

ANZCA BULLETIN



FPM
FACULTY OF PAIN MEDICINE
ANZCA

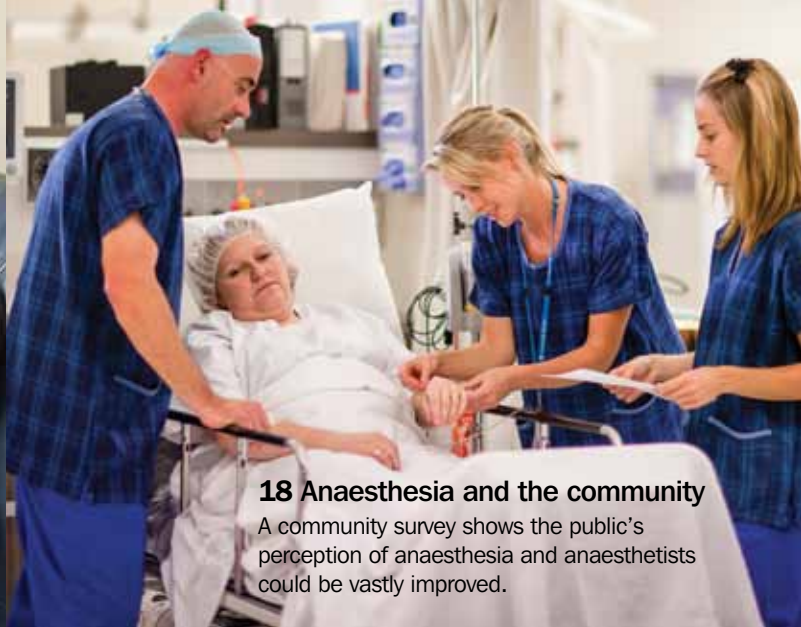


► **OUR
INDIGENOUS
HEALTH
CHALLENGE:
ANZCA'S
COMMITMENT
TO CLOSING
THE GAP**

**NATIONAL
ANAESTHESIA DAY:
SURVEY SHOWS
NEED FOR
EDUCATION**

**ZOO ANAESTHETIST:
THE FASCINATING
"OTHER" JOB OF
A MELBOURNE
FELLOW**

**ADVANCING CPD:
HOW OUR REVISED
CPD PROGRAM
AFFECTS YOU**



24 ANZCA's indigenous health challenge

The College and its Fellows are working at trying to alleviate the many health problems faced by indigenous communities.

18 Anaesthesia and the community

A community survey shows the public's perception of anaesthesia and anaesthetists could be vastly improved.

8 CPD revision continues apace

Anaesthetists and specialist pain medicine physicians can now see how the revised program will work and how it will affect them.



ANZCA Bulletin



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

Cover: Bathurst Island's Annie Clement, with 12 month old Lazenzo, being treated at the Royal Darwin Hospital by Dr Brian Spain.

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

Advertising inquiries

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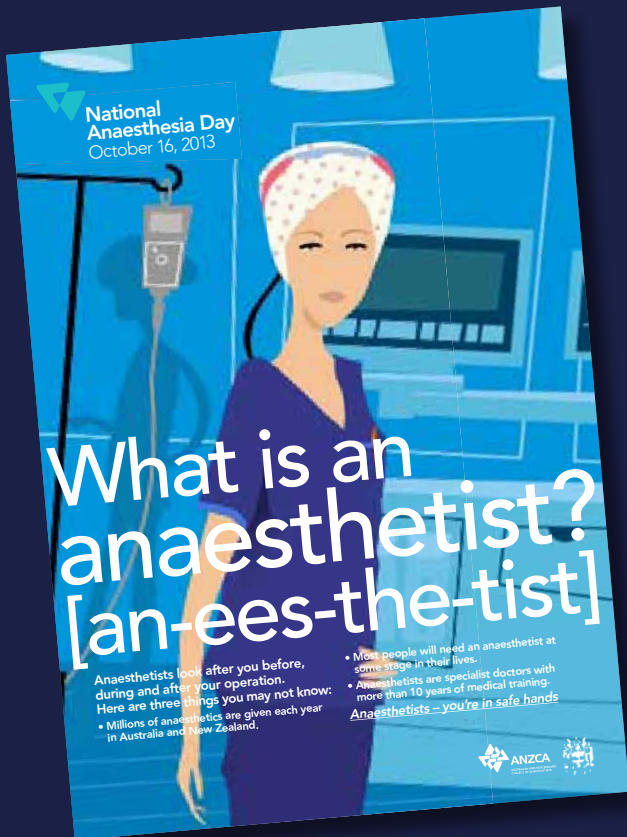
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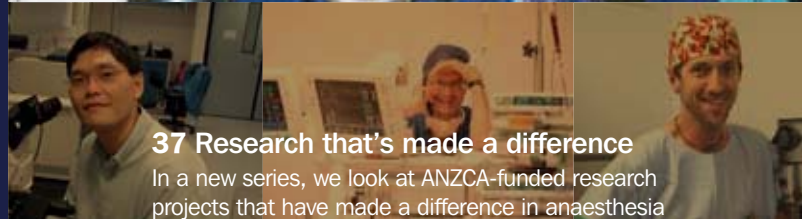
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Hospitals will be sent a National Anaesthesia Day kit in early October so they can participate in National Anaesthesia Day on October 16. Get involved!



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For nearly four decades Dr Kevin Moriarty worked at Melbourne Zoo helping the vets treat orangutans, gorillas, giraffes and many other animals.



37 Research that's made a difference

In a new series, we look at ANZCA-funded research projects that have made a difference in anaesthesia and pain medicine.



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President's message



Dr Lindy Roberts
President, ANZCA

I am sometimes asked about what it means to be a Fellow of ANZCA and FPM, especially “What do I get for my fees?” or even “Why should I remain a member?” While some of the benefits of fellowship are profession-wide, many are of direct relevance to each Fellow’s practice, helping us all keep up to date and reflecting our professional standing in the wider community.

FANZCA and FPPMANZCA – denoting specialists of the highest standard

The post-nominals “FANZCA” and “FPPMANZCA” indicate fellowship of ANZCA and FPM and can only be used by current members. These letters are immediately recognised as a mark of quality, signifying a specialist of the highest professional standing. The College has developed logos for professional use by Fellows – on business cards, letterhead, emails and presentations – the FANZCA logo can be accessed at www.anzca.edu.au/fellows and the FPPMANZCA logo at www.fpm.anzca.edu.au/fellows.

Revised CPD program in 2014

Our College has been tasked by the Medical Board of Australia (MBA) and the Medical Council of New Zealand (MCNZ) to set the standard for continuing professional development (CPD) for all specialist anaesthetists and specialist pain medicine physicians in both countries – something we take very seriously. A team of ANZCA Fellows and staff, led by CPD Committee Chair, Dr Vanessa Beavis, is working hard to develop a revised CPD standard and program that:

- Focuses on safe patient care.
- Has strong Fellow input to meet Fellows’ needs and ensure it is achievable.
- Delivers a state-of-the-art portfolio system, accessible on any device and streamlined by automatic recording (for example, conference attendance, trainee workplace-based assessments and online module completion).
- Is a step ahead of future developments in reaccreditation, broached by the MBA and already part of MCNZ requirements.

CPD participants will be individually transferred to the system later this year with personalised instructions, generous credits and a simple-to-use handbook.

More about the Advancing CPD Project can be found on page 8.

Outstanding conferences, easy to register via your individual ANZCA portal

Every year the College, with significant input from its Fellows and trainees, organises some 80 continuing medical education events in Australia and New Zealand, some with our sister societies, the ASA and NZSA. These events include the annual scientific meeting which in 2014 will be combined with the Royal Australasian College of Surgeons in Singapore; the FPM Refresher Course Day and spring meeting; many tripartite special interest group meetings; the New Fellows Conference (nurturing future leaders); as well as regional and national events.

Each Fellow and trainee now has a customised web portal (accessed through the My ANZCA link after logging in) on the ANZCA website. Online event registration allows you to book for events. In 2014, these bookings will automatically upload to your new CPD portfolio. Your portal will be progressively developed as a single point for making the most of all College services.

Strong advocacy

Your College is maintaining and strengthening its voice at regional and national levels in both Australian and New Zealand, especially important during this Australian election year. ANZCA’s Policy unit is a highly skilled multidisciplinary team that liaises with government and other decision-makers through policy submissions, external representation and advocacy (see their regular report on page 14).

Important current issues for our profession include:

- **Workforce.** Results of the first ANZCA graduate outcome survey are about to be analysed (see report page 13). The College is addressing workforce issues through co-ordinated policy initiatives such as the proposed (Australian) National Medical Training Advisory Network and through direct representation with governments.
- **Workforce reform and expanded scopes of practice** remains topical in both countries. The College remains engaged in these and many other issues through submissions and via numerous Fellow representatives on external bodies (www.anzca.edu.au/about-anzca/Committees/representatives.html).

- The proposed \$2000 cap on self-education expenses (Australia). The College has opposed this ill-devised policy that is at odds with compulsory CPD and will disproportionately affect trainees, and those in rural and remote areas. Implementation has been delayed to July 1, 2015. The College will continue to voice our opposition at the highest levels.

Informing the community about anaesthesia and pain medicine

Our College has a major role in educating the community about what we do, as well as in handling queries and complaints from patients and providing information (www.anzca.edu.au/patients).

The recent community survey (page 18) found that, despite the vast majority having personal experience of general anaesthesia:

- Only half were aware that all anaesthetists are doctors, nearly one in 10 thought anaesthetists weren't doctors and the rest were uncertain.
- Half didn't feel well informed about anaesthesia and many had concerns about risks.
- Most importantly, confidence in anaesthesia and anaesthetists increased when information about our training was provided.

Clearly there is more work to be done and ANZCA has a media strategy focused on educating the community about our work – via media releases and interviews that promote positive stories about anaesthesia and pain medicine.

As part of this strategy, on October 16, we are re-launching National Anaesthesia Day (see page 22). The Communications unit is co-ordinating a media campaign to promote anaesthesia and I encourage you to also get involved – by displaying posters (to be mailed out in early October) or perhaps by setting up displays in your rooms or hospital, for example, in the pre-admission clinic. If you need assistance, please contact communications@anzca.edu.au.

Keeping Fellows and trainees up-to-date

The College keeps Fellows and trainees informed via:

- The ANZCA website (www.anzca.edu.au) with front page links dedicated to forthcoming conferences; safety alerts; your CPD portfolio; the library; the training portfolio system.

- Latest news, including job advertisements, on twitter (@ANZCA).
- The quarterly *ANZCA Bulletin*, accessible online as a “flip book” and accompanied by *College Conversations*, on CD or on the website (www.anzca.edu.au/communications/anzca-bulletin/bulletin-release-2013).
- General e-newsletters and those dedicated to groups (*Training E-Newsletter*, *Synapse*) and events (*ASM E-Newsletter*).
- Publications such as *Acute pain management: scientific evidence* (next edition 2015) and *Australasian Anaesthesia* (due later in 2013).

Ensuring safe and high quality care

Resources and services enable Fellows and trainees to provide safe and high quality care.

- ANZCA and FPM professional documents set the standards for practice.
- Regular safety alerts on the website, in the e-newsletter and the *Bulletin* ensure you are notified as soon as we know about any issues (recent examples include Voluven and the coronial findings on the beach chair position). We are developing an index system for safety alerts, to facilitate easy referencing.
- Critical incident reporting via WebAIRS (www.anztadc.net) overseen by the Australian and New Zealand Tripartite Anaesthetic Data Committee project (with the ASA and the NZSA).

Training the next generation of specialist anaesthetists and pain medicine specialists

I appreciate the invaluable contributions that Fellows have made to the revised training program, and the changes experienced by trainees and Fellows.

I hope you have noticed alterations made in response to your feedback about the training portfolio system (TPS) to improve the way it functions. Further improvements are planned.

The ANZCA curriculum document has just been updated. Ongoing evaluation will ensure it continues to evolve with changes in our practice to remain relevant and contemporary.

The FPM curriculum redesign is well under way and I thank the many Fellows and trainees who are providing input.

The ANZCA Library and other educational resources

The College is developing:

- A growing list of podcasts and courses on clinical, professional and educational topics (www.anzca.edu.au/resources/learning).
- The popular ANZCA Library (www.anzca.edu.au/resources/library) – books (hard copy and online), online journals and assistance with literature searches.

Research – providing the evidence that supports clinical decision-making

The College supports research that fundamentally impacts upon our day-to-day clinical practice.

- Growing research funds means that next year more projects can be funded by the Anaesthesia and Pain Medicine Foundation (see page 37).
- The breadth of College-funded activities includes large multicentre trials, pilot grants, survey research, and support for up-and-coming researchers through novice investigator grants and the Gilbert Brown Prize.

So why should you value being a member of the College and the Faculty?

Quite simply, because the services of the College support your individual practice as well as providing a strong voice and presence that promotes our professional issues in the wider community, with government and in collaboration with other organisations.

United, we can be effective in maintaining high standards of clinical care and ensuring that every Fellow and trainee is supported. We are continually working to improve services for all Fellows and trainees.

You can rightly be proud of your College. I welcome your feedback at president@anzca.edu.au.

Chief executive officer's message



Ms Linda Sorrell
Chief Executive Officer, ANZCA

The history of anaesthesia and pain medicine is important to ANZCA and I am pleased to report on several initiatives that relate to this key part of the College's make-up.

The College has a large collection of valuable portraits, paintings, furniture, silver, antiques, anaesthetic equipment and paraphernalia, books, archives, documents and oral histories, most of which require specialised care and storage.

Recently ANZCA Council approved the establishment of the History and Heritage Expert Reference Panel to oversee this valuable collection. Reporting to me, the panel will consist of three ANZCA/FPM Fellows and/or trainees, two external museum/archives/collections experts and the College's honorary curator and honorary archivist supported by ANZCA staff. If you are interested in joining this panel, please see the advertisement to the right.

It will advise on the management of tangible and intangible assets of the College and Faculty that have heritage or historical value; aspects of history and practice relating to anaesthesia and pain medicine, advise on topical issues suitable for exhibitions, *Bulletin* articles, oral histories and other tangible demonstrations of history; appropriate and relevant promotional activities regarding the history and heritage of the College; current, new and emerging trends in the area of collections, museum and archives practice.

The recording of history is also important and two Fellows have made important contributions to the history of anaesthesia and intensive care medicine through the authoring of two important books.

Tasmanian-based Fellow, Dr John Paull, is an aficionado on the life of Dr William Russ Pugh, an Australian pioneer of anaesthesia, and has written *Not Just an Anaesthetist: The Remarkable Life of Dr William Russ Pugh*. On June 7, 1847 in Launceston, Dr Pugh became the first medical practitioner to successfully administer ether for surgery.

Former ANZCA president, Professor Garry Phillips, has written *Intensive Care Medicine in Australia: Its origins and development* which is due for publication later this year. Professor Phillips outlines the development of intensive care medicine in Australia to 1992, with an epilogue overviewing key events until 2010 when the College of Intensive Care

Medicine of Australia and New Zealand was established.

Written histories are, of course, important but so too are oral histories and the College is delighted to release three more interviews in our web-based "Anaesthesia stories" series.

The first of these new audio-visual interviews is with Dr Patricia Mackay, who has made an outstanding contribution to the Australian community for more than 50 years with her work in the field of patient safety in anaesthesia.

The next is with Professor Ross Holland, who has been a member of the Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) since its inception, and was largely responsible for its establishment.

Also interviewed has been Professor Bill Runciman who has made fundamental contributions to patient safety and quality research both in Australia and internationally, and has been involved in the publication of over 200 scientific papers and chapters.

Many thanks to Honorary Curator, Dr Christine Ball, who did the interviews and has written about them on page 67 of this edition of the *Bulletin*.

These latest three interviews add to ones already done with Professor Tess Cramond, Dr Duncan Campbell and Dr Nerida Dilworth.

Professor Cramond is recognised internationally for her contribution to the field of anaesthesia and pain medicine. She established the Multidisciplinary Pain Clinic at the Royal Brisbane Hospital in 1967 and was the director there for 42 years. Dr Campbell invented the Campbell ventilator in 1973, a ventilator that became extremely popular in Australia and New Zealand. In 2011, he was awarded the Robert Orton Medal for his contribution to anaesthesia. Dr Dilworth has devoted her career to establishing outstanding paediatric anaesthesia in Western Australia, ensuring the reputation of Princess Margaret Hospital as a leading children's hospital. She has been a tireless contributor to the College and has received many awards including the Member of the Order of Australia.

They can all be found at www.anzca.edu.au/about-anzca/anaesthesia-stories.

Safer anaesthesia the legacy of three retiring professors



Professor Ross Holland



Professor Barry Baker



Professor John Hilton

Three trailblazers whose work in anaesthesia safety on the Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) in NSW have retired.

The NSW Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) would like to acknowledge the retirement of Professor Ross Holland, Professor Arthur (Barry) Baker and Professor John Hilton and honour their great achievements in improving anaesthesia patient safety in Australia.

Professor Holland and colleague Professor Douglas Joseph were instrumental in founding the committee in 1960 and it is now the longest running committee of its type in the world. At a time when the estimated anaesthetic related mortality was 1:3500¹, the committee was formed to review deaths occurring due to, during or within 24 hours of anaesthesia. This was one of the first large multicentre quality assurance studies in medicine, let alone anaesthesia. This outstanding achievement led to the formation of various state anaesthesia mortality review committees, and the committee's findings have received international recognition.

Early reports from the committee illuminated the high number of preventable anaesthetic deaths in children, young women and the elderly², and measures to prevent aspiration deaths³. Later, reports encouraged the use of vasopressors to treat hypotension rather than continued fluid loading⁴ in hip fracture surgery, and the committee highlighted fatal cardiovascular collapse with propofol in high risk patients⁵.

Professor Holland served as medical secretary and chairman for a significant period of the committee's existence. His vision and energy for the committee has been unmatched and he will leave a lasting legacy on patient safety in Australia. In 1992 he received the Orton Medal for distinguished services to anaesthesia and in 2006 the Gold Medal of the Australian Council on Health Care Standards.

Professor Baker has served as a committee member since 1997. His long service to anaesthesia, intensive care, research and medical education in both Australia and New Zealand have proved a valuable resource. His honours include the Orton Medal in 1994 and the Douglas Joseph Professorship in 1997.

Professor Hilton has had a distinguished career in Australia and internationally as a forensic pathologist. He had been an advisor to the Anaesthesia Mortality Committee in Western Australia before taking a position on the NSW committee, and more recently has been a member of the NSW Collaborating Hospitals Audit of Surgical Mortality. His professional expertise has been invaluable to the committee when considering complex autopsy findings.

Professor Holland, Professor Baker and Professor Hilton have dedicated themselves over significant periods of time to reviewing patient deaths in NSW and the committee could not function without people like these.

Dr David Pickford, FANZCA
Chair of SCIDUA, NSW

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1. Clifton BS, Hotten WIT. Deaths associated with anaesthesia. Br J Anaesth 1963;35:250-9
2. Interim report of the special committee appointed to investigate deaths due to anaesthesia in New South Wales. MJA, Oct 13, 1962
3. Holland R. Prevention of anaesthetic deaths due to inhalation of vomitus. MJA, May 11, 1963
4. Holland R. Special Communication: Trends recognised in cases reported to the New South Wales Committee Investigating Deaths Under anaesthesia. Anaesth Intens Care 1987;15:97-98
5. Warden JC, Pickford DR. Special Communication: Fatal cardiovascular collapse following propofol induction in high risk patients and dilemmas in the selection of a short acting agent. Anaesth Intens Care 1995;23:485-487

ANZCA and FPM in the news



Quit before surgery

Doctors will offer help to smokers to minimise risks



GRANT McARTHUR

SMOKERS will be asked to quit before undergoing surgery and be referred for help while on waiting lists under new medical guidelines.

A strengthened smoking policy from the Australian and New Zealand College of Anaesthetists will require all elective surgery patients to be asked if they smoke, and for tobacco users to be given referrals to help them quit before their operations.

The policy will not give

practitioners the power to delay or cancel surgery.

But ANZCA president Dr Lindy Roberts said the guidelines would offer smokers the best chance to avoid life-threatening complications by providing them with support. The hope is to convince and help smokers to quit four to six weeks before surgery, while they are already on the waiting list.

"Smokers are at greater risk of complications such as pneumonia, heart attacks and wound infections," Dr Roberts said.

"When you are coming into hospital for something like an operation it does provide you with an opportunity to think

about your health more generally, and the benefits of giving up smoking for your health are in the longer term as well as relating to surgery and anaesthesia.

"It may be that when presented with the risks for a certain procedure that the surgery is delayed to allow somebody to improve their health prior to the surgery.

"A decision may be made between the anaesthetist, the surgeon and the patient to delay the surgery if there is something that can be improved to make them fitter."

The proposed ANZCA policy will ask Australian anaesthetists to undertake a three-step process with smokers by asking them to quit, then

advising them of the increased dangers, and finally referring them for support.

The move follows the success of a program at Frankston Hospital in Melbourne, in which all smokers entering the surgery waiting list were sent a quit pack, prompting 13 per cent to act.

Australian Medical Association Victorian president Dr Stephen Parnis said the college's stance was a positive move.

He said doctors already encouraged patients to delay or cancel surgery in cases where their lifestyles created extreme risks, though the process was difficult.

PAGE 21: Valdman

Media reports quoting ANZCA and FPM Fellows and policies have reached a combined cumulative audience of close to 11 million people.

Strongly boosting media coverage was the widespread interest in ANZCA's revised guidelines on smoking before surgery, which gained broad coverage across radio, television, print and online media.

The Communications unit prepared and distributed seven media releases and ANZCA and FPM Fellows were asked to give their expert opinion on topics ranging from obesity and the problems it presents in anaesthesia to the search for understanding the trigger for pre-eclampsia in pregnancy.

In all, Fellows gave more than 15 interviews. The Communications unit would like to thank all Fellows who support our work in promoting the work of the College, FPM and meetings.

Since June this year ANZCA has generated more than 80 media reports. They include:

- 16 print stories.
- 25 online stories.
- 36 radio reports.
- 4 television reports.

Media releases distributed by the ANZCA media team since June:

- Improving chronic pain in children and adults (August 20).
- Chronic pain major cause of health loss (August 9).
- Rare pig may solve the puzzle of Parkinson's (July 18).
- Cruel disease of pregnancy examined at meeting of specialists (July 15).
- New chair for ANZCA's New Zealand National Committee (July 11).
- How to save a life: doctors hear (June 28).
- Tools of the trade: are new technologies "dumbing down" the anaesthetist? (June 18).

Ebru Yaman
Media Manager, ANZCA

ANZCA and government: building relationships

Australia

A new federal government

Australia has a new federal coalition government. At the time of writing, it is likely that the election of the Abbott government will bring fresh challenges to the health portfolio, but it is not clear what the coalition's policy details are given that health was not a major election issue.

As a previous health minister under the Howard government, Tony Abbott as prime minister brings some knowledge of the health system and has not made any major policy announcements to date other than eliminating waste and ensuring front line services are the priority. Deep cuts to the health bureaucracy under new health minister Peter Dutton are envisioned over time; it is not clear what effect this will have on Health Workforce Australia.

The ever-increasing costs of healthcare and access issues will continue to provide challenges; much elective surgery has now moved into the private sector with public hospitals shouldering the burden of more complex medical admissions. The Policy unit will continue to monitor developments and their impact on the college, profession and community.

Engaging with government

Reform to deductions for education expenses

The government's recent announcement that they would institute a \$2000 cap on work-related educational expense

deductions from July 1, 2014 was met with significant opposition from Australian medical practitioners as well as a number of other professional groups. In response to stakeholder concern, the government has announced it will defer the introduction of the cap until July 1, 2015. The deferral will allow time for further consultation on how best to target excessive claims while ensuring the impact on postgraduate and continuing professional development is minimised.

ANZCA contributed a detailed submission, the focus of which was that the Australian Treasury's mechanism for limiting perceived abuse of deductions on educational expenses was hastily conceived and overly punitive to those pursuing continuing professional development, research and postgraduate study. ANZCA committees, councillors and individual Fellows and trainees all contributed to the submission. In its current form the cap would impact negatively on rural practitioners who find it most difficult to access continuing professional development activities. It is the College's position that deductions provide recognition of the ongoing effort undertaken by ANZCA Fellows and trainees in pursuit of providing quality care to Australians. The College continues to engage with the Australian Treasury in regards to the proposed reform deductions for education expenses.

Medical Training Review Panel

The Medical Training Review Panel (MTRP) was established in 1996 to provide data to the federal minister of health and ageing on medical training opportunities in Australia. ANZCA is represented on the MTRP advisory committee. Each August the College provides relevant data on the ANZCA and FPM training programs that are published in the report under Vocational Medical Training. The MTRP report is published after approval by the minister. Reports are available online from: www.health.gov.au/internet/main/publishing.nsf/Content/work-pubs-mtrp

Policy development

Apart from the ongoing work of reviewing the professional documents, as described in another section of the *Bulletin*, the Policy unit is co-ordinating and supporting two working groups. Work has begun on a dedicated anaesthetic competence and performance guide, modelled on a similar guide produced by the Royal Australasian College of Surgeons. A second group has been formed to advise the ANZCA Council about whether or not it should give in principle approval for the development of a certificate of medical perfusion, final approval contingent upon the establishment of an acceptable business case.

