the specialty.

"Many anaesthetists will see practice evaluation as an extra burden; I hope that they see with a small amount of extra effort, the feedback they get on their practice is very worthwhile and satisfying."

### Case study 2



#### Dr David Belavy

*Anaesthetist, Specialist Services Medical Group; staff anaesthetist, Royal Brisbane and Women's Hospital.*

Understanding his patients' recovery is an important part of practice for specialist anaesthetist Dr David Belavy, who works one or two days a week in private practice and the remainder as a staff anaesthetist at Royal Brisbane and Women's Hospital.

Eager to know how his patients recovered after anaesthesia and surgery, in late 2012 Dr Belavy began to investigate methods of collecting and building outcomes data into his private practice.

Using SMS and web-based technology, Dr Belavy set up an internet-based questionnaire to capture structured data from patients. A day after surgery, patients are sent an SMS with a link to an online questionnaire, which they can complete on their smartphone.

"As I am in solo private practice, it is easier to follow through with new initiatives," Dr Belavy said. "I was fully aware that data would not be captured from all patients but it does facilitate follow up of some patients and also demonstrates a commitment to clinical audit and quality improvement. It also helps to meet requirements for the revised ANZCA CPD program."

Establishing the process was not without challenges, including choosing the right questionnaire.

"I wanted to use a validated questionnaire and I initially chose the Quality of Recovery Score proposed by Myles et al. While this score does assess the quality of recovery, it doesn't really assess the patient's experience of anaesthesia and I am in the process of changing to a different questionnaire. I also include a free-text area for feedback."

The technical challenges involved with handling web servers, survey software and SMS messaging require some IT experience, while Australian Privacy Principles must be considered with the use of SMS messaging and internet questionnaires. Dr Belavy requests consent as part of his online pre-operative assessment.

Limitations also arise because not all patients have a smartphone and some are too unwell to complete the questions; data collection can be biased towards younger, healthier patients.

However the 50 per cent response rate is worth it and has enabled him adapt as required.

"The feedback allows me to identify patients that have had problems and contact them if required," he said. "I have found patients that have suffered with more pain or vomiting than I expected and I have adapted my anaesthetic techniques as a result. It is also rewarding to receive positive feedback."

Dr Belavy said while the barriers and challenges meant he had not tried to extend the system to his public practice, in solo private practice it was adopted with relative ease.

"I now have a continuous process of data collection evaluating at least part of my clinical practice and the process can continue with minimal effort," he said. "I certainly feel that that use of smartphone technology to facilitate outcome evaluation and practice assessment is worthy of research."

While he established the process to help track his patients' recovery, the credits accrued towards CPD provide a secondary benefit. And this is the way it should be, he said.

"I think that practice evaluation and patient outcome assessment should be the primary goal and meeting ANZCA's CPD requirements will naturally follow."

# Important research results showcased at ASM

The much-anticipated results of two ANZCA Trials Group projects – ENIGMA-II and POISE-2 – were presented at last month's Singapore annual scientific meeting (ASM).

Professor Paul Myles, the principal investigator of the ENIGMA-II Trial, announced the results of the trial on May 6 in front of a large audience of anaesthetists, surgeons and trial co-ordinators. The results will soon be published in the prestigious journal, *The Lancet*.

Dr PJ Devereaux, ANZCA ASM Visitor and principal investigator of the POISE-2 study, also presented the results of the Canadian-led, ANZCA Trials Group-endorsed POISE-2 study which was published in the *New England Journal of Medicine* in April.

The success of the ENIGMA-II and POISE-2 trials proves that it is feasible to conduct large, international, high quality trials within budget to improve the evidence-base and guide practice in anaesthesia. These trials reflect the commitment of our investigators, research co-ordinators and patients to debunking longstanding myths around anaesthesia practice and to ultimately improve patient safety.

## ENIGMA-II Trial

### Nitrous oxide anaesthesia and cardiac morbidity after major surgery – ENIGMA-II Trial

Our previous trial, ENIGMA, studied 2050 patients and identified some serious adverse effects, but most patients were not at risk of coronary artery disease (CAD) and so we could not reliably assess serious cardiac complications.

We identified a non-significant increased risk of confirmed myocardial infarction in the N<sub>2</sub>O group, 1.3 per cent versus 0.7 per cent; adjusted P=0.19, and 10 post-operative deaths (1.0 per cent) in the N<sub>2</sub>O group compared with four (0.4 per cent) in the control group P=0.26. Therefore, ENIGMA-II was designed as a large simple multi-centre randomised controlled trial to definitively evaluate the efficacy of removing N<sub>2</sub>O from the anaesthetic in moderate and high-risk patients undergoing non-cardiac surgery.

There are about 20 million anaesthetics given each year in the US (1:10 of the population), with the majority receiving N<sub>2</sub>O. Approximately 25 per cent of patients undergoing major surgery have known coronary artery disease or risk factors for CAD. In 1990, approximately one million of the 25 million Americans who underwent non-cardiac surgery suffered a perioperative cardiac event, resulting in \$20 billion in costs.

N<sub>2</sub>O interferes with vitamin B12 and folate metabolism. This impairs production of methionine (from homocysteine), used to form tetrahydrofolate and thymidine during DNA synthesis. It has been repeatedly demonstrated that N<sub>2</sub>O anaesthesia increases post-operative homocysteine levels. Chronic hyperhomocysteinaemia is associated with cardiovascular disease, and acute hyperhomocysteinaemia is known to cause endothelial dysfunction. Reducing post-operative myocardial infarction and death are important aims for those with CAD undergoing major surgery.



ENIGMA-II is one of the largest trials conducted in anaesthesia. It is an international, randomised, assessor-blinded trial in patients with known or suspected coronary artery disease having major non-cardiac surgery. Patients were randomly assigned to receive a general anaesthetic with or without nitrous oxide. The primary outcome measure was a composite of death and cardiovascular complications (nonfatal myocardial infarction, stroke, pulmonary embolism or cardiac arrest) within 30 days of surgery. Secondary endpoints included surgical site infection, severe nausea and vomiting, and hospital length of stay.

Among 10,102 eligible patients, we enrolled 7112 consenting patients; 3569 were assigned to the no-nitrous oxide group and 3543 were assigned to the nitrous oxide group. The primary outcome occurred in 296 (8.4 per cent) patients in the no-nitrous oxide group and 283 (8.1 per cent) patients in the nitrous oxide group (relative risk, 0.96; 95 per cent confidence interval, 0.82 to 1.13; P=0.64). Surgical site infection occurred in 8.9 per cent and 9.2 per cent of patients (P=0.85), and severe nausea and vomiting occurred in 11 per cent and 15 per cent of patients (P<0.001), in the no-nitrous oxide and nitrous oxide groups respectively.

The median hospital length of stay was 6.1 (interquartile range: 3.3 to 10) days in both groups (P=0.69). In conclusion: In patients having major non-cardiac surgery, nitrous oxide did not increase the risk of death and cardiovascular complications or surgical site infection.

**Professor Paul Myles**  
Principal investigator, ENIGMA-II



“Surgeons and anaesthetists should advise patients to cease aspirin at least three days before non-cardiac surgery unless the patient is at high risk of thrombosis.”

## POISE-2 study

### POISE-2 study delivers first results

The results of the POISE-2 study were published on March 31 in the *New England Journal of Medicine* – the highest ranking general medical journal in the world. The ANZCA Trials Group endorsed the study and, under the leadership of Professor Kate Leslie, ANZCA Fellows recruited more than 500 patients. The study was funded in our region by a project grant from the National Health and Medical Research Council.

POISE-2 looked at aspirin and clonidine to prevent perioperative myocardial infarction in high-risk patients having non-cardiac surgery. Patients with bare metal coronary stents <6 weeks or drug eluting stents <1 year were excluded. 10,000 patients were randomised and the primary outcome (death and myocardial infarction) was measured 30 days postoperatively. The patients were mainly presenting for general, orthopaedic and urologic surgery and only 5 per cent were having vascular surgery.

Aspirin is effective for primary and secondary prevention of myocardial infarction in the non-operative setting. However, in POISE-2, aspirin did not affect the primary outcome and caused more major bleeding. The results were similar in patients who were and were not taking aspirin chronically. This result suggests bleeding may have obviated any beneficial effect of aspirin or that coronary thrombosis is a less important trigger in the operative setting than the non-operative setting. Surgeons and anaesthetists should advise patients to cease aspirin at least three days before non-cardiac surgery unless the patient is at high risk of thrombosis.

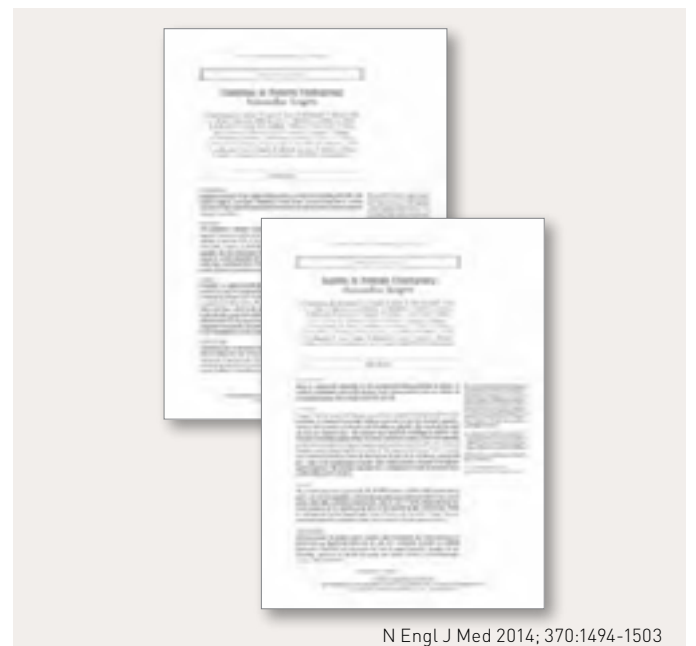
Clonidine may protect against the stress of the perioperative period by rebalancing oxygen supply and demand. However, in POISE-2, clonidine did not affect the primary outcome and caused clinically significant hypotension and bradycardia and more non-fatal cardiac arrest. This result suggests that the hypotensive effect of clonidine may have overcome any benefit of heart rate control in these patients. Clonidine therefore should not be used for the purpose of preventing perioperative myocardial infarction and should be administered to high-risk patients with caution (that is, low doses, regular blood pressure monitoring) for pain management.

Large perioperative trials such as POISE-2 can provide results that immediately change practice. However they cannot be completed without the hard work of many people. The trial was led by the Population Health Research Institute in Canada (chief investigator: Dr PJ Devereaux) and in Australia, ANZCA Trials Group co-ordinators Stephanie Poustie and Anna Parker assisted Professor Leslie and participating centres with start-up and recruitment. ANZCA Fellows attended the first presentation of the results at the American Heart Association meeting in Washington DC on Friday May 28, 2014.

**Professor Kate Leslie**  
POISE-2 Principal Investigator  
(Australia and New Zealand)

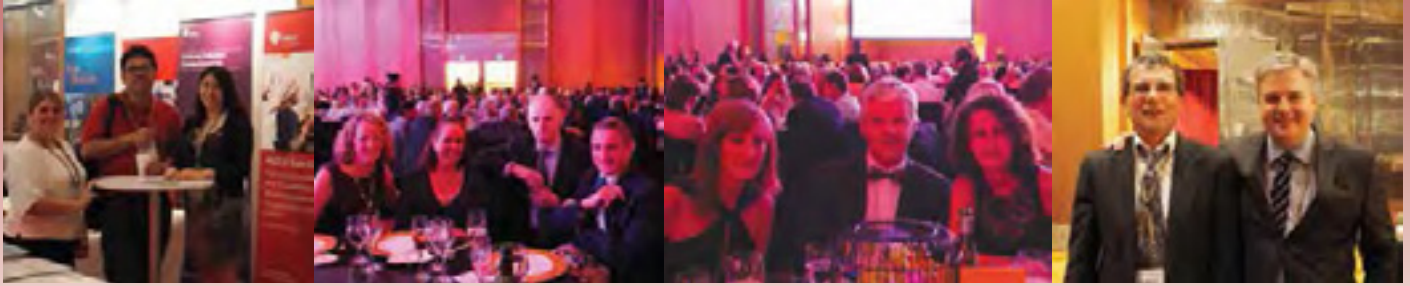


Above from top: Dr Cameron Osborn (The Geelong Hospital), Dr Nico Terblanche (Royal Hobart Hospital), Dr Tom Painer (Royal Adelaide Hospital) and Ms Sue Lang (Royal Adelaide Hospital) (Australian POISE-2 investigators) with staff from the Population Health Research Institute, Canada, at the POISE-2 Investigators Meeting in Washington (March 2014); ANZCA Fellows attend the first presentation of the findings in the US.



N Engl J Med 2014; 370:1494-1503

# Trials group news



## Annual scientific meeting activities

Many ANZCA Trials Group activities were held at the Singapore annual scientific meeting, including the Trials Group Annual Luncheon and a number of workshops and sessions. ANZCA Trials Group co-ordinators Karen Goulding and Sofia Sidiropoulos ran two successful workshops on how to get started in multi-centre clinical research and how to navigate through ethics and research governance.

ANZCA Trials Group executive member Professor David Story chaired the scientific session named "Outcomes worth measuring" featuring presentations on audit outcomes, renal outcomes and long-term outcomes by Associate Professor Andrew Davidson, Dr David McIlroy and Dr Mark Shulman respectively. These presentations, along with a number of presentations by ANZCA Trials Group executive members, can be viewed online at the Virtual ASM website.

The trials group Executive meeting was the last to be chaired by Associate Professor Timothy Short, New Zealand. Associate Professor Short has led the trials group for the past two years and has made major advances in the cause of multi-centre research in New Zealand in particular. Professor Kate Leslie from Victoria was appointed as the new chair of the ANZCA Trials Group Executive at the ANZCA Council meeting held at the end of the annual scientific meeting.

## Current trials group clinical trials

There are now four multi-centre trials recruiting patients and new sites are welcome to join:

- RELIEF – Restrictive versus liberal fluid therapy in major abdominal surgery.
- Balanced Anaesthesia Study – The influence of anaesthetic depth on patient outcome after major surgery.
- METS – Measurement of Exercise Tolerance for Surgery Study.
- ATACAS – Aspirin and Tranexamic Acid for Coronary Artery Surgery.

Each patient successfully recruited into the above trials will attract per patient payments for your anaesthesia department. The ANZCA Trials Group has developed a business case document to justify the employment of an anaesthesia research co-ordinator by a hospital anaesthesia department. This document is intended to assist anaesthesia researchers in building and sustaining their own research departments. A copy of the business case can be obtained by emailing the trials group co-ordinator ([trialsgroup@anzca.edu.au](mailto:trialsgroup@anzca.edu.au)).

The ANZCA Trials Group offers ethics and research governance support for getting started in our current clinical trials.

## ANZCA Trials Group Pilot Grant Scheme

The ANZCA Pilot Grant Scheme assists Fellows who wish to conduct pilot studies for high-quality multi-centre trials that will potentially attract National Health and Medical Research Council or other large-scale peer-reviewed funding. Grants of up to \$10,000 are available each year and applications for two-year grants will be accepted. Fellows wishing to apply for a pilot grant are encouraged to present their research proposal at the upcoming Strategic Research Workshop. The deadline for pilot grant applications is September 10.

## Strategic Research Workshop

The 6th annual Strategic Research Workshop from August 8-10 in Queensland will be held in Palm Cove. Join us to discuss your new research ideas, hear about the latest advancements in clinical research, and ignite and advance research collaborations – all in a relaxed tropical setting at Palm Cove. Confirmed keynote speakers are Professor Philip Clarke, professor of health economics, the University of Melbourne, and Associate Professor Christopher Frampton, biostatistician, University of Otago, Christchurch. Call for abstracts to present your research proposal close on June 20, and registrations close on July 25. For more details visit: [www.anzca.edu.au/fellows/Research/anzca-trials-group-events.html](http://www.anzca.edu.au/fellows/Research/anzca-trials-group-events.html)

## Survey research support policy

The ANZCA Trials Group has developed a Survey and Research Policy to assist Fellows and trainees wishing to undertake survey research. The ANZCA Trials Group facilitates survey research by reviewing survey research applications, assessing the scientific validity of surveys, providing advice to researchers and protecting the privacy of ANZCA Fellows and trainees. The survey must be of a high scientific quality and of a publishable standard.

For more information please visit [www.anzca.edu.au/fellows/Research/trials-group.html](http://www.anzca.edu.au/fellows/Research/trials-group.html) or email [trialsgroup@anzca.edu.au](mailto:trialsgroup@anzca.edu.au).

*Above from left: Ms Sofia Sidiropoulos, Dr Gin Wong, Ms Karen Goulding; Professor Kate Leslie, Ms Sophie Wallace, Associate Professor Philip Peyton and Associate Professor Brendan Silbert; Associate Professor Lis Everard, Professor Paul Myles, Ms Michelle Silbert; Associate Professor Tim Short and Dr PJ Devreaux.*



ANZCA has a long history of supporting groundbreaking research, which has had a major impact on patients' lives. Our series of articles on some of the projects ANZCA has helped fund continues.

## Study reduces risk of death and complications in elderly

Elderly patients face a significant risk of death and/or major complications after elective and emergency non-cardiac surgery. It's both a privilege and a challenge for anaesthetists to help older patients recover as well as possible from surgery so they can live high quality disability-free lives. ANZCA funded research is helping reach this goal.

While we may remark at the expense of our surgeons that "the operation was a great success, but the patient died", ANZCA-funded research has proven that in many ways this is true. The REASON study, a prospective study of 4158 elderly non-cardiac surgical patients in 23 hospitals in Australia and New Zealand, reported that by 30 days post-operatively, one in 20 patients had died and one in five had suffered a major complication.<sup>1</sup> The study also showed that patient factors (age and factors reflecting comorbidity, disability and frailty) were more important predictors of a poor outcome than the type of surgery. To many anaesthetists, including the study's authors, these remarkable results came as a surprise and provided an impetus to find effective preventive measures for death and major complications, including myocardial infarction.

Perioperative myocardial infarction (MI) represents a largely silent epidemic among elderly non-cardiac surgical patients. Around 5 per cent of elderly patients will suffer a perioperative MI and, at 30 days post-operatively, around 10 per cent of these patients will have died.<sup>2</sup> Others will have sustained a cardiac insult that puts them at risk of arrhythmias, cardiac failure and further ischaemia/infarction. ANZCA's Anaesthesia and Pain Medicine Foundation has provided seed funding for several large multi-centred trials aimed at preventing this common complication. This support has been crucial to success with National Health and Medical Research Council (NMHRC) funding and other national grant bodies.

The Master Trial recruited 915 high-risk mainly elderly patients undergoing major abdominal surgery and randomised them to intraoperative epidural or intravenous analgesia.<sup>3</sup> Cardiovascular event rates were high but not associated with analgesic technique. The B-Aware trial, also supported by ANZCA, included a large number of older patients.<sup>4</sup> The incidence of MI was not different between bispectral index-guided anaesthesia and routine care, but a long-term follow-up demonstrated an association between persistent low bispectral index values and increased risk for MI.<sup>5</sup> This provocative result

is being pursued in the Balanced Anaesthesia Study ([www.balancedstudy.org.nz](http://www.balancedstudy.org.nz)). This study received pilot grant funding from ANZCA before attracting large national grants in three countries. Finally, the ENIGMA-1 trial randomised patients (30 per cent of who were aged >65 years) to nitrous oxide-free or nitrous oxide-based anaesthesia, and raised a suspicion of excess cardiovascular morbidity following nitrous oxide exposure.<sup>6</sup> The ENIGMA-II trial was designed to provide a definitive answer to this question and has recently reported its results.<sup>7</sup> The ENIGMA trials received seed funding from ANZCA as well as major support from the NHMRC. ANZCA Fellows have also made contributions to major international studies seeking pharmacological solutions for the problem of perioperative MI in elderly non-cardiac surgical patients.<sup>8,9</sup>

None of these studies could have been completed without the tremendous support of ANZCA Fellows and staff, through our foundation, research grant program and the ANZCA Trials Group, or the efforts of hundreds of enthusiastic ANZCA Fellows and research nurses at hospitals around our region. Congratulations on your success – you've made a difference!

