March 2013

ANZCA BULLETIN

ANZCA
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

FPM
FACULTY OF PAIN MEDICINE ANZCA

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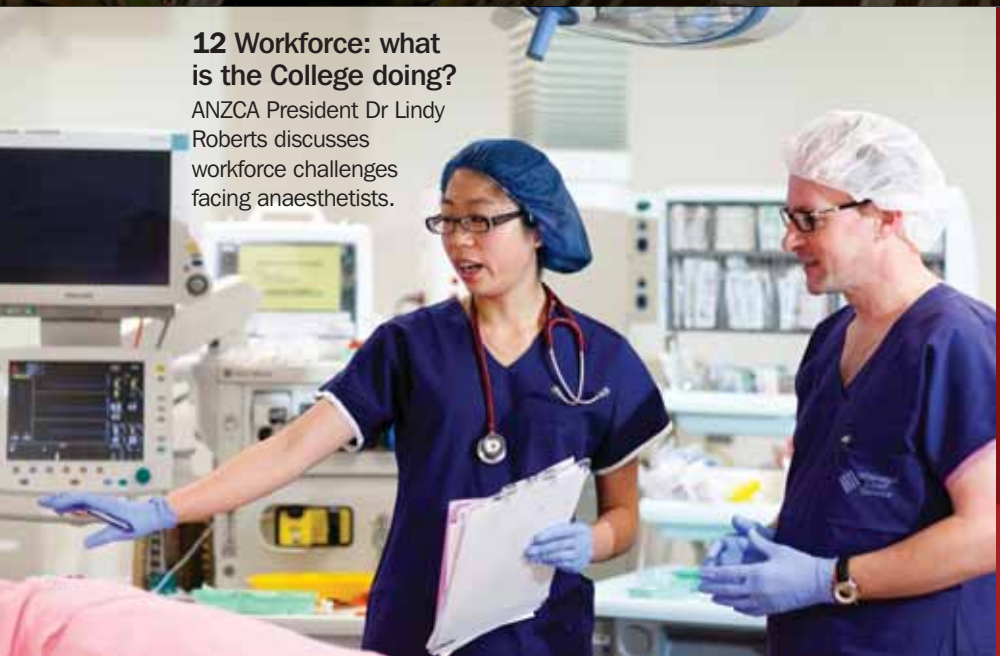

ANZCA Bulletin

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 pain medicine specialists. 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 picture: An Indonesian aero-medical emergency (AME) patient is carried to the AME tent at Banda Aceh Airport by anaesthetist, Wing Commander Marcus Skinner (front left), Squadron Leader Jackie Hardy (front right), Flight Lieutenant Mel deBoer (back left) and Leading Aircraftman Chris Minns (back right), Royal Australian Air Force personnel deployed on Operation Sumatra Assist. Picture courtesy of the Australian Defence Image Library.

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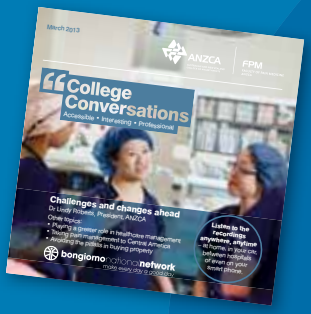
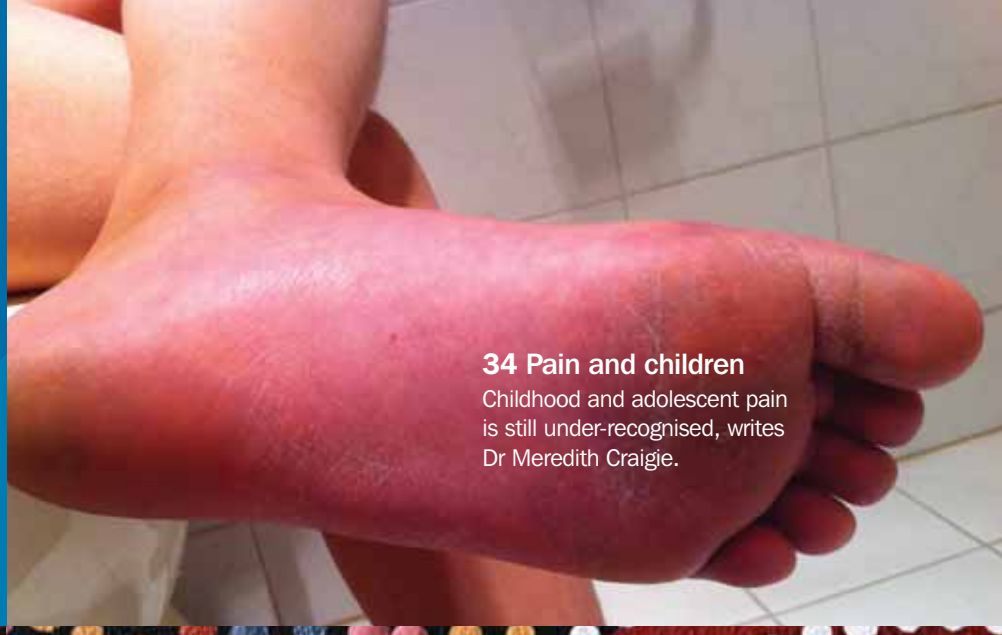


7 College Conversations – anywhere, anytime

A new audio CD, inserted for the first time in your March *Bulletin* and available on the ANZCA website, is a more "mobile" way of informing.