Workforce issues

Anaesthesia workforce issues continue to be at the forefront of consideration by ANZCA, particularly in Australia, where there is evidence of oversupply of graduates and issues with placement of trainees.

ANZCA Council recently agreed to recommendations that include enhanced advocacy and improved collaboration and relationship building with key government agencies, other stakeholders and regional offices, obtaining better data



through the recent Graduate Outcomes Survey, and improved communication of key messages, facts and data to trainees and Fellows, as further detailed below:

- Continuing to work with Health Workforce Australia and monitor the development of the National Medical Training Advisory Network and its impact on Fellows and trainees.
- ANZCA regional/national committees continuing to work with health departments and health services at a local level and collaborate to ensure optimal outcomes for training and employment, within their respective roles.
- Information from the newly implemented ANZCA Graduate Outcomes Survey is used in future planning initiatives by ANZCA and to inform policy submissions and advocacy with key stakeholders.
- ANZCA advocates for and looks for opportunities to strengthen workforce opportunities for members.
- ANZCA maintains a watch on the anaesthesia workforce in New Zealand, and continues to liaise with Health Workforce New Zealand and the New Zealand Society of Anaesthetists on workforce issues.

Further work is being undertaken by the Policy unit to lead a comprehensive strategy to tackle the above issues in a strategic and co-ordinated way using ANZCA senior management and councillors.

Submissions

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

- Australian Health Practitioner Regulation Authority on guidelines for advertising/social media/ mandatory notifications.
- Medical Board of Australia on the “specialist pathway – short term training”.
- AusAID on the Australia-Indonesia Maternal & Newborn Health and Nutrition Program.
- Australian Treasury on the reform to deductions for education expenses.
- Australian Medical Council on the AMC RANZCOG accreditation.
- Health Workforce Australia on the Rural Generalist Draft National Framework.
- Health Workforce Australia on orientation and supervision programs for international medical graduates.

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.

Australian Government grants Specialist Training Program

The outcome of the 2014 Specialist Training Program (STP) application round has been finalised and will be announced by the minister in due course. Applicants whose posts were assessed as suitable for funding have been notified and the College will work with those sites to negotiate funding agreements.

The evaluation of STP has moved into the consultation phase. A sample of STP sites have been interviewed about their STP experience and surveys will be disseminated shortly to Fellows and trainees involved in the program to examine funding, barriers to service and other aspects of the initiative.

Training more specialist doctors in Tasmania

ANZCA has secured a grant through the Australian Government Department of Health and Ageing for the “Training More Specialist Doctors in Tasmania” initiative. The grant will provide a total of \$6 million over three years (to the end of 2016). All funds will be directed to Tasmanian hospitals to support approved specialist fellowship training, undertaken and completed in Tasmania, and to support the training and retention of specialist doctors in the Tasmanian public health system.

ANZCA will manage the associated contracts for training posts, supervisory positions and training coordinator roles for anaesthesia, pain medicine and intensive care.

For further information about STP, including the above Tasmanian initiative, contact Donna Fahie on +61 3 9093 4953 or stp@anzca.edu.au.

ANZCA and government: building relationships continued

New Zealand

The New Zealand National Committee (NZNC) has made a number of submissions during 2013, including comments on PHARMAC's new role in the procurement and management of medical devices. NZNC has put forward the anaesthesia perspective on providing PHARMAC with clinical input into how medical devices are managed, and on how PHARMAC's decision-making criteria might be applied to funding of medical devices. PHARMAC will use a gradual process of implementation, assuming management of most devices by mid-2015 and full management by 2018.

NZNC has also made submissions on:

- The development of a skills and knowledge framework and an education pathway for registered nurses working as assistants for the anaesthetists, to the Perioperative Nurses College (two rounds of consultation).
- Proposals for specialist nurse prescribing.
- Recognition of addiction medicines as a scope of practice in New Zealand, made to the Medical Council of New Zealand.
- Proposals for sole supply of selected medicines, to PHARMAC.
- Hospital use of sugammadex, methoxyflurane, COX-2 inhibitors and gabapentin, to PHARMAC.

Dr Geoff Long represented NZNC at the most recent meeting of the Council of Medical Colleges (CMC), at which Professor Des Gorman, Chair of Health Workforce New Zealand, spoke about the challenges facing the health workforce in New Zealand, including impending nursing workforce shortages, and the potential return of a number of New Zealand-born doctors who had trained in Australia and cannot find jobs after graduation.

The medical council is continuing with the implementation of the audit of medical practice, compulsory for all doctors in New Zealand. ANZCA is working with MCNZ to ensure the revised continuing professional development framework is consistent with the revised audit requirements.

Dr Nigel Roberston, Chair of NZNC, and Dr Kieran Davies, Chair of the FPM NZNC, have both had productive meetings with the Chief Medical Officer of the Ministry of Health, Dr Don Mackie. The NZNC looks forward to continuing open, constructive dialogue with the ministry.

In wider sector news, the Director-General of the Ministry of Health, Kevin Woods, will step down in early 2014.

John Biviano,
General Manager, Policy, ANZCA



What would you do?



ANZCA's professional documents are aimed at assisting Fellows and trainees to provide a high standard of care to their patients. This is part of a series of articles by Dr Peter Roessler, ANZCA's Director of Professional Affairs (Professional Documents) which explain aspects of ANZCA's professional documents in practical terms.

When a patient complains

After completing your usual busy day and providing your normal high quality service, including dealing with a couple of challenging patients, you go home feeling tired but content (and celebrate with a glass of nice red).

Five days later you are notified that one of the patients from that day is extremely dissatisfied and unhappy with the anaesthetic. You are accused of being incompetent, cursory, arrogant and uncaring, and that you do not warrant the fee that you have charged. The patient is incensed and sends copies of their letter to the hospital, surgeon, and the College seeking action be taken.

Given the number of patient contacts that we as perioperative physicians have, the incidence of complaints is relatively low; however, the number of occasions where complaints arise is not insignificant.

There tends to be a common theme where patient expectations are not

explored and so their expectations are unwittingly breached. Time pressure appears to be a contributing factor, limiting the time allocated to those patients who require it and, more importantly, feel they warrant it. Personality conflicts and a failure to relate to or engage with the patient also are common.

What to do?

Attempts to dismiss the complaint as unfounded may inflame the matter. There are two potential consequences to consider should the patient's complaint be escalated either legally or through the Health Complaints Commission (HCC), as there may be competing interests between hospital insurers and the practitioner. Patients seeking medico-legal recourse pose a financial risk, for which indemnifiers/insurers take control, whereas complaints via the HCC may impact on ability to practise (Australian Health Practitioner Regulation Agency) in which case the practitioner retains control. For example,

the advice from the hospital/insurer (if they have been joined in the action) may be to avoid all communication with the patient, whereas direct communication at the earliest stage may have resulted in appeasing the patient and defusing the matter. It is important to seek appropriate advice at the time and from the relevant resource.

Communication is firmly established as an ANZCA role in the 2013 revised curriculum. The above types of problems underscore the importance of communication skills, particularly from the outset when making initial contact with the patient, and throughout the patient's journey. As anaesthetists, we need to be constantly mindful of this as we strive for optimal patient outcomes.

Dr Peter Roessler

ANZCA Director of Professional Affairs
(Professional Documents)

Survey reveals fears and frailties

Concerns about undergoing anaesthetic

PARTICIPANTS WERE ASKED IF THEY WOULD HAVE ANY CONCERNS ABOUT UNDERGOING ANAESTHESIA OR SEDATION. THE FOLLOWING RESPONSES WERE RECEIVED FROM THOSE WHO SAID "YES".

"Not waking up. What happens to you while you are under."

"Just generally being unaware of what is occurring during a procedure... As well as the fear of not being properly sedated and waking up too early."

"That they will give me too much or not enough. My mum woke up during an operation on general anaesthetic."

"Not waking up. I know the risks are small, but they are still there."

"That although I am paralysed, I may still feel what is happening in the surgery and would not be able to alert the doctors that I was actually awake. Afraid of death while in surgery. Afraid of doctors not properly monitoring anaesthesia levels while I am in surgery."

"Safety fears and whether it's done by someone with expertise."

"The professionalism of those who take responsibility for me while under sedation."

"Not reacting properly to it, not waking up from it, drowsiness afterwards, still being able to feel the pain."

"I would be worried they might not put me under properly and I may feel what is happening to me. I would also be worried things might not go to plan and I might not wake back up."

"Not waking up after, not being given enough anaesthesia and being able to feel what was going on."

"The possibility of severe allergic reaction or wrong dosage."



ONLY 50 PER CENT OF PEOPLE ARE AWARE ANAESTHETISTS ARE DOCTORS, AND NEARLY ONE IN 10 DON'T THINK THEY ARE AT ALL WITH ANOTHER 41 PER CENT UNSURE, ACCORDING TO A SURVEY CONDUCTED RECENTLY FOR ANZCA.

This is despite the fact that 96 per cent of those surveyed have had some experience of general anaesthesia (personally or through a close family member). Of those aware anaesthetists are doctors, 41 per cent know they are doctors with the same training/qualifications as other specialists.

Between April and May this year, Acuity Research & Insights conducted a benchmark quantitative research study into the community's understanding of, and attitudes toward, anaesthetists and anaesthesia.

An online survey was completed by 656 people in Australia and New Zealand aged 18 years or over who had heard of anaesthesia.

Interestingly, 14 (2 per cent of the 670 potential participants) did not qualify because they had not heard of anaesthesia. The sample was weighted to represent key age and geographical demographics.

Those surveyed appeared split over whether they felt informed or not about anaesthesia with the key source of information coming from personal (72 per cent), family and/or the experiences of friends (50 per cent).

Three in 10 people listed TV shows as a key source of information, perhaps reflecting the popularity of the drama *Offspring* about the life of an obstetrician and her anaesthetist partner. The next highest source of information is the internet (17 per cent).



THREE IN 10 PEOPLE LISTED TV SHOWS AS A KEY SOURCE OF INFORMATION, PERHAPS REFLECTING THE POPULARITY OF THE DRAMA *OFFSPRING*.



Those who feel well informed about anaesthesia are significantly more likely to list personal experience (84 per cent) and knowing someone in the profession (23 per cent) as information sources. Those who don't feel well informed are significantly more likely to list TV (36 per cent) as a source.

Just over three in 10 (31 per cent) have concerns about undergoing anaesthesia/sedation with the key concerns being negative side effects (27 per cent) and death or not waking up (24 per cent). When prompted, four in 10 are concerned about waking up, with 14 per cent very concerned about this prospect.

More than four in 10 (45 per cent) perceive undergoing anaesthetic or sedation as a moderate to high risk procedure.

A strong majority know that being elderly (83 per cent) and overweight (81 per cent) are two factors that significantly increase risk, with 74 per cent citing illegal drugs and 72 per cent smoking as risks.

Not surprisingly, those who had undergone a general anaesthetic in the past five years (26 per cent) and those who feel well informed about anaesthesia (27 per cent) were significantly less likely to have concerns, compared to those who have never had an anaesthetic (50 per cent) or who don't feel well informed about anaesthesia (36 per cent).

There is significant scope to widen community appreciation of the roles of anaesthetists beyond operating theatres. Of those surveyed, 76 per cent are aware of anaesthetists' roles in labour and childbirth with 57 per cent aware of the role played in intensive care units. Forty per cent are aware of the role anaesthetists play in arranging pain relief following surgery while 39 per cent are aware of the anaesthetist's role in resuscitation.

(continued next page)

Anaesthesia and the community

AN ONLINE SURVEY OF 656 PEOPLE IN AUSTRALIA AND NEW ZEALAND EARLIER THIS YEAR FOUND:

- Almost all (96 per cent) reported some experience of general anaesthetic – either personally or through a close family member.
- Only 50 per cent were aware all anaesthetists are doctors (of these, 41 per cent know they are doctors with the same training/qualifications as other specialists).
- Nearly one in 10 (9 per cent) think anaesthetists are not doctors and another 41 per cent are unsure.
- 50 per cent felt informed/50 per cent didn't feel informed about anaesthesia.
- Just over three in 10 (31 per cent) said they would have concerns about undergoing anaesthesia/sedation.
- 30 per cent reported medical shows/TV as a source of information (personal experience – 72 per cent, family and friends – 50 per cent).
- Four in 10 (45 per cent) perceived going under anaesthesia/sedation as a moderate to high-risk procedure (six in 10 low/almost no risk).
- A strong majority felt being elderly (83 per cent) and overweight (81 per cent) were two factors that significantly increased risk (74 per cent – illegal drugs, 72 per cent – smoking).
- Four in 10 (43 per cent) are concerned about waking up (14 per cent very concerned).



AS A SIMPLE FIRST STEP IT WOULD SEEM REASONABLE FOR ANAESTHETISTS TO ROUTINELY INTRODUCE THEMSELVES AS DOCTORS.



Good patient communication the key

Improving communication with patients is one of the themes that can be drawn from the 2013 Community Attitudes Survey. Dr Allan Cyna and Associate Professor Scott Simmons, from the new Communication in Anaesthesia Special Interest Group, comment on the survey.

The 2013 Community Attitudes Survey commissioned by ANZCA tells us that 96 per cent of people have experienced anaesthesia either personally or through a close family member, yet half of the respondents weren't sure anaesthetists were doctors.

Interestingly, the majority stated that they would feel more confident about having an anaesthetic if they were more informed about the extent of anaesthetist's training and qualifications. As a simple first step it would seem reasonable for anaesthetists to routinely introduce themselves as doctors.

Also, half of those surveyed reported not feeling well informed about anaesthesia. This suggests that further research may be warranted to elucidate which information would be of most value to patients and how such information could be effectively communicated.

At a very simplistic level, while most people may have had contact with an anaesthetist, this encounter is usually extremely brief and often under circumstances of heightened stress, neither of which is conducive to effective learning. There are two issues here, albeit linked. The first is the low public profile of our profession. Unfortunately, isolated promotional exercises do little to change knowledge and attitudes as social media and the internet emerge as the main vehicles for public awareness.

Those surveyed were also asked about research, with one in four (26 per cent) saying they would consider donating to ANZCA's medical research. Many more (72 per cent) thought the government should increase its funding of medical research into anaesthesia, pain medicine and intensive care medicine.

Pain medicine

The survey focused mainly on anaesthesia (with the aim of guiding messaging for National Anaesthesia Day on October 16) through eight questions related to pain medicine.

While 45 per cent of those surveyed are aware that pain medicine is a specialty, New Zealanders (58 per cent) are significantly more likely than Australians (43 per cent) to know of pain medicine as a medical specialty, while those aged 60 years and over (58 per cent) are significantly more aware, especially compared to those aged under 40 years (37 per cent).

Most of those surveyed (55 per cent) are unaware or unsure if pain medicine is a medical specialty and a small minority of those surveyed (13 per cent) reported personal experience (either themselves or close family) with a pain physician or pain clinic in the past five years.

While still at minority levels, those aged 60 years or more (20 per cent) are significantly more likely to have had personal experience with a pain physician or pain clinic in the past five years.

While only a small sample size (32), there is room to improve satisfaction with pain clinics – particularly in terms of length of time until appointments are available with 30 per cent saying this aspect was “terrible” or “not very good”.

Clea Hincks, General Manager Communications, ANZCA



Secondly, and more importantly, is the person-to-person interaction that occurs at the bedside. While the former may help frame the latter, the issues, and potential solutions are vastly different.

The anaesthetist's role, training, and value to the healthcare system more broadly, is poorly appreciated by the public at large and requires strategies and solutions such as wider involvement in decision-making bodies at all levels.

At the level of the clinician-patient interaction, we need to consider how we can mind our language in a way that is truthful, likely to be helpful and, understandable. While many respondents seemed to place importance on being informed of the risks of disability or death, it is important to bear in mind that not all patients have the same needs and anaesthetists should be wary of inadvertently communicating negative suggestions which have been shown to increase anxiety and other adverse postoperative experiences.

Our ethical role as a provider of care is to be aware of the risks not only of the procedure but of compromising patient care by overly focusing on concerns of potential medico-legal action. Patient concerns may be mitigated by focusing on meanings rather than perceptions. For example, by avoiding negative suggestions where possible, such as pain, worry, itch and sting and instead emphasise to the patient how we are optimising their safety and comfort throughout the procedure and recovery while healing occurs.

Dr Allan Cyna and Associate Professor Scott Simmons
Communication in Anaesthesia Special Interest Group

People's experiences with anaesthesia

PEOPLE WHO HAD RECEIVED A GENERAL ANAESTHETIC IN THE PAST FIVE YEARS WERE ASKED TO COMMENT ABOUT THE EXPERIENCE.

"The anaesthetist had an excellent bedside manner, there was very little discomfort when the needle was inserted in the back of my hand, and I had no side effects. I was very pleased."

"The first time I met the anaesthetist was approximately 15 minutes prior to surgery. Although everything was very well explained and he had excellent 'beside manner', given the surgery was booked well in advance I would have preferred a meeting prior to the day of surgery."

"I remember the anaesthetist was very reassuring."

"Was nice to meet all the team looking after me prior to going into the operating room."

"Not a lot of information was given resulting in fear of the unknown."

"The anaesthetist was very well trained and seemed very calm and confident."

"Had major surgery, only saw the anaesthetist 30 minutes before theatre. Never saw him again."

"At the onset of surgery the anaesthetist is the last person you communicate with. It is essential you feel confident and comfortable with them and reassured."

"My procedure was intended to be quite short and simple. Instead it required five hours, the call in of another specialist and was very lengthy. My recovery was thus prolonged and I felt quite ill after the surgery for some time. This was attributed to the anaesthetic."

"It was pretty comforting to have someone speak to me about the whole procedure."

Our indigenous health challenge

It is no secret that the health of our indigenous populations is poor, particularly in Australia. Improving indigenous health is a key element of ANZCA's Strategic Plan 2013-2017. The College is committed to this goal through the work of its Indigenous Health Committee and those dealing with the problems first-hand.



Anaesthetists struggle to close health gap

If you close your eyes and only hear the cough you would be forgiven for thinking it belongs to a septuagenarian smoker. But Lacenzo, coughing and coughing and now crying, is just 12 months old.

For much of his little life his easy baby laugh has been interrupted by a wet, persistent cough that sometimes hurts him. It is August, the weather is dry and warm, and Lacenzo and his mother Annie Clement are away from their Bathurst Island home because Lacenzo has bronchiolitis, a nasty respiratory infection, and not for the first time.

Annie, 26, and Lacenzo have been in Royal Darwin Hospital for 10 days and today, on the eve of their discharge, the little boy undergoes a bronchoscopy. His lungs are drained of pus before he has a CT scan to assess their state. Later, the consultant paediatrician will tell Annie that there is damage to the bottom of both of Lacenzo's lungs.

The bronchoscopy does not take long and before the procedure starts anaesthetist Brian Spain reassures Annie, whose English is not fluent, that her little boy is in safe hands. Lacenzo will be back with her very soon. She nods and waits outside the procedure room, patient, calm and distant. She is, after all, a long way from home.

With Annie's consent some of the fluid drained from Lacenzo's lungs will contribute to a study that compares children's sick lungs with healthy lungs in a bid to understand the scourge of severe lung disease in Australian indigenous communities.

Bronchiectasis is a condition in which damage to the airways in the lungs causes them to widen and become scarred. It is generally considered uncommon but it affects one in 70 indigenous children in Australia. The consequences for adult health are brutal because the lung damage is irreversible.



Dr Spain is Royal Darwin Hospital's director of anaesthesia and believes the incidence of this disease reflects the greatly compromised health of Australia's indigenous population.

The main health problems in the Northern Territory in the indigenous population, he explains, are chronic disease (diabetes, kidney disease, cardiovascular disease) and domestic violence.

Indigenous patients at the hospital are disproportionate in number compared to the non-indigenous community. Their most common illnesses and the high prevalence of chronic and multisystem organ disease reflect statistics from developing nations.

"Working in an environment like this you find a lot of challenges and communication barriers can compound that," Dr Spain says.

The indigenous and mainstream cultural and health divide, despite significant advances and good intentions, remains more chasm than divide, he believes.

"The indigenous community is grossly underrepresented in elective surgery and overrepresented in emergency surgery."

The most common presentations in hospital are kidney disease, diabetes, heart disease, fractures, skin abscesses and pneumonia.

He says that in particular young children are suffering from diseases – rheumatic fever, trachoma, chronic respiratory disease, skin sores and more – in numbers unheard of in non-indigenous communities.

Alice Springs Hospital director of intensive care Penny Stewart, a member of ANZCA's Indigenous Health Committee, says the indigenous health statistics available do not reveal the true extent of the problem.

An indigenous Australian aged 25-40, Dr Stewart says, has a 380 times greater chance of developing end-stage renal failure than a non-indigenous Australian.

"There is a four to five times higher rate of diabetes and it is starting younger and younger."

Type 2 diabetes has broken the health of the indigenous community in Australia. In Alice Springs, Dr Stewart says, the amputation of limbs has become normalised.

While she says it is an extreme example, she does recall one afternoon when there were eight indigenous people in the room and "one leg".

Alice Springs Hospital services a massive 1.5 million square kilometre area of remote central Australia where more than a dozen languages are spoken. Indigenous Liaison Officers are an important resource in both Alice Springs and in Darwin, where they serve as translator, interpreter and cultural bridge.

In Alice Springs a team of indigenous liaison officers (ILOs), all Aboriginal, is led by Neil Pomfrey. Between them they speak most of the 17 languages and dialects in the 750 kilometre radius their patients are drawn from.

"Our main job is interpreting, cultural brokerage, locating patients that have run away and communicating with families," Mr Pomfrey says.

In the remote communities the local clinics will refer a patient to hospital and it is the ILOs that liaise with transport, accommodation and explanations of the reason for the stay.

"Sometimes it is very hard to locate a patient who should be here and we rely on our bush telegraph," he says.

"We make sure that the patient knows they are in hospital and what is happening to them."

Informed consent for surgery and other procedures is a major issue in indigenous communities, remote of metropolitan.

Mr Pomfrey and his team strive to work through the major differences that exist in the understanding of health and illness between a very Western medical system and groups of people for whom English is not just a second, but often a fourth or fifth language.

"Type 2 diabetes has broken the health of the indigenous community in Australia. In Alice Springs the amputation of limbs has become normalised...one afternoon there were eight indigenous people in the room and 'one leg'."

"If we aren't part of the consent process there is usually (self discharge) and then we have to find them. Lack of communication is the main reason a patient will take their own leave before they are well."

Dr Stewart is passionate about the need to build an indigenous health workforce and believes that without one, the path to better health and general wellbeing in Aboriginal communities everywhere will remain fraught.

"There is a very large Aboriginal industry in Australia but very few mechanisms for inclusion," she says.

In the meantime, the health problems, in cities and in remote areas are dire. Dr Spain and Dr Stewart agree that while there are some gains that have been made – childhood immunisation is one area – that improvement is not translated to middle adulthood.

"Slight childhood undernourishment is a trend that rapidly accelerates into obesity by mid-teens and young adulthood. Nutrition is fundamentally difficult but we are living in an area where a bottle of water is more expensive than a Coke," Dr Spain says.

Dr Stewart agrees: "There are many gains to be made. People need employment and they need a reason to go to school. We urgently need to engage an Aboriginal health workforce."

Ebru Yaman, ANZCA Media Manager

Opposite page: Dr Brian Spain with Annie

Clement and son Lacenzo. This page above

from left: Dr Brian Spain; Dr Penny Stewart.



Students mentored far away from home

In a small portable classroom at the Wiltja Residential Program for Woodville High School, about 10 kilometres north-west of Adelaide's CBD, a group of 20 indigenous school students settle down to an informal dinner of wood-fired pizza served straight from the box, fruit platters to follow and, at first, halting conversation.

Dining with them are about a dozen healthcare professionals including GPs, medical students, a psychiatrist, a retired neurosurgeon and ANZCA Fellow and chair of the College Indigenous Health Committee, Dr Rod Mitchell.

The young men and women are aged 13 to 18, are all Anangu and come from the remote tri-state cross-border area of Western Australia, South Australia and the Northern Territory. They are thousands of kilometres from home and are among the 80 students who make up the Wiltja residential program, described as the urban annexe of secondary school programs offered by remote Anangu schools.

The residential program aims to give these students the opportunity and support they need to finish high school and experience living in a metropolitan city. To attend Wiltja they must have been selected by their home communities, which run and govern the program and they travel home each term break.

The gathering is one of several held at various schools every year as part of the Flinders and Adelaide Indigenous Medical Mentoring program (FAIMM). Support for the mentoring program forms one small part of ANZCA's advocacy work in the area of indigenous health.