**Professor Kate Leslie, MBBS, MD, M Epi, FANZCA**  
Chair, Anaesthesia and Pain Medicine Foundation Committee

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# Board of Governors

The Board of Governors is committed to increasing support for medical research and education through promotion of and fundraising for the Anaesthesia and Pain Medicine Foundation.



**Ms Kate Spargo** (Chair) has been a company director for about 20 years, following her career as a lawyer. Her early working life started with five years as a histopathology technician. She is a member of the boards of Sonic Healthcare, Fletcher Building and UGL, as well as engineering consulting firm, SMEC, and ColInvest. She is chair of Suncorp Portfolio Services Ltd, and is the board adviser to patent attorney firm Griffith Hack.



**Ms Priscilla Bryans** is a partner in the Head Office Advisory Team of Herbert Smith Freehills, Melbourne. She advises on a range of Corporations Act, ASX Listing Rule, executive remuneration and corporate governance issues and is a member of the Law Council of Australia's Business Law Section, the Australian Institute of Company Directors' Law Committee, and the Governance Institute of Australia's Legislative Review Committee and Victorian State Council.



**Mr Bruce Brook** is the chair of Programmed Maintenance Services, and a non-executive director of CSL Limited, Boart Longyear and Newmont Mining Corporation (NYSE listed). He is also a non-executive director of the Export Finance and Insurance Corporation, and of the Deep Exploration Technologies Co-operative Research Centre. He is a member of ASIC's Director Advisory Panel. He is a chartered accountant by profession.



**Mr Rob Bazzani** is chair of Victoria KPMG and the national head of KPMG Australia's India practice. Prior to this, he was a senior partner in Corporate Finance and national head of Mergers & Acquisitions (M&A). Rob was also a part of the KPMG Global M&A executive team. Rob has extensive experience in advising on cross-border and domestic investment, divestments and acquisitions, developed over several years in investment banking.



**Mr Ken Harrison** is a philanthropist who likes to have a low profile, but who is an active and significant supporter of organisations including the Royal Botanic Gardens, National Gallery of Victoria, and the Royal Children's Hospital. He was the treasurer for Australian Airlines for many years before starting his own successful business in investment banking.



**Ms Stephanie Poustie** retired as the ANZCA Trials Group co-ordinator in 2013 after overseeing many successful projects and providing research support to ANZCA Fellows and trainees. Her previous roles have included research governance officer in the Department of Epidemiology and Preventive Medicine at Monash University and research fellow in the Medical School of the Australian National University in Canberra.

## Foundation supports excellence in anaesthesia and pain medicine research

The ENIGMA-II and POISE-2 trials (see page 20) were funded by National Health and Medical Research Council grants, secured on the basis of results from exploratory studies funded by the Anaesthesia and Pain Medicine Foundation, with the generous support of ANZCA Fellows.

These are just two examples of how ANZCA Fellows are making increasingly important contributions to new medical knowledge through leading medical research, and its translation into more informed clinical practices and better health outcomes for more patients.

Yet it was alarming to hear Fellow researchers and session presenters at the annual scientific meeting in Singapore say how difficult it is to get the relatively modest support they need for their

exploratory projects, which are the critical foundations of important studies.

It is especially challenging for new ANZCA Fellow researchers with visions for excellence to get started in the competitive research arena, devoting much time to writing grant applications, seeking scarce infrastructure support, and spending the additional time needed to conduct research once funding is secured.

It was therefore exciting in 2013 to see a record number of high-quality new applications for research funding from Fellows, leading to 17 Project Grants, one Simulation/Education Grant, and one Academic Enhancement Grant. Just under \$1.2 million was provided to help investigators' work in 2014.

This year, a record number of applications have been received for research grants on an impressive array of important questions and hypotheses with potential to further improve clinical outcomes.

With the help of its generous donors, the Anaesthesia and Pain Medicine Foundation is continuing to seek, and increase its financial support for these visionary and committed investigators to continue to improve quality, safety, and patient outcomes in the specialties, and to save more people's lives.

**Robert Packer**  
General Manager,  
Anaesthesia and Pain Medicine  
Foundation

To donate, or for more information on supporting the foundation, please contact Robert Packer, General Manager, Anaesthesia and Pain Medicine Foundation on +61 3 8517 5306 or email [rpacker@anzca.edu.au](mailto:rpacker@anzca.edu.au).



# Introducing ANZCA's new council

In May, the make-up of the ANZCA Council changed markedly. This article is part of the "Your ANZCA" series about the work that goes on behind the scenes at the College.

ANZCA is one of the 16 specialist medical colleges accredited by the Australian Medical Council. Six are joint Australian and New Zealand Colleges.

ANZCA is registered as a non-government, not-for-profit organisation governed by a council of 14 councillors, including 12 elected members of the College. The elected councillors are elected by the ANZCA fellowship and serve for three-year terms up to 12 years. A new Fellow councillor, elected by the new Fellows, serves for two years, and the dean of the Faculty of Pain Medicine, elected by the FPPMANZCA membership and who chairs the FPM Board, serves for two years. The council elects its president and vice-president.

The council functions in the same way as a board of directors of any registered company. Therefore ANZCA councillors are directors of the company of ANZCA, and have all the legal obligations and duties of board directors as prescribed by the Corporations Act 2001. The chair (or co-chair) of the National Trainee Committee attends council meetings but is not a director. ANZCA also is bound by other relevant Australian and New Zealand legislation, for example competition law, occupational and work health and safety laws, and privacy legislation, and must conform to Australian Securities and Investment Commission (ASIC), accounting and other commercial standards.

It is important to note that although there is representation on the council from each state as well as New Zealand, councillors act independently as board directors and not as representatives of their region. Such representation is done via the regional (states) and national (NZ) committees. Governance of the Faculty of Pain Medicine is via the FPM Board, however the members of the FPM Board are not directors of FPM or ANZCA (except for the dean).

The roles and responsibilities of the council as a board of company directors are many and include:

- Appointment of the chief executive officer (CEO), determining what functions and powers are delegated to the CEO and monitoring of the CEO's performance.
- Setting the strategy for the College – it is the management's job to implement the strategy.
- Monitoring the company's performance against the strategy and ensuring it remains financially solvent.
- Appointment of the auditor and signing of the annual financial statements.

In addition, company directors have a statutory duty of so-called due care and diligence, to act in good faith and to declare conflict of interest (how it is managed is determined by the other members).

New councillors undergo an induction process and all councillors are encouraged to do a company director's course so that they have a full understanding of their legal and commercial responsibilities. The Australian Institute of Company Directors (AICD) and the Institute of Directors of New Zealand both offer such courses as well as ongoing professional development, and there is a Continuing professional development program for both in order to retain membership. ANZCA regards company director education as a top priority.



The CEO reports to the council. Council has the authority to delegate responsibility and does this to various committees.

The council committee portfolios are varied and complex: The Anaesthesia and Pain Medicine Foundation, Continuing Professional Development, Education, Education Training and Assessment (three separate committees), Executive, Finance and Risk Management, Fellowship Affairs, Indigenous Health, International Medical Graduate Specialists, Investment, Overseas Aid, Quality and Safety, Research, Training Accreditation and Trainee committees. High-level committees have a mixture of councillors, Fellows and staff managers as members. Trainees are represented on several committees and two committees have community representation.

## Introducing our new ANZCA councillors

### Dr Rowan Thomas, Victoria

Dr Thomas is deputy director of anaesthesia at St Vincent's Hospital, Melbourne. His interests include perioperative medicine, regional anaesthesia, health information systems and music. Dr Thomas is the new medical editor of the *Bulletin* and will chair the Fellowship Affairs Committee.



### Dr M Sean McManus, Queensland

Dr McManus is an anaesthetist working in Far North Queensland, covering Anaesthesia, Intensive Care and Outreach to Cape York. He has interests in peri operative medicine, critical care and medical leadership



Above right: ANZCA Council room.



Some committees report directly to the council, others are sub-committees of a council committee. These complex structures are in place to balance and achieve both good governance and timely decision making. An outline of the structure can be viewed at [www.anzca.edu.au](http://www.anzca.edu.au).

This year we have five new members on the ANZCA Council – Kate Leslie and Kerry Brandis have departed after serving 12 years, Michelle Mulligan has left and is taking on a role as a director of professional affairs (DPA) assessor, and new Fellow councillor Gabe Snyder has completed his term. Simon Jenkins, Sean McManus and Rowan Thomas have been elected as councillors and Craig Coghlan has been elected as the new Fellow councillor. Ted Shipton succeeds Brendon Moore as dean of FPM. Later in the year, we will have another addition when Frank Moloney retires.

Councillors bring diverse skills, experience and personal qualities to the ANZCA Council. In selecting councillors, Fellows should consider the wide range of our College’s activities and interests, our strategic direction and the qualities required to undertake, develop and maintain the roles and responsibilities of being a director.

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**Dr Genevieve Goulding**  
ANZCA President

## Dr Genevieve Goulding, takes the reins as ANZCA president

Dr Genevieve Goulding, an obstetric anaesthetist from Brisbane, is the 14th president of ANZCA, taking up her two-year tenure at the annual scientific meeting in May.



Dr Goulding was ANZCA vice-president during Dr Lindy Roberts’ two-year term from 2012. Associate Professor David Scott has taken up the vice-presidency.

Dr Goulding said her presidency would focus on maintaining the high quality of anaesthesia training and anaesthesia delivery for which ANZCA is renowned.

“Australian anaesthesia is among the safest in the world,” Dr Goulding said. “Our standards of professionalism, codes of conduct, continuing medical education meetings and training are outstanding and I’m looking forward to a collaborative and democratic time as president.”

Dr Goulding has particular interests in the welfare of anaesthetists, in medical

education, in professionalism and in quality and safety.

She was co-founder of the Welfare of Anaesthetists Special Interest Group (SIG), first imagined in 1993, after events in her workplace, including a suicide, made her think more had to be done to care for the carers. She realised being a specialist of any kind brought unique pressures and that doctors were not always the best at taking care of their physical, emotional and mental health.

“We started developing a series of resources and wanted to bring awareness of the importance of our own health as doctors,” Dr Goulding said.

The Welfare of Anaesthetists SIG has brought many of these important health issues into the foreground and “out of the shadows”, but also into the training curriculum.

Medical education also remains a passion. Dr Goulding served for four years as chair of ANZCA’s Education and Training Committee.

“Training new specialists and the continuing education of existing specialists is core to the business of ANZCA,” she said. “It an area that is being reviewed, updated and revised regularly. It is the reason we are known as having among the highest training standards anywhere in the world.”

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**Ebru Yaman**  
Media Manager, ANZCA

**Dr Simon Jenkins, SA**

Dr Jenkins is a clinical anaesthetist and department director at the Lyell McEwin Hospital in Adelaide, South Australia. His interests include emergency anaesthesia, difficult airway management, teaching and sailing.



**Professor Edward (Ted) Shipton, Dean of FPM, NZ**

Professor Shipton is the academic head of the Department of Anaesthesia of the University of Otago in Christchurch. He is the medical director of the Pain Management Centre for the Canterbury District Health Board in Christchurch. His interests include regional anaesthesia/analgesia in pain control; the transition of acute to chronic pain; neuropathic pain and complex regional pain syndrome.



**Dr Craig J Coghlan, New Fellow Councillor, NSW**

Dr Coghlan is an anaesthetist working in public and private practice in the Gosford-Wyong area, NSW. His interests include acute pain management, as well as anaesthesia for thoracic surgery, urology and major colorectal surgery. Dr Coghlan is involved in the development of local clinical governance and policy initiatives as the appointed director of medical services at Gosford Private Hospital.





## New ANZCA Council office bearers, committee chairs and other roles (May 2014 to May 2015)

### Office bearers

President (appointed president-elect February 2014 Council)  
**Dr Genevieve Goulding**

Vice-President  
**Associate Professor David Scott**

### Committee chairs and other roles

Honorary treasurer  
**Associate Professor David Scott**

Executive Committee (president, ex-officio)  
**Dr Genevieve Goulding**

Chair of Examinations  
**Dr Patrick Farrell**

Chair, Education, Training and Assessment Executive Committee  
**Professor Barry Baker**

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

Chair, Education, Training and Assessment Management Committee  
**Dr Richard Horton**

Chair, Education, Training and Assessment Strategy Committee  
**Professor Barry Baker**

Chair, Primary Examination Sub-Committee (membership appointed by ETAEC for the 2014 calendar year)  
**Dr Andrew Gardner**

Chair, Final Examination Sub-Committee (membership appointed by ETAEC for the 2014 calendar year)  
**Dr Mark Buckland**

Effective Management of Anaesthetic Crises (EMAC) Course Sub-Committee (membership appointed by ETAEC from May to May)  
**Dr Cate McIntosh**

Provisional Fellowship Program Sub-Committee (membership appointed by ETAEC from May to May)  
**Dr Patrick Farrell**

Scholar Role Sub-Committee (membership appointed by ETAEC from May to May)  
**Associate Professor Michael Bennett**

Teaching and Learning Sub-Committee (membership appointed by ETAEC from May to May)  
**Associate Professor Kersi Tapaorewalla**

Trainee Performance Review Sub-Committee (membership appointed by ETAEC from May to May)  
**Dr Leona Wilson**

Chair, Training Accreditation Committee  
**Dr Mark Reeves**

Continuing professional development officer who will be chair of the Continuing Professional Development Committee  
**Dr Vanessa Beavis**

Chair, Fellowship Affairs Committee  
**Dr Rowan Thomas**

Annual scientific meeting officer  
**Dr Vanessa Beavis**

Chair, Quality and Safety Committee  
**Dr Phillipa Hore**

Chair, Mortality Sub-Committee  
**Associate Professor Larry McNicol**

Chair, Allergy Sub-Committee  
**Dr Michael Rose**

Chair, Research Committee  
**Professor Alan Merry**

Chair, ANZCA Trials Group Executive  
**Professor Kate Leslie**

Chair, International Medical Graduate Specialists Committee  
**Associate Professor Michael Steyn**

Chair, Finance, Audit and Risk Management Committee  
**Mr Geoffrey Linton**

Co-chairs, ANZCA Trainee Committee (appointed by ANZCA Council in December 2013 for 2014 calendar year)  
**Dr Candida Marane**  
**Dr Noam Winter**

Chair, Investment Committee  
**Associate Professor David Scott**

Chair, Overseas Aid Committee  
**Dr Michael Cooper**

Chair, Essential Pain Management Sub-Committee  
**Associate Professor Roger Goucke**

Chair, Indigenous Health Committee  
**Dr Rod Mitchell**

Chair, Anaesthesia and Pain Medicine Foundation Committee  
**Dr Lindy Roberts**

Chair, Anaesthesia and Pain Medicine Foundation Board of Governors (members appointed by the Anaesthesia and Pain Medicine Foundation Committee from May to May)  
**Ms Kathryn Spargo**

Chair, New Zealand Panel for Vocational Registration  
**Dr Geoff Long**

Chair, Joint Consultative Committee on Anaesthesia  
**Dr Frank Moloney**

Medical editor, *ANZCA Bulletin*  
**Dr Rowan Thomas**

Geoffrey Kaye Museum of Anaesthetic History

- Honorary curator  
**Dr Christine Ball**

- Honorary archivist  
**Dr John Paull**

Gilbert Brown Prize chair of adjudicators (ex officio chair, Research Committee)  
**Professor Alan Merry**

The Trainee Academic Prize (formerly Formal Project Prize) chair of adjudicators (ex officio Chair, Scholar Role Sub-Committee)  
**Associate Professor Michael Bennett**

Council representative on FPM Board  
**Dr Rod Mitchell**

Further information about ANZCA committees, including their terms of reference, can be found at [www.anzca.edu.au/about-anzca/Committees](http://www.anzca.edu.au/about-anzca/Committees).



## Reflecting on 12 years on the ANZCA Council

I've enjoyed (nearly!) every minute of my 12 years on the ANZCA Council and sincerely recommend councillorship to any Fellow who wants to participate in shaping our speciality into the future.

So many things have changed since I joined the council in 2002. We have more meetings, but they are shorter and more focused on governance than operations. We consider strategic plans, business plans, risk management plans, budgets, accounts and forecasts from our highly professional management team, as well as matters related to training and fellowship affairs. The Joint Faculty of Intensive Care has departed to form its own College and the Faculty of Pain Medicine now occupies a crucial position in our future. We have a new Fellow director and a trainee representative on council, and improved input from the Australian regions and New Zealand. There are more women on council

and our committees, and we have our fourth female president in a row – a first for an Australasian medical college!

The council has brought to life many wonderful initiatives in the last 12 years – our world-class training curriculum, our Continuing Professional Development Program, the Anaesthesia and the Pain Medicine Foundation and the ANZCA Trials Group (bringing huge brand recognition for the College internationally), the Quality and Safety Committee, the Overseas Aid Committee and the Indigenous Health Committee to name a few. These projects (and others) reflect the increasing external engagement of our College in the health sector. Meanwhile, I have been impressed with innovations in our long-standing functions of training and assessment, continuing medical education and other services to our trainees, Fellows and the profession.

There is more we could and should do. We need to define and support the medical specialties of anaesthesia and

pain medicine, while participating constructively in inevitable workforce innovation. We need to underpin everything we do with sound evidence and critically evaluate the safety and quality of our work. We need to increase the diversity of our traineeship, particularly with respect to Aboriginal and Torres Strait Islander students. We must continue to strengthen our relevance and value to Fellows.

I believe that I've benefited more from being on the council than it's benefited from having me as a member. I've gained a lot of knowledge, learned a bunch of new tricks and worked with hundreds, if not thousands, of great people including Fellows, trainees, staff, contractors and stakeholders. I'd like to thank councillors past and present, and Linda Sorrell and her wonderful staff, for their support and wish the new ANZCA Council all the very best.

**Professor Kate Leslie**  
Past-President, ANZCA

## ANZCA Council farewells...

### Professor Kate Leslie, Victoria

Professor Kate Leslie joined the ANZCA Council in 2002 and was ANZCA president from 2010-12. She was honorary treasurer from 2008-10 and chaired many committees, most recently the IMGs Committee and the ANZCA Foundation Committee. Her interest and influence were wide-ranging, but the promotion and support of research by Fellows and trainees remained her primary passion during her time on the council.



### Dr Gabe Snyder, Victoria

Dr Gabe Snyder joined the ANZCA Council in 2012 as the new Fellow councillor. He was a member of the Fellowship Affairs Committee and Victorian Regional Committee. He played a major role in ANZCA's response to the workforce issue and led the development of ANZCA's inaugural Graduate Outcomes Survey last year, presenting the findings in the March 2014 *ANZCA Bulletin* and at the recent Singapore ASM.



### Dr Michelle Mulligan, NSW

Dr Michelle Mulligan joined the ANZCA Council in 2007 and chaired several committees, including the Fellowship Affairs and Investment Committees. She was the medical editor of the *ANZCA Bulletin* from 2009-14 and was the honorary treasurer from 2012-14. She continues active contribution to the College as director of professional affairs, deputy assessor.



*Editor's note: A special thank you to Dr Mulligan for five years of wise counsel (and speed reading!) as medical editor of the Bulletin.*

### Dr Kerry Brandis, Queensland

Dr Brandis joined council in 2002 and committee roles included chairing the Library Committee, the IT Committee, and the New Programs Committee, as well as being a long-time member of the Education and Training Committee and the Training Accreditation Committee (formerly the Hospital Accreditation Committee). In 1996, he wrote the widely used *The Physiology Viva: Questions and Answers*, revising it in 2002. He is now working on a third edition.



### Associate Professor Brendan Moore, Queensland

As dean of the Faculty of Pain Medicine, Associate Professor Brendan Moore was on the ANZCA Council for two years. During this time, he led the development of the Faculty's 2013-2017 Strategic Plan and the framework for the 2015 revised curriculum. He also initiated the modular education program for primary healthcare providers in 2013 and its expansion this year.





# Serving in remote locations has its rewards



Dr Malcolm Stuart, who completes the maximum 12 years' service with the New Zealand National Committee (NZNC) this month, is not a "bright lights, big city" anaesthetist, despite now living in Wellington. Rather, he has spent much of his career providing much-needed services in some of New Zealand's more remote and unpopular locations, including current practice on a "surgical bus".