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President's message

Dr Lindy Roberts
President, ANZCA

Regional and national committees: supporting Fellows and trainees in the regions

There's an important College force at work in each Australian region and in New Zealand. I refer to the New Zealand National Committee (NZNC) and the Australian regional committees. Supported by the Australian regional offices and the New Zealand national office, these groups support services for Fellows and trainees close to their places of work (and play) – the training program, continuing medical education, advocacy with governments, work with the societies and other colleges, support for the Faculty of Pain Medicine, publications, and promotion of quality and safety in anaesthesia and pain medicine (see reports from page 75).

College regional office staff need a broad understanding of all of the activities of the College, as well as considerable flexibility as, even with the best of planning, the work often runs in peaks and troughs. Our staff undertakes a broad range of support activities from the details of room set up for examinations and continuing medical education (CME) events, signage, catering, audiovisuals, looking after speakers, organising invigilators for exams, minute taking, and also much broader roles, particularly in the New Zealand office. They are also focused on providing Fellows and trainees with a high standard of service and support. Recently they have developed service charters that ensure timely responses to your inquiries.

In 2012, I was fortunate to visit every Australian region and New Zealand to participate in regional events. I plan to do so again in 2013. These visits highlight to me not only the breadth of activities that are undertaken by Fellows and trainees in each region and country, but also the importance of these for the future of our College. They also demonstrate the quality of support provided by ANZCA staff (see article in the *ANZCA Bulletin*, December 2012). I'd like to pay tribute to those who lead and contribute to this work around Australia and New Zealand.

Australian regional committees and regional offices

Each Australian region has a regional committee, elected by the fellowship every two years. The Fellows who chair these committees – Alison Corbett (WA), Thien Le Cong (SA/NT), Carmel McInerney (ACT), Craig Noonan (Victoria), Greg O'Sullivan (NSW), Richard Waldron (Tasmania) and Mark Young (Qld) – provide leadership for the work of their committees. They are ably supported by staff in each region.

Australian regional activities

These include:

- CME events: the annual scientific meeting (ASM), on a rotational basis, as well as more regular meetings and workshops. Many of these are run collaboratively with the Australian Society of Anaesthetists (ASA), often through combined CME committees.
- Training activities, including examinations, hospital accreditation visits, accreditation of training rotations, appointments of supervisors, short and long examination courses, supervisor workshops and training and formal project approval.
- FPM regional committees and events.
- Trainee committees and events.
- Providing local input to publications such as e-newsletters, the *Bulletin* and *Australasian Anaesthesia*.

- Nominations of Fellows and trainees for ANZCA projects, events and awards – for example, nominees to the annual new Fellows conference, representatives to external organisations and meetings, and the award of the ANZCA Council citation.
- Liaison with the ASA, particularly through joint CME events and support for ASA committees in some regions.
- Quality and safety: providing feedback on professional standards, notifying ANZCA of safety alerts and contributing to mortality and morbidity reporting.

The New Zealand National Committee and the NZ national office

The NZNC, under its chair, Geoff Long (Waikato), has input from anaesthetists and specialist pain medicine physicians from throughout the country and meets regularly at the national office in Wellington. The national committee and office have a broad focus, taking a leading role on issues that relate specifically to New Zealand and reporting to ANZCA Council on ANZCA affairs in New Zealand. New Zealand staff members have broad capability in many areas including policy, communication, media and government liaison.

New Zealand activities

The NZNC and New Zealand office agenda includes:

- Advocacy, consultation with and providing advice to external agencies such as the Medical Council of New Zealand (MCNZ), Health Workforce New Zealand, the Ministry of Health and other government and national agencies. This includes advice about international medical graduate specialists to the MCNZ and overseeing workplace-based assessments (WBAs). The focus is on ensuring that the New Zealand health system and environment for Fellows and trainees meets patient and anaesthesia team needs.
- Responding to legislative and other requirements specific to New Zealand, for example, the current review of the Health Practitioners Competence Assurance Act.
- Support for the training program through supervisor training and support; trainee services such as the part 3 course, examinations and pre-examination courses and formal project approval.
- Awarding scholarships such as the BWT Richie prize, the annual registrar meeting prize and the undergraduate anaesthesia prize.
- Continuing professional development (CPD) opportunities such as the New Zealand ASM, visiting lectureships, resources to help Fellows meet regulatory requirements, and co-ordinating a branch of the ANZCA library in New Zealand. CME activities are coordinated by the New Zealand Anaesthesia Education Committee (NZAEC), a joint initiative of the NZNC and the New Zealand Society of Anaesthetists (NZSA).
- Engagement with other colleges through the Committee of Medical Colleges.
- Liaison with other professional groups such as the NZSA, the New Zealand Medical Association and the New Zealand Anaesthetic Technicians Society.
- Support for the FPM NZNC and the College of Intensive Care (CICM) NZNC.
- Publications specifically for NZ Fellows and trainees, including *Gasbag* and New Zealand Trainee Committee newsletters, along with New Zealand contributions to broader ANZCA publications.
- New Zealand media work to ensure an ANZCA has effective voice in workforce debates as well as to promote the skills and training of anaesthetists.
- Addressing quality and safety issues via mortality review committees, disaster response and safety alerts.