Dr Mitchell said the aims of FAIMM were threefold: to provide an environment whereby indigenous medical students can encourage and support each other; to facilitate mentoring of indigenous medical

students by practicing doctors and to visit high schools and boarding schools with a high proportion of indigenous students. The aim is to allow indigenous medical students to introduce and promote tertiary education to young indigenous people who might otherwise have lacked the information, the confidence – or both – to pursue it.

"For the high school students we aren't there to try to persuade them to specifically do medicine, but rather to explore the options of tertiary education," Dr Mitchell said.

"We introduce them to indigenous medical students and other health professionals to encourage them to finish high school and go to university."

He said Dr Mich Poppinghaus (FANZCA) had established a similar program in Newcastle, NSW, which was "working well".

"We would encourage any Fellows who are interested in establishing similar programs in their place of residence to contact the committee through the College."

The ANZCA Indigenous Health Committee was established in 2011 in response to the increasing awareness among Fellows that the College could actively participate in moves to address inequity in healthcare in Australia and New Zealand.

Its purpose is to report to ANZCA Council on proposals to support indigenous health in Australia and New Zealand that have "have appropriate foci in anaesthesia, pain medicine and intensive care" and are developed in consultation with relevant stakeholders. According to the terms of reference, examples of such proposals include:

- Introducing case studies which address indigenous health issues into the new curriculum.
- Production of indigenous health podcasts to facilitate continuing professional development for Fellows.
- Encouraging indigenous anaesthesia trainees.
- Support for clinicians working in indigenous health.

"We introduce them to indigenous medical students and other health professionals to encourage them to finish high school and go to university."

Dr Rod Mitchell, Chair, ANZCA Indigenous Health Committee

- Engaging with indigenous stakeholders.
- Establishing and supporting mentoring programs.

Poor health is inextricably linked to limited access to education and poor literacy and numeracy skills, Dr Mitchell said, and an important step in closing the gap in health outcomes between indigenous and non-indigenous Australians and New Zealanders is to encourage indigenous young people to go to school, to stay at school and then go on to further study.

Outside the FAIMM program, ANZCA has partnered with the Australian Indigenous Doctors Association (AIDA) to encourage indigenous students to go into anaesthesia, pain medicine or intensive care as career paths.

The goal in encouraging indigenous doctors to specialise, Dr Mitchell said, is to make the provision of pain medicine, anaesthesia and intensive care safer, as well as increase the access to traditional medicine by the indigenous population. For this to happen effectively, he believes there must be more indigenous medical specialists.

"A key barrier to good health and medical attention and outcomes is understanding and communication," Dr Mitchell said.

"The difference between indigenous and non-indigenous culture and norms carries significant potential for miscommunication and all this can result in poorer, less safe and unhappier outcomes."

Ebru Yaman, ANZCA Media Manager



Aspiring anaesthetist says communication is key

Dr Dasha Newington is an indigenous first-year medical intern and aspiring anaesthetist working at Orange Hospital, about 250 kilometres west of Sydney. She grew up in Canberra and studied medicine at the University of Sydney after first working in a completely different field – as a store manager with McDonald’s.

When she began her studies in 2008 she was the only indigenous student in a cohort of 300. That has changed significantly in the last five years, reflected in the fact that today there are more indigenous medical students than there are graduates. At Orange Base Hospital she is one of three indigenous doctors.

Of her peers planning to specialise, many turn to general practice, a path they believe will make it possible to return home to their communities.

But Dr Newington believes urban areas, where the majority of indigenous communities in Australia and New Zealand live, are in desperate need of indigenous specialists too.

“It is easier for people to approach someone from their own culture and it will be a great day when we can have all specialties represented with indigenous people,” she said.

“A lot of Aboriginal people are rarely exposed to anaesthesia and that, with cultural differences and miscommunication makes it a very intimidating environment.”

She benefits from and contributes to mentoring programs and thinks they are a powerful way to encourage people to extend themselves emotionally and professionally, by offering support and boosting confidence.

“When I was studying there were not many specialists and there was no mentoring available and I think the programs are great, for high school students and for medical students.”

Dr Newington contributed to the ANZCA “Asking about indigenous status” podcast. In it she shares powerful insights into her own indigenous background and explains that assuming to know another’s racial, cultural or spiritual identity is fraught and one of the main barriers to good communication.

“People think I can’t be Aboriginal because I don’t look Aboriginal to them or don’t look like what they imagine an Aboriginal person should look like, and I did spend much of my life wishing that I had been born with darker skin,” she said.

“A lot of Aboriginal people are rarely exposed to anaesthesia and that, with cultural differences and miscommunication makes it a very intimidating environment.”

Dr Dasha Newington, who plans to become an anaesthetist.

“However, this wouldn’t have changed who I am. I would still be born to an Aboriginal mother, inherited her spiritual strength and suffered from the legacy of the stolen generations. I would still be accepted by my Aboriginal community in the same way; the only difference would be how I was perceived by the non-indigenous community.”

Ebru Yaman, ANZCA Media Manager

An interview with Dr Newington can be heard on the College Conversations CD with this edition of the *Bulletin*.

Opposite page from left: Dr Rod Mitchell (centre) speaks with students from the Wiltja residential program; students and mentors share a meal.

Still work to do in New Zealand

Dr Ted Hughes is an ANZCA Fellow with Pacific Islander heritage and says while the gap between indigenous and non-indigenous health in New Zealand is not as severe as in Australia there is a long way to go before health, education and lifestyle outcomes are equitable.

“Maori and Pacific Islanders have poorer health and social outcomes than non-indigenous New Zealanders and the gains that have been made across the country are not equally represented in the indigenous,” he says.

He says while the difference in life expectancy is not as large as in Australia, it remains at about five years less than the rest of the population. Indigenous New Zealanders are over-represented in the nation’s unemployment figures and are less likely to have a school qualification.

As in Australia, cardiovascular disease and diabetes are high among the major indigenous health problems but Dr Hughes says there is an intrinsic respect in New Zealand between the indigenous and non-indigenous populations, one he doesn’t believe has managed to exist in Australia.

Dr Hughes said New Zealand had a good track record in training indigenous doctors and anaesthetists. A 2012 survey by the Medical Council of New Zealand found that of the 12,017 respondents, 707 indicated they were working in anaesthesia at their main work site (all employment levels included). Of these 707 doctors, 19 identified as either Maori or Pacific Islander.

The number of doctors who responded to the most recent completed survey (from 2012), and indicated they were actively practicing in New Zealand was 12,017. Of these doctors, 351 (2.9 per cent) identified themselves as Maori, and 215 (1.8 per cent) identified themselves as Pacific Islanders. Of the 707 active doctors (defined as those who work more than four hours per week) who indicated they were working in anaesthesia at their main work site (all employment levels included), 522 indicated they were working in an employment capacity of specialist. Of these 522 doctors, 10 doctors (1.9 per cent) identified as either Maori or Pacific Islander.

Ebru Yaman, ANZCA Media Manager

Survey of doctors in New Zealand (2012)

Category	Maori or Pacific Island	All doctors
All active doctors*	566	12,017
Working in anaesthesia at their main work site (all employment levels included)	19	707
Working as a specialist in anaesthesia at their main work site	10	522
Working as a registrar in anaesthesia at their main work site	9	155

*Active doctors are doctors who indicated they were working four or more hours per week. Source: Medical Council of New Zealand.

The state of indigenous health in Australia and New Zealand

The *Burden of disease and injury in Aboriginal and Torres Strait Islander peoples* report showed the potential for a very significant overall health gain in Australia from improving the health of indigenous Australians. This report also showed that 60 per cent of the health gap between indigenous and non-Indigenous Australians is attributable to the health of indigenous people living in non-remote areas of Australia. Indigenous Australians in remote areas experience greater health disadvantage, but because of their smaller numbers, contribute 40 per cent of the health gap.

An increasing number of indigenous people live in urban areas and large regional centres. At the 2006 census, the Australian Bureau of Statistics estimated that 32 per cent of indigenous people in Australia lived in major cities, 21 per cent lived in inner regional Australia, 22 per cent in outer regional Australia, 9 per cent in remote Australia and 15 per cent in very remote Australia. In total, 53 per cent of indigenous people (70 per cent of those living non-remotely) live in cities or regional centres. This is a small increase from the 50 per cent of indigenous people who were reported to be living in major cities and inner regional Australia in 2001.

There is some limited evidence that indigenous people living in urban areas experience different health problems from those in rural and remote areas. For example, children in urban areas have been found to have higher rates of asthma, dental decay and mental health problems, while those in remote areas have higher rates of infectious disease.

Source: *The health of urban Aboriginal people: insufficient data to close the gap.* Sandra J Eades, Bronwen Taylor, Sandra Bailey, Anna B Williamson, Jonathan C Craig and Sally Redman for the SEARCH Investigators; *Medical Journal of Australia*, 2010.

What is Closing the Gap?

“Closing the Gap” refers to a commitment by Australian governments to improve the lives of indigenous Australians, and in particular provide a better future for indigenous children. Its focus is on education, housing, health and employment disadvantage. The Closing the Gap strategy was agreed through the Council of Australian Governments (COAG) and involves various initiatives and funding streams.

In New Zealand “Closing the Gaps” refers to an official government policy of improving the lives of socially disadvantaged ethnic groups, particularly Maori and Pacific Islanders. The phrase was adopted as a slogan of the country’s Labour Party in the 1999 election.

Between 1999 and 2008 social statistics for Maori and Pacific islanders improved but the same statistics for non-indigenous New Zealanders showed a greater improvement. These changes were recorded in the Ministry of Health and Otago University’s series of *Decades of Disparities* reports.

Ebru Yaman, ANZCA Media Manager



Asking about indigenous status



Communication



Consent



Culture



Culture shock (IMGS)



Diffusing anger



Pain management



Pre-operative visit



Traditional parenting

Nine podcasts address treating indigenous people

As part of its commitment to supporting indigenous health training to trainees and Fellows, ANZCA’s Indigenous Health Committee produced a series of nine podcasts on talking to and treating indigenous Australians and New Zealanders.

While the podcasts were primarily put together to help international medical graduate specialists treating indigenous people, they are a valuable

tool for all Fellows and trainees, said the chair of the committee, Dr Rod Mitchell. Subjects include communication and culture, pain management, traditional parenting and consent.

The podcasts can be found at www.anzca.edu.au/resources/learning/podcasts/indigenous-health.

A session on indigenous health in Australia and New Zealand is also planned for next year’s ANZCA Annual Scientific Meeting in Singapore.

WELCOME

TO THE JUNGLE

FROM POST-PARTUM SURGERY FOR AN ORANGUTAN TO FERTILITY AID FOR A GORILLA, THE MEDICAL NEEDS OF RESIDENTS AT ROYAL MELBOURNE ZOO ARE AS REAL – AND AS FASCINATING – AS OUR OWN.

SOME 36 YEARS AGO A UNIQUE PARTNERSHIP WAS FORGED.

I was a staff anaesthetist at the Royal Women's Hospital in Melbourne when I received a call from the sole vet at the Royal Melbourne Zoo. Could I please help? Olga, an elderly primigravid orangutan, had given birth to twins four days earlier and was now moribund. Since my resuscitation expertise in post-partum primates was considerably greater than his – being zero – could I assist?

So began a wonderful journey. Olga was so sick that I was able to put lines in her, give intravascular expansion with hartmann's and haemaccel, then anaesthetise her. She had been seen wearing one placenta on her head (which didn't seem unusual to me after some of the things I had seen done with placentas at the Royal Women's Hospital) so we presumed – rightly – a retained placenta, which was duly removed.

Blood cultures showed clostridium welschii septicaemia, and with repeat top-up infusions, requiring re-anaesthetising over the next few days and appropriate antibiotic therapy, Olga recovered. Her Hb at that stage was 60. Dr Jean Barry at the hospital had cross-matched two units of out-of-date blood, which was compatible! It was not used. The twins, Bono and Suma, however, got a mechanical ileitis from their mother feeding them straw. I put femoral lines in them and recruited Dr Geoff Barker and Dr Jim Court from the Royal Children's Hospital, who ran parenteral nutrition until they recovered.

Over the next few years I treated many varied and assorted animals – gorilla, chimp, orangutan, giraffe, polar bear, baboon, white cheeked gibbon, large cats etcetera. My monitoring equipment at that stage was my oesophageal stethoscope – there was no operating table or theatre lights. We have gradually accumulated these by begging, and receiving, secondhand equipment from hospitals upgrading: anaesthetic machines, operating table, operating lights, full anaesthetic monitoring equipment,

X-ray equipment – often with me giving a registrar talk as payment.

Ketamine was the only intramuscular agent available. At 100mg/ml this would have required doses of about 25ml – an impossible dose (we were using blow darts) literally. I obtained ketamine powder and, by heating sterile water, I could dissolve this powder to give 350-400mg/ml. This was dartable. One had to remember to blow not suck!

The darting – from a distance and through the bars would often deliver glancing blows requiring repeated doses with uncertainty as to how much was in what tissue: subcutaneous, adipose or intramuscular? This led to prolonged recovery times but also a period during which the partly anaesthetised animal might injure itself; climbing to escape, but weakened it could fall.

The countries of origin of many species were in political turmoil – Zaire, Congo, Rwanda, Zimbabwe, Uganda to name a few – poaching and human encroachment on habitat by forest clearing had put many species on the brink of extinction.



Ecotourism was being recognised as a source of income and employment so a number of countries were no longer handing over their native species simply to satisfy the demands of their former colonial masters.

One such species was the lowland gorilla. The Royal Melbourne Zoo had two wild caught gorillas of reproductive age, Rigo and Yuska, but Rigo had shown no interest. I think he preferred blondes. Sydney's Taronga Zoo had had a troupe of five but three had died mysteriously in quick succession and the remaining two, Betsy and Bullerman, were shipped to Melbourne in the hopes of establishing a breeding group. During a previous anaesthetic I had given, a testicular biopsy on Bullerman had shown him to be sterile, a result of mumps orchiditis. It is thought that human mumps was the mysterious killer of the other three gorillas at Taronga.

(Continued next page)



"The program was successful – a world first – and in 1984, Mzuri was born. Aldous Huxley's brave new world!"

Clockwise from top: Anaesthetising a gorilla; zoo medical equipment of all shapes and sizes; Dr Kevin Moriarty and Mzuri; a comparison of endotracheal tubes and other equipment for humans versus large animals; a young Mzuri.

The Royal Womens' Hospital in Melbourne was one of the world leaders in IVF and so I approached Dr John McBain to see if artificial means of conception were possible. Ingenious methods of tracking the female oestrous cycle were invented and, at appropriate times, Rigo was anaesthetised, electro ejaculated, then artificial insemination performed on Yuska, while we watched her ovulate under ultrasound. We were amazed to witness this. The program was successful – a world first – and in 1984, Mzuri was born. Aldous Huxley's brave new world!

My aim over time has been to have reversible anaesthesia with least distress to the troupe, the keepers, all the while keeping in mind the safety of all at present. I began using a premed in a small amount of food. A new induction agent had come along – Zoletil. This is a combination of a benzodiazepine,

zolazepam and a dissociative agent – a ketamine congener – Tiletamine. So the premed I used was alprazolam as I was reversing the benzodiazepine at the end. The benzodiazepine also removed the emergence problem associated with the dissociative agent. This was a much more concentrated formulation and easier to dart. More recently metatomadine has been added to the formulary, again reversible with anepamezole and further reducing the doses of each component. Atropine is needed as an antisilogue, otherwise there is a profusion of tenacious secretions, too viscous to suck out, thus requiring the unpleasant job of manually removing it.

Laryngeal masks have made the transport airway much easier and safer. More recently we have been able to train animals to accept hand held intramuscular injections. This has resulted in safer,

quicker knock down with known doses in known compartments. Recovery is commensurately quicker.

Recovery is achieved in their night enclosure, onside, facing towards us so we can observe them. I put a blue bag on the LMA and a throat pack tie around the LMA – those we lead out through the bars. The IV is loosened, the reversal drugs given then we get the hell out of there and within 45 seconds the gorilla is sitting up and we whip out the IV and LMA. We have come a long way and it has been a privilege to be part of the journey.

The veterinary staff and the keepers have been so welcoming and supportive that I feel I have been accepted into their family.

Dr Kevin Moriarty, FANZCA

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

“The IV is loosened, the reversal drugs given then we get the hell out of there and within 45 seconds the gorilla is sitting up.”



Clockwise from top: A dart gun is used to sedate an animal; Dr Moriarty helps treat a “patient” in the early days; treating a gorilla.

Anaesthesia and Pain Medicine Foundation

Board of Governors has new chair

Kate Spargo has been appointed chair of the Anaesthesia and Pain Medicine Foundation's new Board of Governors.

Ms Spargo is a director of several organisations including Investec Bank (Australia) and the Snowy Mountains Engineering Corporation. She has a strong track record in leadership and corporate governance positions including having served as the deputy chair of Neurosciences Victoria. Ms Spargo also has a strong personal interest in philanthropy and medical research.

Ms Spargo is joined on the Board of Governors by Mr Kenneth Harrison and Ms Stephanie Poustie.

Mr Harrison has served in senior roles in the finance, corporate and community organisation sectors, including executive director of Maracorp Financial Services (Bank of Melbourne), treasurer of Australian Airlines, managing director of Collinsbank and member of the Royal Botanic Gardens Board, Melbourne.

Ms Poustie has recently retired as the clinical trials co-ordinator of ANZCA and the Monash University Department of Epidemiology and Preventive Medicine, a role in which she was central to the formation and success of the ANZCA Trials Group. She was previously a research fellow at the Australian National University and a research co-ordinator for the Accident Care Evaluation Project. She has published 25 original papers and 19 abstracts.

The new Board of Governors was established earlier this year following a restructure. The original Anaesthesia and Pain Medicine Foundation Board was replaced by the Board of Governors, which is specifically dedicated to the development of the foundation's fundraising program, and the Foundation Committee.

The more compact foundation committee will be responsible for oversight and governance. The foundation committee retains Professor Kate Leslie in the role of chair, Professor Alan Merry (Chair of the ANZCA Research Committee), Sir Roderick Deane, ANZCA President Dr Lindy Roberts and Foundation General Manager, Robert Packer.

New terms of reference for each group were drafted and submitted to the ANZCA Council in May.

While the search for additional members is continuing, the Board of Governors is planning an inaugural meeting in September to commence the planning of fundraising activities aiming to bring new individual and organisational supporters to the cause of increasing the support for research and education in anaesthesia and pain medicine.

Vale Dr John Boyd Craig

The foundation's number one supporter and sole governor of the Patrons Program, Dr John Boyd Craig, passed away peacefully at his home in Crawley, Western Australia, on July 12 this year at the age of 95.

Dr Craig made two very generous gifts to the foundation in the late 1980s, which have since been carefully invested and managed to generate financial support for the foundation's pain medicine research program and the many Fellows who have received grants for pain medicine research.

His significant contribution and leadership by example are recognised in perpetuity by the foundation in the form of the annual John Boyd Craig ANZCA Research Award.

John's first wife Audrey died in 1994 after a long illness, and he is survived by Bobbie, his second wife of nearly 20 years, his three children, seven grandchildren and one great-grandchild.

The foundation is extremely grateful to Dr Craig for the wonderful support that he gave to the cause of improving patient outcomes in the specialty, both in terms of his significant financial contribution, and the warm encouragement and moral support he regularly provided.

An obituary by Associate Professor John Rigg is on page 84.

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.

Study debunks theory that epidural analgesia is better for high-risk surgical patients

Making a difference

ANZCA has a long history of supporting ground-breaking research that has had a major impact on patients' lives. This is the first in a series of articles on some of the projects ANZCA has helped fund.



In 1997, Philip Peyton was part of a team that received \$A20,000 in pilot funding from ANZCA which kick-started the MASTER Trial. This investigation found that epidural analgesia provided better pain relief than intravenous analgesia but did not reduce major complications in high-risk surgical patients. Further government funding allowed the completion of the study across 20 centres over five years.

In the early 1990s, the traditional paradigm of clinical research in the field of anaesthesia was about to undergo a major shift.

In other disciplines, such as cardiovascular medicine and public health, large trials were being undertaken that were powerful enough to give reliable answers to important clinical questions on major patient outcomes. However, given

the complexities and logistics of patient care for surgery and anaesthesia, this presented particular challenges to the emerging field of perioperative medicine and research.

There was no more pressing and controversial topic in anaesthesia practice at that time than the potential of epidural infusions for postoperative pain management to influence patient recovery after surgery. Epidural analgesia requires a high degree of skill and meticulous attention for optimal efficacy and has rare but serious potential complications.

A highly publicised US study of 50 high-risk patients had suggested it dramatically reduced patient mortality, backed up by a convincing argument from various laboratory and small clinical studies of reduced physiological stress response from better pain relief. At least one local study of similar size had been unable to reproduce these findings. A trial with statistical power to define the real benefit of epidural analgesia for major abdominal surgery was needed. The likely size of such a study was enormous.

Returning from a sojourn at McMaster University in Canada, Perth-based anaesthetist Associate Professor John Rigg determined to tackle this challenge on

Australian soil. He had been inspired by work alongside international leaders in large public health trials and enlisted the expertise of Professor Konrad Jamrozik, a highly respected Australian epidemiologist and educator, in the task. Associate Professor John Rigg set out to build a collaboration of multiple Australasian anaesthetic departments for a trial of nearly 1000 high-risk patients. Having just completed my specialist training, I was fortunate, among others, to have been approached to join and eagerly agreed.

ANZCA seed funding kick-started early recruitment for the Multicentre Australian Study of EpiduRal anaesthesia (MASTER) Trial. This was critical in attracting two subsequent large National Health and Medical Research Council grants that saw completion of the study across 20 centres over five years. The trial found that, while confirming the clinical impression of better quality pain relief, particularly in the first 24 hours, there was no significant reduction in major post-surgical complications, or in need for postoperative intensive care support. This finding disappointed many clinicians, but is consistent with the findings of subsequent prospective and retrospective studies.

The MASTER Trial was a pioneer in many ways. It addressed and exposed the dangers presented by myriad small weak single-centre trials, which had been the staple of research in our field. These were eagerly published and read, and often had a disproportionate influence on clinical practice, particularly when producing a positive finding, by telling us what we wanted to hear. It established a growing international collaborative network that today, under the leadership of the ANZCA Trials Group is undertaking ever larger and more ambitious studies to reliably inform fundamental aspects of patient care during anaesthesia and surgery. The research achievements of ANZCA owe much to this legacy.

Associate Professor Philip Peyton, MD
PhD MBBS FANZCA
Austin Health, Victoria

Above left: MASTER Trial investigators at the ANZCA ASM dinner in Newcastle in 1997.



Annual Research Workshop

The ANZCA Trials Group conducted its fifth Strategic Research Workshop at the Sea Temple Resort in Palm Cove, Queensland on August 9-11. This is the third time the workshop has been held at Palm Cove, a welcome respite from winter for most delegates.

Eighty participants, including two guest speakers, attended a full program that brought together experienced researchers as well as early career researchers from Australia, New Zealand and Hong Kong. The primary aim of these meetings is to present, mentor and encourage new ideas for pilot studies and multicentre research in anaesthesia, perioperative and pain medicine. The meetings also offer an update on existing research activity, and encourage participants to engage in current and proposed multi-centre trials. It was wonderful to see researchers and co-ordinators from many sites new to research.

This year there were two invited speakers including Associate Professor PJ Devereaux from McMaster University, Ontario, Canada. Associate Professor Devereaux is well known to many through his leadership of the POISE-1 and POISE-2 Trials. His talks included presentations on myocardial injury after non-cardiac surgery, and the fragility of clinical studies and implications for perioperative research. Dr Elizabeth Williamson from the Department of Epidemiology and Preventive Medicine, Monash University was the program's biostatistician. She spoke about compliance-adjusted analyses, and statistical modelling.

Updates were presented for all the trials group associated multicentre research trials, initiated by centres in Australia, New Zealand, Hong Kong and Canada. Some of these trials are coming to an end with their results highly anticipated.

The quality of the new proposals presented at the workshop continues to be very high. There were 15 new proposals covering topics such as measuring serum creatinin for risk-stratification for adverse outcomes after cardiac surgery; waist circumference and outcome in non-cardiac surgery; celecoxib affecting non-small cell lung cancer recurrence; communication failures at transitions of care; dexmedetomidine; several sub-studies associated with the restrictive versus liberal fluid therapy in major



Opposite page clockwise from top: Palm Cove, Queensland; Dr Tim McCulloch and Ms Elizabeth Williamson; Ms Sue Lang and Dr Usha Gurunathan; Associate Professor Philip Peyton, Professor Kate Leslie, Professor Paul Myles, Professor Matthew Chan and Dr Mark Shulman; Ms Rochelle Cotter and Dr Julian Mahood; Professor Matthew Chan and Dr PJ Devereaux.

abdominal surgery (RELIEF) trial and the Balanced Anaesthesia study; obstructive sleep apnoea; obesity in caesarean section; dexamethasone; perioperative model of care; and a proposed study from Canada.

Sofia Sidiropoulos chaired the anaesthesia research co-ordinators special interest group, which was held on Friday afternoon prior to the workshop. This year saw the largest number of delegates attend this breakout session; 31 in all. Topics discussed included good research practice, navigating the ethics and governance processes and issues encountered with new clinical trials. The annual business meeting followed the session.