Dr Stuart completed his undergraduate medical degree at Sheffield University in England and spent the next few years in hospitals in England and Australia, acquiring diplomas in obstetrics and anaesthesia before arriving in New Zealand in 1991 to work at Palmerston North Hospital. He joined the ANZCA training program there, and worked also at Wellington and Christchurch hospitals before completing his FANZCA in 1996.

After a year back in the UK, Dr Stuart decided New Zealand was where he wanted to be. While in Christchurch, he'd had a short stint helping out at the Grey Base Hospital on the South Island's West Coast – a notoriously difficult hospital to staff – and on his return to New Zealand,

he took up a consultant position there.

"I was the first New Zealand-trained specialist there in a long time. I felt I could help make changes. I wanted to get the hospital to the same standards as Christchurch with new machines, resuscitation training, anaesthetic technician support, simulation training," he said. Over the next 10 years he achieved much of that.

Dr Stuart was assisted by short-term help from staff from other New Zealand hospitals and international medical graduates. However, key responsibility for maintaining anaesthesia services fell to him – including being perpetually on call and assisting with retrieval work in an area stretching 600km north to south. "You had to be a Jack of all trades."

His service to the community included being medical adviser to the ambulance service and serving two terms (six years) on the West Coast District Health Board, with the distinction of being the highest polling candidate.

"It was very rewarding that you could make a difference and change how things had been done," he said, but it was also at a cost.

"The professional isolation was hard. I missed having registrars and being able to teach them."

There also was strain on family life: "I was always on call. My work went way beyond whatever I was contracted to do. If I was called, I would go – we have that duty of care. I spent an awful lot of time

"Even when cover was arranged, I could not actually leave until the person was there as they could be delayed – by snow, for instance. I missed an All Blacks' game once when waiting for a locum to get through."

at the hospital. Even when cover was arranged, I could not actually leave until the person was there as they could be delayed – by snow, for instance. I missed an All Blacks' game once when waiting for a locum to get through."

Since leaving Greymouth in 2007, much of Dr Stuart's work has included being a specialist anaesthetist on the popular "surgical bus" – a mobile surgical unit operated by Mobile Health Solutions (MHS). This privately owned company works in partnership with the Ministry of Health, district health boards and local health providers to deliver low-risk day surgery at rural locations that lack permanent surgical facilities.

This enables people to have surgery close to their support structures and homes. Since it began operating in February 2002, the bus has treated more than 14,000 patients and delivered more than 35,000 hours of education by both hands-on and virtual means to medical professionals who can find it difficult to get leave to go to educational events.

While around 300 different procedures can be performed on the bus, two of the most common are hernias and dental treatment for children from the lower socio-economic group – "I am passionate about that – it is much safer and makes a real difference to their lives," Dr Stuart says.

The 20-metre long, 39 tonne truck and trailer unit travels on a five-week loop of New Zealand, stopping for the day at 23 regular sites, usually at a local hospital or medical centre, which is accessed to provide the power for the operating theatre (backed up by a generator if there is a power outage). The trailer sides expand to double its width to accommodate an administration area, waiting room, scrub room, operating theatre and recovery room, as well as clean utility and dirty utility space.

Dr Stuart spends two weeks out of five working on the bus at various South Island locations, and otherwise works



privately in Wellington with some locum work in Rockhampton. As the only anaesthetist on board, he says that “being on my own and having to cope is not alien to me though colleagues in major centres think that is slightly eccentric”. However, he acknowledges the importance of the perioperative team as a whole, which includes fully trained anaesthetic technicians and clinical nurse leaders.

“I enjoy it immensely. We save people having to travel for minor operations and they can be home in the comfort of their own beds at the end of the day.”

The theatre exceeds ANZCA’s standards and is as good as any at a hospital providing a similar level of surgery, he says. Also “the anaesthetist has the final say as to what is appropriate and what isn’t – you feel valued.”

With the encouragement of its then chair, Dr Sharon King, Dr Stuart was elected to the NZNC in 2002 – being seen as someone who could speak for those working in difficult-to-staff and more remote areas.

That same year he took on the role of representing the NZNC on the NZ Anaesthetic Technicians (NZATS) Executive. This brought him his “proudest moment” – when anaesthetic technicians won the right to registration under the Health Practitioners Competence Assurance Act after five years of consultations and negotiations to which he, along with fellow FANZCA Dr Andrew Warmington, made a major contribution. “This was really important for the safety, standards and quality of the perioperative team as a whole.”

He held the NZATS role until 2013, standing down to avoid any conflict after being appointed to the Anaesthetic Technician Advisory Committee of the Medical Sciences Council of New Zealand, which administers anaesthetic technician registration.

Since 2010, Dr Stuart has also been the NZNC representative on the NZ Resuscitation Council, a role that has included work as a resuscitation instructor. He also has been a member

of the international medical graduate (IMG) interview panel and an assessor for workplace-based assessments of IMGs.

Dr Stuart has enjoyed the collegiality that his NZNC membership has brought and cited a number of NZNC members as role models. “I have learnt a lot from them over the years and, hopefully, passed it on.”

But the hardest task of his NZNC work? Taking his children when going to Wellington for a College meeting and having to sit on the vertical bungy with them!

He says he could as easily have become involved in the NZ Society of Anaesthetists – it was just that the NZNC approached him first – and he would like to see the two groups work together more closely. “My hope is that we can be one big anaesthesia family in New Zealand, even if we have different perspectives on some issues.”

Dr Stuart’s service to the NZNC will be acknowledged at its annual dinner on June 27.

**Susan Ewart,**  
Communications Manager, New Zealand



*Opposite page: The mobile surgical unit parked up and ready for action in typical Central Otago snow at Lakes District Hospital, Queenstown.*

*This page clockwise from top left: Dr Stuart using the bus technology to teach students at the Gippsland campus of Monash University in Australia; The surgical bus theatre in operation; Dr Stuart demonstrating what happens during an operation to children in Gore, in the far south of New Zealand.*

*Photos courtesy of Dr Malcolm Stuart and Mobile Health Solutions.*



# WORKING TOGETHER IN SINGAPORE

Anaesthetists, pain specialists and surgeons met at the Sands Expo and Convention Center, Marina Bay Sands from May 5-9 for the RACS ASC and ANZCA ASM themed "Working together for our patients".







The 2014 Singapore Annual Scientific Meeting attracted 2388 ANZCA delegates, including 1244 full registrants, 128 day registrants and 204 new Fellows who attended 13 plenary presentations, 73 concurrent sessions, 119 workshops and 36 small group discussions.

### ASM convenor's report

Wow, what a week! The 2014 Combined ANZCA/Royal Australasian College of Surgeons (RACS) meeting began as a small seed and grew into one of the most exciting meetings I have had the pleasure of being involved with.

Two years ago, the 2014 ANZCA Annual Scientific Meeting was scheduled to be held in Sydney and the 2014 RACS Annual Scientific Congress (ASC) was scheduled for Melbourne – then we heard that the Sydney Convention Centre was closing for renovation and the Melbourne Convention Centre bumped the RACS meeting. What to do and where to go? Could we possibly join together and take the meeting to Singapore? It seemed timely to hold a conjoint meeting – we had been a Faculty of RACS and participated in their annual meeting until 1992, in 2000 we held a meeting co-located but not truly conjoint and yet day in day out we work together, face challenges together and strive to do our best for our patients. Surely we could learn together and have some fun together?! So “Working together for our patients” evolved.

We took the opportunity to throw tradition out the window – we now had a Monday to Friday program, a “workshop day” on the Monday – which allowed an earlier start for the College Ceremony so that we could kick off the social side of the meeting with a combined Welcome Reception on the Monday night, we had three speakers in the plenary sessions and a spectacular combined Gala Dinner with the surgeons. We embraced a whole new audio-visual system, developed an

app and the Virtual ASM. We combined our healthcare industry exhibition with the surgeons so that break times could involve mingling of the specialties. Each step of the way took communication and compromise – but every member of the Organising Committee and ANZCA's Events staff approached the meeting with enthusiasm, an open mind and a smile.

The week was amazing – there was a buzz in the air and the corridors of the convention centre were packed despite the temptations of Singapore beckoning outside. The Sands Convention Centre was made for this type of meeting with plenty of breakout rooms for all the sessions. The catering was fabulous – showcasing the multicultural cuisine of Singapore.

The College Ceremony saw 205 new Fellows welcomed to fellowship. It was a delight to see the beaming smiles on the new Fellows and proud partners and parents. The Australian High Commissioner to Singapore, Mr Philip Green, treated us to an excellent oration. He spoke about our relationship with Asia, the growing Asian middle class and what this might mean for the Australasian medical profession. Once the formalities were over we moved to level 5 of the convention centre where the ballroom had been transformed into a hawker centre – with Hainanese chicken rice, roti prata and laksa all washed down with a glass of champagne (or a Tiger beer!). There was a great mix of surgeons, anaesthetists and pain medicine specialists – with many comments about how fabulous it was to mingle and catch up with friends.

The Gala Dinner capped off the week in style – Singapore Slings and champagne to start the evening followed by a dragon dance and then into the ballroom for a fantastic Chinese banquet. When the band started the dance floor was packed while coffee and a saxophonist provided some respite in the Supper Club. At midnight hundreds of surgeons and anaesthetists headed to the after party for more dancing and fun. It really was a spectacular night!

As the meeting drew to a close I was stopped time and time again asking when we could do this next. The main complaint seemed to be not enough combined sessions. I don't think they realised how hard it was to get the combined sessions we had! It was a start – but the next one will be even better!

One of the things to come out of this meeting that I am most excited about is the Virtual ASM – how many times do you walk out of a session to hear everyone raving about a session you missed? Well now you don't have to miss it – you can hear the audio and see the slides. Fantastic!

Finally, a big thank you to all who came to Singapore. I hope you had a rewarding educational experience and as much fun as I did. To those of you who kindly stayed at home to ensure provision of some anaesthesia services – thank you. Enjoy the Virtual ASM and make sure you get in early for the next combined ASM!

**Dr Nicole Phillips**  
Convenor, Singapore ASM





## Scientific program provides something for everyone

The 2014 ASM scientific program opened with a joint ANZCA-FPM-RACS plenary session and closed, at the end of the week, with an amusing and thought-provoking dramatisation of an anaesthetist's and a surgeon's conflicting concepts of leadership. Between these sessions were four jam-packed days of lectures, hypotheticals, pro-con debates, discussion forums, and even a world cafe (look it up). It was a testament to the excellence of the scientific presentations that delegates' enthusiasm survived such a full week – right through to the 5pm finish on Friday!

Our keynote speakers provided an outstandingly solid scientific foundation for the meeting. The 2014 ASM Visitor was PJ Devereaux from McMaster University. Unusually for an ASM Visitor, Dr Devereaux is not an anaesthetist. As a cardiologist with a career focused on perioperative medicine, PJ is making outstanding contributions to our knowledge of the mechanisms, significance, and management of myocardial injury after surgery. This joint ANZCA-RACS meeting provided an ideal forum to explore an issue of such importance to our aging surgical population. Our Australasian Visitor, Professor Britta Regli von Ungern-Sternberg, impressed audiences with her extensive body of research on paediatric

airway and respiratory complications and our Singapore Visitor, Professor Alex Sia, shared his extensive experience in developing methods for individualising analgesia in the labour ward. Beverley Orser from Toronto delighted with her engaging ability to convey insights from her intriguing research into new classes of neuronal receptors that mediate the amnesic effects of anaesthetic agents. Last in our list of stellar keynote speakers was Andy Lumb from Leeds. We overheard among delegates much questioning of routine practice following Andy's provocative presentation on the potential harms of hyperoxia. His plenary presentation on the problems of breathing systems as they get further separated from the earth's atmosphere (think Mars) was informative and entertaining.

Multiple scientific sessions were held in conjunction with various surgical disciplines. These joint sessions were too numerous to list but included sessions on perioperative care, enhanced recovery, surgical oncology, medical education, history of anaesthesia and surgery, the ageing practitioner, and the medical workforce. An obvious issue of common interest to anaesthetists and surgeons is blood management. On "Bloody Thursday" several sessions explored issues such as preoperative optimisation, intraoperative haemorrhage and coagulation control, postoperative transfusion triggers, and blood products in isolated locations.

The Airway Management Special Interest Group held a satellite meeting prior to the ASM, giving us an opportunity to take advantage of several visiting international airway experts. In particular, Michael Seltz-Kristensen from Copenhagen contributed generously to workshops and several scientific sessions including a very popular session on the shared airway held in conjunction with the relevant RACS sub-specialty groups.

This ASM also provided an opportunity to tap into the expertise of Singaporean anaesthetists and intensivists. We are extremely grateful for the generous support given to our meeting by the Singaporean medical community and we are particularly indebted to those who gave their time to chair sessions and to give presentations, workshops, and small group discussions.

### "New" technology

A new app was developed for this ASM and a new website, the "Virtual ASM". With these innovations, delegates were able to download the program, view the abstracts, and build a personalised schedule all before they left home. During the sessions the audience used their phones and tablets to submit questions electronically and, in some sessions, participate in audience polling. This facility was taken up with great enthusiasm by the ANZCA delegates. Another innovation was the recording of both audio and slides from almost every presentation. With so many multiple





concurrent sessions, it was a bonus to be able to visit the Virtual ASM and view sessions that one could not attend. It is intended that the Virtual ASM will be preserved as an ongoing educational resource for ANZCA members.

We also noted the rise of a community of young and not-so-young FANZCAs using Twitter at the ASM to share their comments, criticisms and insights with each other and the outside world. This form of “meta-meeting” certainly enhances the ASM and broadens its influence.

#### **ePosters**

The convenors were impressed with the outstanding quality of abstracts submitted to the ASM and we believe this reflects the growing interest in quality research among ANZCA Fellows and trainees. Some abstracts were selected for the Gilbert Brown and Formal Project Prize sessions and some were selected for oral presentation at moderated sessions. The remaining abstracts were presented as ePosters displayed on screens at the venue. Another innovation for the 2014 ASM was the publication of ePosters on the Virtual ASM. This greatly increases exposure of the authors work as ePosters could be viewed at any time, including prior to arrival at the meeting, and the ePosters will be preserved on the Virtual ASM.

**Dr Tim McCulloch**  
**Dr Gerald Wong**  
 Scientific Co-Convenors

#### **Workshops**

On and off-site workshops were presented in an expanded and novel format featuring 88 over a single day to mark the start of the conference. This mega-workshop day, co-ordinated by convenors Dr Andy Wang and Dr Andrew Lansdown, proved hugely popular – the program sold out and feedback from those involved was resoundingly positive.

Facilitators brought fresh and innovative approaches to many common workshop themes. There are too many to mention individually but the demonstration of perimortem delivery of Peppa the Pig is worthy of special recognition.

Thank you to our passionate and tireless team of local and international workshop co-ordinators who managed the challenging task of staging these sessions at an offshore location and finding a diverse group of demonstrators from all corners of the globe to present a truly memorable workshop day. We also acknowledge the support of the healthcare industry, which, despite the scale, expense and logistical barriers, was particularly generous in providing the extensive range of equipment essential to the workshops.

**Dr Andy Wong**  
**Dr Andrew Lansdown**  
 Workshop and SGD Co-Convenors

*Above from left: The College Ceremony: Professor Alan Merry, Ellen O’Sullivan and Dr Lindy Roberts; New Fellows awaiting presentation; Dr Roberts speaking; ceremony applause.*

## **SESSIONS**

**Plenary presentations: 13**

**Concurrent sessions: 73**

**e-posters: 82**

**Moderated e-posters: 38**

**Workshops: 119**

**Small group discussions: 36**



## Combined FPM/RACS pain medicine program a collaborative success

The pain medicine program at this year's annual scientific meeting was the most extensive ever, covering five days and featuring a number of combined sessions with Royal Australasian College of Surgeons (RACS) disciplines.

The program began with the Refresher Course Day, "Pain at the cutting edge: Surgery and pain", at the newly refurbished Suntec convention centre. Exploring the interface between surgery and pain, the program featured sessions on the epidemiology of pain after surgery, underlying mechanisms, rational use of opioids and some of the strategies that can be employed to minimise pain after surgery and treat persistent post-surgical pain. As well as the FPM invited speakers, Professor Audun Stubhaug and Professor Jane Ballantyne, the speakers included the RACS international invited speakers, Professor Robert Foreman and Professor Dirk De Ridder, and an outstanding panel of Australasian and south-east Asian experts. There were 215 registrations for the Refresher Course Day, making this the highest attendance ever by a considerable margin. It was followed by a fabulous Faculty dinner at the East India Rooms at Raffles Hotel.

This year's ASM featured a new format on Monday May 5 consisting of a full day of workshops. The FPM program included small group workshops and

topical discussion sessions, which consisted of a panel of speakers presenting on a range of occasionally contentious issues followed by robust interactive discussion. These innovative sessions were extremely well received and delegates enjoyed the opportunity to interact with internationally recognised experts in a smaller forum.

Professor Audun Stubhaug, who explored the transition from acute to chronic pain, delivered the Michael Cousins Lecture in the opening plenary. This subject was particularly relevant given the surgical presence this year. The presentation discussed the risk factors for the development of post-surgical pain, including genetic influences, and looked at some possible preventative strategies.

The FPM Singapore Visitor was Professor Jane Ballantyne whose thought-provoking plenary lecture explored the limits of allopathic or conventional medicine in the management of persistent pain. Professor Ballantyne's other presentations discussed the issues associated with opioid use both in the acute postoperative period and longer term.

There were a number of highlights throughout the combined FPM/RACS program and sessions were extremely well attended, several being standing room only. The session discussing the relative merits of early neuromodulation or surgery for back pain provided a rare opportunity for fascinating discussion between pain specialists, surgeons and anaesthetists.

The Dean's Prize and Best Free Paper session attracted a large number of high quality entrants and selection for presentation in the session was extremely competitive. The FPM Dean's Prize was awarded to Dr Julia Dubowitz for her paper on the "Incidence of persistent post-surgical pain after pelvic exenteration" and the best free paper went to Dr Sumitra Bakshi for "ReSOOnS trial – RECTus Sheath block for postoperative analgesia in gynaeco-Onco Surgical patients – a double blinded randomised controlled trial".

There was extensive media coverage of the content of the FPM program with interviews with professor Audun Stubhaug, Professor Jane Ballantyne and Professor Dirk De Ridder receiving widespread coverage, including articles in *The Age* and *The Sydney Morning Herald*.

Overall the format of the extended FPM/RACS pain medicine program was extremely successful. It was well attended and delivered an extremely high quality program due to the excellent speakers from all disciplines. The feedback from all delegates indicated that there would be great interest in further combined meetings in future years.

**Dr Lewis Holford, FANZCA, FPPMANZCA**  
FPM Scientific Convenor





## Raising our profile

### Media

More than 20 interviews with Fellows and other guest speakers were conducted at this year's annual scientific meeting (ASM) and FPM Refresher Course Day resulting in more than 600 media reports in print, radio, television and online that reached a combined cumulative audience of nearly five million, according to ANZCA's media monitoring service, iSentia.

Five media releases were generated and 44 individual news reports about anaesthesia and pain medicine which were widely syndicated across Australia and New Zealand. iSentia reported that more than 400 reports were also posted online on news websites as well as health and medical websites. The media coverage had an estimated value of more than \$650,000 in equivalent advertising dollars, according to iSentia.

Professor Paul Myles gave 13 radio and print interviews after presenting the results of the ENIGMA-II research, a study that showed nitrous oxide could be used safely in surgery. Other presenters interviewed were Dr Dirk de Ridder on burst stimulation, a new approach to pain control, Associate Professor Ian Seppelt on faecal transplants as a cure for persistent stomach bugs and Professor Kate Leslie, who added her voice to the discussion about the struggle faced when anaesthetists encounter morbidly obese maternity patients.

At the Refresher Course Day and at the ASM, Professor Audun Stubhaug was interviewed at length about chronic pain after surgery and Professor Jane Ballantyne was featured in print talking about opioids, with Associate Professor Brendan Moore and Dr Mick Vagg giving local perspectives.