Strengthening connections between the regions and the central College

ANZCA's president, vice-president and chief executive officer hold regular meetings with the chairs of the Australian regional committees and the New Zealand National Committee. This provides an opportunity for the ANZCA Council to communicate to the regions, as well as for the chairs to report on developments within their areas and raise issues of concern to Fellows and trainees directly with the council and the chief executive officer.

One of the key aspects of the ANZCA Council's vision for our College is to strengthen the connections between its different parts. This means support for the regional and national committees and offices so that they continue to provide relevant services for Fellows and trainees. Over the past few years, this investment has increased so that about one in six of our staff is now located in the regional and national offices.

Rollout of the revised curriculum

The regional and national committees and staff have been integral to the rollout of the revised curriculum. I wish particularly to acknowledge the work of our education and deputy education officers – Indu Kapoor (NZ), Simon Robertson (ACT), Natalie Smith and Nicole Phillips (NSW), Jeneen Thatcher, Mark Gibbs and Emile Kurukchi (Qld), Margaret Wiese (SA/NT), Colin Chilvers (Tas), Rick Horton (Vic) and Jodi Graham and Jay Bruce (WA), along with the rotational supervisors, supervisors of training and the WBA champions in both countries.

How to get involved

Any Fellow can nominate for their regional or national committee. This is an important way to have your voice heard as well as to contribute to our profession. For more information, contact your office or committee via the ANZCA website (see links to each region along the bottom of each page).

Chief executive officer's message

Ms Linda Sorrell
Chief Executive Officer, ANZCA

Improving our information systems

Last year, much effort was put into planning how technology-based services will work best for the College. As a result, we now have the Information Management and Information Technology (IM/IT) Roadmap.

The IM/IT Roadmap, developed by the Strategic Project Office, provides ANZCA with a clear path to transform its information systems and deliver an improved suite of technology-based services to Fellows, trainees and staff.

In 2012, the strong focus was on technology outcomes that benefited ANZCA trainees in particular. The biggest of these projects was the development of the new training portfolio system (TPS).

In 2013, the College will further enhance the training portfolio system and is seeking feedback from Fellows and trainees about where these are needed. Feedback can be sent to training@anzca.edu.au. Updates will be detailed in College e-newsletters and the *ANZCA Bulletin*.

The revised examination management system (EMS) also was delivered last year and improvements are planned for this year. In addition, ANZCA upgraded its core system database, iMIS.

As the College moves into 2013, the focus is shifting slightly towards what we can do for our Fellows.

Projects include the introduction of multiple online service initiatives and improved online library services.

The objective will be to deliver solutions that give Fellows and trainees ownership of their information using flexible online services, via website and mobile-based technology.

Next year the College will move further along its roadmap journey with additional initiatives, including an upgraded ANZCA and FPM website with greater mobile capability, and the delivery of an online environment to support the ANZCA and FPM learning programs.

Also included in the roadmap are initiatives that contribute to ANZCA's organisational sustainability.

Developing and delivering the roadmap has involved collaboration with all levels of the College. We received feedback from the ANZCA Council and several committees, and held workshops and meetings with staff on information and technology systems to ensure that all business units have had input.

The ANZCA Strategic Plan 2013-2017 principles have been used to inform all aspects of the roadmap.

Drivers for the IM/IT Roadmap include:

- A good experience for Fellows and trainees is central to the design of services and change implementation.
- Information will be valued as an asset. Fellows and trainees will be provided with tools/systems to manage their own information.
- Online services will be provided where possible ensuring they will be available to Fellows and trainees at any time, from any place and via multiple channels. ANZCA will provide easy-to-use processes and tools, which enable self-service.
- The policies, processes and systems that support and deliver each ANZCA/FPM function will be consistent across the organisation.
- Information will be collected once, and shared as required with minimal manual processing.
- Preference will be to use existing systems to meet newly identified needs. Buying "off the shelf" will be favoured over custom solutions.

As we move through 2013, I hope you will start to see the results of our efforts to make interactions with the College easier and more streamlined.

Australia Day honours

Dr Alan William Duncan (WA) was appointed as a Member of the Order of Australia (AM) for significant service to medicine in the field of paediatric intensive care as a clinician and educator.

Professor Ben Marosszeky (NSW) was appointed as a Member of the Order of Australia (AM) for significant service to rehabilitation medicine and through contributions to people with arthritis.