The ANZCA Trials Group Executive Committee met at the conclusion of the workshop, and the committee moved to include Associate Professor Philip

Peyton on the executive. The committee also agreed to move in line with all other ANZCA committees and change its chair at the ANZCA annual scientific meeting.

The Trials Group executive is pleased to announce that Dr Usha Gurunathan has been awarded the final Pilot Grant for 2013, for her project entitled "Waist circumference and outcome in non-cardiac surgery". Congratulations Usha!

Conference delegates enjoyed welcome drinks and a conference dinner in the Temple of Tastes restaurant on Friday night, while Saturday evening saw drinks and dinner on a balmy terrace among the lush gardens. It was the perfect tropical setting to think about research and escape wintry weather and, on a sadder note, to farewell Stephanie Poustie. This year's workshop was the last for Stephanie who

recently retired. Professor David Story gave a wonderful speech, with Professor Paul Myles jumping in to add a few words. Professor Kate Leslie presented Stephanie with a gift on behalf of the College. Stephanie will be sorely missed, though she commented that farewelling everyone at Palm Cove meant she was leaving on a wonderful high.

The trials group executive would like to thank Dr Shiva Malekzadeh (Vic) for being our "in-house" photographer. Shiva has taken photos at most of our workshops, and you can see her work in the *Bulletin*. Thank you Shiva.

Anna Parker and Stephanie Poustie
ANZCA Trials Group co-ordinators



Stephanie Poustie retires

Stephanie Poustie, who retired from her role as ANZCA Trials Group co-ordinator in August, has played a valuable role in anaesthesia research in Australia and New Zealand, with her contribution widely acclaimed as pivotal to the success of the ANZCA Trials Group.

Originally a general and critical care trained nurse, Stephanie joined the Department of Anaesthesia at the Austin and Repatriation Medical Centre as a research nurse in 1997. This led to a fruitful and enthusiastic association with many leading perioperative clinical researchers in Australia and New Zealand. During her time at the Austin, Stephanie was heavily involved in the MASTER trial, which was the impetus for the establishment of the ANZCA Trials Group in 2004. Stephanie's other roles have included research governance officer in the Department of Epidemiology and Preventive Medicine, Monash University, and research fellow

in the Medical School of the Australian National University in Canberra. During this time she co-ordinated a large cohort study of patients recovering from motor vehicle accidents in the ACT (the Accident Care Evaluation Study).

Stephanie completed her master of public health degree in 2001 through Monash University, one of the first anaesthesia research co-ordinators to do so. We were fortunate to have her return to anaesthesia research when she took up her position of ANZCA Trials Group co-ordinator in 2007.

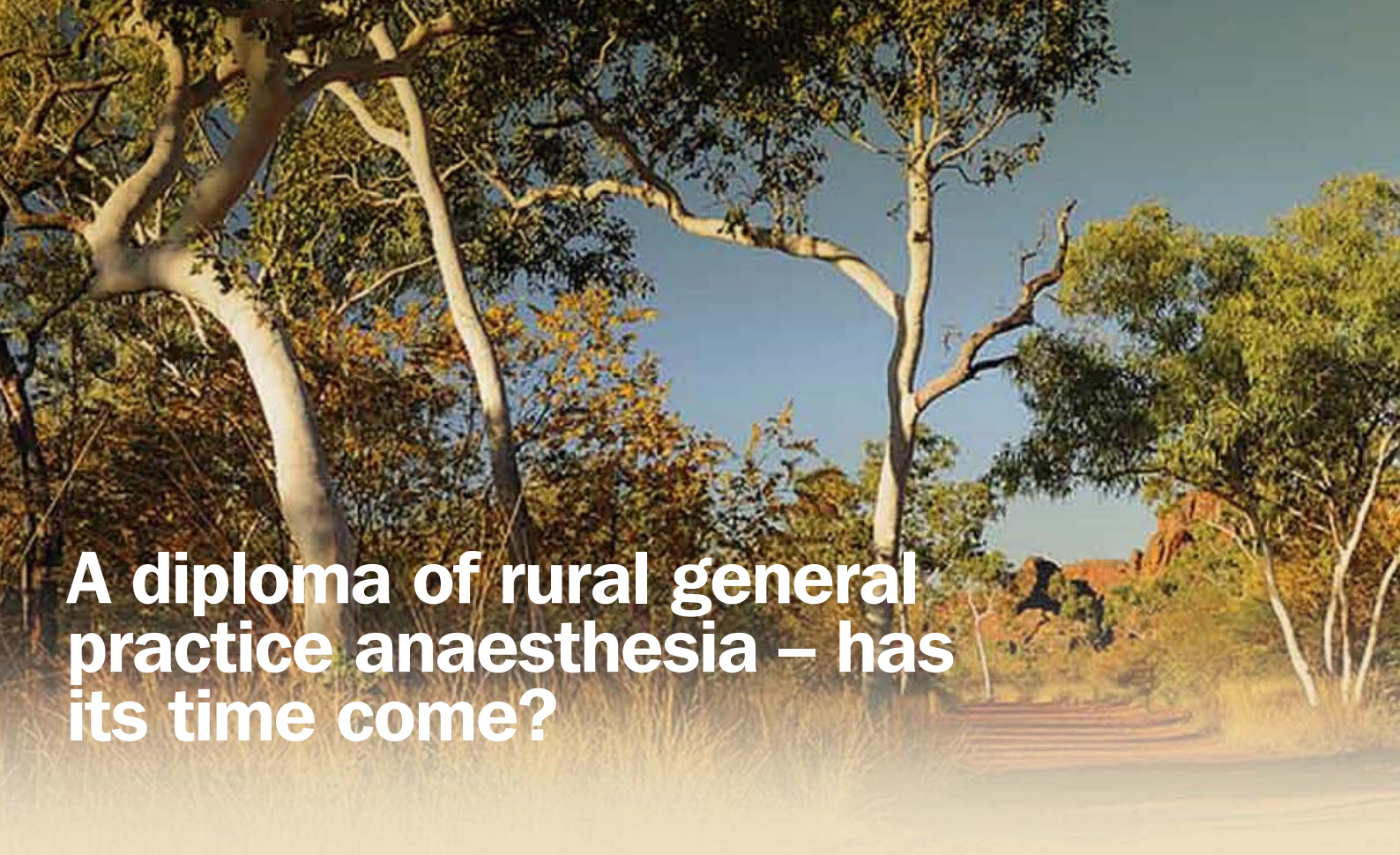
Stephanie has played a key role in overseeing many successful ANZCA Trials Group projects. Her responsibilities have included co-ordinating most of the multicentre studies in anaesthesia, providing high quality research support to College Fellows and trainees, and ensuring that the ANZCA Trials Group fulfils its governance responsibilities to both ANZCA and Monash University. Some of the major studies include research into elderly patients undergoing anaesthesia and surgery (REASON Study), and the effect of aspirin in cardiac (ATACAS) and non-cardiac surgery (POISE-2). Part of the success of the trials group has been the rapid evolution of the annual ANZCA Trials Group strategic research workshops from a few people with research proposals meeting at the College to a weekend meeting driving studies of international importance with multi-million dollar budgets. Stephanie has been central to the success of these meetings.

Research governance and good clinical practice in research are major passions for Stephanie. Her understanding of these areas has been an asset for both novice and not-so-novice investigators. She has developed a systematic process, with good governance, for Fellows and trainees conducting survey research through ANZCA. Stephanie has spent many hours helping survey researchers optimise their surveys as well as providing advice to ANZCA staff wishing to survey Fellows.

Stephanie has delivered invited lectures on research ethics and governance to hospital departments, Monash University medical students, and at College scientific meetings. She has co-authored more than 21 original papers, including studies on road trauma and the effect of compensation, natural justice and ethics committee procedures and acid-base chemistry, and was the lead author on an important publication in the *Medical Journal of Australia*: "Implementing a research governance framework for clinical and public health research". *Med J Aust* 2006; 185: 623-6.

All of us who have worked closely with Stephanie have valued her hard work and dedication, her generous spirit and enthusiasm. We wish her well in her retirement.

Professor Paul Myles, Professor David Story, Professor Kate Leslie and Associate Professor Tim Short
ANZCA Trials Group



A diploma of rural general practice anaesthesia – has its time come?

The remoteness of some areas of Australia and New Zealand means that specialist anaesthetists will not always be available.

The College has long aimed to ensure that medical practitioners providing anaesthesia services in remote and regional areas are appropriately trained and supported. Through collaboration, we have been involved in the training, assessment and continuing professional development (CPD) of hundreds of GP anaesthetists in Australia, and rural hospital doctors in New Zealand, many of whom play a vital role in providing safe anaesthetic services in rural and remote regions.

This article summarises the work of the ANZCA GP Anaesthesia Working Group (GPAWG), which was established by ANZCA Council in 2012 to review the history of ANZCA's involvement in GP anaesthesia training, to review developments relevant to GP anaesthesia training (including the activities of other colleges), and to make recommendations regarding ANZCA's future involvement in GP anaesthesia training.

After considering the final report of the working group, presented to the ANZCA Council in June, the council gave in principle support to establishing a diploma of rural general practice anaesthesia, pending scoping of the project and consultation with

the ANZCA Fellows and trainees, the Joint Consultative Committee on Anaesthesia (JCCA) and the boards of the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM).

The council's goal is to provide appropriate training and ongoing support for GP anaesthetists practising in rural and remote Australia, and rural hospital doctor anaesthetists in New Zealand. The introduction of an ANZCA diploma based on the JCCA training program would increase the rigour and reliability of training for rural and remote GPs, would provide an incentive to rural and remote general practice and would entrench the College as the key provider of anaesthesia training in our region. The qualification would be designed for GPs intending to practice where full-time specialist services are not available but where anaesthetic skills are urgently required.

GP ANAESTHESIA IN AUSTRALIA

Current numbers and scope of practice

There are about 500 GPs providing anaesthesia services in Australia, with the numbers being stable over the past 10 years. Approximately 70 per cent of GP anaesthetists administer anaesthesia for more than 150 cases per year. Medicare and survey data indicate that GP anaesthetists have a limited scope of practice, which may include

simple elective and emergency surgeries, anaesthesia and analgesia for labour and delivery, sedation for endoscopy, and resuscitation and stabilisation of critically ill patients prior to retrieval to definitive care. A 2006 survey indicated that 90 per cent of GP anaesthetists provided anaesthesia for paediatric patients and 64 per cent provided epidural anaesthesia/analgesia.

JCCA training

Joint Consultative Committee on Anaesthesia trainees are trainees of the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM). RACGP offers the fellowship in advanced rural general practice (FARGP), which has advanced rural skills training among its requirements. One option is anaesthesia, which uses the JCCA curriculum and accreditation as its requirement for satisfactory completion. ACRRM fellowship requires trainees to complete 12 months of advanced skills training in one of 10 areas. One of these is anaesthesia and ACRRM uses the JCCA curriculum and JCCA accreditation as its requirement for satisfactory completion. Some GPs who have already been awarded FACRRM, FRACGP or FARGP choose to complete an advanced skill training program in anaesthesia at a later date – this is usually supported by ACRRM and RACGP, but securing a training position is up to the individual and again the GP colleges require completion of the JCCA program.



“Council gave in principle support to establishing a diploma of rural general practice anaesthesia, pending scoping of the project and consultation.”

There are several dozen JCCA trainees in accredited posts at any one time.

JCCA training is 12 months long and occurs in facilities approved by ANZCA, Royal College of Anaesthetists or JCCA. Maximums of six months training overseas and three months training in intensive care medicine are permitted. Satisfactory completion of the training period is certified by two supervisors (specialist and GP). Formal assessments include a 60-minute viva examination (with questions designed for each examination locally) and completion of a written review of three cases and/or a small research project or audit. All trainees must complete the Early Management of Severe Trauma or Effective Management of Anaesthetic Crises course. At the end of training, competence in epidural anaesthesia is noted to be present or not, and a lower age limit for paediatric patients is granted (the minimum is three years). The JCCA maintains a register of GPs participating in its triennial Anaesthesia Maintenance of Professional Standards program.

NON-SPECIALIST ANAESTHESIA IN NEW ZEALAND

Provision of anaesthesia by GPs was common in New Zealand, particularly in small centres, until the 1980s. The concentration of services in larger centres and the move to an exclusively specialist or medical officer anaesthesia

workforce means that there are now no GP anaesthetists practising in New Zealand.

In New Zealand, medical officers are doctors registered in the general scope of practice, and practise anaesthesia with the collegial oversight and support of a vocationally registered specialist. There are approximately 20 medical officers working in anaesthesia in New Zealand as of September 2012. Most are international medical graduates who have skills and experience that enable them to practise anaesthesia within their prescribed scope of practice, but who have chosen not to complete the ANZCA training program (if non-specialists) or international medical graduate specialist process (if specialists).

The Division of Rural Hospital Medicine – Royal New Zealand College of General Practice (DRHMNZ) trains doctors for practice in smaller centres, focusing on a broad range of generalist skills, including anaesthesia. Registrars must complete a three month “run” in anaesthesia, and can elect to do a six month run. ANZCA Fellows advise DRHMNZ on the skills that should be covered in the three and six month runs. The guiding principles for DRHMNZ training in anaesthesia are based on the JCCA framework. DRHMNZ registrars must complete an elective year as the final year of training with workplace-based assessment. To date, only one registrar has done a year in anaesthesia.

(continued next page)

GP anaesthesia working group

Members

- Professor Kate Leslie (Chair, Vic)
- Dr Lindy Roberts (President, WA)
- Ms Linda Sorrell (CEO, ANZCA)
- Dr Vanessa Beavis (NZ)
- Mr John Biviano (ANZCA)
- Dr Mark Gibbs (Qld)
- Mr Oliver Jones (ANZCA)
- Dr Andrew Michael (SA)
- Dr Craig Mitchell (Vic)
- Dr Rod Mitchell (SA)
- Dr Frank Moloney (NSW)
- Dr Brian Spain (NT)
- Associate Professor Deborah Wilson (Tas)
- Ms Juliette Whittington (ANZCA)

Sub-project chairs

- History (Professor Kate Leslie)
- Australia (Dr Brian Spain)
- New Zealand (Dr Vanessa Beavis)
- Other non-specialist programs (Associate Professor Deborah Wilson)
- Final report (Professor Kate Leslie)

Assisting

- Ms Michaela Lodewyckx (ANZCA)
- Mr Fraser Faithfull (ANZCA)
- Ms Pam Garrard (JCCA)

“ANZCA and its predecessor, the Faculty of Anaesthesia (RACS), have been involved in training GP anaesthetists for nearly 40 years.”

OTHER PROCEDURAL GP PROGRAMS

ANZCA's GP Anaesthesia Working Group looked at several other programs aimed at training general practitioners headed for rural and remote practice in a limited scope of specialist practice.

RANZCOG's programs in women's health

The Royal Australasian College of Obstetricians and Gynaecologists (RANZCOG) has successfully provided non-specialist pathways in women's health for many years. A three-tiered non-specialist qualification was introduced in 2011 to address concerns around deficiencies in training and assessment associated with the previous program. The pathways were developed by RANZCOG, in conjunction with RACGP and ACCRRM and are the certificate of women's health, the diploma and the advanced diploma. Assessment methods for the three qualifications include multiple-choice question examination, completion of a log book, satisfactory assessment by a supervisor, workplace validation of clinical and procedural skills, oral exams (for the diploma and advanced diploma) and five written case syntheses (advanced diploma only). These qualifications are all re-certifiable and time-limited qualifications (three-yearly contingent on relevant CPD participation).

ACEM's emergency medicine programs

In 2009 the Australasian College for Emergency Medicine (ACEM) determined to provide more education, training and supervision for non-specialist doctors working in emergency departments, particularly in regional and rural Australia. The emergency medicine certificate and the emergency medicine diploma were subsequently introduced. Both qualifications aim to provide non-specialist practitioners of emergency medicine with adequate knowledge and sufficient clinical experience to be safe, efficient practitioners in emergency departments. Candidates must undertake a work placement within an emergency department under the supervision of an approved ACEM supervisor. The requirements for these qualifications include completion of online learning modules, workplace-based assessments, workshops, courses, written reviews of cases, an online multiple-choice question exam and supervisor reports.

Rural generalist pathways in Australia

There is strong political support for the development of rural generalist pathways to address workforce shortages in the rural and remote areas of Australia. These pathways are generally proposed and supported by state or territory governments. While each of these programs is slightly different, core components include specialisation in general practice, either with RACGP, with an additional fellowship in advanced rural general practice (FRAGP), or with ACCRM and additional non-specialist qualifications in anaesthesia, obstetrics and gynaecology, surgery, emergency medicine or indigenous health are also an option. The JCCA qualification is the only one recognised in anaesthesia for the purpose of rural generalist pathways.

Professor Kate Leslie

On behalf of the GP Anaesthesia Working Group



Dr Frank Moloney AM was a foundation member of the JCCA and has served as its chair since 2006. Frank has been Director of Anaesthesia at Orange Base Hospital since 1983 and in that role has trained and mentored dozens of GP anaesthetists. Frank has also served as inaugural chair of the Rural Special Interest Group (1993-5) and remains a member. He joined the ANZCA Council in 2005 and was a member of the GP Anaesthesia Working Group. Frank has been awarded an AM for services to anaesthesia.

The history of GP anaesthesia in Australia

ANZCA and its predecessor, the Faculty of Anaesthesia (RACS), have been involved in training GP anaesthetists for nearly 40 years.

After recognising that specialists would not always be available, the Faculty of Anaesthesia Board encouraged Fellows to participate in GP anaesthesia training courses and created professional documents to guide the credentialing of specialists and GP anaesthetists.

In the early 1980s, the Royal Australian College of General Practitioners (RACGP), National Association of General Practitioner Anaesthetists and the Faculty formed the National Liaison Committee, which laid the foundations for the future of GP anaesthesia training.

By 1991, the committee believed that more formal governance and management of GP anaesthesia training was required and recommended establishment of a joint consultative committee. ANZCA and the RACGP approved the recommendation and the Joint Consultative Committee on Anaesthesia (JCCA) met for the first time on March 11, 1994, at ANZCA in Melbourne.

The committee got to work addressing all the training and continuing professional development requirements of GP anaesthetists in Australia, including identification and accreditation of posts, revisions of the curriculum, guidelines for assessment, and guidelines for accreditation and reaccreditation of GP anaesthetists.

Throughout the years, the issue that continually arose was the question of the certification of GP anaesthesia, such as a diploma. This was never resolved.

Discussion about a diploma arose again among the members of the JCCA and the General Practitioner Anaesthetist Committee (GPAC) of the Australian Society of Anaesthetists (ASA). The matter was raised at ANZCA's Education and Training Committee and the ANZCA Council and in 2012 the council convened the GP Anaesthesia Working Group, chaired by Professor Kate Leslie.

The working group has reviewed the history of GP anaesthesia training in Australia and summarised the status of GP/non-specialist anaesthesia in Australia and New Zealand, and the work of other colleges in training GPs in procedural practice.



Steppe by Steppe: *Initial emergency care in Mongolia*

Dr Simon Hendel gained much from his experience as the recipient of an ANZCA Overseas Aid Trainee Scholarship.

Being largely ignorant of Mongolia and its history prior to travelling there, my notions were no more formed than clichéd ideas of Chinggis Khan merged somehow with years of Soviet occupation. I had prepared myself for boiled mutton fat washed down with homemade vodka for breakfast, lunch and dinner. I couldn't have been more wrong.

It's an exciting time for Mongolia and not only for anaesthetists. Sandwiched between Russia and China and rich in mineral resources, Mongolia is in the throes of an economic and social boom, driven largely by the mining industry. This boom has seen vast sums of money injected into the country, particularly the capital, Ulaanbaatar.

Boutique stores such as Louis Vuitton, Hugo Boss and Ermenegildo Zegna

juxtapose potholed roads and the city's population of urban poor. Like many booms in developing countries, one effect is to highlight the enormous disparity between the haves and the have-nots. The other is to inject money into a country that previously didn't have much.

It's not my place to discuss the relative merits and detriments of foreign investment for development in general, however, the Australian investment of time and money into the joint Australian and Mongolian anaesthesia project has been overwhelmingly successful.

Australian anaesthetists have travelled annually to Mongolia since 2001, when Ulaanbaatar, I'm told, was still a small town. The origins and progress of anaesthesia in Mongolia since that time have been previously published in the *ANZCA Bulletin*, so I won't go through it again. The secret to the program's success

lies in the collaborative support provided to key local champions by Australian anaesthetists and in the educational focus of the project. It was a privilege to participate in this project in my final year of training, as the recipient of an ANZCA Overseas Aid Trainee Scholarship.

The Joint Australian Society of Anaesthetists (ASA)/Mongolian Society of Anesthesiologists (MSA) Continuing Medical Education Seminar for 2013 was a successful first step in the implementation of initial emergency care education in Mongolia. The Australian and New Zealand College of Anaesthetists and the Australian Society of Anaesthetists donated 100 oximeters jointly – 26 were successfully distributed during this seminar along with the corresponding education package. The remainder will be allocated by the MSA.

“The opportunity to work together and grow friendships with anaesthetists of a similar age in low and middle-income countries is an important part of ensuring the longevity of organisational relationships”



The much-lauded Essential Pain Management course was also run with great success.

The support of ANZCA in making this scholarship available is an enormous asset, which enables Australian trainees to gain experience and build professional relationships in other parts of the world. The opportunity to work together and grow friendships with anaesthetists of a similar age in low and middle-income countries is an important part of ensuring the longevity of organisational relationships, such as this.

The ready access to email, Skype and social networking sites, such as Facebook and LinkedIn, make collaborating with our Mongolian colleagues easier than ever. However nothing beats face-to-face communication. It is only with the strength of a genuine professional and

personal friendship with peers that we can support one another to improve outcomes for our patients. By collaborating, as with the ASA/MSA partnership, we each gain significantly and take valuable lessons back to our practice.

There is widespread and growing interest among prevocational and vocational trainees in global health. This is clear in the number of undergraduate and graduate global health societies as well as annual conferences such as the Global Ideas Forum. An increasing number of resident medical officers, registrars and Fellows are pursuing further global health training through masters of public health or masters of international health degrees.

ANZCA has shown leadership among other specialty colleges by supporting scholarships such as this for interested and qualified trainees. Engaging trainees in the

issues of global health and development is essential for the future of relationships as described above, but also for producing grounded and globally minded specialists.

Dr Simon Hendel, FANZCA

For more information on the ANZCA Overseas Aid Trainee Scholarship 2014 please visit www.anzca.edu.au/fellows/overseas-aid or email overseasaid@anzca.edu.au.

Clockwise from left: The view from Arkhangai Aimag Hospital; Dr Simon Hendel and Dr Tim Furlong feeling slightly underdressed with the National Mongolian Military Band in their dress uniforms at the course dinner in Ulaanbaatar; Airway training in Ulaanbaatar; Australian and Mongolian Faculty with Mongolian course participants in Arkhangai Province. Professor Ganbold Lundeg, the immediate past president of the MSA is seated fourth from the left; Delivering a Lifebox pulse oximeter to the operating theatres in Arkhangai province.

Advancing education, training and assessment: ANZCA revises its governance

ANZCA has revised the structure of its educational committees following widespread consultation and a comprehensive review of its education, training and assessment governance, led by ANZCA Vice-President, Dr Genevieve Goulding.

The new structure is designed to better serve ANZCA's education, training and assessment needs.

Since it was introduced, the Education and Training Committee (ETC) grew to oversee all of the education, training and assessment activities of ANZCA. The introduction of the revised curriculum and an increase in quality, complexity and offerings in education, training and assessment, meant it was time to review the ETC and its sub-committees.

The review sought input from all ETC members and ETC sub-committees, the ANZCA Council, regional committees, education officers, trainees, the Medical Education Special Interest Group and other stakeholders.

The new structure shown on the opposite page was introduced at the start of September.

The new committees, sub-committees and project groups will ensure ANZCA's curriculum is contemporary, fit for purpose, innovative, responsive to community needs and aligned to regulatory standards.

More efficient processes for high quality outcomes

The review found that committee agendas were overloaded with delivering existing processes, so new initiatives and making significant changes, such as those in the revised ANZCA curriculum, were proving difficult.

Encouraging more involvement from Fellows and trainees

The review also confirmed that committee members would prefer shorter-term involvement as their priorities and workloads changed.

As an underlying philosophy of the revised governance structure, ANZCA will welcome Fellows and trainees who have the interest, knowledge and skills to contribute to continually improving education, training and assessment.

Opportunities will also exist for Fellows and trainees to contribute to project groups with specific, time-limited work requirements.

Networks of key individuals, for example examiners, supervisors of training or special interest groups, will be strengthened with more collaborative forums and valuable resources to share knowledge and experiences.