ANZCA hosted three medical editors at the ASM – Julia Medew from Fairfax, Grant McArthur from News Limited and Clifford Fram from Australian Associated Press. Between them, these journalists wrote 13 print articles that were widely syndicated throughout Australia and New Zealand.

Reports appeared in publications including Melbourne's *The Age*, the *Sydney Morning Herald*, *The Australian*, Brisbane's *Courier Mail*, the *Adelaide Advertiser*, *The West Australian* and many regional papers. Radio outlets included Radio National (Australia), Radio New Zealand, 3AW and ABC 774 (Melbourne), 2UE (Sydney), 4BC (Queensland), 5AA (Adelaide).

### ASM E-Newsletters

Five ASM E-Newsletters were distributed from Monday to Friday of the ASM both to ANZCA and FPM delegates. Fellows and trainees not at the meeting also received the e-newsletter, allowing them access to all plenary lectures.

It featured a video interview with each invited speaker plus audio visual recordings of each plenary lecture. Additional interviews with selected speakers and key College figures, such as the new ANZCA president, Dr Genevieve Goulding, and new FPM Dean, Professor Ted Sipton. The e-newsletters also linked to photo galleries and media updates.

A full list of media coverage, the ASM E-Newsletters and a link to the Virtual ASM can be found on the ANZCA website via the Events/Annual scientific meetings tab.

### Clea Hincks

General Manager, Communications



Below from left: Down to business: At the convention centre; delegates listen to a lecture; in the healthcare industry area; Dr Genevieve Goulding speaks.



## Prizes

### **Gilbert Brown Prize:**

Dr Jonathan Hiller for "Neuraxial anaesthesia reduces lymphatic flow: proof-of-concept in first in-human study providing a plausible mechanism for impact on cancer recurrence".

### **Formal Project Prize:**

Dr Dale Currihan for "The effect of interscalene anaesthesia on cerebral oxygen saturation".

### **Open ePoster Prize:**

Dr Ashley Webb for "Stop before the op: Increasing preoperative tobacco cessation by systematic delivery of a printed intervention to patients at time of wait-list placement".

### **Trainee ePoster Prize:**

Dr Jason Bendall for "Higher insertion success with the i-gel® supraglottic airway in out-of-hospital cardiac arrest: A randomised controlled trial".

### **FPM Free Paper Prize:**

Dr Sumitra Bakshi for "ReSOOnS trial – REctus Sheath block for postoperative analgesia in gynaeco-Onco Surgical patients – a double blinded randomised controlled trial".

### **FPM Dean's Prize:**

Dr Julia Dubowitz for "Incidence of persistent post-surgical pain after pelvic exenteration".

### **Ellis Gillespie Lecture**

Dr Phillip James Devereaux,  
ANZCA ASM Visitor  
*The task ahead: what will it take to improve perioperative outcomes?*

### **Michael Cousins Lecture**

Professor Audun Stubhaug,  
FPM ASM Visitor  
*From acute to chronic pain: risk factors, genetics and possible preventative strategies*

### **Australasian Visitor Lecture**

Professor Britta Regli-von Ungern Sternberg, Australasian Visitor and Douglas Joseph Professor  
*Respiratory complications in paediatric anaesthesia*

### **Mary Burnell Lecture**

Professor Beverley Orser,  
Organising Committee Visitor  
*Understanding cognitive deficits after surgery and anaesthesia*

### **FPM Singapore Visitor Lecture**

Professor Jane Ballantyne,  
FPM Singapore Visitor  
*The limits of allopathic medicine in chronic pain management*

### **ANZCA Singapore Visitor Lecture**

Professor Alex Sia,  
ANZCA Singapore Visitor  
*Individualising analgesia in obstetrics*

### **Organising Committee**

#### **Visitor Lecture**

Dr Andrew Lumb, Organising Committee Visitor  
*Breathing in closed environments – using a really big circle system on Mars*

### **ASM slide presentations available to all**

All ANZCA Fellows and trainees, including those who did not attend the Singapore ASM, can access speaker-approved presentations via the Virtual ASM – <http://asm.anzca.edu.au/virtual-asm>.

### **App stats**

The introduction of the Virtual ASM (VASM), including a downloadable app, was a first for ANZCA ASMs. Statistics for the use of the app and VASM show that it was positively received – there were 1629 app users, 1564 VASM users, 4932 notes taken on the VASM and 39,860 page views on the VASM.

**There were 43 sponsors and exhibitors at the Singapore ASM including four major sponsors – Drager, Mundipharma, Mindray and Edwards.**

*Below: Scenes from the Gala Dinner.*





## New Fellows leave a legacy of advice for future specialist anaesthetists



*"Anaesthetists in future will have to value-add. We have to ensure we continue to be indispensable".*

So the stage was set for the 2014 New Fellows' Conference at Sentosa Island, Singapore. Delegates projected decades into the future, laying out advice for fresh consultant anaesthetists at the New Fellows' Conference of 2039. The theme "Time capsule – my legacy" mandated collection of sage advice from senior colleagues, and salient wisdom from the attendees themselves.

### **Know your limitations, but challenge those limits**

Representatives from each state, territory and overseas ANZCA region and two Kenyan ANZCA international scholarship holders were to create a map for themselves. By considering what they wanted their legacy to be when they reached retirement, they were to select their ideal career destinations, and then discuss with peers their course from their position today. All the new Fellows were a resource for each other, and the open-endedness of the topic led to honest and revealing speeches – goals as diverse as "to make a mark in humanitarian medical missions", "that my wife and daughters always thought I made time for them", "to always demonstrate conviviality and altruism", and "that I would always do what's best for the patient and not what's the easiest".

The first unique part of the 2014 New Fellows' Conference was the creation of a time capsule to be stored in the ANZCA museum in Melbourne. Along with the advice to anaesthetists of the future, each doctor brought an object emblematic of our working lives today – a photograph of doctors marching to protest against new 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.

### **Doctors are not infallible**

The second novel aspect of the overseas New Fellows' Conference was the presence of the three invited experts for the whole of the proceedings. This changed their traditional role from being hosts of an isolated seminar, to having the same position as learner/teacher beside all the "new" Fellows. The first formal session, directed by Professor Richard Walsh, a former ANZCA president, focused on the dark days of our careers, including unethical behaviour, loss of morale and funding, and inadequate performance of senior staff. There was also input from Dr Richard Morris, director of anaesthetics, St George Hospital, Sydney, in his discussion, "Department of dreams", and Professor Christine Jorm, anaesthetist and lecturer in the school of medicine, University of Sydney, spoke about "Changing the system". The issues raised ranged from the exciting to the uncomfortable, the jovial, the

enlightening and the challenging. Also contributing were the College president, Dr Lindy Roberts, ANZCA councillor Dr Patrick Farrell, and FPM board member Dr Melissa Viney, by way of a personal speech on their legacy and the legacy of the college, and as an equal with the selected delegates.

### **Be friends with your surgeons**

The third special element of the 2014 New Fellows' Conference was collaboration with the surgeons of the Young Fellows' Forum. The Saturday afternoon was spent in a joint three-part session. Firstly, the team of Dr Hamish Ewing (surgeon) and Dr Wayne Morriss (anaesthetist) talked about their experience of large overseas aid work projects. Next came a complete departure, with Dr Andrew Kennedy (anaesthetist) interviewing Dr Phillip Antippa (cardiothoracic surgeon) about his leadership of the viola section of the Australian Doctors' Orchestra for two decades, and more broadly on his concept of music and medicine. Finally there was an extremely valuable and energetic workshop, "Publishing surgical outcomes data", led by Professor Russell Gruen (trauma surgeon) and Professor Christine Jorm (academic anaesthetist). Each small breakout group had to construct a plan from a 10-point hypothetical government strategy for becoming the national leader in reporting surgical morbidity and mortality publicly.

The final conference highlight was a joint dinner with the surgeons at the chic Tanjong Beach club on Sentosa Island, with a performance of the Mozart clarinet quintet by surgeon Dr Phillip Antippa, anaesthetists Dr Andrew Kennedy and Dr Rowan Thomas, medical student Ms Molly Gilfillan, and guest Singaporean artist Mr David Loke Kai Yuan. There followed judging of the surgeons' team photo competition by their anaesthetic colleagues with a few comical images and quips about an afternoon adventuring in Singapore! All that remained was to solidify the plan to have ongoing co-operative meetings between our colleges and enjoy one last Singapore sling, in line with the timely suggestion:

*"Don't feel guilty about allowing yourself to enjoy life".*

**Dr Andrew Kennedy**  
Convenor, New Fellows' Conference



# Antimicrobial stewardship and the anaesthetist

Many hospitals have established antimicrobial stewardship committees to ensure appropriate administration of antibiotics. While there is variation between hospitals, basic principles based on good evidence should be used to guide therapy.

Antibiotic prophylaxis is an important mechanism for preventing surgical site infection and the choice of agent follows several basic principles.<sup>1,2</sup> In general, single dose therapy is adequate for most procedures to minimise adverse effects and the development of resistance. There is some evidence to justify extending the duration to 24 hours for orthopaedic arthroplasty, cardiothoracic sternotomy and vascular graft procedures.

The optimum efficacy requires delivery of the antimicrobial to the operative site before contamination occurs. Traditionally this has been at the time of induction, although evidence suggests a lower rate of infection is achieved when used at least 15 minutes but less than one hour prior to incision.<sup>1</sup> Redosing should be considered where the surgical duration extends for more than two half-lives of the drug, or if extensive blood loss (>1500mls). For example, cephalosporin with a half-life of 1.2 to 2.2 hours would ideally be re-dosed at three to four hours.

Procedures where prophylaxis is indicated include where mucosal surfaces are breached (for example, gastro-intestinal, urological, gynaecological, ENT) or where the consequences of infection are significant (for example, neurosurgery, implantation of devices – orthopaedic, cardiothoracic, vascular, neurosurgery). The selected agent should be active against the most likely pathogens found at that site, be safe, easy to administer and cheap, with a suitable pharmacokinetic profile. Patient factors should be taken into account, such as body weight and allergies. If patients have recently travelled (within last 12 months) to high-risk locations, such as south-east Asia or the Indian subcontinent, they are at risk of enteric colonisation with multi-resistant organisms and this may need to be taken into account, particularly for urological or gastrointestinal surgery. Renal or hepatic dysfunction may not be as important for a single prophylactic dose. Several different options may be suitable for any particular indication, so cost and convenience are considerations.

## Changing recommendations

There are two areas where recent review of surgical antibiotic prophylaxis has resulted in changing recommendations.

### MRSA

As methicillin-resistant *Staphylococcus aureus* (MRSA) is now endemic in most tertiary institutions, risk factors should be sought to identify those who would benefit from broader MRSA cover. These include current or past known infection or colonisation with MRSA, and residence in hospital for more than five days. For these patients vancomycin should be administered together with a cephalosporin. In a large surveillance program across Victoria, where vancomycin was used alone, an increase breakthrough rate of infections caused by methicillin-sensitive *Staphylococcus aureus* was observed.<sup>3</sup>

### Gentamicin

For many years gentamicin, inexpensive and easily administered, has been used for prophylaxis against Gram-negative organisms. However the downside of this agent has not been widely appreciated. Known to cause renal, vestibular toxicity and sensori-neural deafness, some have assumed these side effects are cumulative and occur after a period of sustained administration. This is not the case, and each of these significant adverse effects have occurred after only a single dose. Vestibular toxicity is the most disabling side effect as it is largely irreversible and frequently misdiagnosed. A series of 103 patients presenting to one centre with gentamicin related vestibular symptoms was published in the *Medical Journal of Australia*.<sup>4</sup> Patients presented primarily with imbalance or oscillopsia, a debilitating symptom where objects in the visual field appear to oscillate. It is caused by dysfunction of the vestibulo-ocular reflex. This may be more disabling than deafness as sufferers are unable to maintain focus while moving, such as walking or driving a car. The finding that “gentamicin can be vestibulotoxic in any dose, in any regimen, at any serum level” needs to be considered when it comes to selecting an antibiotic for routine prophylactic use. As many patients will present weeks to months after the administration of gentamicin, an accurate assessment of the magnitude of this problem is difficult to measure. Relating to sensori-neural damage, inherited mitochondrial gene mutations have been discovered that markedly heighten the risk for hearing loss after gentamicin exposure.<sup>5</sup>

In 2012 the Coroner’s Court of Victoria issued a written finding regarding gentamicin usage that all clinicians and prescribers:<sup>6</sup>

- (i) Be directed to the “Therapeutic Guideline: Antibiotic” and be made aware of the changes to gentamicin for empirical and/or directed therapy.





- (ii) Define a clear pathway for access to senior medical staff with a special interest in infectious diseases to assist with gentamicin decision-making.

An editorial for *Anaesthesia and Intensive Care* entitled “Gentamicin prophylaxis: time to break the habit?” argues that given the risks associated with gentamicin, each time this is prescribed for prophylaxis, the appropriateness to do so should be considered.<sup>7</sup> The point that has been articulated in successful litigation is that a safer alternative is usually available. Commonly observed areas where gentamicin has been widely used include urological surgery prophylaxis (utilising anti-pseudomonal activity) and in the insertion and withdrawal of urinary catheters. There is only weak evidence for the use of antibiotics at the time of catheter insertion for prevention of infection and routine use is not recommended.<sup>8</sup>

Thus gentamicin use is justified only in limited circumstances: for prophylaxis in patients with a complex allergy profile or multi-drug resistance; for early treatment of severe sepsis with a likely Gram negative (ICU); or directed therapy where alternate treatment options are limited.

Alternate options where Gram-negative coverage is considered necessary include third or fourth generation cephalosporins, for example ceftriaxone, or ceftazidime where pseudomonas cover is also required. Fluoroquinolones in general have a very low barrier to resistance, so should be avoided for routine prophylactic use (for example, Ciprofloxacin).

Antibiotics are a precious tool that we must use judiciously to maximise the benefit for patients today and to preserve activity for future use. Toxicity needs to be considered regarding prophylaxis, as distinct from directed therapy where benefit may outweigh risk, with particular regard to gentamicin usage.

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#### Dr Jonathan Darby

Department of Infectious Diseases,  
St Vincent’s Hospital, Melbourne

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ANZCA Professional Document PS28: *Guideline on Infection Control* is currently undergoing its 12 month pilot phase and is available on the ANZCA website.

# Alerts

## TGA quarantine of propofol batches

At the time of going to press the potential contamination of two batches of propofol (Provide MCT-LCT 1% 20ml vials) with the bacterium *Ralstonia picketti* was still under investigation. Further information and updates can be viewed on the ANZCA website.

## Change to Levophed™ formulation

Hospira has notified that Levophed™ has changed its formulation and presentation from noradrenaline 1:1000 2mg/2ml to a 4mg/4ml ampoule. The new presentation contains a reduced amount of sodium metabisulfite and has a reduced shelf life (18 months compared to two years). The active ingredient and concentration remain the same, however the new formulation will have double the volume and thus double the amount of noradrenaline compared to the old formulation.



## Failure to clear deadspace in injection lines

Reports continue to be received of adverse events related to failure to clear injection ports and lines of drugs which have significant clinical effects in small doses. These include remifentanyl, vancomycin and muscle relaxants. The problem generally occurs in the post anaesthesia care unit or ICU when these lines are flushed or used for further drug administration. This issue will be reflected in the upcoming revision of *PS51: Guidelines for the Safe Administration of Injectable Drugs in Anaesthesia*.

## Potential risk of airway obstruction with denture adhesives

Certain types of denture adhesive are presented as a glue-infused fabric 'wafer' which is cut to size by the wearer and swells, becoming sticky, when activated by saliva. Patients with dentures should be asked about use of such products and care should be taken to ensure removal of the 'cast' when dentures are removed perioperatively.

## Wrong site block

There have been multiple recent reports of wrong site blocks, all by experienced anaesthetists and often associated with perceived time pressures. A working party is being established to consider the best way to address this issue. Consideration should be given to marking the block site after checking consent and before sedation as well as a pause moment before needle insertion.

## ECRI alerts

### Arrow – Percutaneous Sheath Introducer Kits: Dilator tip may be damaged

Arrow has issued an urgent recall of certain batches of its percutaneous sheath introducer kits for vascular and haemodialysis catheters. The dilator tip on the introducer may be damaged with the potential for vascular damage when used.

Product and lot numbers are available from Arrow.

Meanwhile the dilator tip should be inspected before use.

### Failure of various Rusch endobronchial and tracheostomy tubes to seal necessitating reintubation of patient

Teleflex has issued an Urgent Medical Device Recall letter. Certain Rusch endobronchial and tracheostomy tubes (catalog no. 116200) may fail to seal because of asymmetrical cuff inflation. This may lead to desaturation and/or loss of volatile anaesthetic delivery and may necessitate reintubation of the patient.

### ISIS Tracheal Tubes with Subglottic Secretion Suction Ports: May kink

Teleflex has received reports that the above tracheal tubes may kink during use with the potential for desaturation and necessitating reintubation.

### GE – Version 01 Neuromuscular Transmission Modules used with ElectroSensor: Displayed values may indicate deeper-than-actual muscle Relaxation

Clinically, visual movements of the hand may be seen with TOF stimulation but no counts displayed on the patient monitor. The problem may occur when the modules are plugged into the CARESCAPE or Datex-Ohmeda S/5 anaesthetic monitor. There is potential for delivery of an inadequate dose of muscle relaxants. GE will arrange correction of affected modules.

### Heartstart MRX Monitor/Defibrillators

Phillips has issued multiple device correction letters. These relate to various models but include incorrect CPR instructions, accelerated wear between pad therapy cable and connection port with potential for delay in therapy and damage by electrostatic discharge. Further details can be obtained from the Safety Alerts section of the ANZCA website [www.anzca.edu.au/fellows/quality-safety/safety-alerts](http://www.anzca.edu.au/fellows/quality-safety/safety-alerts)

## Deaths under anaesthesia report

The NSW *Special report from Special Committee Investigating Deaths Under Anaesthesia 2011-2012* has been published.

Although the overall rate of anaesthesia-related mortality is low, the report highlights the failure of adequate preoperative assessment as a contributing factor to adverse outcomes. [www.cec.health.nsw.gov.au/programs/scidua](http://www.cec.health.nsw.gov.au/programs/scidua)

### Dr Phillipa Hore

Communication and Liaison Portfolio  
Quality and Safety Committee

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](http://www.anzca.edu.au/fellows/quality-safety/safety-alerts)



# Dean's message



It is a great privilege for me to serve the Faculty of Pain Medicine as dean. It is a huge honour to follow the deanship of Brendan Moore. With a dynamic and talented new Faculty Board, I hope to consolidate the progress managed by him in several areas. In line with the Faculty's strategic plan, I would like to concentrate the efforts of the board and our Fellows to serve the Faculty in the following five areas.

*Help build the capacity and capability of the Australian and New Zealand fellowship, including promoting pain medicine as a career and attracting trainees.*

In November 2005, the Australian Medical Council declared pain medicine to be an independent medical specialty, and pronounced the Australian and New Zealand Faculty of Pain Medicine to be the body responsible for training, education and standards for pain medicine in Australia. This soon resulted in the expansion of the number of training units, training posts and trainees. The recent acceptance of pain medicine as an independent vocational specialty registration by the Medical Council of New Zealand (in December 2012) with the resultant formation of the New Zealand National Committee of the Faculty will now encourage fellowship training in New Zealand. This needs to be actively supported to expand our overall Faculty membership.

*Help sustain the progress and implementation of the Faculty's Curriculum Redesign Project.*

Training and education of specialist pain medicine physicians is at the heart of FPM's role and reason for its being. The goal of the Faculty's Curriculum Redesign Project is to create a world-class training and assessment program, so we continue to lead the way with postgraduate pain medicine education around the world. Members of the Curriculum Redesign Project Steering Group have spent many hours laying the foundation to allow us as Fellows to contribute to this project. The revised curriculum needs to be ready to receive the first trainees in New Zealand in December 2014, and the first trainees in Australia in January 2015.