Letter to the editor

Thanks for the memories

Dear Editor

Having reached the age of 80, I find myself looking back over my career and remembering the most rewarding experiences during those years.

As a result of those reminiscences I am writing to thank the College for providing one of the highlights of my professional life, an invitation to speak at the annual meeting in Melbourne, and also to speak at departments of anaesthesia in Auckland, Adelaide and Sydney.

The hospitality was incredible everywhere I went, and I developed life-long friendships along the way.

Of course, the frosting on the cake was being made a member of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons, now the Australian and New Zealand College of Anaesthetists. This was an unexpected honour and one of which I am (and always will be) extremely proud. I thank the College for this honour, and thank the many members who were so kind to me and who made my Australian and New Zealand experience so memorable.

Alon P. Winnie, FANZCA
Illinois, US

ANZCA in the news

Since December last year, ANZCA has generated...

- 12 print stories
- 20 online stories
- 5 radio reports
- 20 TV reports

News about ANZCA and the Faculty of Pain Medicine has been accessed by a potential cumulative audience of more than 2.8 million people since December. Four media releases have been released, generating 57 media reports.

The Geoffrey Kaye Museum of Anaesthetic History was promoted as part of the International Symposium on the History of Anaesthesia, with the museum's Honorary Curator, Dr Rod Westhorpe, doing several radio interviews, some broadcast nationally, about the museum's collection and the history of anaesthesia.

ANZCA President, Dr Lindy Roberts, defended anaesthetists' skills, training and professionalism in a debate about workforce issues that appeared in the *Sunday Age* and *Age* newspapers. Dr Roberts was also interviewed about the revised curriculum in an article that appeared in the *Medical Journal of Australia*.

Other highlights included ANZCA Fellow and member of the Research Committee and Trials Group, Professor David Story, talking at length about anaesthesia on Melbourne radio station RRR, and Quality and Safety Committee Chairman, Associate Professor David Scott, responding to the shortage of morphine sulfate.

Pain medicine has also been in the news, with FPM board member, Dr Ray Garrick, appearing on *A Current Affair* to talk about migraines; FPM Fellows and gynaecologists, Dr Susan Evans and Dr Thierry Vancaillie, discussing pelvic pain in Fairfax papers; and former FPM Dean, Dr David Jones, highlighting in the media the recognition of pain medicine as its own scope of practice in New Zealand.

Media releases distributed by ANZCA since December

College and Interplast help world's poor manage pain better *(February 25)*
Christine Jackman wins 2012 ANZCA Media Award for pain story *(February 14)*
Rare anaesthesia artefacts on display for world symposium *(January 23)*
Patients to benefit from ANZCA research projects *(December 18)*

All media releases can be found at www.anzca.edu.au/communications/Media

ANZCA Media Award

Former *Australian* journalist, Christine Jackman, won the 2012 ANZCA Media Award for "World of pain", a compelling and informative story about chronic pain.

Her article, which appeared in the *Weekend Australian Magazine* in March last year, described how many patients continue to suffer pain long after any initial cause has been treated.

"Our readers expect a story with a problem and a solution – and it was vital to communicate that chronic pain is not a simple condition with one simple cure, while maintaining their interest," Ms Jackman said.

"My central aim here was to introduce readers to a new way of thinking about a very old problem, one that is often dismissed as 'malingering' or 'hypochondria'."

Ms Jackman found compelling case studies to illustrate the story, including young, outgoing and active people who live with persistent pain, to shatter the stereotypes of chronic pain sufferers.

Her article was one of 15 entries for the award and was judged the best news story or feature about anaesthesia or pain medicine that appeared in the Australian or New Zealand media in 2012.

The award was judged by *ANZCA Bulletin* Medical Editor and ANZCA councillor, Dr Michelle Mulligan; former ABC journalist, lecturer and media training expert, Doug Weller; and former *Age* health editor and communications expert, Tom Noble. They said:

"'World of pain' took us on a journey. It was interesting, comprehensive, well written, well researched and informative. It included a very important message about pain which is important to get across to patients and the community. Ms Jackson produced a body of work that was outstanding in its clarity and fact."

The winning entry can be viewed at www.anzca.edu.au/communications/Media.

Meaghan Shaw
Media Manager, ANZCA

Workforce, a hot topic: what is the College doing?

In just about every forum I attend these days, not surprisingly, the hot topic is health workforce, innovation and reform. New Fellows and trainees express particular concerns about declining opportunities for public hospital positions in Australian east-coast metropolitan centres. Cuts to Australian health department budgets have impacted on demand with cutbacks in elective operating lists and senior public hospital employment opportunities. Post-GFC caution and the impact on superannuation funds have no doubt also altered plans of some anaesthetists nearing retirement.

In contrast, colleagues in regional centres express optimism as job advertisements now receive FANZCA applicants. Those in rural and remote areas, who have suffered from workforce maldistribution, maintain guarded optimism that this situation may have a positive impact on them and their communities. This is welcomed, given chronic shortages and reduced access to specialist care in regional and rural Australia and New Zealand.