New committees include:

- **The Education, Training and Assessment Executive Committee**
The dean of education chairs this committee, which reports to the ANZCA Council. The committee oversees, guides and reports on the activities of the Education, Training and Assessment Management Committee and Education, Training and Assessment Development Committee to ensure implementation of the education, training and assessment initiatives of the College strategic plan and annual business plans.
- **The Education, Training and Assessment Strategy Committee**
The dean of education also chairs this committee, which reports to the ANZCA Council. The committee provides advice to enable the definition of the College's strategic direction with respect to education, training and assessment to ensure our activities are world class.

- **The Education, Training and Assessment Management Committee**

Dr Richard Horton (Vic) will chair this committee, which reports to the Education, Training and Assessment Executive Committee and hence to the ANZCA Council. It is the decision-making committee ensuring ongoing quality assurance and management on all components of education, training, assessment and accreditation.

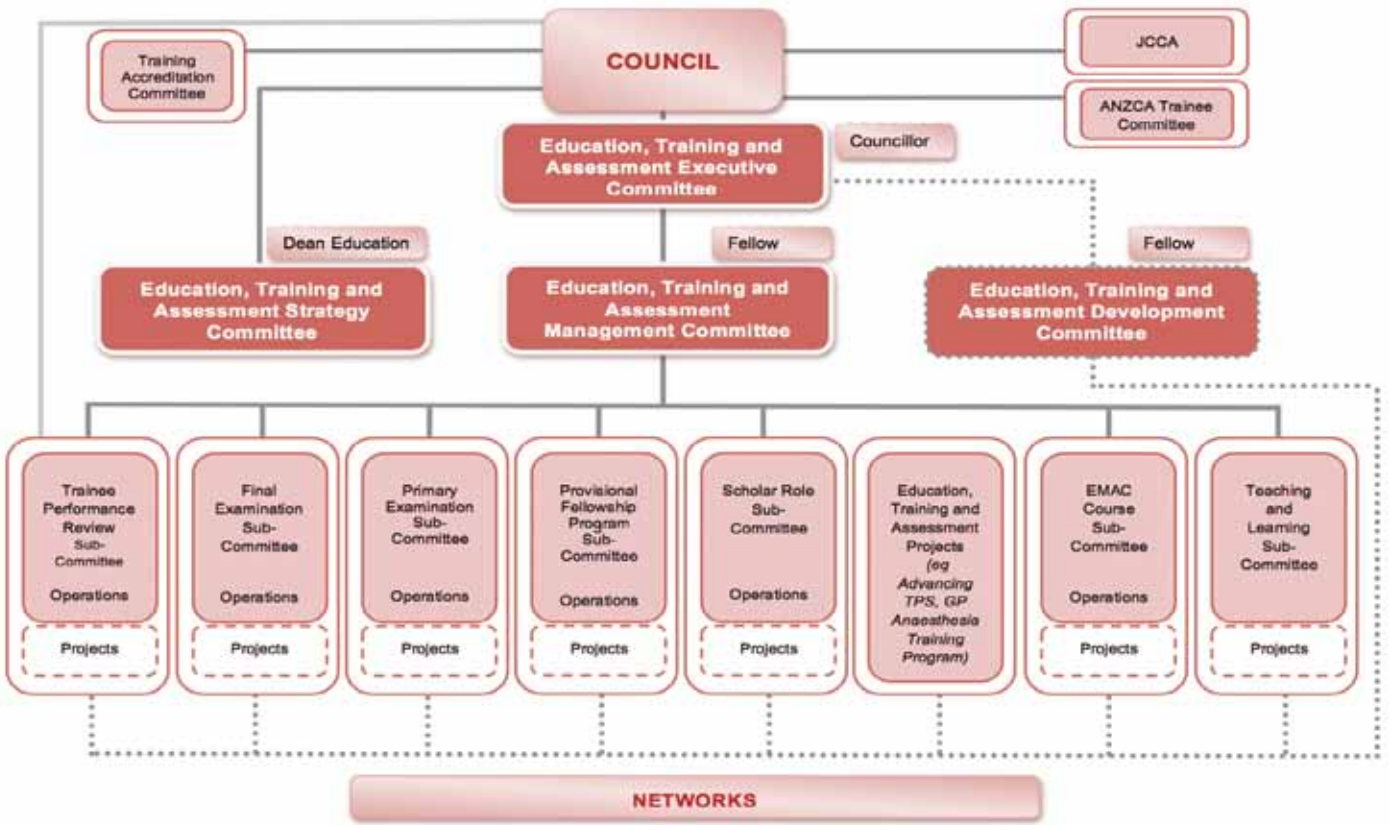
- **The Education, Training and Assessment Development Committee**

Dr Damian Castanelli (Vic) will chair this committee, which reports to the Education, Training and Assessment Executive Committee and hence to the ANZCA Council. It ensures ongoing quality improvement of all components of education, training and assessment through the oversight of significant improvements and new initiatives in education, training and assessment.

The sub-committees (for example, the exam and EMAC sub-committees), driving the delivery of all areas of education, training and assessment (as outlined in the diagram on the opposite page) will typically report to the Education, Training and Assessment Management Committee to ensure ongoing quality in delivery. Sub-committees will be encouraged to suggest new initiatives, improvements and review projects, which will typically result in establishment of project groups of a sub-committee or of the higher level committees. The projects will be fully defined and will have the required resources to ensure successful delivery and high quality outcomes.

Dr Genevieve Goulding
ANZCA Vice-President

Education Governance at ANZCA



New Fellows Conference

Time capsule – my legacy

How do you wish to be remembered? When you evaluate your career at its close, 25 years from now, what will your professional and personal legacy be?

In Singapore next year, invited new Fellows will bring emblems of contemporary anaesthetic practise, and their advice to young specialists of the year 2039, to put in a time capsule. Following this, from May 2-4 at the luxurious Sentosa Resort, the group will share experiences and hear from expert colleagues, finally formulating recommendations for the legacy and direction of anaesthesia.

Professor Richard Walsh, a former ANZCA president and medical board member, will illuminate some of the

“darkest days” faced by anaesthetists and departments – struggles with funding, accreditation, bureaucracy, illness, recognition, tricky decisions. Dr Richard Morris, the director of anaesthesia at St George Hospital in Sydney, will help draft your foundation plans for the “department of your dreams”, creating a culture aligned with your vision, recruiting, balancing, and nurturing yourself and your peers. Professor Christine Jorm, an anaesthetist, neuropharmacologist and sociologist, will discuss propagation of information and refashioning a large system – “Is change a myth?”, is there such a thing as autonomous innovation with inertia, pride, adminstrivia, so many entrenched customs? And, what does modern psychology show us about how change comes about?

Uniquely, the 2014 New Fellows Conference will include crossover

sessions with the surgeons’ Young Fellows conference. There will be input from both sides of the drapes in international aid, music, communication, work-life balance and an inevitably feisty comedy debate about open disclosure and surgical statistics.

The pace of the sessions also will allow for recreation, peace and informal socialising. Delegates will have the chance to try standing wave surfing at the island, sample a variety of the representative Asian cuisines, and enjoy many resort leisure activities including petanque, volleyball, tai chi, and indulgence in the beautiful pool and waterfront.

Dr Andrew Kennedy, FANZCA
Convenor, New Fellows Conference

Applications now open New Fellows Conference 2014

“Time capsule – my legacy”

Friday May 2
– Sunday May 4
at The Sentosa,
Resort & Spa,
Sentosa Island

Applications are invited from Fellows in all training regions for selection to attend the 2014 New Fellow’s Conference (NFC) in Sentosa Island, Singapore. To be eligible, Fellows must be within five years of fellowship on Friday November 1, 2013 and attending the 2014 Annual Scientific Meeting (ASM).

Selection will be undertaken by the regional and national committees of ANZCA and FPM.

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

The College and Faculty will be responsible for the costs of this seminar; however the applicant is

responsible for the cost of travelling to and from Sentosa Island and all ASM registration and associated fees. This conference is strictly for Fellows and families will not be permitted to attend.

Written applications, with accompanying curriculum vitae and the names of two referees, should be forwarded to the relevant ANZCA regional or national committee or the Faculty of Pain Medicine by Friday November 1, 2013. Successful applicants will be notified in early December. Committee details can be found at www.anzca.edu.au/about-anzca/Committees/regional-and-national-committees.html.

For further information please contact: Eleni Koronakos, ASM Co-ordinator, ANZCA, 630 St Kilda Road, Melbourne, Victoria, 3004, Australia.

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Fax: +61 3 9510 6786
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New Fellows Conference 1992: Where are they now?

The New Fellows Conference (previously the Younger Fellows Conference) is designed to provide participants with skills to assist them in dealing with their professional lives and relationships during their work in anaesthesia and pain medicine. Special emphasis is placed on professional excellence, leadership and involvement in College and Faculty affairs.

In 1992, the year ANZCA became a college, the Younger Fellows Conference was held at Thredbo, NSW. We asked seven participants how life, and anaesthesia, had treated them in the last 21 years.



**Associate Professor
Marianne Chapman,**
Royal Adelaide Hospital

After finishing her training in Jerusalem the year after the conference, Associate Professor Chapman returned to Australia as an intensive care consultant at the Royal Adelaide Hospital. Her interest in research, coupled with a “dire lack” of intensive care researchers saw her career steer into part-time research while she continued her clinical commitments.

She completed a PhD in nutrition in critical illness and has continued her research into nutrition and glucose management in intensive care patients. Her research program has been supported in part by the Anaesthesia and Pain Medicine Foundation.

Associate Professor Chapman said in intensive care the focus is traditionally on the management of organ dysfunction, particularly ventilation and circulation, and as a result nutrition is often a low priority. But she believes it is vital to address how critical patients can be adequately nutritionally managed if they are to enjoy their best chance at recovery.

“In critically ill patients there is abnormal gut function,” she said.

“It is the gut’s response to severe illness – it stops working properly, stops contracting and stops absorbing.”

In her research program she quantifies abnormal gut function and how that affects nutrient delivery and absorption.

“When patients are in intensive care for a number of days to weeks, many will leave with muscle wastage, poorly nourished and with their strength gone.

“Our aim is to help them recover faster, stronger and better.”

“It is wonderful, anaesthesia is one of the greatest discoveries that has ever happened in medicine – imagine the world without it – but it always has the potential for disaster unless safe and established practices are followed.”

Dr Neville Gibbs



Dr Neville Gibbs,
Sir Charles Gairdner Hospital, Perth

Dr Gibbs already had six years of experience as an anaesthetic consultant when the College formed in 1992 – three years in the US and three years in Australia. While his primary interest through most of his career has been cardiac anaesthesia, he admits to a “love of all anaesthesia”, including liver transplants and echocardiography. He has worked mainly at Sir Charles Gairdner Hospital in Perth, where he was Head of Department from 1997-2013. He has pursued research interests into anaesthesia safety and blood coagulation and has published many research and review articles and book chapters. He also completed a Doctor of Medicine degree. He has been highly active in education, being a primary examiner for 12 years. Dr Gibbs edited the last three “Safety in anaesthesia in Australia” triennial reports and still participates in the ANZCA Quality and Safety Committee. He is currently the chief editor of the journal *Anaesthesia and Intensive Care*. He said he has particularly enjoyed his involvement in the promotion of the specialty of anaesthesia and anaesthesia safety.

Dr Gibbs remains enthusiastic about his career and his profession. “I still love giving anaesthetics – the wonder of it, of being able to prevent awareness and to relieve pain,” he said. “Every single time, I think ‘wow, isn’t that amazing!’ Anaesthesia is one of the greatest discoveries in medicine – imagine the world without it – but it always has the potential for disaster unless safe and established practices are followed.”



Dr Paul Wajon,
Royal Prince Alfred Hospital, Sydney
and private practice

Dr Wajon has specialised in cardiothoracic anaesthesia and twice a year treks to Burma with a cardiac team to teach local doctors new skills.

“A cardiac team is a big team and as a big country with a small skills base Burma doesn’t have the workforce to meet the need,” Dr Wajon said.

Although he pursued some research interests in his area of expertise in the 1990s his interest was always more clinical than research-based.

While medical interventions are more sophisticated and effective than 20 years ago, Dr Wajon said he has been struck by the changing demographics of patients in just one generation.

“Cardiothoracic patients are getting older and sicker, surgery is more complicated and operations are longer.

“Then there is the insidious increase in patients with multi-system organ disease.”

The role of the anaesthetist has changed too, he believes, with the perioperative approach to patient management and greater anaesthetist involvement in post-operative management of pain.

New Fellows Conference 1992: Where are they now? continued



Dr Charles Loader,
private practice, Melbourne

In 1992 Dr Loader was a staff anaesthetist at St Vincent's Hospital in Melbourne. Eventually he moved into private practice, which has now made up the majority of his career. Choosing not to enter research, he has a typical mix of any practice, but with an interest in the fields of spinal and colorectal surgery. "Research is vitally important but unfortunately is underfunded in Australia."

Dr Loader said the last 20 years had ushered in a great many changes and new challenges for anaesthesia, mostly for the better and some, he said, making his profession cumbersome, particularly in relation to administrative and compliance burdens, and issues facing the private health insurance model. Workforce issues and an apparent oversupply of anaesthetists are also of concern for young fellows entering the system.

"There are a whole new lot of drugs and monitoring equipment as well as the widespread use of ultrasound," he said.

"Technology has dramatically improved and patient outcomes are better – survival now in cases that may have not been possible 20 years ago.

Another change has been the rise of the number of obese patients "a new area of potential stress for every anaesthetist" and an increased number of patients who present with multisystem disease makes procedures more complex, but also more satisfying when things work out well.

He has an interest in the welfare of anaesthetists and how simulation can improve outcomes. "Often our services go unappreciated because the results are generally so good."



Dr Keith Greenland,
Royal Brisbane and Women's
Hospital and private practice

Dr Greenland was in private practice at the time he attended the Younger Fellows Conference until 1997 when he went to Hong Kong to work – one week before the transfer of sovereignty from the UK to China.

"It was interesting time and a lot of professionals were leaving because of the changeover," he said.

Dr Greenland returned to Australia in 2004 and from that time mixed his workload between private practice and the public system, including preparing 10 coronial reports and providing expert opinion to the state coroner.

His particular interest is in airway management and he received a doctor of medicine for his thesis in 2010.

The last 20 years have seen a lot of changes in the way anaesthetists work driven he said, by "huge leaps forward" in technology which has made the work easier than it was one generation ago.

But despite the advances, he said, anaesthesia never lost its challenge.

"It can be the simplest cases that can fall apart. You have to constantly be thinking ahead.

"We are often aligned with the aviation industry but the truth is 747s are all the same but every patient is like a different plane.

"A good anaesthetist comes with experience and a great duty of care.

"Even surgeons sometimes say we just put people to sleep but the truth is anaesthesia is a huge task to master and anaesthetists are one of the few true generalists in medicine."



Dr Lachlan Doughty,
Launceston General Hospital
and private practice

Dr Doughty didn't hesitate when asked what had been among the greatest emerging challenges in his field since 1992.

"The ever-increasing mass and size of patients," he said.

Obesity created complexities for the anaesthetist and was often associated with other conditions such as type 2 diabetes and cardiovascular disease, which compromised the patient's overall health during surgery.

While there had been a great improvement in the management of patients, Dr Doughty said he was concerned that time pressures meant there was not always the time to develop a rapport with the patient and this also meant a lack of time to explain the out-of-pocket expenses patients incurred.

"Patients aren't always prepared for the gap payment, especially in rural and regional areas and the situation is untenable," Dr Doughty said.

"If we follow the [suggested price schedule], patients have crippling out of pocket expenses.

"The Medicare rebate has not increased according to CPI and it really needs to be reviewed."

Other areas of improvement in anaesthesia were the increase in day-only admissions, the advent of new drugs and the important introduction of propofol and reduced recovery time.

He believes there has been dramatic improvement in anaesthesia since he started his career – but working in a regional centre is a great motivator for staying at the top of your game.

"You see the families and the patients, you know them and they know you. That is the biggest quality control program around."

What it means to be the new Fellow councillor



Dr Nicholas Gemmell-Smith,
Canberra Hospital and private practice

A paediatric anaesthetist who also works in orthopedics, Dr Gemmell-Smith spent a year in the US after the 1992 conference and today mixes private and public work in Canberra.

Dr Gemmell-Smith travels every year to a developing country to share his skills and provide balance in his career.

At home the biggest changes he describes in his paediatric work is the growth in gastroscopy and endoscopy procedures which, which he believes, is evidence of the increase in coeliac disease and other inflammatory bowel disease.

The increase in ultrasound identification of foetal abnormalities in pregnancy is largely the reason, he believes, for the decrease in his lists of major surgery in newborns and he has enjoyed watching the advances in technology lead to more sophisticated drugs and equipment.

“People are getting mobile faster and we are better at managing pain than when I started in anaesthesia, which is satisfying to see,” he said.

But he joins his colleagues in describing one of the biggest challenges of the last 20 years: the “tidal wave of obesity” in patients.

Ebru Yaman Media Manager

The eighth anaesthetic representative at the 1992 Younger Fellows’ Conference, Dr George Osborne, died in 2001.

“Another change has been the rise of the number of obese patients ‘a new area of stress for every anaesthetist’ and an increased number of patients who present multi-system disease makes procedures more complex.”

Dr Charles Loader



My two-year term as new Fellow councillor started in May 2012 and I will be handing over to the next new Fellow councillor at the ASM in Singapore in 2014.

Nominees for the next new Fellow councillor on ANZCA Council will be called for in November with voting from February. What follows is a brief description of the role.

The new Fellow on Council must be within three years of attaining fellowship; the term is for two years; they have full voting rights; they are ex-officio to their respective national or regional committee. The new Fellow Councillor is also a member of the Fellowship Affairs Committee, and is invited to the New Fellows Conference that precedes each annual scientific meeting (ASM).

In addition, there are lots of other ANZCA activities in which the new Fellow councillor can get involved. Examples of this include participation in various working groups and regularly being asked to give a new Fellow’s perspective on issues such as continuing professional development (CPD) and other services for Fellows.

From a more selfish point of view, there is opportunity for personal development around the role of being a board member. This could potentially include doing an Australian Institute of Company Directors course. I have also found that simply listening to and participating in the discussions at ANZCA Council is very worthwhile. I have enjoyed discussing big-picture policy issues, such as those surrounding workforce, revalidation and the new ANZCA curriculum.

With the large number of new Fellows in Australia and New Zealand, I feel that it is increasingly important that young anaesthetists starting out their careers have an opportunity to influence ANZCA strategy and policy. ANZCA has acknowledged this for some years, and the position of new Fellow on Council is one of the key ways that new Fellows have been given a voice.

Since being on Council, I have also come to the view that the new Fellow position provides some balance on a Council which, for better or worse, tends to be weighted towards directors of departments and others in senior positions.

With this in mind, I encourage all interested new Fellows to consider running for the position of new Fellow councillor.

Dr Gabriel Snyder, FANZCA New Fellow Councillor

Electing a new Fellow councillor

At the end of November, all Fellows within three years of admission to ANZCA fellowship by training and examination will be invited to nominate for the role of new Fellow on ANZCA Council. Ballot papers are sent out at the end of February and the ballot count completed in mid-April with the successful candidate informed soon after.

For further information, email president@anzca.edu.au.

Dean's message



After years of nurturing, the electronic persistent pain outcome collaboration (ePPOC) initiative has now taken its first steps towards data collection.

ePPOC has been a major initiative priority of the Faculty for three years. In line with the Faculty's strategic plan, our second key pillar is to "build curriculum and knowledge". ePPOC provides a platform to contribute meaningfully to the international knowledge base of pain medicine and directly change clinical practice accordingly.

ePPOC is a collaborative effort with the Australian Pain Society and the Australian Health Services Research Institute. More recently, in response to the recommendations of the National Pain Strategy, the NSW minister for health, via the Agency for Clinical Innovation (ACI) has provided the necessary funding to bring the project to fruition. This project illustrates the effective co-operation that is achievable with external bodies for the overall benefit of pain medicine practice and ultimately the treatment of pain in the community.

The benefit of outcome data in improving pain management was addressed in the leading review article in a recent edition of our official Faculty journal, *Pain Medicine*.¹ In this publication, the importance of outcome data is emphasised as a vehicle to develop an evidence-based system that efficiently and effectively improves chronic pain treatment quality and cost effectiveness. This article provides a timely endorsement of the value of the ePPOC project and the direction of the Faculty strategic plan.

Congratulations and thanks goes to Dr Chris Hayes who has championed this project over a number of years on behalf of the Faculty. Thanks also to Dr Carolyn Arnold who is the Faculty's second representative on the newly formed ePPOC National Reference Group.

In light of the recent federal election, it is timely to review the important role that we as clinicians have, both individually and via our peak medical organisations, such as the Faculty and College, in appropriate advocacy to improve healthcare in our community. In this regard, there are important recent lessons to be learned from abroad.

The published findings in the UK of the Francis report *The Mid Staffordshire NHS Foundation Trust Public Inquiry* released in February 2013 were damning in their condemnation of the "saving at all costs agenda of the Mid Staffordshire NHS Foundation Trust".²

This report documented avoidable patient deaths, injury and suffering attributed primarily to misguided priorities of the governing NHS board. Political and financial benchmarks had overcome patient outcomes as the key driving government objections.

Don Berwick's recently published response to the *Mid Staffordshire* report, commissioned and published on behalf of the NHS, is both constructive and appropriate and an example of learning from previous mistakes. Titled "A promise to learn, a commitment to act – improving the safety of patients in England"³, there are many lessons in this significant document. In the opening executive summary there are 10 recommendations listed. Importantly, seven of these recommendations can be summarised as emphasising the importance of audit, learning and education for health professionals as well as patient-centred care. It is heartening that these core principles constitute the central values of the Faculty's own strategic plan.

The colleges and faculties of our medical system occupy a privileged position in the medical landscape as well as in our society. As well as a delegated obligation to train and examine aspiring specialists, there is a wider obligation to advance and advocate on behalf of our patients. The Mid Staffordshire report emphasises the importance of specialists, individually and collectively, accepting this privileged position as well as accepting the important responsibility to continue to advocate on behalf of our patients.

Associate Professor Brendan Moore
Dean, Faculty of Pain Medicine

References:

1. Witkin L, Farrar J, Ashburn M. Review Article: Can Assessing Chronic Pain Outcome Data improve outcomes? *Pain MED* 2013; 14: 779-791.
2. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Robert Frances. February 2013
3. A promise to learn – a commitment to act. Improving the safety of patients in England. National Advisory Group on the Safety of Patients in England. Don Berwick. August 2013

Admission to fellowship of the Faculty of Pain Medicine

By examination:

Yin Yee Leung, Daniel Berge, Sunny Yuk Ming Lee, Safa Hamza, Aarathi Rachel Vaska, Renuka Mendonca

We are pleased to report that this takes the total number of Fellows to 354.

Training Unit Accreditation

Following successful reviews, the Hunter Integrated Pain Services and the Concord Hospital Pain Management Unit have been reaccredited for pain medicine training.



Faculty of Pain Medicine Board 2013

Back row: Dr Chris Hayes, Dr Michael Vagg, Dr Newman Harris, Professor Stephan Schug, Associate Professor Ray Garrick, Associate Professor David Scott, Ms Helen Morris (General Manager).

Front row: Dr Kieran Davis, Dr Melissa Viney, Professor Ted Shipton (Vice-Dean), Associate Professor Brendan Moore (Dean), Dr Dilip Kapur, Dr Meredith Craigie, Associate Professor Andrew Zacest.

Chronic pain a major cause of health loss

Chronic pain is a leading cause of health loss for New Zealanders, a report has found.

Health Loss in New Zealand, which can be found on the www.health.govt.nz website, details results from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006-2016. The study analyses health losses sustained by New Zealanders of all ages, both sexes and both major ethnic groups. Health loss (or burden of disease) measures how much healthy life is lost due to premature death, illness or impairment.

The report found that chronic pain is one of the leading causes of health loss for New Zealanders, collectively accounting for at least 5 per cent of the health loss recorded in the study. This makes it a

burden similar in size to that of anxiety and depression, which the report ranks as second only to coronary heart disease in terms of its contribution.

The Chair of the Faculty of Pain Medicine's New Zealand National Committee, Dr Kieran Davis, issued a media release on Friday August 9 commenting on these points.

The report provided valuable data, which could assist with health policy and planning, Dr Davis said.

He noted that the figures in the report were based on 2006 data and said: "...with an ageing population, we can expect the incidence of chronic pain to increase considerably and to require much more of our healthcare resources.

"There has already been acknowledgement of this, with the medical council recently recognising pain medicine as a specialist scope of practice and several health boards having specialist pain clinics but much more will be needed. We must not underestimate chronic pain when it comes to New Zealanders' quality of health."

Earlier on August 9, Dr Davis had discussed chronic pain in a "very productive" meeting with Dr Don Mackie, an anaesthetist who is the Chief Medical Officer at the Ministry of Health.

Susan Ewart,
ANZCA Communications Manager,
New Zealand

Zit bacteria causing back pain – a spotty hypothesis

While there is cause for optimism, this proposed cure for back pain is far from revolutionary.