*Help design and implement an online modular educational program (as spearheaded by the immediate past dean) for primary healthcare and an online education program in pain medicine for medical school undergraduates.*

This is in accordance with our policy to develop and advance our relationships with other colleges and organisations to ensure an ever-increasing number have access to pain medicine training. Members of the Faculty's Education Committee, with their multidisciplinary expertise, have worked hard to ensure progress for our Fellows and trainees in a number of areas. These include the development of policy and educational documents. This should continue. The Education Committee has established a Mentoring Facility with a database on its website that requires further expansion. In a joint FPM/RACGP initiative the Education Committee helped to develop an innovative online modular educational program for primary healthcare comprising six key pain topics. This will need expansion and updating to at least 10 modules. The plan is to expand our online pain management education resources to enable us to offer educational resources in pain medicine to the various allied medical disciplines, including nursing. In addition, the establishment of an undergraduate medical student program is envisaged to offer to medical schools.

Marketing of the present Undergraduate Prize in Pain Medicine needs to continue to promote uptake by more medical schools. This will ensure extra pain medicine training for more medical students in more undergraduate programs.

*Help further develop the multidisciplinary approach of our new specialty, and grow our Faculty.*

We have worked hard to interact with the Australian and New Zealand pain societies and with PainAustralia. Growth challenges ahead include the development and implementation of the Pain Device Implant Registry, and the roll out (after the present trial) of the Electronic Persistent Pain Outcomes Collaboration. As a Faculty we need to use our expertise within the practice of medicine to lobby and advise government agencies, thereby indirectly advocating for patients suffering in pain.

*Help establish the Faculty as the pre-eminent trainer of specialist pain physicians in the world.*

We want to create an excellent curriculum based on sound education principles and the use of high quality information technology. In this way we can sustain training support not only centrally, but in developing, benchmarking, and improving the quality of our accredited training units. We then need to use our resources to help other healthcare professionals and undergraduate students gain access to pain medicine education.

Making progress in the above five areas requires committed teamwork and support. I have been amazed how many of our Fellows willingly donate their valuable time to developing our Faculty. Our general manager, our capable administrative staff, and our director of professional affairs ably support us. Finally, we are fortunate to receive tremendous infrastructure support and expertise from ANZCA.

In the months ahead we hope to build on and further strengthen the goodwill and trust that exists between the ANZCA Council and the Faculty Board.

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**Professor Ted Shipton**  
Dean, Faculty of Pain Medicine

# Reflecting on the deanship of Brendan Moore

For the past two years it has been a great privilege for me to serve as vice-dean of the Faculty of Pain Medicine under the deanship of Brendan Moore.

Brendan has a passion for the development of pain medicine education and training in Australian and New Zealand. With the support of the Faculty Board he articulated a clear vision of what needed to be done. He went about his deanship with a determination to see that progress was made.

At the start of his deanship, Brendan led the board in revising the Faculty's strategic plan. The new Faculty's strategic plan sets out a five-year framework (from 2013 to 2017) on which to focus its work. Its vision is "to reduce the burden of pain in society through education, advocacy, training and research." The Faculty's Strategic Plan has two main aims, to advance pain medicine and to improve patient care. Brendan instructed the Faculty's committees in all their work to focus on three priorities: to build fellowship and the Faculty; to build the curriculum and knowledge; and to build advocacy and access.

His leadership skills have guided the Faculty through a growth phase in

several areas. His first challenge was to lead the board in laying the framework for the development of a new curriculum to be carried out both centrally and in the workplace environment. He advocated to ANZCA to have high quality information technology available to ensure this took place smoothly. The curriculum process involved consultation with the fellowship, the development of a governance structure, the appointment of staff and sub-committees, and the start of writing the learning objectives and the content.

It was his initiative to engage the Royal Australian College of General Practitioners in a joint venture with the Faculty to obtain a Bupa Health Foundation grant to successfully develop an innovative online modular educational program for primary healthcare comprising six key pain topics. Recently, additional funding was obtained from the Commonwealth Department of Health and Ageing, facilitated through the Australian Medicare Local Alliance, to enable the Faculty to offer this pain management educational program more broadly to the various allied medical disciplines.

Brendan has been instrumental in the initial moves to develop a Pain Device Implant Registry, galvanising the device companies to provide initial funding for the Faculty to use for its establishment.



He has been actively supportive of the Electronic Persistent Pain Outcomes Collaboration as well.

Under his watch, the Medical Council of New Zealand accepted pain medicine as an independent vocational specialty registration.

To many of us, Brendan has been a trusted advisor and friend. On behalf of the Faculty Board, the general manager, and the Faculty staff, I thank Brendan for his many hours of hard work and for his collaborative leadership as dean.

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**Professor Ted Shipton**  
Dean, Faculty of Pain Medicine

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## Admission to fellowship of the Faculty of Pain Medicine

By examination

**Dr Sampath PRABHU, FANZCA (WA)**

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**Dr Hema RAJAPPA, FRACP (NSW)**

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**Dr Jacqueline EVANS, FANZCA (Qld)**

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**Dr Michael DAVIES, FRACS (NSW)**

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**Dr Joann ROTHERHAM, FANZCA (Qld)**

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**Dr Barry SLON, FANZCA (Vic)**

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**Dr Harold EEMAN, FAFRM (RACP) (Vic)**

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**Dr Tim HO, FAFRM (RACP) (Vic)**

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By election

**Dr Paul ROLAN, FRACP (SA)**

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We are pleased to report that this takes the number of Fellows admitted to 373.

## Examination dates

### 2014 Pre-Exam Short Course

The 2014 Pre-Exam Short Course will be held from September 19-21 at the ANZCA/FPM Queensland Regional Office. Further information will be available soon.

### 2014 Faculty of Pain Medicine examinations

The written exam will be held in ANZCA/FPM regional and national offices on Friday November 7. The clinical exams will be held at the Royal Adelaide Hospital, South Australia on November 29-30.

The closing date for exam registrations (both written and clinical) is Monday September 22. Further information will be available soon.



# News



## Refresher Course Day

The Faculty's Refresher Course Day and annual scientific meeting programs held last month in Singapore were a tremendous success.

The Refresher Course Day attracted a record 213 delegates and strong support from the healthcare industry with five exhibitors.

The theme, "Pain at the cutting edge: Surgery and pain", explored the interface between surgery and pain medicine. The program examined the science underlying post-surgical pain and discussed issues surrounding the management of pain in the peri- and postoperative period and the link between pain management and surgical outcomes.

The Refresher Course Day wrapped up with dinner at the iconic Raffles Hotel and an entertaining dinner speaker, Dr Phoebe Scott, who delivered an informative presentation on art in Singapore, including the re-opening of the former Supreme Court building as the National Art Gallery Singapore.

Associate Professor Brendan Moore was thanked for his leadership and significant contributions as dean in advancing the Faculty's strategic initiatives.

Media coverage was widespread (see the Communications update on page 37), and the *ASM E-Newsletter* was well received. Thanks to all who contributed to these fantastic events.

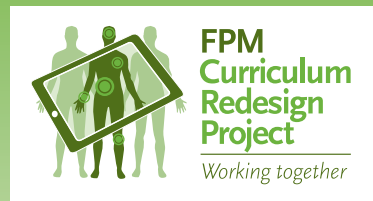
## Dean's Prize and Best Free Paper

The Dean's Prize is awarded at the FPM annual general meeting to the Fellow or trainee judged to have presented the most original pain medicine or pain research paper. This year's winner at the Singapore ASM was Dr Julia Dubowitz, an ANZCA trainee from Victoria, for her paper titled "Incidence of persistent post surgical pain after pelvic exenteration". Dr Dubowitz was awarded a certificate and a grant of \$A1000 for educational or research purposes.

The Best Free Paper Award is awarded for original work judged to be the best contribution to the free papers session of FPM. The Faculty free paper session is open to all annual scientific meeting registrants. This year's winner was Dr Sumitra Bakshi, from India, for her paper titled "ReSOoS trial - RECTUS Sheath block for postoperative analgesia in gynaeco-Onco Surgical patients – a double blinded randomised controlled trial". Dr Bakshi was awarded a certificate and a grant of \$500 for educational or research purposes. Congratulations to Dr Dubowitz and Dr Bakshi.

*Clockwise from top left: Refresher Course delegates at Suntec Singapore; Associate Professor Brendan Moore and FPM Singapore Co-convenor Dr Kian Hian Tan; Associate Professor Brendan Moore and FPM Scientific Convenor Dr Lewis Holford; Associate Professor Brendan Moore and Dr Sumitra Bakshi, FPM Best Free Paper Award winner; Associate Professor Brendan Moore and Dr Julia Dubowitz, FPM Dean's Prize winner; Pre-dinner drinks in the Raffles courtyard; FPM Annual Dinner at Raffles.*

# FPM Curriculum Redesign Project



## Introduction

In June 2011, the Faculty of Pain Medicine Board approved a major review of the pain medicine training program and instituted the Curriculum Redesign Project (CRP). The current program had been in place since the inception of the Faculty and it was time to review and update the training program in response to changing community and patient needs, concerns about the

effectiveness of consultants as the field of pain medicine has grown and new approaches to specialist medical training driven by changes in regulatory requirements of the Australian Medical Council and the Medical Council of New Zealand. In line with the Faculty's strategic objective, the outcome is a redesigned curriculum and world-class training program, which will be introduced in New Zealand in December 2014 and in Australia in February 2015.

## The philosophy

The redesigned program will prepare trainees for the roles of a junior specialist pain medicine physician. The philosophy underpinning the redesigned curriculum reflects recent changes in the conceptual model of pain from the biopsychosocial to the sociopsychobiological, acknowledging the importance of social and psychological factors determining patients' presentations with pain'. The focus will be on the trainee and their learning through structured acquisition of knowledge and skills. Additional support for trainees and their supervisors will be provided centrally. New teaching and learning techniques will be enhanced by new technology, built on the learning collaboration and management system.

## The program

The training program will be two years for everyone. The curriculum and the program will be characterised by being focused on modified CanMEDS roles, where medical expert comprises clinician, professional, scholar, communicator, collaborator, manager/leader and health advocate. It will be based on competencies, spiral in nature (that is, incremental, cumulative and integrative) and implemented as a hybrid delivery program, with online, interactive and group learning opportunities.

The program will consist of three stages (see table 1):

- 1) The foundations of pain medicine.
- 2) The core training stage.
- 3) The practice development stage.

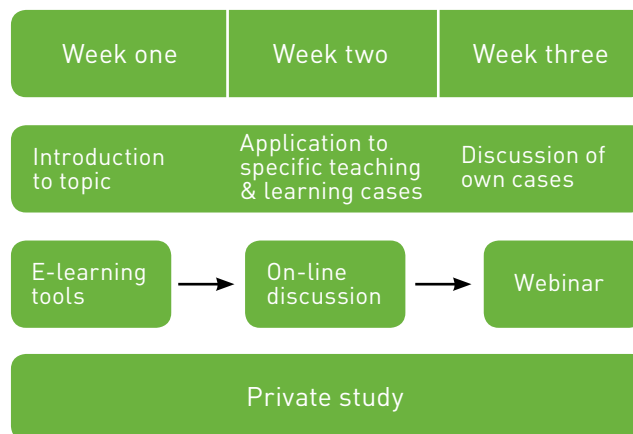
By definition, trainees in pain medicine are progressing to an additional specialist qualification and will have considered this vocational pathway carefully. They will be expected to have attained preparatory knowledge and skills in pain medicine through completion of the foundation component, the Foundations of Pain Medicine. Formal instruction in this foundation component will not be offered but will be outlined and resources provided for the topic areas to be learned.

Table 1: Topics for each stage of pain medicine training

| Foundations of Pain Medicine  | Core training stage   | Practice development stage   |
|---|---|--|
| <b>Topics</b> <ul style="list-style-type: none"> <li>• Background</li> <li>• Fundamental concepts</li> <li>• Terminology</li> <li>• Basic sciences</li> <li>• Assessment of pain</li> <li>• Management of pain</li> <li>• Critical appraisal of the medical literature</li> </ul> | <b>Essential topic areas (ETAs)</b> <ul style="list-style-type: none"> <li>• Neuropathic and related pain</li> <li>• Acute pain</li> <li>• Spinal pain</li> <li>• Problematic substance use</li> <li>• Visceral pain</li> <li>• Cancer pain</li> <li>• Headache and orofacial pain</li> <li>• Complex regional pain syndromes</li> <li>• Chronic widespread pain</li> </ul> | <b>Other topic areas (OTAs) (Suggestions only)</b> <ul style="list-style-type: none"> <li>• Paediatric pain medicine</li> <li>• Addiction medicine</li> <li>• Pain medicine in aged care</li> <li>• Palliative care</li> <li>• Physical interventions</li> <li>• Consultation liaison Psychiatry</li> <li>• Chronic pelvic pain</li> <li>• Research project</li> </ul> |

The core training stage is a mandatory 12-month period spent in a Faculty-accredited training unit. This stage will be highly structured, with a focus on the roles of clinician, professional, scholar, communicator and collaborator, through studying selected defined clinical situations, known as essential topic areas (ETAs), that increase in complexity and requirement for cognitive integration as the year progresses. Learning outcomes for the Pain Medicine Roles in Practice and the essential topic areas are defined in the curriculum document. During this stage there will be two streams of integrated teaching and learning. Stream A will be delivered centrally, with a knowledge focus, and stream B will be delivered in accredited training units, with a skills focus. Each of the nine essential topic areas will be the focus of a three-week teaching block with the nine blocks spaced out through the year (see diagram 1). Two compulsory workshops, one early in the year and the second mid-year, will focus on clinical skills development.

Diagram 1: The learning process for each essential topic area



(continued next page)



# FPM Curriculum Redesign Project (continued)

The practice development stage is a mandatory 12-month period of approved activity directly relevant to the field of pain medicine. This applies to all trainees, irrespective of their primary specialty background. As this stage is integral to the program, vocational trainees will be required to identify a prospective pathway(s) through it. The assessor must approve any such pathway. Trainees will be required to determine their own learning needs. Some suitable other topic areas have been suggested to provide guidance only. This stage may be divided into a minimum of three-month time blocks so additional experience may be gained in more than one area. Trainees will need to nominate an appropriate supervisor(s) for this stage. Prior to commencement of this stage, appropriate learning outcomes and assessment methods must be determined through discussion between trainee and supervisor(s), with assistance from the Faculty as required prior to submission to the assessor.

The essence of this stage is a clinical role(s) directly relevant to pain medicine where trainees can work under appropriate supervision. Such roles may be hospital and/or community-based, and may incorporate a research component (clinical or public health). This stage will include the other roles of the specialist pain medicine physician: manager/leader and health advocate.

The assessor may grant limited recognition of prior experience of up to a maximum of six months towards the practice development stage following presentation of a portfolio and supporting documentation.

A comprehensive review of the assessment processes has occurred with a range of changes proposed as follows. The focus of assessment will be redirected towards assessment for learning. A range of workplace-based assessment processes will be introduced and will be ongoing throughout each year. These will include:

- Clinical skills assessment (CSA).
- Management plan assessment (MPA).
- Case-based discussions (CbD).

- Professional presentations (PP).
- Multi-source feedback (MSF).

Summative assessment will be progressive as well. Foundation knowledge will be assessed by a multiple-choice question paper early in the core training stage and must be passed to progress with this stage of training. Long case assessment will be undertaken regionally during the year, and will no longer be included in the end of year examination. The written examination will be conducted in the regions at the end of the year followed by a one-day oral examination undertaken centrally two to three weeks later. The clinical case study will be retained in its current form. Feedback on performance in these assessment tasks will be provided to enhance the trainee's learning.

### The project

The Curriculum Redesign Project is progressing according to the timeline. Transition processes for current trainees have been defined and are available on the FPM website. A provisional iteration of the curriculum was launched on April 11 this year for consultation with Fellows, trainees and other stakeholders. The Teaching and Learning Expert Panel has started work on the e-learning approach and development of the learning resources will begin in June. Work is well underway on the handbook, regulations governing the training program and other administrative processes. Further work on the curriculum document will incorporate the assessment processes and an outline of the practice development stage. The full revised curriculum and training program will be launched at the Faculty's Spring Meeting in September.

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**Dr Meredith Craigie,**  
Chair, Curriculum Redesign Project Steering Group

### Reference:

1. Carr, D, Bradshaw, Y (2014). Time to flip the pain curriculum? *Anesthesiol* 120(1):12-14.

# Communication to avoid claims

Studies in Australia and overseas have confirmed one of the prime reasons for patients seeking to make claims against their doctor after an adverse outcome is the manner in which the doctor dealt with them and communicated with them.

In other words, the way doctors and hospitals communicate with their patients after an adverse event will substantially influence whether the patient considers making a formal claim or even suing for negligence.

A doctor who is attentive, responsive and sympathetic after an adverse outcome is less likely to be sued than the doctor who is dismissive, distant or less empathetic.

Doctors who lack a “bedside manner” or who are racist or belittling to patients are more likely to attract claims.

It is common knowledge that there are doctors who achieve less than optimal outcomes, but whose patients would never think of taking action against them. This is because their patients “love them” as a result of the attention, empathy and friendly treatment they receive.

There are occasions when doctors, despite their best efforts, and with no suggestion of legal negligence, nonetheless face claims from patients because of the perception of less than optimal outcomes or the perception of poor care.

Best practice communication in healthcare occurs at all stages:

- **Before** – informing the patient in relation to realistic outcomes, risks, side effects and costs (especially out-of-pocket expenses).

This is both a legal obligation (“informed consent”) as well as ensuring that patients do not have unrealistic expectations of their care and outcomes.

- **After** – dealing with adverse outcomes (whether or not legally “negligent”).

Prompt, sensitive and frank discussions can mitigate the patient’s inclination to sue or complain (“open disclosure”).

As part of a response by federal and state governments in Australia to the medical indemnity crises in the 1990s, legislation was introduced in most states to permit “open disclosure”. That is, the legislation now permits doctors to have a frank discussion with their patients, without adverse legal implications or an admission of legal liability.

“A doctor who is attentive, responsive and sympathetic after an adverse outcome is less likely to be sued than the doctor who is dismissive, distant or less empathetic.”

The legislation fosters the concept of openness and a frank discussion with patients after an adverse outcome (whether or not there has been negligence). There can be an open acknowledgment of an adverse outcome and even an apology (to express regret for the fact that the patient has not had an optimal outcome).

It may not be “trendy” in Australia to give an apology. However, in the case of adverse events, an apology may well be a critical factor as to whether a patient sues a doctor or not.

Legislation in Australia now allows doctors to deal with adverse outcomes, without there being any admission of liability, by:

- Expressing regret or apologising for an adverse outcome.





- Expressing sorrow or sympathy.
- Reducing fees.
- Waiving fees entirely.

Such events also will not constitute an admission of professional misconduct or otherwise expose doctors to civil liability for carelessness, incompetence or unsatisfactory performance.

In addition to these legislative changes, the Australian Safety and Quality Commission has issued standards or guidelines to assist doctors and hospitals in discussing these issues frankly with patients.

The standards address:

- Openness and timeliness of communication.
- Acknowledgment of the adverse event.
- Apology or expression of regret.
- Recognition of the reasonable expectations of patients.
- Support for staff throughout the process.
- Processes for risk management and systems improvement.
- Governance frameworks to ensure appropriate clinical risk management.
- Confidentiality.

The standard is designed to assist doctors, nursing staff and administrators in dealing with the issues raised by “open disclosure”.

Once an adverse event has occurred, it is important that the patient is kept informed, as appropriate. The clinical team should ensure that:

- They establish the basic clinical and other facts relevant.
- Assess the event and the level of response required.
- Identify who will take responsibility for advising the patient.
- Consider whether additional patients support is required.
- Identify other support and needs.
- Ensure all appropriate staff are sufficiently informed and ensure a consistent response to the patient.

Clearly, as matters develop, patients should be given sufficient and up-to-date information so they feel appropriately informed. Recommendations for further remedial care should be made as soon as possible. Follow up is an essential part of the process.

Nonetheless, the process should ensure:

- Confidentiality, privacy and professional privilege.
- Responses to any negligent or criminal or unsafe acts (if any), including coronial investigations.
- Consider whether any disclosure of particular information might further harm the patient (if the patient is particularly unwell or fearful)..
- Consideration of any other insurance or contractual arrangements.