The complexity of the situation is exacerbated by long-standing workforce shortages and maldistribution in New Zealand, and the trend for a net flow of anaesthetists to Australia. Add to this the significant reliance in both countries on international medical graduate specialists (IMGS), many of whom have provided long years of service to areas of need and made substantial contributions as Fellows.

The recent unprecedented growth in Australian medical school graduates provides challenges, exemplified by recent intern place shortages. This pipeline effect will hit the vocational sector in a couple of years, meaning that more posts and supervisors will be required. Fellows and trainees will be aware that, from 2004, ANZCA decided to deregulate training and accredit departments rather than posts. This was done in the interests of transparency and equity to ensure that doctors undertaking largely identical positions could count these in their training – thus employers (Australian state and territory jurisdictions, district health boards and hospitals) determine training numbers.

Changing workforce patterns add further complexity. Many of us want more flexible hours, to work part-time or intermit for personal and family reasons. Scopes of practice are expanding into pain medicine, perioperative medicine, "outside areas" (or "off-floor activities"), as well as services such as retrieval medicine, simulation, clinical leadership, research and teaching.

All this is set against a background of debate about workforce reform across the health sector, concerns about unsustainability of current workforce models, rising health costs as a proportion of gross domestic product, and pessimism about keeping up with the demands of our ageing populations and more technologically complex healthcare. We face a complex and challenging future.

What is the College doing?

The most common question I am asked is "What is ANZCA doing about this?" The answer is "A lot, as it is vitally important that ANZCA has a strong and influential voice on behalf of its members and safe and high quality patient care".

ANZCA's responses may not be obvious to Fellows and trainees at the coalface, so I thought it would be helpful to outline some of our workforce activities.

A clearer picture is needed

Much better data is need about the situation in both countries. The College is developing a graduate outcome survey of all new Fellows. We are investigating the methodology used by universities to ensure that the results are meaningful and representative. The survey will be repeated annually to further our understanding of work opportunities and future plans in an evolving way.

ANZCA provided data to Health Workforce Australia (HWA) for modelling of anaesthesia workforce in *Health Workforce 2025: Medical Specialities Volume 3*, released November 2012 (see www.hwa.gov.au/health-workforce-2025). Workforce modeling is potentially unreliable and I welcome plans by HWA to regularly update their modelling over coming years. In New Zealand, the College undertook and published *The demand for and supply of anaesthesia services in New Zealand 2010-2030* (see www.anzca.org.nz/publications) in 2010. This report is publicly available to decision-makers and is used in our advocacy with government and Health Workforce New Zealand (HWNZ).

Policy and advocacy

The College has strengthened its policy and advocacy role with governments and organisations such as HWA and HWNZ (see article by ANZCA General Manager, Policy, John Biviano on page 16). We welcome opportunities to increase co-ordination within the medical training pathway, particularly given the complex factors at play and the involvement of multiple bodies in the workforce demand-supply equation. HWA has released a consultation document on a National Medical Training Advisory Network (NMTAN), aimed at co-ordinating workforce planning in Australia. ANZCA will make a strong and detailed submission about this. Individuals are encouraged to do likewise.

The College maintains ongoing dialogue with our sister societies. Our organisations have complementary roles in these debates and it is important that perspectives are shared. I speak regularly to the President of the Australian Society of Anaesthetists, Dr Richard Grutzner, and the President of the New Zealand Society of Anaesthetists, Dr Rob Carpenter, and we attend each other's council meetings.

Promoting innovation but not at the expense of safety and quality

With an increasingly unsustainable rise in health spending, health economists, the productivity commission and health workforce organisations in both countries propose innovation and change, and investigate new models of care. The College works hard to maintain a strong voice in this debate, in line with our mission to maintain the quality and safety of care for our communities.

ANZCA is developing a position statement on workforce roles in anaesthesia care delivery that can be used to promote the College's position and inform our policy submissions to governments and others. Change is inevitable but should not occur at the cost of safety and quality of patient care.

The College is involved in initiatives that address maldistribution, to increase access of rural and regional communities to anaesthesia care. ANZCA's involvement in the Specialist Training Program (STP) is substantially about positions in regional centres and other expanded settings. Recent examples include the Royal Flying Doctor Service in Western Australia, the North Queensland Persistent Pain Service with outreach to isolated communities, and positions in Toowoomba and Tamworth.

Employers can advertise job vacancies on the College website – see www.anzca.edu.au/resources/anaesthesia-job-vacancies.

What can Fellows and trainees do?