You are most definitely going to hear a lot more about this Danish study (“Does nuclear tissue infected with bacteria following discherniations lead to Modic changes in the adjacent vertebrae?” in *European Spine Journal* (2013) 22:690–696) regarding back pain. The claim the researchers are making is very interesting. They present plausible preliminary evidence that a bacteria called *Propionibacterium acnes* seems to be present in some degenerated lumbar discs at rates well above chance. This is the same bug that is thought to cause good old spots, zits, blinders etc (the clue is in the name). They also report that a prolonged course of a common antibiotic (100 days was the duration chosen, rather arbitrarily perhaps) was able to significantly reduce back pain symptoms in patients with a particular type of MRI change on their scans.

These studies have been greeted with fairly fulsome praise from some quarters and more measured reporting from others. There has been talk of Nobel prizes. I wouldn't disagree that if firmly established this could be the biggest advance in infectious diseases since Barry Marshall chugged a schooner of live *Helicobacter Pylori* on stage at a conference to highlight his and Robin Warren's work on its link to gastric ulcers. Not many voices are being raised in reply. Here are my comments about this work in no particular order.

- The proposed mechanism is plausible, though there are some significant issues. *P Acnes* is a very low-virulence organism and its presence may well be incidental or an epiphenomenon. It can provoke inflammation with even a low-grade infection however, and this is perhaps the main appeal of the hypothesis.

- Establishing a causal relationship for an organism to cause disease is usually done by proving Koch's postulates for the bug concerned. This hasn't been done for *P Acnes* in low back pain.
- Another reliable set of criteria for establishing causation is the Bradford Hill criteria, which is also far from being completed. More basic science will surely follow as a matter of urgency now this evidence has been published. Note that Marshall and Warren had mostly done all this groundwork by the time they advanced their hypothesis to public attention.
- The antibiotic used in the study was Amoxicillin combined with Clavulanic acid. Clavulanic acid has been previously shown to have an anti-inflammatory action via its ability to inhibit pro-inflammatory cytokines. In other words, a large and well-established body of research suggests that the antibacterial action of the antibiotic may very well be irrelevant to its painkilling ability. I have several patients with chronic pain of various types whose pain is temporarily relieved for a few weeks by a stiff course of antibiotics.
- Extraordinary claims demand extraordinary evidence. The evidence presented by these researchers is fascinating and intriguing but most definitely not extraordinary. As well-conducted as this research has been, the idea that “40 per cent of all chronic back pain can be cured” is completely misleading and overblown. In fact, the research as presented does not in fact suggest a cure but just a reduction in average levels of pain.

- Even if one accepts the slightly patchy argument that a substantial chunk of chronic back pain is due to infection by *P Acnes* the proposed treatment is highly problematic. Overuse of Amoxicillin/Clavulanic acid is one of the major contributing factors to the rise of antibiotic-resistant superbugs. A prolonged course as described would leave you with nothing but a gutful of highly antibiotic-resistant flora. Serious super-infections from notorious marauders such as *Clostridium Difficile* would be inevitable. Such super-infections take weeks of isolation and barrier nursing to resolve. Not to mention the routine diarrhoea. You may well not fancy the idea of needing a faecal transplant to cure a life-threatening complication of your back pain treatment.
- There is no really practical way to tell yet whether any given individual would benefit from undertaking a trial of such experimental therapy. Chronic pain sufferers are incredibly easy to sign up for improbable treatments, and their interests need to be advocated for by subjecting any claim to a cure to serious scrutiny. I wouldn't recommend this therapy to one of my patients unless I had a way of knowing I could offer them good odds.

So hold the phone to Stockholm. Proposed mechanisms of causation for chronic back pain have come and gone. This one is at least plausible, and gives a direction for further research. In the best traditions of science, it allows one to formulate disprovable predictions. Although regular careful readers will be able to detect the undertone of optimism and excitement in my appraisal, this proposed mechanism of long-term back pain has a long way to go before I'm going to call it revolutionary.

Dr Michael Vagg, FFPMANZCA
Clinical senior lecturer at Deakin
University School of Medicine and pain
specialist at Barwon Health

*This article first appeared on
The Conversation website –
<http://theconversation.com/au>*

THE CONVERSATION

Alerts

Hydroxyethyl Starch Solutions (Hes)

The use of hydroxyethyl-starch (HES) solutions has been under scrutiny following publication of studies of its use in critically ill patients^{1,2,3}. These compared HES with crystalloids and demonstrated increased risk of kidney injury requiring dialysis in patients with severe sepsis treated with HES. Two of the studies also showed a higher mortality in the HES group.

ANZCA has received advice that the Therapeutic Goods Administration in Australia is initiating a full inquiry into hydroxyethyl starch solutions and has issued the following caution regarding Voluven and Volulyte, advising that it should be used only in low-risk patients: "At this time, health professionals are advised not to use hydroxyethyl starch in patients with sepsis, renal failure including those requiring dialysis, severe liver failure, fluid overload, severe hyperchloraemia or hypernatraemia, patients with intracranial bleeding, and in patients with a known hypersensitivity to hydroxyethyl starch."

MedSafe NZ is reviewing information from the manufacturer of Voluven and Volulyte.

Alternatives to starch-based colloid solutions for volume resuscitation include gelatin-based solutions, with shorter effect durations and a higher incidence of anaphylaxis, and albumin. Crystalloid or albumin should be used for fluid resuscitation in sepsis and probably in other patients at risk of renal impairment.

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3. Myburgh JA, Finfer S, Bellomo R, et al. Hydroxyethyl starch or saline for fluid resuscitation in intensive care. *N Engl J Med* 2012;367:1901-11.4. www.fda.gov/BiologicsBloodVaccines/SafetyAvailability/ucm358271.htm

Philips HeartStart MRx Monitor/Defibrillators: malfunction of paddles, therapy cable connection and ECG acquisition

Several models have been implicated in each of these malfunctions and Philips has issued an urgent notification.

In automated external defibrillator (AED) mode, an affected device may experience difficulty interpreting the pads' ECG waveforms with potential for failure of analysis or incorrect analysis of the waveform during a resuscitation attempt. This may result in inappropriate therapy or failure to deliver therapy. In the manual mode, the user may have trouble interpreting the pads' ECG waveform and determining whether or not to deliver a shock.

The same monitor/defibrillator models have shown accelerated wear of the cable connection between the pads/paddles and device port when used in transport. This may result in delayed therapy, incorrect energy delivery, spontaneous discharge and interrupted pacing. All devices should be inspected and removed from use if displaying signs of wear.

One model may fail to analyse a 12 lead ECG during acquisition and this can be rectified with a software update from Philips.

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



The Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) and the web-based anaesthetic incident reporting system (webAIRS) has undergone some significant developments, including an enhanced demonstration program¹, registration assistance links, frequently asked questions and additions to the morbidity and mortality reporting tool.

ANZTADC also is hosting the Australian and New Zealand Anaesthetic Allergy Group (ANZAAG) website on the webAIRS server. There are great synergies with this arrangement primarily with the possibility of sharing of information relating to anaphylaxis data.

Presentations

There are 57 hospitals registered with webAIRS and 1799 incidents had been reported until July 31. A presentation at the ANZCA 2013 ASM highlighted drug errors, management of anaphylaxis, and the potential to use mobile apps in crisis management. This presentation is available in the logged-in users area of the ANZCA website.

At the Australian Society of Anaesthetists National Scientific Congress in Canberra in September there will be a webAIRS presentation titled "Lessons from critical incident reporting in anaesthesia". This will include the interim analysis of data from the webAIRS database along with some practical examples of how to improve clinical care. This is a joint session with Professor Keith Ruskin presenting "Judgement, decision-making and risk management" and Professor Colin Mackenzie presenting "Video task analysis in healthcare".

Publications

WebAIRS interim data also has contributed to a paper titled "The introduction of pre-filled metaraminol and ephedrine syringes into the main operating theatres of a major metropolitan centre". This invited paper has been submitted to *Australian Anaesthesia*². A further invited paper titled "Incident reporting at the local and national level" has been submitted to *International Anesthesia Clinics*³, as a joint effort between ANZTADC and the Anesthesia Quality Institute.

Recent alerts

Alerts reported include two reports where failure of equipment led to airway management problems.

- WebAIRS has received an alert that two patients have bitten through the wall and into the lumen of a new brand of reinforced LMA. Both cases occurred during the emergence phase after eye surgery. At this webAIRS site, one of the anaesthetists performed a comparison bite test with this model LMA and a standard reinforced endotracheal tube. He easily bit through the wall of the LMA and was unable to bite through the reinforced ETT. The site that reported the problem has since withdrawn this brand of armoured LMA from use. webAIRS cannot release the brand name before it has received a reply from the manufacturer and reported the problem to the Therapeutic Goods Administration in Australia and Medsafe in New Zealand. In the meantime, webAIRS would be grateful if Fellows would report any problems that they have had with patients biting through disposable LMAs.

- The second alert was regarding a problem with an intravenous cannula bung. The patient presented to theatre for a caesarian section with pre-existing intravenous infusion via a 16-gauge cannula. On arrival a bung was connected to the cannula and then further connected using a dual port extension set to an oxytocin infusion and a hartmann's infusion. All the connections were covered with transparent dressings, which hindered access to the cannula.

Prior to pre-oxygenation, the IV system was working well. During the rapid sequence induction high resistance to injection was noted and only half of the suxamethonium could be injected. The patient was successfully intubated with the use of sevoflurane to deepen anaesthesia, and then a new 18-gauge cannula was inserted for IV access. After the baby was delivered, the mother experienced an asystolic arrest, which responded rapidly to chest compression and atropine. The event was not thought at the time to be connected to the difficulty with the intravenous line. The final outcome for mother and baby was good.

Investigation by the anaesthetist revealed that the occlusion was due to the bung slightly unscrewing and although still connected the line was shut off by the valve in the bung. This highlights some of the potential difficulties with intravenous lines and the need to meticulously check all intravenous connections made via a bung or, if possible, remove the bung and connect infusions directly to the cannula.

WebAIRS would be very interested in the experiences of other anaesthetists with problems with bungs attached to intravenous cannulae.

WebAIRS thanks the reporters for these interesting alerts. We plan to release more de-identified alerts in coming webAIRS reports. ANZTADC will be grateful if future, unusual reports are flagged as alerts when reported. Also remember to report problems with LMAs or intravenous bungs as suggested above via webAIRS or directly to ANZTADC@anzca.edu.au if not registered with webAIRS.

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

Demo at www.anztadc.net/demo

References:

1. WebAIRS demo. www.anztadc.net/Demo/IncidentTabbed.aspx
2. The introduction of pre-filled metaraminol and ephedrine syringes into the main operating theatres of a major metropolitan centre. Dr Nathan Goodrick, Dr Torben Wentrup, Dr Geoffrey Messer, Patricia Gleeson, Adjunct Professor Martin Culwick and Dr Genevieve Goulding. Submitted to *Australian Anaesthesia*.
3. Incident reporting at the local and national level. Patrick J. Guffey, Martin Culwick, Alan F. Merry. Submitted to *International Anesthesia Clinics*.

NZ Health quality and safety markers – first report out

The New Zealand Health Quality & Safety Commission (HQSC) has published its first report of district health board performance data against its new health quality and safety markers.

The markers are aimed at encouraging district health boards to improve their performance at reducing patient harm caused by falls, healthcare associated infections and surgery – all part of the HQSC's national patient safety campaign, "Open for better care".

The markers set goals for district health board use of interventions and practices known to reduce patient harm in those areas:

- 90 per cent of older patients are given a falls risk assessment.
- 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 WHO surgical safety checklist used in 90 per cent of operations.

The results published in the first report represent a baseline from which district health boards are expected to continue to improve over time. They indicate some excellent achievements, such as a reduction in the national rate of central-line associated bacteraemia (CLAB) to almost zero. However, they also highlight inconsistencies in district health board use of the above interventions and practices. No district health board performed at the highest level on all four measures, or performed badly on all four.

Quality and Safety Markers baseline data for each district health board is published at www.hqsc.govt.nz. The HQSC will next report against the markers in December and quarterly after that.

Information on the "Open for better care" campaign can be found at www.open.hqsc.govt.nz. Reducing harm from surgical site infections is the second topic of focus for the campaign and will be promoted from October.

The markers set a goal of 70 per cent compliance with good hand hygiene practice. On August 20, Associate Health Minister Jo Goodhew announced that the latest report from Hand Hygiene New Zealand showed that 13 district health boards had achieved compliance rates of 70 per cent or above, while six had rates between 60-69 per cent. On average, the compliance rate among district health board healthcare professionals increased by nearly six per cent in the three months up to August 20.

Susan Ewart,
ANZCA Communications Manager,
New Zealand



Pugh lecture celebrates the birth of anaesthesia

The second celebratory lecture commemorating Dr William Russ Pugh's first Australian general anaesthetics for surgical procedures on June 7, 1847 was held on June 16 at the Queen Victoria Museum and Art Gallery at Inveresk, Launceston. More than 100 people attended.

Lecturer Dr John Paull presented an entertaining narrative and showed historic and contemporary pictures illustrating the properties where Pugh stayed, his hosts and the primitive road he travelled on his mid-summer month-long 200 kilometre walk from Hobart to Launceston in February 1836. Pugh's diary records that he consumed "bad brandy and water" as an aid to surmounting several of the steep hills he had to cross. He walked an astonishing 39 miles (62 kilometres) including traversing Constitution Hill, on the first day.

The current owners of four of the homesteads where he stayed were in the audience, including Mr Richard Archer, the owner of Brickendon Homestead, near Longford, and great-great grandson of Pugh's host, Mr William Archer.

Pugh rejected the advice of all the settlers with whom he stayed that he should abandon the idea of establishing a medical practice and concentrate on farming sheep instead, which is probably fortunate for anaesthesia.



When he reached Brickendon, three and a half weeks after leaving Hobart, Pugh was delighted when his portmanteau arrived by carrier from Hobart. Why was he so pleased? His diary records, "Its arrival was anxiously awaited because not having any clothes but those I walked in has prevented me from paying a visit to Launceston." After donning a clean set of clothes and hiring a pony he set off for Launceston, preferring to ride the last 16 miles (26 kilometres), rather than walk and possibly arrive in a lather of sweat.

What drove Pugh to travel to Launceston? Initially it was the fact that no doctors in Hobart Town, or Sydney, which he also visited, would accept his entrance to their towns as a doctor.

Secondly, when he arrived in Hobart he proposed marriage to Cornelia Kerton, with whom he had travelled for four months on the Derwent from London, a proposal she rejected. Not one to give up easily Pugh decided that Launceston, where Cornelia had relatives, must be his destination.

Shortly after his arrival on March 6, 1836, she accepted his second proposal and they married three months later.

Several days after arriving he wrote, "And then, I was called to my first patient! I had launched my profession in Launceston."

Dr Paull will launch his biography of Dr Pugh, *Not Just an Anaesthetist: the remarkable life of Dr William Russ Pugh* in Canberra in September and in Launceston in October.

The Launceston Historical Society and the Launceston General Hospital Historical Committee and anaesthetic department sponsored the 2013 Pugh Day Lecture.

Dr Chris Ball, the honorary curator of the ANZCA Geoffrey Kaye Museum of Anaesthetic History, will deliver the 2014 Pugh Day Lecture in Launceston on Sunday June 15.

The York and Albany Inn at Oatlands, where Pugh "requested dinner, and saw a fine leg of lamb, green peas, beans, and potatoes, all as good of their kind as Old England could have afforded," was demolished in 1969.

Dr John Paull, FANZCA

Above: Dr John Paull delivers the 2013 Pugh Day Lecture.



Limited edition cards

The Geoffrey Kaye Museum of Anaesthetic History recently released a limited edition card set showcasing six unique and iconic objects from the historic collection.

Pick up a free set or individual cards next time you visit any of the College offices. Alternatively, please contact the museum to have a set sent to you: museum@anzca.edu.au.

New anaesthesia stories for 2013 – reporting and safety in anaesthesia



In the words of Professor Bill Runciman “anaesthesia is largely a success story”, thanks to the profession’s commitment in the areas of reporting and safety. Professor Runciman, Professor Ross Holland and Dr Pat Mackay, who have all made huge contributions and continue to be active in this area, are the latest subjects to be interviewed for ANZCA’s “Anaesthesia stories” series. Their interviews follow last year’s successful pilot of recorded oral histories with distinguished retired anaesthetists. The interviews can be found at www.anzca.edu.au/about-anzca/anaesthesia-stories.

After the first public demonstration of anaesthesia on October 16, 1846, the medical world was faced with a dilemma. On the one hand, by inhaling ether, a patient could be rendered insensible to pain. But, as rapidly became apparent, a fit healthy person could potentially die as a result of inhaling a toxic substance for the purpose of relieving temporary suffering. This dilemma saw patients having operations without anaesthesia for many decades after the discovery of ether and chloroform. The dilemma continues to confront us today, especially with extremely ill patients at the extremes of age – how to weigh up the risks and benefits,

how to ensure that every procedure, with its attendant surgical and anaesthetic risk, is in the best interests of the patient.

In order to provide this information to our patients and surgical colleagues, we must have data, some facts with which to establish a risk profile, guide our practice and inform our patients. Deaths under chloroform anaesthesia provided the impetus for the earliest analysis of risk, beginning with the coronial enquiry into the death of Hannah Greener in 1848¹. The subsequent work of John Snow², the Chloroform Committee of 1864³ and the Hyderabad Commissions that followed did not provide any solutions, but they did begin the process of adverse event reporting and analysis.

In 1925, Francis McMechan published a report evaluating surgical risk, which addressed causes of death in the operating room⁴. This work led him to Australia in 1929 to speak at the Australasian Medical Congress in Sydney. There he met Geoffrey Kaye, then a young man of 26, who had compiled a report into deaths under anaesthesia in Australia⁵. With McMechan’s support, Kaye produced another comprehensive report in 1935⁶, and Gilbert Brown compiled a report on deaths at the Royal Adelaide Hospital in 1937, with recommendations for future avoidance of incidents⁷.

The 1950s saw an increase in interest worldwide with seminal papers by Beecher and Todd⁸ in the United States, and Edwards and colleagues in Britain⁹. Australia continued at the forefront of this important area with the creation of the first government-supported committee, the Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) in 1960. Ross Holland was the founding president and continues in this role to this day. SCIDUA laid important foundations for future committees, ensuring confidentiality of data and extending the time period for investigation of operative deaths into the

first 24 hours after an operation.

In 1976, the Victorian Consultative Council on Anaesthetic Morbidity and Mortality (VCCAMM) was formed to investigate, not just mortality, but also morbidity. This was an important shift of thinking, increasing the workload but providing valuable data. The 1980s saw the development of the Australian Incident Monitoring Study (AIMS), investigating critical incidents, producing many publications and reports, and making significant recommendations for crisis management.

Dr Christine Ball, FANZCA

Honorary Curator, Geoffrey Kaye Museum of Anaesthetic History

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Above from left: Professor Bill Runciman, Dr Pat Mackay and Professor Ross Holland.

Library update

New online books

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

The anesthesia guide / Atchabahian, Arthur [ed]; Gupta, Ruchir [ed]. -- 1st ed -- New York: McGraw-Hill Medical, 2013.

Morgan and Mikhail's clinical anesthesiology / Butterworth, John F.; Mackey, David C.; Wasnick, John D. -- 5th ed -- New York: McGraw-Hill, 2013

Endocrine physiology / Molina, Patricia E. -- 4th ed -- New York: McGraw-Hill, 2013.

Obesity / Jones, Stephanie B.[ed]. -- International Anesthesiology Clinics Hagerstown, MD: Wolters Kluwer/Lippincott Williams & Wilkins, 2013.

Principles and practice of mechanical ventilation / Tobin, Martin J [ed]. -- 3rd ed -- New York: McGraw-Hill, 2013.

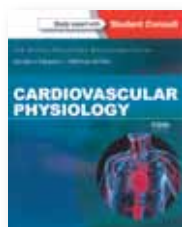
Pulmonary physiology / Levitzky, Michael G. -- 8th ed -- New York: McGraw-Hill, 2013.

Vander's renal physiology / Eaton, Douglas C; Pooler, John P. -- 8th ed -- New York: McGraw-Hill, 2013.

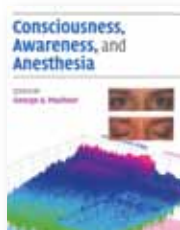
The Vortex approach: management of the unanticipated difficult airway / Chrimes, Nicholas; Fritz, Peter. -- 1st ed -- Los Gatos, CA: Smashwords, 2013.

New books for loan

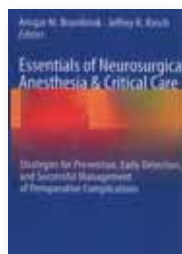
Books can be borrowed via the ANZCA Library catalogue: www.anzca.edu.au/resources/library/book-catalogue.html



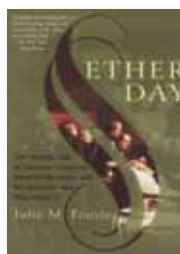
Cardiovascular physiology / Pappano, Achilles J.; Wier, Withrow Gil.; Levy, Matthew N. -- 10th ed. -- Philadelphia, PA: Elsevier/Mosby, 2013.



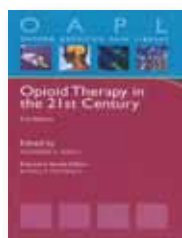
Consciousness, awareness, and anesthesia / Mashour, George A. [ed]. -- Cambridge: Cambridge University Press, 2010.



Essentials of neurosurgical anesthesia & critical care: strategies for prevention, early detection, and successful management of perioperative complications / Brambrink, Ansgar [ed]; Kirsch, Jeffrey R. [ed]. -- New York: Springer, 2012.



Ether day: the strange tale of America's greatest medical discovery and the haunted men who made it / Julie M. Fenster. / Fenster, Julie M. -- 1st Perennial ed. -- New York, NY: Perennial, 2002.



Opioid therapy in the 21st century / Smith, Howard S. [ed]. -- New York: Oxford University Press, 2013.



A History of the Melbourne Anaesthetic Group / Hare, Robert. -- Melbourne, VIC: Robert Hare, 2013. Kindly donated by the author.

More multimedia for training and professional development

The ANZCA Library subscribes to journals, e-books, and the Medline and Embase databases through the OvidSP platform, and now you can access even more with multimedia material recently added to the collection. OvidSP Multimedia includes hundreds of videos of procedures, expert interviews, diagnosis and treatment techniques, lectures and article discussions, as well as thousands of images for visual diagnosis, education, presentations and more. Browse related videos and images along with the full-text articles or filter the results by media type or duration of video to suit your training and professional development requirements.

Access through the OvidSP Medline and Embase databases or the various OvidSP journal and e-books available through the ANZCA Library website.

Australian Drug Information update

Many Fellows and trainees are making good use of the drug information database, Catalyst, particularly the recently launched mobile version. Catalyst has recently changed name and is now known as AusDI – Australian Drug Information. AusDI delivers rapid access to a comprehensive and up-to-date database of independent drug monographs, pharmaceutical company product information, consumer medicine information documents, product summaries, drug product images and Interactions and Safety monographs, in one single resource.

It contains over 80,000 pages of medicines information, covering over 5000 products including prescription medicines, hospital use, over-the-counter products including many complementary medicines, devices, diagnostic agents and dressings.

Search the new Interactions and Safety module to identify clinically significant drug-drug, drug-food and drug-

complementary medicine interactions, duplicate therapy warnings and shared adverse effects.

Access AusDI through the ANZCA Library Databases list on the ANZCA website.

New ECRI safety publications

Operating Room Risk Management, June 2013

- Office-based surgery and anaesthesia.

Operating Room Risk Management, August 2013

- Event report interviews.
- Addressing the special needs of bariatric patients.

Health Devices, Vol. 42, No. 6, June 2013

- Cardiac Output Monitoring – reviewing the evidence on four systems.

Health Devices, Vol. 42, No. 7, July 2013

- Getting infusion data where it needs to go - advice on tackling infusion pump integration.
- Vital signs monitors.

Health Devices, Vol. 42, No. 8, August, 2013

- Alarm management as a patient safety goal.

Latest anaesthesia and pain medicine research

All articles can be sourced in full text from the ANZCA Library's online journal list:

www.anzca.edu.au/resources/library/journals

Motola I, Devine LA, Chung HS, Sullivan JE, Issenberg SB. Simulation in healthcare education: A best evidence practical guide. AMEE guide no. 82. Med Teach. 2013 Aug 13.

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Apfel CC, Turan A, Souza K, Pergolizzi J, Hornuss C. Intravenous acetaminophen reduces postoperative nausea and vomiting: A systematic review and meta-analysis. Pain. 2013;154(5):677-689.

Wang S-M, Harris RE, Lin Y-C, Gan T-J. Acupuncture in 21st century anaesthesia: Is there a needle in the haystack? Anesth Analg. 2013;116(6):1356-1359.

Frawley G, Bennett M, Thistlethwaite K, Banham N. Australian paediatric hyperbaric oxygen therapy 1998-2011. Anaesth Intensive Care. 2013;41(1):74-81.