These statutory reforms are helpful. They should give confidence to doctors and medical administrators to enable them to deal with adverse outcomes (whether negligence or not) in a caring and humane way. It is, after all, human nature to be able to express regret and sympathy where a patient has had an adverse outcome to treatment or procedure, without such concern being considered an admission of legal liability.

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**Michael Gorton**

Honorary Solicitor, ANZCA  
Partner, Russell Kennedy Solicitors

# Experience in the development of an in-house, consultant-focused, anaesthetic crisis management course



We recently embarked on the development of an educational program for specialists within our department: the Flinders Anaesthetic Crisis Training (FACT) course. This program has been designed to help us optimise our preparedness for rare but potentially life threatening clinical events. Here we outline the development of the course and our initial experiences with running it.

## Establishing the course

In December 2010, the European Resuscitation Council held a conference in Porto, to discuss the scientific basis for changes in the International Liaison Committee on Resuscitation (ILCOR) guidelines for advanced life support. During this meeting, the issue of preparedness for uncommon and rare events was raised. One of our number returned from this meeting keen to develop a sustainable program of ongoing training for members of our department.

A working group of like-minded colleagues was established. After discussions with many of our colleagues, we embarked upon developing a modular education program. This resulted in a program that consists of a theoretical component with online reading material and multiple choice questions, and a practical component with scenario-based simulation, delivered in our usual workplace, using mobile simulation equipment.

We have developed seven modules, covering critical situations such as cardiac arrest, can't intubate, can't oxygenate (CICO), major trauma, and obstetric and paediatric emergencies. The content has been developed with the support of the relevant experts within our department. The entire program runs over three years and coincides with the ANZCA CPD triennium.

One of the main strengths of the FACT course is the location of the simulation-based sessions in our usual working environment, and the involvement of other operating theatre personnel. This allows all staff to rehearse their role in a team response to clinical emergencies. An added potential benefit is the identification of deficiencies in planning and equipment in the theatre suite.

## Setting up an educational website with "Moodle"

To create our online educational resource, we chose a software program called "Moodle", a powerful, free, open-source software, in widespread use across SA Health.

Setting up your very own Moodle website requires a high degree of computer literacy. A savvy department member assisted us with this, but the initial steps aren't easy. We would recommend trying to locate someone in your institution who knows Moodle – try the nursing education department, or google for Moodle courses in your hospital or area.

With access to Moodle, course creation is relatively straightforward. We have a combination of PDF files, PowerPoint, video and audio presentations, multiple choice questions, web links and photographs. The educational content is based on a mixture of published articles, guidelines and expert opinion and is tailored to the needs of consultants within our institution. It links closely with the simulation aspect of each topic we have created. Access to the course can be opened to everyone, or limited by a password system, and assessments can be voluntary or mandatory. An activity log records the time spent on the website and can be used as documentation for CPD requirements.

*(continued next page)*

*Above: Anaesthetists Steve Kinnear and Nick Stradwick work with nursing staff Robyn Faehse and Morag Richards during a simulated clinical emergency.*



# Experience in the development of an in-house, consultant-focused, anaesthetic crisis management course (continued)



## Setting up the simulation-based sessions

This has required close collaboration with senior nursing staff. The department's senior technicians have provided invaluable practical support. We have been fortunate to receive a great deal of help from the Department of Simulation and Clinical Skills at Flinders University, not least through the provision of a wirelessly controlled mannequin and monitor.

Sessions are held once a fortnight, and last for an hour. We run two scenarios lasting 15 minutes, with each followed by an immediate review by the participants and facilitators lasting a further 15 minutes. Participants include two anaesthetists and two to four nursing and ancillary staff.

Participating in simulated emergencies can be challenging. This is made more threatening by the presence of colleagues and co-workers. We all value our reputations and don't want to be seen to underperform. It is made clear at the beginning of each session that there is no element of assessment. In addition, all participants sign a confidentiality agreement.

Wherever possible, we use real drugs and equipment. Exceptions are made if cost is prohibitive or supply limited. In these cases mock-up alternatives are used. These are clearly labelled and it is the responsibility of facilitators to check that all equipment relating to the session is removed at the end to prevent contamination of operating theatre stock.

## Our experience so far

The FACT course has been running for six months. Timing the simulation-based sessions to coincide with the weekly departmental meeting and nursing education sessions has allowed for maximal participation across the theatre team.

We began with advanced life support scenarios in the setting of intraoperative events such as local anaesthetic toxicity and bone cement implantation syndrome. Participants rapidly become immersed in the scenarios and discussions after each scenario have been uniformly constructive.

Problems encountered during simulations have generated important learning points. We have uncovered a small number of shortcomings with equipment, which have been rectified. Incorrect assumptions about the location and availability of certain emergency drugs and equipment have also been identified.

Overall the sessions have been well received by anaesthetists, nursing and ancillary staff. Feedback has allowed an appropriate progression in the variety and complexity of the scenarios.

## The future

Our aim is that participating members of the department become comfortable with simulation-based training, and feel able to contribute suggestions for scenarios and material for the website. We also hope to involve as many as possible as session facilitators. In this way, the whole department will own the course and not just a small faculty.

In time, we hope to run scenarios in other locations, such as the endoscopy suite and labour ward, thereby exposing other staff groups to the process.

There has been excellent collaboration and co-operation among the groups involved in this process, and even if no other benefit accrues, it will have been a worthwhile undertaking.

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**Dr James Hafner, Dr Merv Atkinson, Dr Kirsten McCullough, Dr Giresh Chandran, Dr Kuan Lee Ng and Dr Robert Young**

FACT course organising committee, Flinders Medical Centre, Adelaide

*Above: The Moodle-based website.*

# Wealth of information in Geoffrey Kaye book collection



*"He who studies medicine without books sails an uncharted sea."*

*Sir William Osler*

The ANZCA Library, archives and Geoffrey Kaye Museum of Anaesthetic History house a treasure trove of material chronicling the development of anaesthesia, intensive care and pain medicine in Australia. While these resources frequently reward historians with new information regarding the scientific, clinical and technical evolution of these specialties, some collections also reveal unique and unexpected insights

into the lives of the individuals who donated them.

Occupying several shelves in the ANZCA Library, the Geoffrey Kaye book collection comprises more than 170 textbooks and monographs amassed by Dr Kaye following commencement of his undergraduate medical training in 1921. Incorporating many of his pre-clinical books, the collection includes a physics text with extensive notes penned in Kaye's distinctive handwriting and a pamphlet with the label "Medical physics: first year medicine, University of Melbourne" glued inside the back cover, as well as three

volumes of Werner Spalteholz's *Handatlas der Anatomie des Menschen*. Widely regarded as one of the most elegantly illustrated anatomical atlases of all time, its German text would have posed no obstacle to Kaye, who had excelled in modern languages at secondary school. This too may explain the somewhat eclectic inclusion of the complete works of Shakespeare in German in Kaye's book collection.

In his fourth year at medical school Kaye was awarded an undergraduate prize in forensic medicine. A book on this subject, written by C H Mollison,

## New home for Geoffrey Kaye museum

An exciting new exhibition is being developed for the Geoffrey Kaye Museum of Anaesthetic History which will be officially re-opened in September in its new home, ANZCA's historic Ulimaroa building in Melbourne.

The exhibition, which will include new subjects such as pain medicine and the scientific advances born out of war, is being developed by Honorary Curator Dr Christine Ball and new Museum Collections Officer, Monica Cronin.

To mark the re-opening, there will be a number of events and activities where Fellows, trainees and staff can be involved. More information will be available via the ANZCA website - [www.anzca.edu.au/about-anzca/History](http://www.anzca.edu.au/about-anzca/History).

The museum has also been working towards museum accreditation which requires demonstration of best practice and implementation of national industry

standards. There are more than 800 museums in Victoria of all sizes and shapes and about 80 of them have successfully gained accreditation. The accreditation application will be submitted later this year.

During the relocation, the museum has been adding collection items to its online space, Victorian Collections. This online space is the result of a collaborative project between Museum Victoria and Museums Australia (Victoria) that has produced an online cataloguing system. The museum's presence on Victorian Collections helps provides a knowledge sharing space and enables global access to its collection. The collection can be found at <http://victoriancollections.net.au/organisations/geoffrey-kaye-museum-of-anaesthetic-history>

For further information, please contact the museum at [museum@anzca.edu.au](mailto:museum@anzca.edu.au).





a lecturer in forensic medicine at the University of Melbourne, is among the most heavily annotated in the collection, incorporating macabre entries from Kaye, such as “cut throat in a woman is very suggestive of homicide” and “slow poisoning by one member of the family of others, usually with arsenic, may occur.”

Kaye graduated in 1926 and began to foster an interest in anaesthesia as a resident medical officer at the Alfred Hospital. Sadly for a man who was passionate about research, the specialty was still in its infancy in Australia and devoid of a firm scientific basis or formal teaching. The multitude of British and American textbooks that Kaye purchased around this time hint at his unwillingness to accept this status quo, and in 1929, aged just 26 years, he embarked on a life-changing journey to England, Germany, North America and Canada where he met and rapidly formed lifelong friendships with most, if not all, of the significant names in anaesthesia in these countries.

Kaye’s book collection contains a number of manuscripts purchased during the course of this, and subsequent

international travels, and copies of important monographs published during the 1940s and 1950s by international authorities such as Noel Gillespie, Robert Macintosh and William Mushin. All of these bear personal dedications to Kaye and serve to reinforce the lasting nature of the friendships that Kaye fostered.

In addition to the many anaesthetic texts published during his lifetime and the books to which he contributed, Kaye’s collection incorporates a handful of rare manuscripts including a well preserved first edition of Arthur Ernest Sansom’s *Chloroform: Its Actions and Administration*, published in 1865, and books concerning the history of anaesthesia and medicine, which appear to have interested Kaye during the 1960s and 1970s following his retirement from anaesthesia.

Notably, many of the books contain a striking bookplate on the inner cover. While the provenance of this has proved elusive to date, Dr John Paull, who knew Kaye personally, feels its allegorical meaning is clear: “The ship, bearing Geoffrey’s spirit and as judged by its sails

is moving toward the distant horizon, following the starlight track on the water, from the large star in the night sky. I think this sums up Geoffrey’s approach to life and the acquisition of knowledge perfectly.”

**Dr Peter Featherstone**  
Member of ANZCA History and Heritage  
Expert Reference Panel

*Opposite page from left: Many of the books contain this striking bookplate on the inner cover; Notes in a forensic medicine text; One of three volumes of Werner Spalteholz’s Handatlas der Anatomie des Menschen.*

## College Conversations



The June edition of *College Conversations*, included in the *ANZCA Bulletin*, introduces ANZCA’s newly elected president Dr Genevieve Goulding. Dr Goulding talks about what she sees as the priorities for the College and the profession over the next two years and what she plans to bring to her style of presidency. She shares her passion for obstetric and gynaecological anaesthesia, her own

specialty, and her interest in medical education, welfare of anaesthetists and quality and safety.

There also is an interview with ANZCA solicitor Michael Gorton, who discusses legal considerations of the peer-review process, and what Fellows should understand.

Dr Peter Featherstone from the ANZCA’s History and Heritage Expert Reference Panel shares his enthusiasm for the College collection of anaesthesia and pain medicine artefacts. These items are an important part of the history of the profession and tell a story about those who used them, and their patients.

The POISE-2 study, which attracted widespread media attention when its results were released in April, has revealed risks in surgery for those who take aspirin. Professor Kate Leslie, who led the Australasian arm of the study, talks about the implications of the findings.

The Australian Federal Budget, handed down in May, stirred considerable controversy with a raft of new measures, particularly in the health, medical and research sectors. Bongiorno Group founding partner Tony Bongiorno and director Michael Waycott explain the key messages for medical specialists contained in the budget.

National Anaesthesia Day in October this year will focus on raising awareness of the benefits of giving up smoking before surgery and Dr Ashley Webb, one of the architects of ANZCA’s perioperative guidelines on smoking, talks about his research on how to best help patients “stop before the op”.

Listen to the CD at home, in your car, or download it on to your smart phone or other device from the ANZCA website [www.anzca.edu.au/communications/anzca-bulletin](http://www.anzca.edu.au/communications/anzca-bulletin).

We hope you enjoy this edition.

# New online books and new books for loan

## New online books

Online textbooks can be accessed via the ANZCA Library website: [www.anzca.edu.au/resources/library/online-textbooks](http://www.anzca.edu.au/resources/library/online-textbooks)

**Anesthesiology : examination and board review** / Dershwitz, Mark; Walz, J Matthias. -- 7th ed -- New York: McGraw-Hill, 2014.

**Atlas of ultrasound-guided regional anesthesia** / Gray, Andrew T. -- 2nd ed -- Philadelphia, PA: Elsevier Saunders, 2013.

**Case files. Anesthesiology.** / Conlay, Lydia Ann. -- New York: McGraw-Hill, 2011.

**Chestnut's obstetric anesthesia : principles and practice** / Chestnut, David H [ed]. -- 5th ed -- Philadelphia, PA: Mosby Elsevier, 2014.

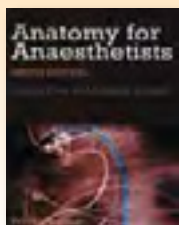
**Clinical fluid therapy in the peri-operative setting** / Hahn, Robert G [ed]. -- Cambridge, UK: Cambridge University Press, 2011.

**Irwin and Rippe's intensive care medicine** / Irwin, Richard S [ed]; Rippe James M [ed]. -- 7th ed, rev. -- Philadelphia: Lippincott Williams and Wilkins, 2011.

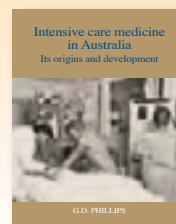
**Opioids in cancer pain** / Davis, Mellar P. [ed]; Glare, Paul A. [ed]; Hardy, Janet [ed]; Quigley, Columba [ed]. -- 2nd ed -- Oxford: Oxford University Press, 2009.

## New books for loan

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



**Anatomy for anaesthetists** / Ellis, Harold; Lawson, Andrew. -- 9th ed -- Chichester, West Sussex, UK: Wiley Blackwell, 2014.



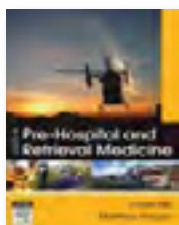
**Intensive care medicine in Australia: its origins and development** / Phillips, Garry. -- 1st ed -- Melbourne, VIC: Australian and New Zealand College of Anaesthetists, 2014.



**ATLS, advanced trauma life support, student course manual** / American College of Surgeons Committee on Trauma. -- 9th ed -- Chicago, IL: American College of Surgeons, 2012.



**Oh's intensive care manual** / Bersten, Andrew D [ed]; Soni, Neil [ed]. -- 7th ed, rev. -- Edinburgh: Butterworth-Heinemann Elsevier, 2014.



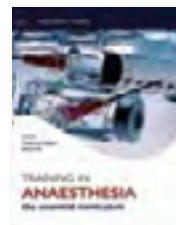
**Cases in pre-hospital and retrieval medicine** / Dan, Ellis.; Hooper, Matt. -- Sydney: Churchill Livingstone, 2010.



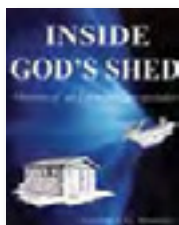
**Regional anaesthesia : a pocket guide** / Chuan, Alwin; Scott, David. : Oxford University Press, 2014.



**Echo made easy** / Luthra, Atul. -- 3rd ed -- New Delhi: Jaypee Brothers Medical Publishers, 2012. NEW ZEALAND OFFICE.



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



**Inside God's shed: memoirs of an intensive care specialist** / Worthley, Lindsay I G. -- Adelaide, SA: JANDL Holdings Pty Ltd, 2014.

(continued next page)





## Searching made easy

Ever found the one perfect article on the clinical topic you are interested in and then unable to find any other relevant literature? The new *MeSH on Demand* tool is an easy way to identify relevant MeSH (Medical Subject Heading) terms.

Use *MeSH on Demand* to find MeSH terms relevant to your topic up to 10,000 characters from your text such as an abstract or grant summary. One of the strengths of *MeSH on Demand* is its ease of use without any prior knowledge of the MeSH vocabulary and without any downloads. *MeSH on Demand*: <http://ii.nlm.nih.gov/Interactive/MeSHonDemand.shtml>

ANZCA Library staff are always available to assist with any searching needs, such as finding procedural videos or locating relevant articles for a case or presentation. Contact the library with your search query.

## New ECRI safety publications

From 2014, *Health Devices* will no longer be published as a print magazine but will provide articles and reviews online. Contact the library if you are interested in receiving updates or articles from this publication: [library@anzca.edu.au](mailto:library@anzca.edu.au)

### Health Devices articles

- Don't lose the evidence – sequestering equipment after an incident.
- No policy on staff use of medical apps? You're not alone.
- New video: Six steps to clinical alarm safety.

### Updated Postanesthesia Care guidance available

“The most important room in the hospital”: that is what a landmark case – *Laidlaw v. Lions Gate Hospital*, decided in Canada in 1969 – called the phase I postanesthesia care unit (PACU) because of the dangers to patients receiving that level of care. Postanesthesia Care, a new analysis available on the ORRM members' website, reviews issues related to patient safety, worker safety, and claims and lawsuits, as well as regulations and standards. It also offers an action plan to help managers and their organisations address issues such as safety culture and quality improvement, personnel and care co-ordination issues, handoffs, patient assessment and monitoring, specific clinical and safety challenges, and discharge.

### New application-specific connectors will replace Luers to combat misconnections

Upcoming standards will define new application-specific small-bore connectors to replace the widely used – and misconnection-susceptible – Luer design. Facilities that adopt the new connectors may experience fewer misconnections and near misses.

## Latest anaesthesia and pain medicine research

All articles can be sourced in fulltext from the library's online journal list: [www.anzca.edu.au/resources/library/journals](http://www.anzca.edu.au/resources/library/journals)

Scott IA, Shohag HA, Kam PC, Jelinek MV, Khadem GM. Preoperative cardiac evaluation and management of patients undergoing elective non-cardiac surgery. *Med J Aust.* 2013 Nov 18;199(10):667-673.

Nix CM, Margarido CB, Awad IT, Avila A, Cheung JJ, Dubrowski A, et al. A scoping review of the evidence for teaching ultrasound-guided regional anesthesia. *Reg Anesth Pain Med.* 2013 Nov-Dec;38(6):471-480.

Albrecht E, Kirkham KR, Taffé P, Endersby RVW, Chan VWS, Tse C, et al. The maximum effective needle-to-nerve distance for ultrasound-guided interscalene block: An exploratory study. *Reg Anesth Pain Med.* 2014;39(1):56-60

Banchs RJ, Lerman J. Preoperative anxiety management, emergence delirium, and postoperative behavior. *Anesthesiol Clin.* 2014 Mar;32(1):1-23.

Kennedy CC, Cannon EK, Warner DO, et al. Advanced airway management simulation training in medical education: a systematic review and meta-analysis. *Crit Care Med.* 2014 Jan;42(1):169-78.

Necib S, Tubach F, Peuch C, LeBihan E, Samain E, Mantz J, et al. Recovery from anesthesia after craniotomy for supratentorial tumors: Comparison of propofol-remifentanyl and sevoflurane-sufentanyl (the PROMIFLUNIL trial). *Journal of Neurosurgical Anesthesiology.* 2014;26(1):37-44.

### Contact the ANZCA Library

[www.anzca.edu.au/resources/library](http://www.anzca.edu.au/resources/library)  
 Phone: +61 3 8517 5305  
 Fax: +61 3 8517 5381  
 Email: [library@anzca.edu.au](mailto:library@anzca.edu.au)

# Canadian lessons for roles in practice teaching



Dr Kerryn Bunbury, a former supervisor of training and staff anaesthetist from The Alfred in Melbourne, spent her recent sabbatical in Canada looking at resources for teaching the CanMEDS' intrinsic competencies and their relevance for the roles in practice component of ANZCA's training program. She tells Susan Ewart about her research and where it might lead for ANZCA.

While the ANZCA curriculum has included the CanMEDS' competencies since 2004, the ANZCA Roles in Practice in the 2013 curriculum make these competencies much more explicit. As a supervisor of training, I found myself wondering how we might best teach the intrinsic non-medical roles.