- Respond and contribute to surveys: this ensures that data collected by the College and others provide an accurate picture. This strengthens the impact of any survey about workforce issues.
- When interacting with patients, every Fellow and trainee can, as opportunities arise, advocate for our profession (and its professionalism). This improves understanding of the specialty in the general community.
- Recognise where the controls in this situation reside: employment decisions are beyond the scope of the College.
- Consider your own role in health leadership and decisions addressing workforce supply and demand. Advocate or act (for those in leadership positions) on issues that you can influence.
- Support the College in its attempts to advocate for considered policy decision-making that ensures access to high quality healthcare for all Australians and New Zealanders.
- Recognise that each country's stated aim to reduce its reliance on international migration will mean that locally trained anaesthetists are required in regional and rural areas.
- Ensure that significant department changes that may impact on training are reported to the ANZCA Training Accreditation Committee to ensure high quality training is maintained.
- Get involved: make group or individual submissions on issues such as the proposed National Medical Training Advisory Network (see www.hwaconnect.net.au).

You can be confident that the College is ensuring we have a strong and effective voice in health workforce initiatives and debates.

Dr Lindy Roberts
ANZCA President

Rewards and challenges of overseas fellowship



Trainees and Fellows develop valuable skills by working overseas but it may not give them the advantage they need to enter the Australian jobs market.

The fellowship year is a time where trainees are at their peak of knowledge and experience in a breadth of anaesthesia sub-specialties.

For a trainee or newly appointed Fellow, it is a crucial time to develop further skills both clinically and in preparation for employment as a staff anaesthetist.

Going abroad for a fellowship can be rewarding but the process is often met with challenges, which will be outlined here.

I am approaching my 17th month in Canada, having spent 12 months doing a fellowship in Vancouver in transplant and regional anesthesia, and now as a postgraduate Fellow/staff anaesthetist working in pediatric anaesthesia in Calgary.

When I left Australia after obtaining my FANZCA in August 2011, I was told that going abroad and "gaining skills you can bring back" would assure me a strong possibility of a position in an academic department.

I returned to Melbourne last July, a few publications under my belt including abstracts presented at international conferences, to discover that many of the colleagues who had graduated before and after me had barely scraped a day or two of appointments. They had faced months of uncertainty despite having surpassed the hurdles of the training program. And the word on the street was that there were no jobs.

I also was told that being away had left me at a slight disadvantage. Eventually I returned to Canada to practice. This was not an easy process, but I had little choice.

I thought it would be pertinent to address this problem, so trainees preparing to go abroad appreciate the implications of an overseas fellowship.

The pros and cons and process involved in preparing to go abroad discussed here are specific to Canada but are relevant for any overseas position.

Getting there

This takes about a year or two before leaving Australia, when the application process begins. Shortlisting for most North American fellowships typically occur 12 months before the job starts, so there is a long time between applying and finding out if you get an interview.

Once offered a job, the tedious process of paperwork begins, and most departments are organised about this process. The longest step is verification of credentials which occurs via the ECFMG (Education Commission for Foreign Medical Graduates) International Credentialing Services (EICS), takes six to nine months, is costly (around $US800), and involves tracing medical qualifications back to university and obtaining signatures from all prior clinical rotations in residency. Without this verification, provincial licensure for practice cannot be obtained.

The visa and immigration requirements take a few months, and the current cost for a medical exam is $A450, excluding the visa, which costs $US75-80.

Other incidental costs include certificates of conduct from professional bodies in Australia (AHPRA etc).

Therefore trainees thinking of going abroad should prepare to spend hours and dollars to complete various steps to move out.

I have not mentioned personal organisation – I had a property and belongings I had to store, which again cost me a significant amount of money and time.

Pros

Once you get past the first step, and arrive in your country of choice and job, it can be the beginning of an amazing experience.

In addition to travelling and making new friends or learning how to ski, you learn how to "skin a cat differently" as the old adage says. There is opportunity to gain a sub-specialty interest and/or develop a niche of practice. Being a Fellow invites rewarding research and learning opportunities.

There is potential to develop work practices outside comfort zones and you

quickly adapt to working in unfamiliar territory, which will strengthen skills of communication, technical procedures and professionalism. At the end of the year, the experience may create employment opportunities, which the trainee had not thought of before. Being part of an overseas department immediately builds international relationships with other specialists to further research and training in the specialty.

Cons

The process takes time and patience, and forward planning is necessary. There are significant financial commitments, but most overseas jobs pay a fraction of the salary in Australia. This can also be an issue. Universities or departments fund most fellowships so usual benefits and overtime are not paid. The red tape can be frustrating. Furthermore, many fellowships do not provide formal contracts and there can be a lack of clarity around the job, which may conflict with expectations.

Trainees must consider exactly what they want to gain from their year abroad to ensure it will deliver the skills they need to set themselves apart from their peers when the re-enter the local job market.

Finally, being abroad means being far away from family and friends, which can be lonely when you are finding your feet in a new environment, and the temperatures are a lot lower!

It is important for trainees to appreciate that the job market in Australian metropolitan teaching hospitals is not great and being away can pose a disadvantage in terms of knowing what positions are coming up.

Trainees must have specific fellowship goals; mentorship plays a crucial role. Before you go away, review what skills departments are seeking so you can go abroad and obtain them. This will give you the best chance of standing ahead in a job interview.