Contact the ANZCA Library

www.anzca.edu.au/resources/library

Phone: +61 3 8517 5305

Fax: +61 3 8517 5381

Email: library@anzca.edu.au

Special interest group events

Cardiothoracic, Vascular and Perfusion SIG meeting



The first week of July seemed appealing for those in southern Australia and New Zealand to escape the cold climate and warm old bones. The 2013 Cardiothoracic, Vascular and Perfusion Special Interest Group biennial meeting was held at Sea Temple Resort and Spa in Port Douglas and the weather gods provided a week of good conditions with the temperature sitting comfortably in the mid 20s.

The conference venue proved popular, with an auditorium space appropriate to form groups of 100 or less persons. The hotel offered registrants and their families very competitive room rates with around a 50 per cent discount off the rack rate.

Registrants found the meeting to be very informative and educational.

The contribution from all speakers was greatly appreciated by the organising committee. In particular I would like to mention the three outstanding visiting speakers.

Andy Klein is a cardiothoracic anaesthetist from Papworth Hospital, Cambridge, UK. Andy is also a sub-editor for *Anaesthesia*. Andy provided great talks relating to anaemia and its drivers as well as neurological outcomes and TAVI discussions. He also applied his editorial hat to provide some very useful advice to young researchers at the meeting. We were very fortunate that Andy was able to accommodate our group between the Melbourne and Sydney Test matches between Australia and the British Lions.

Hilary Grocott is an anaesthetist from Winnipeg, Canada, following on from a long research fellowship at Duke University. Hilary spoke on topics related to neuro-cognitive outcomes, cerebral oximetry and spinal cord protection. Hilary's presentations were engaging and effective.

During our traditional echo sessions on the final day we were lucky to be able to extract Stanton Sherman away from the fourth of July celebrations in Boston. Stan brought enormous clarity to very difficult topics relating to transoesophageal echocardiography. Stan also facilitated a fantastic workshop session using the 3D QLab applications. It really was of enormous benefit to have an expert within the anaesthesia field discuss his techniques and approach.

During the week in Port Douglas, SIG Fellows Dr Mark Buckland, Dr Chris Bain and Dr David Daly journeyed north from Port Douglas with Andy and Hilary: destination Daintree River. The Daintree is a beautiful waterway with steam rising from the depths early in the morning as crocodiles sun themselves along the banks. The fishing gods were a bit quiet after early action. Regrettably, the catch of the day was a 67cm barramundi attributed to our friend from Cambridge, hereafter know to all as "Barra Klein". Andy emailed me last week to let me know that his book on barramundi fishing was due for imminent publication.

All up, it was a very successful meeting from both an educational and social point of view.

Dr David Daly, FANZCA
Convenor

Above from left: Dr Andrew Klein with "Barra Klein"; SIG Fellows on the Daintree River.

Rural SIG meeting



The Rural SIG held its sixth annual meeting at the Millennium Hotel, Rotorua from July 12 to 14 with the title “Obstetric anaesthesia for the bush”. The meeting’s first visit to New Zealand saw numbers down slightly on previous years with around 60 delegates, however this still included many GP anaesthetists and we were well supported by trade displays.

The plenary sessions covered a range of topics including analgesia for labour, anaesthesia for sections, obstetric emergency scenarios and the New Zealand national Maternal Morbidity Audit. The speakers included a mixture of Rural SIG members from NZ and Australia along with invited speakers, including local obstetrician Dr Allison Barrett and anaesthetists Dr Ulrike Buehner and Dr Aidan O’Donnell, and Australian specialists Dr David Elliott and Dr Nico Terblanche. We also held our first debate where the consensus was that non-luer lock epidural technology will be adopted in Australia in time but we can wait for the UK to sort out the technology first.

The meeting again hosted workshops with a continuation of the education theme from 2011 with module four from the “Teaching on the Run” facilitated by Dr Di Khursandi. An ultrasound workshop was run by Dr Nico Terblanche (epidurals) and Dr Mike Haines (TAP blocks) with support from Sonosite, Ms Rose Batchelor ran a neonatal resuscitation workshop and Ms Anna Lawson and Ms Lucy Petit ran an obstetric resuscitation scenario.

We held a poster prize for a second year running with the prize going to Dr Samantha Bonnington from Victoria. We plan to run a poster competition in 2014 and posters can be on any topic relevant to rural anaesthesia.

The social events were well attended with delegates able to meet old friends and network. The drinks reception on the first evening included a traditional Maori welcome with the convenor taking on the role of visiting chief. The dinner on the Saturday was held in the splendid Rotorua museum, a converted spa complex and we were fortunate to have guides taking short tours of some of the museum’s treasures.

The meeting was a great success and I would like to thank local co-convenor Dr Deb Gardiner for all her support, Hannah Burnell who, in her role as SIG co-ordinator, assisted in planning and hosting the meeting as well as all the speakers, whose high quality presentations ensured the meeting was an academic success.

The final business of the meeting was the Rural SIG AGM where plans for next year’s meeting were discussed. The meeting will be titled “Pain – proven performers and promising pioneers” and will be held at the Pullman Hotel, Cairns, Qld, from July 4 to 6, 2014.

Dr David Rowe, FANZCA
Co-convenor

Above clockwise from top: Dr David Rowe at Maori welcome; Delegates in ultrasound workshop; Ms Rose Batchelor facilitating the neonatal resuscitation workshop; Rotorua museum.

Special interest group events continued

Neuroanaesthesia SIG meeting report



The Neuroanaesthesia Special Interest Group held its biennial meeting at the Millennium Hotel, Queenstown from July 19 to 21. The conference returned to Queenstown with a meeting theme of “Neuroanaesthesia: past, present, future”. The meeting was well supported with more than 60 delegates attending Queenstown in the middle of a Central Otago winter.

The first day focused on the medical management of stroke, including interventional management and perioperative stroke. Our invited non-Fellow speaker, Professor Alan Barber, outlined the medical management, followed by speakers highlighting the anaesthesia and neuro-interventional aspects of management. Dr Hilary Madder, our invited overseas speaker, presented data from Oxford about their experience of decompressive craniectomy for malignant MCA stroke. Professor Matthew Chan from Hong Kong outlined the under-recognised problem of perioperative stroke.

The next two days focused on more traditional neuroanaesthesia management. Highlights included Dr Mark Hayman describing the issues of anaesthesia in the sitting position, Dr Veronica Gin outlining areas of contention with fluid therapy for the neurosurgical patient and Professor Tony Gin informing us of the prospects and attributes of new intravenous agents, which may be close to market.

Queenstown had just had a fresh fall of snow so delegates were able to ski on Coronet Peak and the Remarkables ski fields or enjoy many Queenstown’s other winter activities. The conference dinner was held at the Millennium Hotel. We had an excellent evening with convivial company followed by drinks around a roaring fire.

We also held our annual general meeting and Dr Doug Campbell tendered his recognition as chair and a replacement will be elected in the next couple of months. A decision about the date and venue of the next SIG meeting in two years time has been deferred until a new chair is elected.

The meeting was a huge success. I would like to thank Sarah Chezan for her meticulous organisation of the meeting, which ran seamlessly. Also thanks to all our speakers who gave up their time to present.

Dr Doug Campbell, FANZCA
Convener

Above from left: Queenstown, New Zealand; Dr Edward Mee, Dr Doug Campbell and Professor Tony Gin.

New Zealand news



New Zealand National Committee (NZNC)

New chair

The June meeting saw a change in officers for the NZNC, with Dr Nigel Robertson taking over as chair from Dr Geoff Long, who had held the position for two years.

Born in Scotland, Dr Robertson graduated from Edinburgh University and commenced anaesthesia training in Scotland before immigrating to New Zealand in 1988. He completed his training in Auckland and has worked at Auckland Hospital since 1991.

Dr Robertson's clinical specialty interests include neuroanaesthesia and major orthopaedics. He also has developed an interest in operating room design and efficiency after spending four years as the design co-ordinator for the new Auckland City Hospital's operating rooms. This interest has seen him invited to speak at two American Association of Clinical Directors' meetings and contribute a textbook chapter on the subject.

Dr Robertson was clinical director of Auckland's Adult and Trauma Department of Anaesthesia and Perioperative Medicine from 2003-09. He joined the NZNC in 2009 and was its deputy chair from 2011-13.

His other interests include sports, developing a three-acre block west of Auckland and traditional music.

The other NZNC officers for the 2013-14 year are: Deputy Chair, Dr Gary Hopgood (Waikato); Education Officer, Dr Indu Kapoor (Wellington); Deputy Education Officer, Dr Sally Ure (Wellington); Quality and Safety Officer, Dr Geoff Laney (Dunedin); Formal Project Officer, Dr Jennifer Woods (Christchurch).

Stakeholder function

As a prelude to its June meeting, the NZNC hosted leaders from many health organisations, including the Minister of Health, Tony Ryall, at a stakeholder function. This provided an opportunity to farewell outgoing NZNC chair, Dr Geoff Long, and to introduce the incoming chair, Dr Nigel Robertson.

Left from top: Incoming NZNC Chair Dr Nigel Robertson speaking at the NZNC stakeholder function; At the NZNC stakeholder function, from left: ANZCA councillor Professor Alan Merry, outgoing NZNC chair Dr Geoff Long, RACS NZ CEO Justine Peterson; At the NZNC stakeholder function, ANZCA CEO Linda Sorrell (right) with Joan Crawford from the Medical Council of New Zealand; At the NZNC stakeholder function, ANZCA President Dr Lindy Roberts with New Zealand's Minister of Health, Tony Ryall.

Above: The New Zealand National Committee for 2013-14, from left: Dr Geoff Laney, Dr Sally Ure, Dr Nigel Robertson (chair), Dr Jennifer Woods, Dr Gary Hopgood, Dr Geoff Long, Dr Kerry Gunn, Dr John Smithells, Dr Peter Doran, Dr Rochelle Barron. Absent: Dr Indu Kapoor, Dr Sabine Pecher, Dr Malcolm Stuart, Professor Alan Merry, Dr Vanessa Beavis, Dr Kieran Davis.





NZ Anaesthesia Education Committee (NZAEC)

NZ Anaesthesia ASM

Registration is still open for the NZ Anaesthesia Annual Scientific Meeting being held in Dunedin, November 6-9, which has the theme of “Best practice: aiming for excellence”.

The keynote speakers are Professor Mark Warner (US) discussing how new technologies and evolving economies and policies affect patient safety and the practice of anaesthesia; Auckland Professor Jamie Sleight presenting on “General analgesia is the future of general anaesthesia”; and Professor Eric Jacobsohn (Canada) speaking about the effect of disruptive behaviour in the operating room.

The other plenary sessions, workshops and problem-based learning discussions cover a wide range of subjects, including some non-clinical topics such as medical economics and medical law, and a post-conference practical digital photography workshop.

Associated courses include a Rapid Assessment by Cardiac Echocardiography (RACE) Course, an AirwaySkills Course and an ANZCA Teachers Course. The popular and limited-numbers Part 3 Course for senior trainees will run on the Saturday, November 9.

Social events include a welcome reception, “A toast to the arts” cabaret night and the traditional dinner at Lanarch Castle.

For more information and to register, see www.nzadunedin2013.com.

BWT Ritchie Scholarship applications open

Applications for the 2013 BWT Ritchie Scholarship grants close on October 31. This scholarship enables New Zealand-based trainees to obtain experience in other countries, with the proviso that they bring that experience back to New Zealand.

The scholarship is open to trainees who have passed their final examination for ANZCA fellowship and are eligible to proceed to training year five, or those who wish to undertake a further year of study outside New Zealand in the year after completing their fellowship. It is may be awarded for one further year, if appropriate.

The 2013 scholarship is valued at up to \$25,000. Candidates must be nominated and supported by their training departments.

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

NZ Anaesthesia Visiting Lectureships – Wanganui symposium

The NZAEC established the NZ Anaesthesia Visiting Lectureship so that smaller regional hospitals could benefit from outstanding presentations originally made at larger metropolitan hospitals. Usually, lecturers present individually at two regional centres each. This year, the NZAEC supported a change in format that saw two of the lecturers present on the same day to anaesthetists from five lower North Island hospitals – the initiative of Dr Nigel Waters from Palmerston North Hospital. Here is his (edited) report about the day:

I suggested to NZAEC Chair Dr Kerry Gunn that a combined regional meeting would serve three purposes: get greater regional exposure to the visiting lecturers, encourage and strengthen regional collaboration, and get greater value for the NZAEC’s money.

About 30 anaesthetists from the Hutt, Hawke’s Bay, Masterton, Palmerston North and Wanganui hospitals attended the full-on meeting held at Wanganui Hospital on July 5. The meeting started at 11am and finished around 3pm, allowing same-day travel to and from the venue.

In the morning, Professor Brian Anderson from Starship Hospital presented on “Age-related pharmacology in anaesthesia” and “Aspects of paediatric anaesthesia and intensive care”. After a superb lunch, Dr Matt Taylor (Middlemore)

presented on “Enhanced recovery after surgery, “Fluid management” and “Intraperitoneal local anaesthesia”.

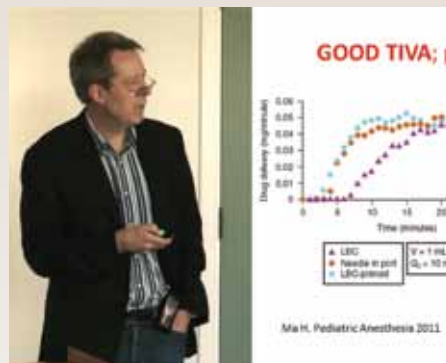
Both speakers’ presentations were informative, thought provoking and geared towards the audience. There was plenty of discussion and questions after each presentation. I think many of us were both reassured about our anaesthetic practice outside of the main centres and took home one or two pearls for consideration.

This meeting more than achieved the Visiting Lectureship aim of promoting the sharing of knowledge and experience through outstanding presentations – it reinforced collaboration as well.

A big thank you to NZAEC, Brian Anderson and Matt Taylor for what truly was a most informative day; and to Dr Mike Miller and GoodHealth Wanganui for hosting this meeting.

Dr Nigel Waters

FANZCA, Palmerston North Hospital



Above: Professor Brian Anderson (top) and Dr Matt Taylor presenting at the Wanganui symposium.

Visiting lectureship nominations for 2014

Nominations for the 2014 NZ Anaesthesia Visiting Lectureships should be made by September 30. A visiting lecturer should be an anaesthetist who will give a stimulating, informative and well-delivered presentation to colleagues and be willing to travel to two other centres in New Zealand to present their lecture/workshop. Nominations should be made by the head of department or practice with the consent of the nominee, using the form available at www.anaesthesiaeducation.org.nz. Those awarded the lectureship receive \$500, with the NZAEC paying associated travel costs.

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

Other news

Lifebox donation from Wanganui

In June, the Lifebox Foundation received a donation of \$NZ1600 from the Wanganui South Rotary Club, which was encouraged to raise the money for five pulse oximeters by member Dr Mike Miller, the Director of Anaesthetics at Wanganui Hospital. The club hopes to fund more units in the future.

In a letter of thanks, the Lifebox Foundation's Chief Executive, Pauline Philip, said the donation would be used to fund training and equipment in Vietnam.

The Lifebox campaign has so far facilitated the distribution of more than 4300 pulse oximeters and education kits to facilities in 70 countries, and held local training workshops for almost 2000 anaesthesia providers.

Shakes 2013 – small investment, big return

Having enjoyed last year's "Shakes" CPD meeting organised by the Christchurch anaesthesia department, Dr Geoff Long made a point of getting to this year's meeting too, and reports (edited) on it here:

The morning session started with a very interesting and interactive small group discussion around the challenging management of an opioid-addicted patient requiring surgery. This was followed by a practical airway course involving videolaryngoscopes, fiberoptic bronchoscopy and surgical airway access, all areas where we need to keep our skills honed.

In the afternoon, keynote speaker Dr John Moloney from Sydney stressed the importance of non-technical skills using aviation examples and the risks inherent in complex systems where a combination of system failures, coupled with human factors, may set good people up to fail. We were reminded of issues that may impair our performance and of our responsibility to facilitate teamwork.

All the other speakers were local. Matt Greyling gave an excellent contemporary overview of coagulopathy in trauma and the improvement in outcome that can be achieved with compliance with massive transfusion protocols, and the use of adjuncts such as transexamic acid. David Bain gave a good review of thoracic trauma – practical and pragmatic. Rowan Schouten, a spinal surgeon, reviewed cervical spine trauma and the challenges in "clearing the cervical spine". Mark Waddington discussed airway management in cervical spine injury – use what you know, do what you are best at and remember it is a team sport.

The afternoon wrapped up with a great presentation by Wayne Morris on gunshot injuries – ballistics and management. It took me right back to my work with Afghan war wounded when I was working with the International Committee of the Red Cross many years ago.

Happy hour and an excellent dinner followed.

Again, the Christchurch Department turned on a brilliant one-day meeting. Along with a good keynote speaker, the local contributors excelled and reminded me of the depth of talent we have here in New Zealand. I encourage you all to think about getting down to Shakes next year – a small investment of time and money for an excellent return with a relaxed, collegial and informative day. Thanks to Mark Waddington and the team – you did yourselves proud.

Dr Geoff Long

FANZCA, Waikato Hospital

North Shore's Elective Surgery Centre now operating

The Waitemata District Health Board's new Elective Surgery Centre (ESC) at North Shore Hospital began taking patients from July 15. The centre is expected to reduce significantly the time patients wait for non-urgent surgery. Its model of care is based on a successful pilot conducted at Waitakere Hospital, which resulted in: reduced theatre times, enabling 20-30 per cent more surgeries to be performed over the same period of time; patients recovering faster; savings in surgical costs; and high levels of staff and patient satisfaction.

A key aim is to provide elective surgery at 80 per cent of the average cost nationally while maintaining a high standard of care. This was achieved in the Waitakere pilot across a range of surgical specialties. This model is also expected to reduce the work outsourced to the private sector at a higher cost, providing savings that can be invested in further elective surgery.

The ESC houses four operating theatres, a post-anaesthesia care unit (PACU), a theatre sterile supply unit, 40 inpatient beds, four pre-operative consulting rooms, four outpatient consulting rooms and two pre-admission assessment rooms. It is expected to undertake nearly 6000 operations per year, with approximately 25 per cent of those being additional operations.

Trainees are being rostered to the unit for blocks of training with specialists but are not required to provide service commitment by staffing lists unsupervised. The ESC will be covered by ANZCA's accreditation inspection of North Shore Hospital in November.



Technology meets tradition

The “Technology meets tradition” meeting was held at the Sydney Hilton on Saturday June 15. The meeting attracted anaesthetists from across Australia and New Zealand and was very well received, covering a broad range of new technology and advancements and addressing whether this always had a positive impact on the day-to-day clinical environment and patient safety.

Some of the topics covered were “the anaesthetist of the future”, “anaesthesia – neuroprotective or neurotoxic?”, “robotic surgery”, “anaesthesia for robotic surgery”, “point of care testing”, “management of paediatric diabetes”, “perioperative management of patients with personality disorders” and “volunteering in anaesthesia”.

The problem-based learning discussions (PBLDs) and workshops were facilitated by expert presenters and addressed new techniques and equipment.

We congratulate the NSW ACE committee and NSW ANZCA staff on the success of this event, which is already being planned for next year.



ANZCA Foundation Teacher Course – Sydney

Twenty participants took part in the ANZCA Foundation Teacher Course which was once again successfully delivered by Maurice Hennessy, Manager of Education Training and Development, ANZCA in the College’s Sydney office from June 26-29 (above).

Above clockwise from top left: Associate Professor Stuart Thomas and Dr Andrew Howard presenting their talk on “Peri-op arrhythmia – recognition and management”; One of the trainees presenting in the “Registrar brief scientific presentations”; Dr Anthony Padley’s workshop on “New emergency airway tools”; Delegates being welcomed in the main plenary room.

Tasmania



Obstetric anaesthesia expert to speak at Tasmanian meeting

Respected international obstetric anaesthesia expert, Professor Jose Carvalho from the University of Toronto, is the keynote speaker at the 2014 Combined Annual Scientific Meeting (ASM) of the Tasmanian regional committees for ANZCA and the ASA to be held in Hobart on the weekend of March 1-2, 2014.

Ultrasound use in obstetric anaesthesia is the focus of the one and a half day meeting, "State of (the) art" which is being held at the UTAS Medical Science Precinct, which houses the Menzies Research Institute and University Medical School. Both have excellent educational facilities.

A unique feature of the meeting will be the applied anatomy and ultrasound workshops. These practical, interactive workshops are designed for anaesthetists and will offer the opportunity to review the anatomy of the spine and upper limb and teach participants how to perform related ultrasound-guided regional anaesthesia techniques.

Dissected cadavers, prosected specimens, skeletons and anatomical models will be utilised to facilitate a review of the relevant anatomy. Ultrasound facilitators using state-of-the-art ultrasound machines will be onsite to enable participants to relate ultrasonic images to anatomical structures using live models and fresh cadavers.

The applied spinal ultrasound component is thought to be the first of its kind and will be facilitated by Professor Carvalho, a pioneer in this field. His presentations will be covering topics including "the application of ultrasound in obstetric anaesthesia", "the state and future of obstetric anaesthesia", and "state of the art uterotonic use in obstetric anaesthesia".

Other presentations on significant anaesthesia-related public health issues, including the possible link between postoperative cognitive dysfunction and dementia, will be given by Professor James Vickers (head of the University of Tasmania Medical School) and Associate Professor Marcus Skinner (Director of the Department of Anaesthesia, the Royal Hobart Hospital).

The significance of central blood pressure monitoring in anaesthesia will be presented by Associate Professor James Sharman, a senior fellow of the Hobart Menzies Research Institute. Revalidation for anaesthetists will be addressed by Dr Genevieve Goulding (ANZCA Vice-President) and Dr Richard Gruzner (ASA President).

The social program has been designed to fit in with the "State of (the) art" theme. The Friday evening cocktail reception will be held at the Despard Gallery hosted by a local artist. The recently refurbished Tasmanian Museum & Art Gallery (TMAG) will be the venue for the conference dinner.

For further information, please contact Tasmanian Regional Co-ordinator, Ms Janette Papps via jpapps@anzca.edu.au.

Above from left: Professor Jose Carvalho; Professor James Vickers.

Australian Capital Territory

Annual general meeting

The ACT Regional Committee held its annual general meeting on August 19 with a record attendance by ACT Fellows. The meeting began with the Chair, Dr Carmel McInerney, presenting a video of the opening scenes of “Mr and Mrs Murder” at ANZCA House. Dr McInerney provided the ACT Fellows with an update on ANZCA activities including the curriculum review. Following the meeting there was opportunity for Fellows to socialise informally.



Weekend workshop in the bush

Tasmania’s first continuing professional development (CPD) weekend workshop in the bush at Freycinet Lodge, Coles Bay was attended by 21 registrants, including one from interstate, who participated in lively talks and discussions.

Topics included critical incident monitoring, workforce Issues and a humorous and lively presentation by MDA’s sponsored speaker Dr Andrew Miller on “Healthcare evolution and the anesthetic specialist – we have a problem”. Other speakers included Dr Richard Grutzner and locals, Dr Peter Wright and Dr Matthew Yarrow.

Freycinet Lodge is located in Freycinet National Park, Coles Bay, a truly relaxing and inspirational location to hold what is hoped to be the first of many annual CPD weekend workshops in the bush.

Previous Tasmanian Regional Committee chair and now ANZCA councillor, Dr Richard Waldron, said the weekend was a success and boded well for future meetings.

Committee Chair, Dr Nico Terblanche, said the weekend provided anaesthetists with important networking opportunities and the chance to earn CPD points without having to travel too far.

“We want to make next year’s workshop even better and will be seeking ideas and feedback on topics, location and timing,” he said. “Informal feedback so far has been very positive with attendees pleased with the catering, location and discussions that were held. The CPD landscape is changing and it is vital that we strategically respond by developing suitable workshops that meet those changing needs.”

Australian news

continued

Western Australia



WA Regional Committee activities

The WA Winter Scientific Meeting “Perioperative pandemonium” was held on July 20 at the University Club of WA and attended by 117 delegates.

Four presenters from the Alfred Hospital and Monash University in Melbourne attended; Dr Joel Symons presented the Ian McGlew Lecture on postoperative cognitive dysfunction, Dr Chris Bain presented on perioperative genomics, Dr Rishi Mehra presented on aortic stenosis and the perioperative management and Dr Chris Ball presented on the cardiac patient for non-cardiac surgery. Dr Symons and Dr Bain also presented an interactive panel buzzer session titled “Perioperative potpourri” which was well received by the audience.

Dr Nerida Dilworth presented the Free Paper Session prize to Dr Robert Glasson for “What is the correlation of cauda equine nerve root volume with body mass index in the normal population”. The conference was a success and received excellent sponsorship. The convenor position has now been passed onto Dr Michela Salvadore for the next three years. We thank the convenor Dr Anton van Niekerk for all his work on the Winter Scientific Meeting for the past three years.

In other WA activities, the EO/SOT Committee met on August 1, the ASA committee met on August 5, the WARC met on August 6 and the CME Committee met on August 19.