I didn't have a good bank of resources to teach the competencies of communicator, collaborator, professional, health advocate and manager, and I wondered whether other supervisors of training were experiencing similar issues. In particular, I struggled with finding local relevant resources for teaching the manager and health advocate roles.

I decided to use my sabbatical to investigate this.

My first step was to survey all supervisors of training in Australia and New Zealand to assess the need to

develop resources for teaching these roles. While the survey results are awaiting publication, they definitely indicate a perceived need for such resources.

I also decided to investigate how these CanMEDS' competencies are taught in Canada.

All postgraduate medical training there is overseen by Canada's only medical college – the Royal College of Physicians and Surgeons of Canada – which accredits universities to provide the training. In Toronto, for example, the University of Toronto provides the training for anaesthetists, with the trainees rotating around local hospitals under the university's supervision. This gives trainees and educators access to a fantastic range of resources at the university.

My initial contact was with Dr Jason Frank, who is the director, specialty education, strategy and standards in the Office of Specialty Education at the Royal College. He was instrumental in establishing CanMEDS. He recommended the Post Graduate Medical Education Unit at the University of Toronto, led by anaesthetist Professor Sal Spadafora and emergency department physician Dr Glen Bandiera. I was warmly welcomed at that unit as their first "visiting scholar".

Alongside this, I liaised with the anaesthesia program director at the University of Toronto, Professor Mark Levine, to see how the competencies were being taught. I was very impressed with the blueprint he had developed for teaching all the competencies across each training year.

## What are CanMEDS?

In 1996, the Royal College of Physicians and Surgeons of Canada adopted an innovative framework for medical education called the CanMEDS



Physician Competency Framework – an initiative that evolved out of public demand for more accountability of doctors and a recognition of the greater roles that a 'good doctor' has in society. The CanMEDS framework is organised around seven roles: Medical Expert (the central role), Communicator, Collaborator, Health Advocate, Manager, Scholar and Professional. This framework has been adopted in jurisdictions around the world, including by ANZCA, which uses it to underpin the Roles in Practice component of the ANZCA Training Program.

I was also impressed by the commitment local educators had to developing teaching resources for these competencies. This educator commitment was facilitated through a strong faculty development unit at the university. Through the unit, program directors and other educators of all specialties were offered training in skills to teach these competencies. The inter-professional nature of this unit led to a very collaborative environment and a sharing of resources.

This saves much duplication and I would like to see ANZCA develop a centralised system for sharing and accessing teaching resources for the intrinsic roles in practice.

The Canadians have developed some great innovative resources so we don't need to reinvent the wheel. We can use them as a guide and adapt them for anaesthesia and for our own health systems to teach ANZCA's Roles in Practice, especially those of health advocate and manager, which have proved the hardest to teach in all jurisdictions.





Dr Bunbury travelled to Canada with her husband, paediatric anaesthetist Dr Dean Bunbury, and their two daughters, Sarah and Laura, now aged five and three respectively.

“We wondered how the kids would adjust to the climate but we were very positive about living in a place with snow and the kids picked up on that. One of my favourite memories now is pulling them to school on a sled.”

After finishing their study in Canada, they will return to their home country of New Zealand to take up positions at Middlemore Hospital in Auckland.

They are the most difficult to understand and to get educators to embrace, yet the roles are very relevant to the view of the modern anaesthetist who also works outside of the operating theatre. Because of the nature of where we work, we are ideally positioned to be leaders both in health advocacy and in health management roles.

My sabbatical was wonderful. I found the Canadians very welcoming. They are pleased to see international uptake of their innovative CanMEDS program and keen to share what they know, provided their work is acknowledged. They have a highly developed culture of networking – offering introductions and being keen to meet you.

The Post Graduate Medical Education Unit has close ties with the Royal College and the Wilson Centre (the University of Toronto’s centre for educational research and an internationally acclaimed medical research institute). The director of the Wilson Centre, Professor Charlotte Ringsted, is also an anaesthetist by training and this year I have been based at the centre completing a masters in

medical education while my husband finishes a fellowship in paediatric anaesthesia at the Hospital for Sick Children (SickKids Hospital) in Toronto.

I want to bring the results of my research to my role as a member of ANZCA’s Teaching and Learning Sub-Committee. I hope to continue investigating the best way of providing resources and training for educators in these competencies.

It would be great to get a team of interested people on board who each want to take ownership of one of the individual roles in practice and champion it – in the way that we had workplace-based assessment champions – and to develop the resources to support that. Anyone interested in this is encouraged to email me through [education@anzca.edu.au](mailto:education@anzca.edu.au) (putting my name in the subject line).

My sabbatical was invaluable for my career development. It has opened doors. There were so many people keen to share what they know. Also, as the first visiting scholar in that unit, I have been able to establish some great links for those who want to follow.

*Opposite page: Dr Kerryn Bunbury (right) with Professor Sal Spadafora, Vice Dean of Post Graduate Education, University of Toronto, standing beside the korowai (miniature Maori cloak) symbolising prestige and honour that she presented to the department as a token of gratitude.*

*This page: Dr Kerryn Bunbury and Dr Dean Bunbury with daughters Laura and Sarah enjoying the snow in Canada.*

# Successful candidates



## Primary examination February/April 2014

Sixty five candidates successfully completed the primary fellowship examination at this presentation and are listed below:

### AUSTRALIA

#### Australian Capital Territory

Anthony Robert Gray  
Trent Steven Evans

#### New South Wales

Alison Louise Clark  
Christina Anne Jenkins  
Christine Sarita Velayuthen  
Gwynn Cameron Forrest  
Katherine Jane Jeffrey  
Katherine Jialynn Lee  
Matthew Gerard Van Zetten  
Mehwish Khalil  
Simon Andrew Campbell  
Stefan Joshua Aveling  
Sushari Chamindika Muthumuni  
Xinmei Yao

#### Queensland

Adrian Lim Fung Kin  
Anne Veena Nilakshi Jayamaha  
Christopher L Futter  
Daniel John Haenke  
Jacob James Carter  
Malaka Devinda Dias  
Meredith Ann Betts  
Paul Daniel Slocombe  
Winnie Man Wai Yu

### South Australia

Armin Baghini  
Conor Patrick Day  
John Pieterse  
Katharine Ingham Sporne  
Kirsty Georgina Belfrage  
Lee Edward Tayler  
Peter Francis Webb  
Richard Branden Emmerson  
Stewart Robert Anderson  
Timothy Aaron Donaldson

### Tasmania

Adam John Mahoney  
Kate Elizabeth Drummond  
Robert Gregory Easterher

### Victoria

Faraz Rashid Syed  
Irina Baleanu-Mackinlay  
Nicholas James Lanyon  
Olivia Millay  
Sarah Therese Wallis

### Western Australia

David Brian Anthony Rawson  
Emil Martin Peska  
Gary Robert Devine  
Jing Xiao  
Kristen Lorraine Kiroff  
Ottilia Ananda Anna Elvira Magnusson  
Sigrid Elisabeth Pfeiffer  
Zaki Abdul Aziz Ibrahim

### NEW ZEALAND

Adam John Hollingworth  
Andy Hoi Kei Wong  
Ann-Marie Stevenson  
Annu Priya Shanmuganathan  
Daniel Fung  
David Poh Kim Tan  
David Sainsbury  
Edwin Coates  
Elizabeth Mary Page  
Hsi-yu Ku  
John Hay  
Martin Andrew Bailey  
Richard Paul Benson  
Robert James Barr  
Sathishlingham Shanmuganathan  
Stephen Chun Young

### Renton Prize

The Court of Examiners recommended that the Renton Prize for the half year ended May 31, 2014, be awarded to:  
Adam John Mahoney, Tasmania

*This page from left: Court of Primary Examiners; Court of Examiners and Candidates at the last Primary Viva Examination in Hong Kong (2013.2 sitting).*

*Opposite page: Court of Final Exam, May 2014, Melbourne.*





## Final examination March/May 2014

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

### AUSTRALIA

#### Australian Capital Territory

Edward Erle Coxon  
Ross Ingle Hanrahan

#### New South Wales

Andrew Gene Allenby  
Sunshine Austin  
Aman Deep Singh Bamra  
Sarah Rebecca Bowman  
Claire Diana Burrows  
Erin Chamberlen-Sofair  
Sarah Renee Crosby  
Emma Louise Culverston  
Amy Louisa Dickson  
Ryan Gregory Downey  
Paul Andrew Drakeford  
Benjamin Douglas Greenhalgh  
Neil Christopher Greensmith  
Hui-Joo Heng  
Ji Young Heo  
Daniel Hernandez  
Adam Mark Hill  
Karen Ann Hungerford  
Dhivya Kailasapathy  
Nina Kloth  
Benedict Anselm Krupowicz  
Lloyd Edward Kwanten  
Katherine Mary Lanigan  
Lei Lei  
Yuting Liu  
Patrick Antony Mamo  
Philip Sidney McGrath  
Donald Andrew McLachlan  
Simon Christopher McLaughlin  
Robert Charles McMonnies  
Dale Fergus Murphy

Candice Peters  
Khoi Pham  
Natalie Janette Purcell  
Arathi Ajith Rajan  
Nathan Peter Royan  
Lara Rybak  
Alyssa Joan Scurrah  
Alexandra Nadine Simmons  
Nathan Roy Thompson  
Eng Tiong  
Timothy Joseph Weston  
James Zi-Feng Xian  
Tao Yuen Alan Yam

#### Northern Territory

Sorcha Eibhlin Evans

#### Queensland

Saya Aziz  
Andrew Beck  
Matthew John Beech  
Kellie Maree Bird  
Jolyon Jay Bond  
Rodney James Cansdell  
Peter Michael Casey  
Peter Francis Correa  
Joanne Lyn Cummins  
Nellie Dick  
Wai-Mee Foong  
Stephen Fung  
Karl James Gadd  
Jesse Gilson  
Madeleine Hanly  
Peter Michael Kerr  
Nadia Alejandra Kohler Vargas  
Julie Lee  
Phillip Kwan-Giet Lee  
Victor Khi Leong Lee  
Claire Margaret Amy Manning  
Kate Elizabeth McCrossin  
Linh Tien Nguyen  
Clinton John Patricks  
Desiree Vanguardia Perez  
Nathan John Peters  
Jee-Hui Poh  
Daniel James Robertson

Gemma Slykerman  
Lisa May Lin Stanton  
Katherine Anne Steele  
Rajdev Toor  
Lenore Frances Van Der Merwe  
Christian Van Nieuwenhuysen  
Abigail Ngar Yee Wong  
Jacqueline Yung

#### South Australia

Preeti Anand Ananda Krishnan  
Ravi Khan  
James Arthur London  
Martin John Tyson

#### Tasmania

Bibi Fatimah Shedleyah Dhuny  
Elizabeth Hilke Power  
Tin Win

#### Victoria

Joel Thomas Adams  
Omeed Albazzaz  
Vaughan Edward Bertram  
Audrey C-Yuen Bren  
Kelly Victoria Bucca  
Gregory Michael Bulman  
Ying Chen  
Rachel Ann Corris  
Clara Anamaria Cotaru  
Timothy Guy Coulson  
Joanne Ee  
Jacquelyn Maree Evans  
Megan Farrell  
Michelle Yvonne Fehlberg  
Jenny Clare Hewlett  
Craig Murray Ironfield  
Daniel Knox Joyce  
Pungavi Kailainathan  
Debra Weng Sze Leung  
Jin Li  
Adele Grace Macmillan  
Sarah Kate Magarey  
Angela Maree Marsiglio

*(continued next page)*

# Successful candidates (continued)

James Austin McGuire  
Ryan Basil McMullan  
Ailin Mohajeri  
Sangeetha Murthi  
Catherine Laurien Pease  
Amandeep Singh Sarai  
Alireza Shangarffam  
Lalitha Sivagnanam  
Gwendolyn-Mary Stewart  
Thomas Peter Sullivan  
Timothy Zien Tay  
Yoshiaki Uda  
Gordana Ukalovic  
Kacey Nicole Williams  
Noam Benjamin Winter  
Faizan Zia

## Western Australia

Renuka Alakeson  
Daniel Eric Anderson  
Ebrahim Bham  
Emily May Fergie  
Karina Gotjamamos  
Jeremy Ian Milne  
Colm James Quinn  
Samuel Jack Rigg  
Ing-Kye Sim  
Katherine Adele Smither  
Jen Aik Tan  
Nicolaas Edward Charles Patrick  
Velzeboer

## NEW ZEALAND

David John Allen  
Duane Elijah Anderson  
Rochelle Amanda Barron  
Ruth Elizabeth Brown  
Siew Ting Chin  
Kiew-Chai Law  
Helen Agnes Lindsay  
Stuart Michael Millar  
Heidi Joanna Mary Nelson  
Sarah Jane Phipps  
Scott Yu-Chun Wu

## HONG KONG

Lai Tsun Yin  
On-Yat Wong  
Silky Wong

## SINGAPORE

Samuel Kent-Neng Loh  
Say-Yang Ong  
Jong-Chie Claudia Tien  
Jolin Wong

## IMGS examination March/May 2014

Five candidates successfully completed the International Medical Graduate Specialist Exam at this presentation:

## AUSTRALIA

### New South Wales

Rafik Monir Nessim Zakharious

### South Australia

Karthikeyan Chandrasekaran  
Mahdi Panahkhahi  
Daniel Roertgen

### Victoria

David Comyn

### Cecil Gray Prize

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended June 30, 2014, be awarded to:

Gregory Michael Bulman, Victoria

### Merit certificates

Merit certificates were awarded to:

Neil Christopher Greensmith, NSW  
Jolyon Jay Bond, Queensland  
Peter Michael Casey, Queensland  
Kiew-Chai Law, NZ



# Special Interest Group events

## Airway Management Special Interest Group biennial meeting



The Airway Management Special Interest Group (SIG) biennial meeting was held at the Marina Bay Sands Hotel, Singapore from May 2-4. The venue was fantastic, the presentations inspiring, the workshops exceptional and the weather hot.

The theme of the meeting “Preventing airway catastrophes – better prepare and prevent than repair and repent” was carefully drafted by key members of the SIG executive over the past 18 months. It involved plenty of behind the scenes discussions to achieve the optimal balance of international and national experts, while giving younger Fellows of the SIG an opportunity to present. Their hard work was evident from the quality of the conference.

The keynote speakers were Society of Airway Management President Professor Richard Cooper, Dr Michael Seltz Kristensen, the Chair of the European Airway Management Group, and Associate Professor Lauren Berkow from John Hopkins, US. Local speakers included members of the executive, members of the SIG, Canadian Dr David Wong and the Chair of the Singapore Airway SIG, Wendy Teoh.

This gave a truly worldwide perspective on safety in airway management.

The lectures focused on assessment, safety, teamwork, nontechnical skills, cognitive aids, specific airway situations and effective dissemination of airway information. Dr Murray Stokan brought the end of the first day’s lectures to a visually explosive and entertaining finish with serious take-home messages about nitrous oxide and KY jelly. The medical director of the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC), Professor Martin Culwick, gave an Australasian perspective on adverse airway events based on the webAIRS initiative. The closing lecture was an informative update on “can’t intubate, can’t oxygenate” (CICO) by Dr Andrew Heard.

There were 15 concurrent workshops on airway management ranging from neonates to paediatrics to obstetrics, many involving simulation and skills stations.

Our meeting was exceptionally well attended by 250 delegates including the president of the Irish College and former DAS president Dr Ellen O’Sullivan, and president of SHANA, Dr David Healy. The provisional feedback was inspiring.

The conference dinner was held at Raffles and provided a perfect opportunity to mingle and enjoy a Singapore Sling or two. During the dinner, it was my privilege to formally present Dr Chris Acott (accepted by Dr O’Sullivan), Dr Paul Baker and Associate Professor Reny Segal, with an acknowledgement award for their contribution in forming the Airway Management SIG.

The meeting was an outstanding success and I thank the delegates for their attendance, the speakers for their contributions, the workshop faculty for their commitment and the College for purchasing the CICO models. Finally special thanks to Dr Paul Baker, Dr Keith Greenland, Associate Professor Reny Segal and Ms Kirsty O’Connor from the College for their assistance in putting together this great meeting.

I’m already looking forward to the next meeting in 2016 and wish Dr Tish Stefanutto all the best as the incoming chair of the SIG.

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**Dr Pierre Bradley**  
Past chair, Airway Management SIG  
Melbourne

*Above from left: Dr Pierre Bradley, Dr Paul Baker, Dr Michael Kristensen, Dr Hock Tan; Workshop participants; Workshop facilitator Dr David Healy (left) with participants.*

## Obstetric Anaesthesia Special Interest Group meeting



The 2014 Obstetric Anaesthesia Special Interest Group held a meeting, “Expect the unexpected when expecting”, at the Shangri-la in Sydney from March 21-23. It was very well supported with over 250 delegates attending.

The meeting provided a broad-ranging update in obstetric anaesthesia best practice. It began on the Friday afternoon with Dr Roshan Fernando, president of the Obstetric Anaesthetists’ Association in the UK, giving an update on new techniques for running epidurals in labour. Our other international invited speaker, Professor Warwick Ngan Kee, from Hong Kong, gave an excellent recipe for the ideal regional anaesthesia for caesarean section, featuring his unit’s research.

Particularly well received were the talks from non-anaesthetists in the program. These included the role of interventional radiology in managing placental abnormalities by Dr Tim Harrington; the medical management of pre-eclampsia by Dr Mark Brown; and

surviving obstetric sepsis by Dr Tom Solano, who emphasised the importance of a travel history in predicting likely antibiotic resistance. A special mention goes to Dr Fiona Barron, a Darwin anaesthetist, who presented an insightful talk on the issues around caring for indigenous patients.

Six workshops were held on Saturday morning covering skills for anaesthetists in obstetrics, including neonatal resuscitation, ultrasound use and dealing with airway emergencies. The workshops were well attended and, based on feedback, more time will be allocated for workshops in future meetings.

I would like to especially thank Fran Lalor and the team from the College for all their help in making both the meeting and social program a success. Thanks also to Dr Ross Keen for the workshops and all the great speakers and presenters who gave their time and effort.

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**Dr Jane Brown,**  
Chair Obstetric Anaesthesia SIG,  
Sydney

*Above from left: Conference dinner at the Australian Museum. Guests dined in the Dinosaur Gallery among 10 life-sized dinosaur skeletons; Plenary session, Obstetric Anaesthesia SIG meeting.*



# New Zealand news



## New marker added to rate hospital safety

Data on surgical site infections have been added to the quality and safety markers on which district health boards are required to report quarterly. The Health Quality & Safety Commission introduced the markers last year to drive improvement in patient safety. Markers are selected because proven interventions can reduce patient harm in those areas.

In April, Associate Minister of Health Jo Goodhew said that results from the latest quarter showed steady improvements being made in the first four markers, which aim to reduce harm to patients from falls, surgical errors, infections linked to hand hygiene and the insertion of central lines in intensive care units.

Key findings from the quarter included:

- More than half of district health boards are now using all three parts of the World Health Organization's surgical safety checklist in at least 90 per cent of operations.
- Nationally, 90 per cent of older patients have been assessed for their risk of having a fall, and 86 per cent of those have been given an individual care plan to address those risks.

- District health boards have sustained their use of safety procedures for inserting central line catheters, which is estimated to have prevented almost 170 new bloodstream infections and saved more than \$3 million in less than two years.

The results from this and previous quarters can be found on the Health Quality & Safety Commission website ([www.hqsc.govt.nz](http://www.hqsc.govt.nz)).

The quality and safety markers set the following goals:

- 90 per cent of older patients given a falls risk assessment (with 90 per cent of those assessed as at risk of falling given an individualised care plan addressing those risks).
- 90 per cent compliance with procedures for inserting central line catheters.
- 70 per cent compliance with good hand hygiene practice.
- All three parts of the World Health Organization (WHO) surgical safety checklist used in 90 per cent of operations.
- Antibiotic given 0-60 minutes before "knife to skin" in 100 per cent of operations (with the right antibiotic given in the right dose in 95 per cent of operations and appropriate skin preparation in 100 per cent of operations).