Being abroad for longer than a year can lead to the "out of sight, out of mind" phenomenon, so it is important that trainees or Fellows maintain connections with colleagues at home to stay up to date with employment and College news.

I hope this encourages overseas fellows to maintain a connection with the Australian job market. It is important for trainees to continue to go abroad and return with skills to enhance their practice and foster international networks for the betterment of our specialty.

Perhaps a focus group for Fellows working abroad could be developed so there is a support network and leadership group keeping us connected to the College and the anaesthesia community.

Dr Balvindar Kaur, FANZCA
Alberta Childrens Hospital,
Calgary, Canada

"Going abroad for a fellowship can be rewarding but the process is often met with challenges."

ANZCA and government: building relationships

Australia

Election

ANZCA will watch with interest as the major parties release their health policies in the lead up to the Australian federal election, which will be held on Saturday September 14.

The College will analyse potential impacts on the health sector and the profession.

Engaging with government

The College met with the chair of the Pharmaceutical Benefits Advisory Committee (PBAC) in February to outline the Faculty of Pain Medicine's approach to improving the education of opioid prescribers, and associated monitoring and access issues. This is an important area for the Faculty to take the lead and advise on relevant policy approaches. The PBAC is awaiting the results of a data utilisation study and analysis, which will form the basis for a comprehensive review and development of an appropriate strategy.

The Policy Unit and the Tasmanian Regional Committee are working with the Australian government and Tasmanian health services to develop a funding package for improved training and supervision of specialists linked to the Specialist Training Program initiative (see opposite page). It is anticipated that several new training positions and supervisory roles will be funded for anaesthesia and pain medicine, all subject to further consultation and government approval.

The Medical Education and Planning Group of the Victorian Department of Health has been established to improve planning for increased numbers and appropriate mix of interns and other postgraduate training places in Victorian hospitals. ANZCA has been invited to join the group, along with stakeholders including other colleges, major hospitals, universities and related industry organisations. The Victorian Regional Committee is being consulted on strategies consistent with local needs and educational imperatives. The planning is aligned to Health Workforce Australia's work in this area to ensure consistency of workforce data and modelling. Local adjustments will be made where applicable.

ANZCA welcomes the opportunity to work with the health jurisdictions, health providers and related bodies to improve education and training in anaesthesia and pain medicine, which benefits our Fellows, trainees and the community.

Policy development

The Policy Unit has been working with ANZCA units and committees to revise all regulations following the release of the revised curriculum. Regulation 38, specific to the affiliated training regions, was released in January. The complementary *ANZCA Handbook for Training and Accreditation in the Affiliated Training Regions* is being developed.

Meanwhile, the Policy Unit is co-ordinating and supporting two working groups to explore the general practitioner anaesthetist role and develop a position statement on alternative providers in anaesthesia respectively.

ANZCA, via the president, also has set up a working group to explore workforce issues and to review the College's role in advocating for improved education and training within health services, on behalf of Fellows and trainees. A graduate outcomes survey is planned to help the College understand the experience of new Fellows in the workplace.

Submissions

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

- Clinical Excellence Commission of NSW Health on the NSW Peripheral Intravascular Cannulation Policy.
- The Department of Health and Ageing on the review of Australian government health workforce programs.
- Australian Medical Council on the proposed Intern Training Framework in the national registration and accreditation scheme.
- Pharmaceutical Benefits Advisory Committee on the status of electronic recording and reporting of controlled drugs.
- NSW Health on the composition of the Medical Council of NSW.
- NSW Health on the accreditation of specialist medical training sites project.

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 found on the website at: www.anzca.edu.au/communications/submissions.

Regulatory framework for the Australian and New Zealand Therapeutic Products Agency (ANZTPA)

In June 2011, the Australian and New Zealand governments announced they would proceed with a joint scheme to regulate therapeutic goods on both sides of the Tasman. The first step in sector consultation is a high-level policy paper outlining a possible regulatory framework for the scheme.

The proposed scheme would cover the standards, manufacture and product approvals of medicines, medical devices, blood and blood components. It provides for the provision of information on products, exemptions, promotion of therapeutic products and provision of expert advice.

ANZCA has responded to the paper and will continue to engage with the ANZTPA team as work progresses.

Australian government grants – Specialist Training Program

The College has finalised a variation to our contract with the Department of Health and Ageing (DoHA) to extend the Specialist Training Program (STP) to the end of 2015. All participating hospitals have received new funding agreements or deeds of variation and negotiations are under way. The dates for the 2014 Specialist Training Program application round will be announced soon and interested hospitals should understand that this may be the last opportunity to apply for funding under the this program because the government will reach their anticipated 900 training positions by next year. DoHA usually provides a short turnaround time to submit applications, so those interested in applying for funding should start the process as soon as possible.

Further information is available at: www.anzca.edu.au/training/rotations-training-sites/specialist-training-program.html

For further information about the Specialist Training Program, please contact Donna Fahie (Manager, STP) on +61 3 9093 4953 or stp@anzca.edu.au.