Final Exams were held from August 23-24 at the Perth Convention and Exhibition Centre and the Royal Perth Hospital outpatients clinic. We wish the trainees well with the results.

The “Updates in anaesthesia meeting” will be held from October 11-13 at the Pullman Resort in Bunker Bay. The theme is “Enhanced recovery after surgery” and is convened by Dr Rupert Ledger from Fremantle Hospital. Dr Monty Mythen will present an overview on the topic and Dr Ron Collins will be present on Canadian Colorectal ERAS program via video link from London and Canada respectively.

Above clockwise from top left: Delegates listening to a presentation; Dr Nerida Dilworth presenting the free paper session prize to Dr Rob Glasson; Dr Chris Bain presenting on Perioperative Genomics.

Victoria



34th ANZCA/ASA Combined CME Meeting “MythBusting in anaesthesia”

The title of this meeting, held on Saturday July 27 at the Sofitel Melbourne on Collins, was both contemporary and historical and captured the interest of the fellowship as is evidenced by the excellent number of attendees at the meeting.

The interesting program was put together by the convenor Dr Peter Seal, Chair of the Victorian Section of the Australian Society of Anaesthetists and ably supported by his co-convenors, Dr Usha Padmanabhan and Dr Zoe Keon-Cohen. The presentations were challenging and thought-provoking and provided much interaction from the audience with the panellists.

The program was divided into four sessions titled airway anaesthesia, paediatrics, monitoring and malignant hyperthermia.

Our sincere thanks go to all our guest speakers for their contribution to our meeting. Their time, effort and interest in supporting our annual event is gratefully acknowledged and much appreciated.

We would especially like to thank Dr Jim Villiers, retired anaesthetist and guest speaker who recently turned 90, for his absorbing account of a well-documented case on malignant hyperthermia in the early 1960s in which he was the participating anaesthetist. Added to the ambience of the talk, was the presence at the meeting of Mr Kingsley Mills the participating orthopaedic surgeon, who is now also retired.

Dr Villiers’ presentation received a standing ovation. His abstract can be found at www.vic.anzca.edu.au for those who did not attend the meeting and as a tribute not only to him but anaesthesia.

Our other retired anaesthetists Dr Patricia Mackay and Dr Kester Brown were guest panellists with Mr Mills for the fourth session of the day and were warmly welcomed and given due recognition for their presence at the meeting.

Once again, the healthcare industry played an important part in our program. We thank them for their efforts and support and look forward to their continuing involvement in our continuing medical education events.

Above from left: (Standing) Speaker Dr Brad Hockey; Session Chair Dr Rod Westhorpe; Speaker Dr Robyn Gillies; Guest Panellist Dr Kester Brown; Guest Panellist Dr Patricia Mackay; Guest Panellist Mr Kingsley Mills; Speaker Dr Jim Villiers; Speaker Dr Christine Ball; Convenor and Chair ASA Victoria Dr Peter Seal. Session Chairs (sitting) Dr Usha Padmanabhan, Dr Mark Hurley and Dr Zoe Keon-Cohen.



Primary full-time course

Trainees from interstate and overseas took part in the primary full-time course that ran from Monday July 29 to Friday August 9 at the College.

I would like to thank all the lecturers for their generous contribution and participation which in no small way underpins the viability and sustainability of our pre-fellowship courses. We are grateful to Dr Stanley Tay who travels from Darwin twice a year to lecture at our courses and also Dr Matt Chacko and Dr Veronica Gin who travelled from New Zealand.

I would also like to welcome Dr Amanda Dalton, Dr Veronica Gin, Dr James Koziol, Dr Lachlan Miles and Dr Gareth Symons who recently joined our valued group of pre-fellowship course lecturers.

The course followed closely on from the annual combined meeting this year and it is a tribute to the organisation and planning of course co-ordinator, Ms Monica-Jane Glenn, who joined the College in March this year, that it was run efficiently and successfully.

Dr Adam Skinner

Convenor

VRC Primary Fulltime Course

Above from left: Lecturers Dr Alister Ford and Dr Gareth Symons; Lecturer Dr Abhay Umraniyar with a trainee at the course.

South Australia and Northern Territory



Part 0 orientation course

The SA and NT part 0 orientation course was held for the trainees entering the training scheme for the mid-year intake. It was facilitated by SA/NT Trainee Committee Chair, Dr Vicki Pentelow, with a number of consultants giving input on a broad range of trainee issues including the new curriculum, workplace-based assessments, the training portfolio system, welfare, rotational issues, part 1 course and GASACT.

Above from left: Brigid Brown (GASACT representative), Margaret Wiese (Education Officer), Vicki Pentelow (Trainee Committee Chair), Nick Harrington, Conor Day, Rebecca Jeffery, Sheng Lim, Kian Lim, Alvin Yeap, Adam Badenoch (GASACT representative).



NT biennial CME meeting: “Trauma, crises and cycling”

The 6th Biennial Northern Territory Anaesthesia continuing medical education meeting was held at the Royal Darwin Hospital auditorium on June 1. The meeting was themed around trauma anaesthesia, with clinically focused talks complemented by discussions on improving teamwork and quality of care. More than 70 people attended the meeting.

NSW aviation safety expert Dr Graham Edkins gave a presentation about aviation and convenor Dr Dan Holmes about professional cycling. (Any suggestion the latter was an excuse to trumpet recent British success over the Aussies is to be disregarded, as all content was purely in the interests of education!)

Keynote speaker Associate Professor Dr John Moloney, of the Alfred Hospital in Melbourne, discussed up-to-date thinking in trauma anaesthesia and Dr David Read, of the National Critical Care and Trauma Response Centre, gave insight into the challenges posed by dealing with trauma in the remote top end of Australia.

A beautiful, tropical, outdoor dinner at Char restaurant topped off a very successful meeting. With our biggest audience ever, we have now outgrown our hospital-based venue, so will seek more salubrious surroundings for our next meeting in 2015.

Dr Dan Holmes
Royal Darwin Hospital, Northern Territory

Above from top: Dr John Moloney and Dr Brian Spain; Dr Dan Holmes.

Queensland



Queensland Regional Committee news

Overseas and interstate registrants were amongst the 123 delegates who attended the 37th Annual Combined CME Conference at the Brisbane Convention and Exhibition Centre on June 22.

Titled “Anaesthesia in the team environment: Together everyone achieves more”, the meeting included presentations from other members of the perioperative team, including a cardiologist, Dr Anders Taylor, from a largely private practice background, and Dr Rob Bird, an experienced and influential haematologist talking about the challenges of perioperative blood management.

Professor David Story from the Austin Hospital in Melbourne discussed the challenges of perioperative care on the modern ward and presented some of his research on this topic. He also participated in a Q&A style discussion forum with Dr Sean McManus and Dr Rod Brockett, an experienced perioperative physician.

The afternoon was busy with workshops and hands on skill stations, including an excellent series of airway workshops facilitated by Dr Keith Greenland and his team from the Royal Brisbane and Women’s Hospital (RBWH), as well as echocardiography and debriefing workshops.

The facilities and catering were of a world class standard, and feedback from delegates suggested a thought provoking and educational day was had by all. Sincere thanks to the organising committee, presenters, and workshop facilitators who helped on the day, as well as ANZCA’s Queensland regional office staff, whose tireless efforts have not gone unnoticed. We are already planning next year’s conference which will be held on July 19, again at BCEC.

On August 20, we had a dinner meeting with Dr Liam Balkin presenting on “Trends in transfusion and trauma”, which covered the state-of-play with trauma resuscitation. We are now finalising our last dinner meeting for October 29, a presentation by Dr Symon McCallum on “Acute to chronic pain and beyond”.

FPM held CME lectures on visceral pain with a presentation by Professor Gerald Holtmann on June 11. The following month, Dr Graham Radford-Smith of RBWH presented on “pain and pain syndrome in patients with Crohn’s disease”. The last scheduled CME lecture for the year is on October 15 and is a presentation on sleep and pain by Dr Curtis Grap.

The FPM QRC would like to thank the sponsors of these presentations – Mundipharma, Janssen Cilag and Pfizer.

The FPM pre-exam course is scheduled for September 13- 15. This course is a series of presentations by various Doctors and includes a series of VIVA practice sessions.

In recent weeks we started presenting the CME lectures to regional members via live webinars. This is under way for ANZCA, ASA and FPM meetings. We are purchasing more equipment which will assist in the audio presentation of these meetings.

The Queensland Regional Committee would like to acknowledge the work of the dedicated and capable convenors, lecturers and webinar presenters who have offered trainees valuable learning opportunities:

- Primary lecture program, semester 1 – Dr Gamini Wijerathne (Convenor).
- Primary exam preparation course – Dr Tiffany Wilkes (Convenor).
- Final exam preparation course, semester 2 – Dr Helmut Schoengen (Convenor).
- Convenors Meeting attended by Dr Jeneen Thatcher, Dr James Hosking, Dr Gamini Wijerathne, Dr Tiffany Wilkes, Dr Helmut Schoengen, Dr Gamini Wijerathne, Dr Behin Moser.
- Four introductory training webinars presented by Dr Phillip Stephens, Dr Ben Crooke, Dr Tom Matthieson and Dr David Dolan
- Supervisors of training meeting co-ordinated by Dr Thatcher, Education Officer.
- Directors of Anaesthesia meeting chaired by Dr Chris Butler.

Above: Dr Conrad Macrokanis and Dr Sean McManus participating at the 37th Annual Combined CME Conference at the Brisbane Convention and Exhibition Centre.

Dr John Boyd Craig

1918 – 2013



John Craig died at his home in Crawley, Western Australia, on July 12, in his 95th year.

“JB”, as John was known by friends, colleagues and family, was a great Australian, whose contributions to his country, in aviation medicine, anaesthesia and pain medicine, education and research were never fully appreciated during his lifetime. This was due to the breadth of these contributions over many years, his reserved demeanor and his great modesty and humility.

In 1987 and 1988, a few years before the formation of the Australian and New Zealand College of Anaesthetists, John made large donations to the Faculty of Anaesthetists at the Royal Australasian College of Surgeons to establish a perpetual annual bursary for research in the field of pain medicine. The bursary continues to support pain medicine research through the Anaesthesia and Pain Medicine Foundation’s annual research grants, and is recognised in the form of the annual John Boyd Craig ANZCA Research Award. These donations, and the dedication of John’s life’s work to anaesthesia and pain relief, were driven by his childhood experience of his father, Leslie Craig, suffering lifelong phantom limb pain following a leg amputation for injuries sustained at Gallipoli during World War 1. In 2009, the ANZCA Council acknowledged these earlier very generous donations by awarding John the title of the inaugural Life Governor of the Anaesthesia and Pain Medicine Foundation.

John Craig was born in Perth on October 8, 1918. His forebears came to WA from Scotland in 1850 and settled in York, 100 kilometres east of Perth. JB spent his early childhood at the family farm, at Dardanup, near Bunbury, WA. From 1930 to 1936, he attended Hale School in Perth. He excelled academically and at sport, particularly football and rowing and became school captain in 1936. His choice of a career in medicine was influenced by his mother, Frances, herself the daughter of a doctor from Northern Ireland.

In 1937, John was resident at St Georges College at the University of Western Australia where he completed the first year of his medical degree. In 1938 he moved to Ormond College, Melbourne, where he completed his degree at the University of Melbourne. In 1944 John joined the RAAF as a medical officer; he remained with the RAAF until 1960, serving at seven different bases in Queensland, WA and Victoria. John became a leader in the emerging and rapidly advancing field of aviation medicine. He became medical officer in charge of the decompression chamber at Point Cook in Victoria and was appointed director of aviation medicine with the RAAF, in Melbourne.

During this time in Melbourne, he began further training at the Royal Melbourne Hospital where his emerging interest in anaesthesia flourished and in 1952, he became a founding member of the newly established Department of Anaesthetics.

In 1946, he met Audrey Herring, who, as a wing officer at the time, outranked him in the air force; they married at St John’s church in Toorak in 1948. Their three children, Leslie Boyd, Frances and Kate were born between 1949 and 1953. In 1960, he was posted to Malaya but decided to resign his commission and relocate to Perth to begin a full-time career in anaesthesia. John entered private practice with the Perth Anaesthetic Group and remained there until his retirement in 1985. He held honorary appointments at several Perth teaching hospitals.

In 1981, JB became a patient himself, undergoing major heart surgery. But his own health was not a key focus for him. This was something to be dealt with quickly so that he could get on with the important work of helping others. John’s generosity was amazing, not only to his family, but many other people and to numerous worthy causes. His dedication to, and belief in, the value of education, led to him setting up several perpetual scholarships. In particular he wanted to assist outstanding secondary students to pursue their educational dreams. These ongoing scholarships are at Hale School, St Hilda’s and St Mary’s, all in the Perth metropolitan area.

John provided inspiration for his grandchildren and, much to his great delight, all seven graduated at university level, most of them now with higher degrees as well. More recently he made a substantial contribution to the St George’s College Chapel renovations at the University of Western Australia. Other organisations that enjoyed John’s support include the Aerospace Medical Association and Ormond College in Melbourne.

John’s first wife Audrey (better known as “Pete” to friends and family) died in 1994, after a long illness. He is survived by Bobbie, his wife of nearly 20 years, three children, seven grandchildren and one great grandchild. He lived his whole life inspired by the motto of his beloved mother, Frances:

*“I shall pass through this world but once.
Any good thing I can do, or any kindness
I can show to any human being,
Let me do it now.
Let me not defer it or neglect it, for I shall
not pass this way again.”*

Associate Professor John Rigg, FANZCA

Dr Mangalika Mendis

1960 – 2013



Our beloved friend and colleague, Mangalika Mendis, (“Manga” to most of us), passed away on Friday July 5 after a long and courageous battle with breast cancer. Her husband, Ruchitha, and her daughter, Medhavia, survive her.

Rather than mourn her death, I wish to celebrate her life, because Mangalika was full of life! Her dazzling smile, even in the face of adversity, her passion for her profession, and her desire to help her fellow man all reflect a truly selfless and giving soul. She touched the lives of many, and most certainly left her mark on Caboolture Hospital where her mothering instinct became the heart and soul of our small department. A lover of conversation, Mangalika somehow discovered every birthday, pregnancy, and life event. She cried at the bedside of a sick colleague, cuddled new babies born to our registrars, cooked meals for colleagues on call, and was known to bare her bald head to a patient suffering from cancer, as an example, to encourage him not to give up.

Born in Sri Lanka on March 2, 1960, the youngest of four children, Mangalika grew up in the town of Polgahawela, and moved to Kandy after grade six to attend boarding school. She went to university in Lvov, USSR (now Ukraine), as did many Sri Lankans who could not afford to study in prestigious universities in the UK or elsewhere. It was here that she met her husband, Ruchitha, an engineering student. Mangalika’s family laughs about her ability to speak Russian (apparently she once reduced a patient to tears by unintentionally saying something inappropriate!) However, her command of the language was sufficient to earn her a degree in medicine in 1988!

Back in war-torn Sri Lanka, Mangalika completed house officer terms in medicine, and obstetrics and gynaecology. She was an intern in obstetrics and gynaecology during her pregnancy by design to facilitate her pregnancy and delivery. Because attendance was strictly monitored, and house officers who took too many days off would fail the rotation and have to repeat the year, Mangalika worked until the day of her delivery and was back on the job two days later! Living in doctors’ quarters at the hospital, she’d pop home as often as possible to visit baby Medhavia. She subsequently studied anaesthetics in Sri Lanka from 1992 until 1996, when the family moved to Auckland. In New Zealand, Mangalika completed several house officer jobs in various disciplines. She earned a diploma in obstetrics and gynaecology from Auckland University, and was offered a place in the training program, but instead, pursued her passion for anaesthesia. It was as a registrar in Middlemore Hospital that Mangalika discovered a breast lump and was diagnosed with cancer. Under anaesthesia she suffered a severe anaphylaxis to the patent blue violet dye injected to detect sentinel lymph nodes, and survived CPR and defibrillation. Tragically, more than two years later, a mass in the axilla heralded the spread of breast cancer. More surgery, a radical mastectomy and axillary clearance, and more chemotherapy ensued. Amazingly, through this turbulent time, Mangalika had passed her part one exam in 2003, while continuing to work full time and fulfil her role as mother.

2005 saw Mangalika working as a registrar at Auckland’s North Shore Hospital. Despite ongoing cancer treatment, she passed her part two exam in 2006. Mangalika attributes much of her success to the fantastic support of the staff at North Shore during her therapy, and always remembered the department fondly.

Mangalika was a great inspiration to fellow doctors. During her studies, she was known for encouraging others. Setting an example with her own determination (giving up was never an option for Manga!), she spurred many others to success in the exams. Mangalika became a Fellow of ANZCA in 2007.

Another achievement of note: Mangalika was involved in a judicial review with seven other women suffering from breast cancer against a decision by New Zealand’s Pharmac not to fund a year’s course of Herceptin for cases of HER2 positive early stage breast cancer.

Evidence shows that women who took Herceptin over the course of a year had a 46 per cent reduction in cancer recurrence compared to a control group of women who did not take the drug. A year’s supply of the drug can cost up to \$100,000, making it inaccessible to many. Mangalika spoke publicly, and was quoted as saying “I am fighting this battle not only for myself, but for those women who cannot finance the complete course of Herceptin.” The eight women, dubbed the “Herceptin heroines”, gave of their own time to raise money for legal representation. They finally won their cause in 2008 after elections when the national government said “yes” to Herceptin!

Then: another move for the family. At Manga’s urging, they moved to Australia. After a brief stint as a locum in Hervey Bay, Mangalika accepted a consultant position at Caboolture Hospital in Queensland.

In 2009 a routine preoperative screening CT scan detected a liver mass. This was the first evidence of advanced breast cancer. Mangalika was given less than a year to live, and began an aggressive course of chemotherapy, which landed her in ICU. Four weeks later, I met Mangalika in the theatre change rooms. She was beaming from ear to ear. “I’m so lucky to be able to come back to work,” she said. I resolved on that day never to feel sorry for myself again!

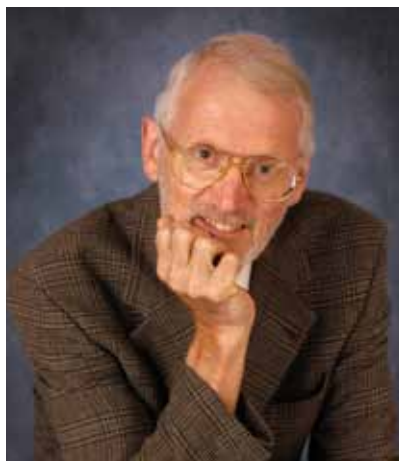
Her work was her driving force, and reason to live, trumped only by her family. She continued to work full time through rigorous regimes of chemotherapy, radiological interventions, and the appearance of more cruel metastases. Mangalika never complained, never balked at work, or heavy night calls, and never accepted any offers share her workload. In fact she was always ready to offer help to others. She arranged her treatments on her days off and rarely took sick leave.

Mangalika fought her disease with the same guts and determination that earned her various qualifications across three continents against many odds. She lived her life to the full, a true humanitarian and a tribute to our profession. There are few people who are truly good and selfless to the core, unfettered by hypocrisy, ego or vanity. I believe I have met one, and I count myself lucky to have known her.

Dr Simone Malan-Johnson
Staff specialist, Caboolture Hospital

Dr Hugh Timothy Spencer

1941 – 2013



Hugh Timothy Spencer, ONZM, died in July after a long battle with cancer, which he bore bravely and fought every inch of the way.

Born in England in 1941, Hugh immigrated with his parents to New Zealand in 1953. He attended New Plymouth Boys' High School and then Waitaki Boys' High School when the family moved to Oamaru in the South Island. He attended Canterbury University where he represented the university at soccer, completed an MA degree, and met and married Margaret Mitchell. Margaret was a tremendous support for Hugh and, in his own words, she was his "best friend".

Hugh quickly decided he could contribute more to society through medicine than history so he applied for and was accepted into Otago Medical School. Despite receiving the gold medal in obstetrics and gynaecology, Hugh wanted to be a rural GP, which, in the early 1970s, meant being able to turn your hand to anything, including anaesthetics.

With Margaret and their two children, Hugh travelled to Lincoln, England, where he completed a DA and the first part of the then the Fellow of the Faculty of Anaesthetists of the Royal College of Surgeons (FFARCS) exam. He then returned to the southern hemisphere where he worked in rural Western Australia doing locums. In 1974, he arrived back in New Zealand and took up a chance vacant position as an anaesthetic registrar at Waikato Hospital where he passed the final FFRACS in 1977 and worked for the next 30 years.

Hugh became director of anaesthesia in 1986, a position he held for the next 10 years through a time of unprecedented change at Waikato Hospital.

Hugh was an innovator: on the clinical front, he popularised local anaesthetic blocks and fostered the development of anaesthetic subspecialties. Never losing sight of his concern to alleviate pain and suffering, he personally ran the chronic pain clinic.

In the anaesthetic department, he oversaw enormous growth, with the number of specialists employed doubling. Also the number of registrar training posts and the amount of training that could be done at Waikato increased dramatically. Hugh embraced the concept of anaesthetic technicians in theatre and Waikato now has a very active and successful technician training programme due in no small part to his efforts. The first academic appointment in anaesthesia at Waikato, an associate professorship, was made under Hugh's watch and was due largely to his considerable persuasive powers.

Hugh never forgot his early goal of contributing to society but it was the people of the Pacific rather than those of rural New Zealand who were the beneficiaries of his work. He spent countless hours battling bureaucracy so that anaesthetists from the Pacific could come to Waikato and work alongside their New Zealand counterparts. They became part of the growing commitment to teaching at Waikato Hospital, and anaesthetic technicians from Pacific nations also benefited from this liaison. Hugh established a fund to assist these people to come to New Zealand to broaden their education and experience. He often used his leave to go to the islands as a locum (sometimes unpaid) so that the local anaesthetists could attend courses and conferences. On several occasions Hugh was the tutor at the South Pacific Course in Anaesthesia in Fiji, and he established an assistance program for the University of Port Moresby's MMed (Anaes) degree. He was also the Australian representative on the establishment committee for the AUSAID program for hospital maintenance in six small Pacific nations, and a member of the Tripartite Committee for Australasian Overseas Aid.

Academically able and a very good teacher, in 1992, Hugh was the Australasian Visitor for the Australian Society of Anaesthetists. He was made an honorary member of the Australian Society of Anaesthetists that year and the following year a life member of the South Pacific Society of Anaesthetists. Hugh served on ANZCA's New Zealand National Committee from 1994 to 2004 and was education officer from 1994 to 2002, and formal project officer from 2002-04. He also served as the Waikato delegate to the NZ Medical Association for a number of years.

In 2010, New Zealand acknowledged the enormous contribution Hugh had made to medicine, in particular to anaesthesia, when he was appointed an Officer of the New Zealand Order of Merit (ONZM).

Despite all this, Hugh was a very humble man who cared deeply about others. He was a loving family man with a passion for music. He delighted in farming his lifestyle block, growing unusual crops in his garden, and tramping and exploring the outdoors. After his retirement, he continued to do locums both at home and abroad until stopped by ill health in 2012.

Hugh is survived by his wife Margaret, two children and three grandchildren.

Dr John Moodie, FANZCA
Dr Geoff Long, FANZCA

Dr Philip John Armstrong

1927 – 2013



Dr Philip Armstrong was born in Sydney on August 29, 1927. He graduated MBBS from the University of Sydney in 1952, and had residential experiences in Sydney and Launceston. From there, he took a registrar position at The Alfred Hospital in 1954 where his obvious skill, dedication, concern for his patients before and after surgery, and his superb management of sometimes difficult argumentative surgeons branded him a real acquisition. He completed a completed a DA at the University of Melbourne in 1955, and through hard work and determination obtained his FFARACS in 1956. A two-year trip to England led to his English fellowship and diploma.

In 1957, Philip Armstrong became a foundation member of the Victorian Anesthetic Group and, following his return from England, he continued as an honorary anesthetist at The Alfred for more than 15 years, working with a variety of noted surgeons – Jim Guest, Nick Hamilton, David Kennedy, Alex Rollo, Bob Zacharin and David Gunter, among others.

His contributions to medicine were generous, often sacrificial and always of the highest ethical standard. As a teacher and practitioner, he brought great credit not only to himself but also to the specialty and hospital he served with such diligence for so long.

Philip retired from anaesthesia in 1997 and in 2005 published a book of his own poems (including one entitled “Anaesthesia Blues”), stating in the preface: “Retirement is an inevitable stage in life, but you cannot easily put aside forty-five years of concentrated work in an occupation where teamwork is everything, and sit back to watch the world go by; yet that is what society requires of most people. Something is necessary to fill the void, and writing poetry seemed to be an interesting alternative to the operating theatre and the intensive care unit.”

Philip died on May 17 this year. He is survived by his wife, Joan, and children, Stephen, Richard, Philippa and Juliette.

Dr Ian Rechtman, FANZCA

Melbourne

(with thanks to Dr Bob Gray for his invaluable input)