## Workforce flow key issue for New Zealand National Committee

The state of the anaesthesia workforce in New Zealand (and in Australia) will be one of the key items on the agenda for the New Zealand National Committee's (NZNC) June 27-28 meeting and at the preceding joint meeting between the NZNC and the Executive of the NZ Society of Anaesthetists.

New Zealand has regularly lost a steady number of new Fellows to Australia but with workforce becoming an issue in Australia, there is potential pressure on the available positions in New Zealand. Other medical specialties are in a similar position and the Council of Medical Colleges (CMC) has taken a lead on this issue. Its March meeting was preceded by a forum focusing on the origins and significance of bulges in New Zealand's medical workforce pipeline.

The council also facilitated a meeting on May 14 with the Director of Health Workforce New Zealand, Graeme Benny, and Health Workforce New Zealand's (HWNZ) Manager, Workforce, Education, Intelligence and Planning Team, Ruth Anderson. That meeting identified the need for colleges to provide further data and information so HWNZ can develop an accurate picture of the current and likely workforce situation so that medical students and pre-vocational doctors can make their career choices accordingly.

## Annual general meeting

ANZCA's annual general meeting for New Zealand Fellows will be held during the Annual Queenstown Update on Anaesthesia (AQUA), which is being held on August 22-23. The AGM is scheduled for the Saturday.

## BWT Ritchie Anaesthesia Scholarship applications

Applications are open for this year's award of the BWT Ritchie Scholarship, which is open to New Zealand-based ANZCA, Faculty of Pain Medicine and College of Intensive Care Medicine trainees. The scholarship helps fund overseas experience during or immediately following the final year of training and, if appropriate, during an extension for one further year, with the proviso that the trainee bring that experience back to New Zealand. The 2014 scholarship is valued at up to \$25,000. Applicants must be nominated and supported by their training departments. The deadline for nominations is October 31, 2014. For further information about the scholarship conditions and how to apply, see the BWT Ritchie section of [www.anaesthesiaeducation.org.nz](http://www.anaesthesiaeducation.org.nz).

## Patients to give feedback on hospitals

From July, patients will have the opportunity to rate their experiences in hospital. District health boards will run a quarterly survey of patients to find out what they think about their most recent stay in hospital. The survey has 20 questions covering issues such as whether patients understood the advice they were given by their doctor, whether they were involved in decisions about their care and treatment, and whether they were treated with respect and dignity by hospital staff. Responses will be collated to give each district health board a rating out of 10 in four areas: co-ordination, partnership, communication, and physical and emotional needs. The Health Quality & Safety Commission has developed the survey to help district health boards make improvements in care. Results from the first survey will be published in October 2014.

## New hospital facilities

A new \$NZ190 million clinical services block at Middlemore Hospital in Auckland was officially opened on April 11. Named after an eminent orthopaedic surgeon, the five-storey Harley Gray Building has 14 new operating theatres replacing 11 older theatres, a 38-cot neonatal care unit, a 42-bed medical assessment unit, a 23-bed post-anaesthetic care unit, a 20-bed theatre admission and discharge unit, and a state-of-the-art central sterile supply department. There also is space to include laboratories and radiology services in the future. The Harley Gray Building's construction is part of a \$NZ209 million project at Counties Manukau District Health Board and was supported by \$100 million of government funding.

The government has signed off the business case for a new 60-bed hospital facility at Greymouth on the west coast. The \$NZ67 million redevelopment plan will see virtually all of the Grey Base Hospital rebuilt. There will be new wards, a bigger maternity unit, four older person rehabilitation cottages, an emergency department, an intensive care unit, three new operating theatres and an integrated family healthcare centre. Site work is expected to begin later this year. Other funding will provide for a new car park opening in 2016, and the development of an inpatient mental health facility to commence in 2017.





# Australian news

## Queensland



### 17th Annual Queensland Registrars Scientific Meeting

This year's meeting was held on Saturday April 5 at ANZCA's Queensland Regional Office in Brisbane. The meeting provides an opportunity to present quality research to peers. All Queensland anaesthetic trainees and Fellows within one year of admission to fellowship were encouraged to attend and showcase their scientific work. The meeting attracted 23 registered delegates, including trainees and active and retired Fellows, who enjoyed a relaxing Saturday filled with interesting lectures.

We would like to thank Dr Shirley Cheung, Queensland's education officer, for attending and supporting our trainees. Many thanks also to our adjudicators Dr Sanjiv Sawhney, Dr Helmut Schoengen and Dr Martin Heck, who meticulously assessed all presentations.

Six presenters delivered high standard speeches. We extend our thanks to: Dr Jeremy Brammer, Dr Dan Lazzari, Dr John Lee, Dr Kate McCrossin, Dr Pierre Kotze, Dr Kris Skeggs.

Congratulations go to our three award winners. Dr Pierre Kotze won the ANZCA Tess Cramond Award for his project "Controlled release oxycodone for post caesarean section pain relief (The CROPP Trial) an open label randomised controlled trial". Dr Daniele Lazzari won the ASA Chairman's Choice Award for his project "Outcome comparison of different anaesthetic techniques for total knee replacement". Dr Kristopher Skeggs won the AXXON Health Award for his project "Tramadol improves emergence in children undergoing ambulatory dental extractions under general anaesthesia".

It is with highest respect that we thank Professor Tess Cramond for attending this meeting once again. Tess is one of the greatest supporters of our young generation of anaesthetists. Tess gave an inspiring, passionate speech encouraging everyone to live up to the highest standards and to contribute to our College's affairs.

Special thanks to the staff of the Queensland Regional Office, who were most supportive ensuring a smooth day. Changes in the revised ANZCA curriculum mean that scientific activities conducted by our trainees will be showcased in a slightly different format next year.

**Dr Kerstin Wyssusek**  
Convenor  
Formal project officer, Qld

### 38th Qld ANZCA/ASA State Conference

The Queensland Combined ANZCA/Australian Society of Anaesthetists Continuing Medical Education Committee is pleased to announce the 38th Qld ANZCA/ASA State Conference will be held on July 19. The theme of the conference is "Go where and do what?!?! – Anaesthesia in the challenging environment".

We are planning a single day meeting, with lecture-style presentations, hypothetical panel discussions with a question and answer format, as well as small group practical sessions. You will learn about work being done by your colleagues in remote, risky locations, have the opportunity to work through similar scenarios in discussion, and to practice emergency response scenarios in hands-on sessions.

We invite all Fellows to consider attending. In previous years numbers were limited so please book early to secure your place.

### Final exams in Brisbane

Final exams were held at ANZCA's Queensland Regional Office in Brisbane in late March with 51 people sitting both the final and clinical exams.



*Clockwise from top left: Dr Pierre Kotze who won the "ANZCA Tess Cramond Award", Professor Tess Cramond, Dr Kerstin Wyssusek Convenor, Dr Dan Lazzari who won the ASA Chairman's Choice award and Dr Kristopher Skeggs who won the AXXON Health Award; Clinical examination taking place in the Brisbane office.*

## South Australia and Northern Territory



## SA and NT Continuing Medical Education meeting

The first combined ANZCA/Australian Society of Anaesthetists Continuing Education Meeting for the year “Anaesthesia for vascular surgery” was held on March 12 at the Women’s and Children’s Hospital in Adelaide. Attendance was outstanding with 104 in attendance as well as being video conferenced to the Northern Territory’s Alice Springs and Royal Darwin hospitals, and the South Australian regional Mount Gambier Hospital. Guest speaker Dr Ivan Ward, a consultant anaesthetist and supervisor of training at Flinders Medical Centre, presented on “Endoluminal vs open aortic aneurysm repair and the anaesthetic implications”. Surgeon Dr Conor Marron, a Fellow of the Royal College of Surgeons of England with vascular interest in the management of vascular disease and trauma, presented on “Endovascular versus open repair for AAA. The evidence and surgical implications”. The cross-specialty presentations received excellent feedback and there was valuable question time and much networking after the event.

*Above from top: SA and NT Continuing Medical Education Committee Chair, Dr Nathan Davis, and guest speaker Dr Ivan Ward, FANZCA; Surgeon Dr Conor Marron was a guest speaker at the event.*

## Tasmania

### Tasmania – Quality learning opportunities

Tasmania will host two innovative workshops in the second half of the year.

The rugged and beautiful Freycinet National Park at Coles Bay will again be the location for the winter continuing medical education workshop on Saturday August 23. Located two and a half hours from Hobart and Launceston, the Freycinet workshops provide an opportunity for quality learning in a unique and stunning part of Tasmania. Participants can fulfill their ANZCA continuing professional development (CPD) requirements by attending an advance life support (ALS) refresher course in the morning. In the afternoon there will be presentations by Dr Vanessa Beavis on the revised ANZCA CPD Program, an update on the latest workforce issues from Dr Richard Grutzner, and Dr Sara Bird will talk on topical medico legal issues such as mandatory reporting obligations under federal law and anaesthetists’ obligations when dealing with impaired colleagues.

The ALS course will include six workstations and will provide opportunities for participants to gain hands-on knowledge and experience. Participants in the ANZCA CPD Program may claim this cardiac arrest course as an emergency response activity in their CPD portfolio.

Demand for this workshop will be high and is restricted to 24 positions. More information and registration is at: [tas.anzca.edu.au/events](http://tas.anzca.edu.au/events)

The second workshop is a first for Tasmania. It comprises a workshop on emergency airway management jointly run by ANZCA, the Australian Society of Anaesthetists and the Laryngology Society of Australasia and will be held on Friday November 7 from 7.30am to 1.30pm at the Medical Sciences Precinct, corner of Campbell and Liverpool Streets, Hobart. The course is designed to provide a practical multidisciplinary approach to the management of difficult airways in both elective and emergency situations.

Including a series of focused lectures and six hands-on workshops hosted by a mix of anaesthetic and otolaryngology consultants, this course will prove useful in daily practice and help fulfill continuing medical education requirements. A unique aspect of this course is the use of cadaveric specimens to help develop practical skills, including:

- Surgical anatomy.
- Video laryngoscopy/direct laryngoscopy.
- Fibre optic intubation/rigid bronchoscopy.
- Managing shared airways and jet ventilation techniques.
- Cricothyrotomy and “can’t intubate, can’t oxygenate” scenarios.
- Tracheostomy in emergency.

Only 30 positions are available. Registration for the workshop is \$450. Registration will soon be available at: [www.laryngology.consec.com.au](http://www.laryngology.consec.com.au)



# Australian news (continued)

## Victoria



### Primary full-time course

The course ran from May 26 until June 6 at the College and was once again very well received. Our numbers were excellent with 60 trainees participating and providing daily evaluations on the lectures and presentations. The course concluded with practice viva sessions and we thank the Fellows and advanced trainees who assisted. We are again indebted to our lecturers for their contribution and participation which go a long way in maintaining the sustainability of this course. In this connection we were pleased to welcome Dr Raja Rengasamy as a new lecturer and thank him for his commitment and support.

**Dr Adam Skinner**  
Convenor

### New members

June 2014 marks the commencement of our new term of office and we welcome our newly elected members, Dr Andrea Bowyer and Dr Garry Reilly, and look forward to their participation in the VRC.

Also joining us for the new term is Dr Benjamin Jones as the new Fellow to VRC. This portfolio provides an opportunity to work within the structure of the committee and to contribute to our aims and objectives.

In February we welcomed Dr Maggie Wong as the incoming education officer for Victoria. The committee is grateful for Dr Wong's acceptance of this portfolio and looks forward to working with her. Assisting Dr Wong will be Dr Damian Castanelli and Dr Andrea Bowyer, who have been appointed deputy education officers with effect from June 2014.

### Retiring members

The Victorian Regional Committee (VRC) held its annual dinner this year on May 26 following a regular meeting. The occasion was used to farewell Professor Kate Leslie, who served on the committee as a member and chair from 1994 to 2002. Professor Leslie continued to serve on our committee until May this year in an ex-officio role as an ANZCA councillor. We pay tribute to her valuable contribution to the VRC and her support for our academic initiatives.

The VRC also congratulates Professor Leslie on being announced the 2014 winner of the Australian Medical Association (AMA) Woman in Medicine Award at the recent AMA National Conference in Canberra.

The start of the year saw the end of Dr Richard Horton's membership on our committee. Dr Horton served on our committee for 10 years and held the role of regional education officer and convenor of our pre-fellowship courses. Dr Horton also was the prime motivator behind the restructured Victorian Anaesthesia Training Scheme, which launched in February 2013. Included in no small way in the success of this new scheme, are the Victorian directors of anaesthesia and the supervisors of training in our local training hospitals. We are extremely grateful to them for their time, effort and dedication in bringing together a viable and applicable training program to advance the speciality of anaesthesia in Victoria.

Dr Andrew Schneider also retired after eight years of service on the VRC. Dr Schneider held the role of honorary treasurer and co-convenor for our quality assurance meetings over the years. We thank him for his valuable contribution and commitment.

To all our retiring members we wish them success in their future endeavours and look forward to their continued support of our academic initiatives.

## Australian Capital Territory

### Quality Assurance Meeting

A quality assurance meeting was held at the College on Saturday March 29. The program was put together by the convenor, Dr David Bramley, assistant continuing medical education officer of the Victorian Regional Committee. The meeting began with lectures at 1pm followed by interactive group discussions until 5.30pm. This format has proven very successful over the years. Registration numbers were excellent and the program was well received by the participants.

We especially thank our lecturers: Dr Gareth Symons, Dr Lahiru Amaratunge, Dr Chong Tan and Dr Andrew Schneider.

Our next quality assurance meeting has been scheduled for October 18 at the College. The registration form and flyer will be available on our website in August.

### Victorian Trainee Committee annual dinner and meeting

The Victorian Trainee Committee held its second meeting for the year on April 24. This was followed by their annual dinner.

The Trainee Committee has representation on the Victorian Regional Committee and the chair uses this forum to update our members on trainees' concerns with the curriculum, workforce and other related issues. The chair, Dr Noam Winter, also sits on the ANZCA Trainee Committee as co-chair.

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**Dr Debra Devonshire**

Chair, Victorian Regional Committee

### ACT registrars workshop

An ACT Registrars Workshop will be held on August 30 in the theatre complex of the Canberra Hospital. The themes of the workshop will centre around crisis management and human factors, particularly focusing on algorithm use, team management, and the process of decision-making. There will be four "stations", each using a mixture of simulation, discussion, teaching, demonstration and reflective learning. This workshop is open to ACT ANZCA trainees; online registration is available at [act.anzca.edu.au/events](http://act.anzca.edu.au/events).

### ACT Regional Committee 2014-16

We warmly welcome the incoming ACT Regional Committee for 2014-16. The members are: Professor Thomas Bruessel, Dr Andrew Hehir, Dr Natalie Marshall, Dr Carmel McInerney, Dr Catherine Muggeridge and Dr Ross Peake. Office bearers will be advised in the next edition of the *ANZCA Bulletin*. We also welcome back our Faculty of Pain Medicine and Australian Society of Anaesthetists co-opted members, Dr Romil Jain and Dr Guy Buchanan respectively.

Two long-serving members of the ACT Regional Committee, Dr Caroline Fahey and Dr Don Lu, are leaving us this year. We thank them for their many years of service on the committee and their continued commitment to the College.

### 2015 Art of Anaesthesia

Planning for the 2015 Art of Anaesthesia meeting is underway. Look out for further details in the near future on the ANZCA ACT website: [www.act.anzca.edu.au](http://www.act.anzca.edu.au).

*Opposite page from left: Lecturer Dr Peter Howe; Attendees at the course.*



# Australian news (continued)

## New South Wales



### NSW supervisor of training meeting

More than 40 supervisors of training from throughout NSW met at the NSW regional office on Friday April 4 for our first supervisor of training meeting of the year. Our business meeting covered topics including training portfolio system entries, a local audit tool for measuring the learning environment that each supervisor of training had distributed in their departments, and lessons learned from the 2013 initial assessment of anaesthetic competence (IAAC) process. The rest of the day was spent in a variety of workshops and presentations. ANZCA staff helped us work through important issues with the training portfolio system and brought us up to date with additions to the system. Dr Michelle Moyle presented an excellent session on the trainee in difficulty process (TDP), and the meeting was given a refresher on workplace-based assessments. We were delighted to meet our NSW scholar role champions, who presented on their experiences thus far. Our plans for the next meeting include more on the TDP process and workplace-based assessments.

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**Dr Natalie Smith**  
Education Officer NSW

*Above: More than 40 enthusiastic supervisors of training crowded into the NSW Regional office on April 4.*

## Western Australia



### Autumn meeting

The ANZCA/Australian Society of Anaesthetists (ASA) Autumn Scientific Meeting was held on March 15 with the topic “Anaesthesia for bariatric patients”. The meeting delivered an insight into the experience of an anaesthetist caring for a bariatric patient and acknowledged that providing care to these patients is often challenging.

The conference was convened by Dr Lip Yang and included presentations by Professor Jeffrey Hamdorf, Dr Greg Lumsden and Dr Leon Cohen. Dr Lindy Roberts and Dr Richard Grutzner presented updates from ANZCA and ASA respectively. The meeting attracted 185 participants and we thank them for their attendance and support.

The Western Australian Regional Committee met on April 1. Dr Alison Corbett (chair), Dr Jodi Graham (education officer) and Dr Lindy Roberts (president) are stepping down from their roles on the committee though will continue to attend as members. We thank them and all committee members for their continued attendance and support.

The ASA Committee met on April 7. Education Officer/ Supervisor of Training Committee and the Faculty of Pain Medicine Committee met on May 1. If you have interest in joining one of these committees please contact the WA office on +61 8 6188 4555.

On April 15, Dr Lindy Roberts presented to WA Fellows on “Regulation, revalidation and CPD – our professions’ approach and meeting the new standard” at the WA office. We thank Lindy for presenting to the Fellows and answering queries on this topic.

Dr Richard Riley presented to the Part II tutorial group on airway issues on May 21. These tutorials are held weekly to assist trainees who wish to sit their exams. If you would like to attend these tutorials please contact the WA office.

The Winter Scientific Meeting will be held on July 26 at the University of Western Australia. Dr Michela Salvadore is convening the meeting, which has a topic “Updates on all things respiratory”. The Country Meeting is planned for October 17-19 at the Pullman Resort Bunker Bay. Dr Silke Brinkmann and Dr Twain Russell are convening this meeting with the topic “Crisis management”. Advanced life support and CICO workshops will be available at this meeting.

*Above from left: Autumn Scientific Meeting;  
CPD talk by Dr Lindy Roberts; WARC Committee.*



# Dr Sally Drew 1936 – 2014



Sally Elizabeth Drew was born in Adelaide in 1936, and spent most of her school years at Woodlands Church of England Girls Grammar School, where she studied English, Latin, Maths, Chemistry and Physiology.

Sally went on to study medicine at the University of Adelaide, and was awarded a Commonwealth Scholarship to support her studies in 1959-60. She specialised in anaesthesia, gaining her fellowship in 1968.

Sally joined the anaesthesia department at the Royal Adelaide Hospital later becoming an assistant director.

With the opening of the new Modbury Hospital in north-eastern Adelaide in 1973, Sally began to split her time between both, but returned full-time to Royal Adelaide in 1976 and was appointed the Director of Administration within the Department.

When the head of department, Dr Maurice Sando, retired in 1982, Sally refused an offer to be appointed the Senior Director, as she and others, including Professor Derek Frewin, were working towards a Chair in Anaesthesia and Intensive Care in the University of Adelaide. The hospital and the university initially resisted, but after lengthy negotiations Sally accepted the position of acting Senior Director on condition that the Department pursue the establishment of a Chair.

Professor Bill Runciman was appointed the Maurice Sando Professor of Anaesthesia and Intensive Care, University of Adelaide, in 1988.

Sally's unselfishness was a major benefit to the development of anaesthesia and intensive care at the Royal Adelaide and University of Adelaide and she continued in her position as the Director of Administration until her retirement in 1997.

Her significant contribution to anaesthesia was recognised in 2003 when she was awarded the ANZCA Medal at the Perth annual scientific meeting for her services to anaesthesia.

In her late 60s, Sally's memory began to fail and she was admitted to residential care 10 years later. Sally died on March 31, aged 77.

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**Professor John Russell and  
Sarah Constantine, Dr Drew's niece**