College accreditation update

The College and the Faculty of Pain Medicine were granted accreditation by the Australian Medical Council (AMC) on December 17 to continue training programs in anaesthesia and pain medicine, and to run continuing professional development programs for another six years until December 31, 2018. The College and Faculty provided comprehensive submissions to the AMC and the Medical Council of New Zealand (MCNZ) in April last year. ANZCA is now working on a progress report, which will be provided to the AMC in March. The AMC has provided a copy of the report to the MCNZ for its consideration.

New Zealand

Pharmac continues to consult on the contents of its preferred medicines list (PML), a nationally consistent list of pharmaceuticals that will be available in all district health boards. The New Zealand National Committee has been actively involved in commenting on various categories of drugs. Recent submissions include recommendations on the inclusion of and indications for sugammadex, and proposed preferred medicines list inclusions for dermatological, endocrine and central nervous system drugs.

Other recent submissions have included comment on a proposed expanded scope of practice for anaesthetic technicians in New Zealand, including insertion of PICC lines and working in a post-anaesthesia care unit.

John Biviano
General Mananger, Policy
ANZCA

Indigenous health podcast series now available

The ANZCA Indigenous Health Committee is pleased to launch the College's indigenous health podcast series. The series, which was funded by the Department of Health and Ageing under the Rural Health Continuing Education program, includes nine short independent learning podcast modules that focus on the needs of rural and remote anaesthesia and pain medicine specialists working with indigenous patients and communities in Australia. The modules are now available on the e-learning section of the ANZCA website (www.anzca.edu.au/resources/e-learning/podcasts).

The podcasts were developed by ANZCA and FPM Fellows, doctors with experience in indigenous health, Aboriginal liaison officers and an Aboriginal doctor, to share the experiences of working in indigenous health and provide information specific to the needs of specialist anaesthetists and pain medicine physicians.

The series aims to improve communication between clinicians and indigenous patients, thus facilitating quality and safe healthcare. Communication is a theme recurrent throughout the series and is also the focus of one of the podcasts. Informed consent also is discussed as it applies to indigenous patients. Other topics include pain management, culture, culture shock, the preoperative visit, traditional parenting, interactions with indigenous patients with indigenous and non-indigenous heritage and diffusing anger.

The indigenous health podcast series adds an important resource to the College's electronic learning programs and is available for all Fellows, trainees and international medical graduate specialists.

In the future, the series will be available to specialists from Australasian medical colleges through the Network for Indigenous Cultural and Health Education (NICHE). The NICHE web portal is an inter-college initiative designed to provide a central location for rural and remote specialists seeking indigenous health resources. It will be launched this year.

The ANZCA Indigenous Health Committee recognises that the disease burden of Aboriginal, Torres Strait islanders, Maori and Pacific islanders is disproportionately greater than for other Australians and New Zealanders. The College has identified the provision of support for indigenous health as an important component of its 2013-17 strategic plan (http://www.anzca.edu.au/about-anzca/Structure-and-governance/pdfs/ANZCA%20Strategic%20Plan%202013-2017.pdf).

The strategic aims of the Indigenous Health Committee are to improve quality and safety in healthcare, improve access of mainstream healthcare by indigenous patients, facilitate indigenous role models and advocate on behalf of the indigenous community. The following initiatives are being developed:

- Incorporate education on indigenous health and cultural competency into the revised ANZCA curriculum. The Indigenous Health Committee acknowledges the work of Dr Elizabeth Gooch in this endeavour.
- Promote anaesthesia as a career to indigenous medical students.
- Support indigenous trainees and Fellows through mentoring programs.
- Develop podcasts exploring various themes in indigenous health.
- Collaborate with the Council of Presidents of the Medical Colleges to advocate on behalf of indigenous communities.

For further information on the work of the Indigenous Health Committee please contact Paul Cargill, Policy Officer, Community Development at pcargill@anzca.edu.au or +61 3 8517 5393.

This project was funded by the Department of Health and Ageing under the Rural Health Continuing Education sub-program (RHCE) Stream One, which is managed by the Committee of Presidents of Medical Colleges.

The Australian and New Zealand College of Anaesthetists is solely responsible for the content of, and views expressed in any material associated with this project.

Dr Rod Mitchell
Chair, ANZCA Indigenous Committee

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 the first in a series of articles by Dr Peter Roessler, ANZCA's Director of Professional Affairs, Policy, which explain aspects of ANZCA's professional documents in practical terms.

The appropriate discharge of patients

At the preoperative visit on the morning of surgery, a patient scheduled for a day-stay procedure, replies to your query about discharge transport by stating "I'm going home by taxi".

On further questioning you discover that there will be a responsible adult at home, but not until some hours later. The facility either does not have the capacity or refuses to extend the patient's stay for several hours.

What do you do in such cases?

There are two issues. One is the appropriateness of taxi transport after a day-stay procedure and the other is the presence of a responsible adult to care for the patient on arrival and overnight.

These questions have been the source of numerous inquiries from nursing staff and facility administrators. ANZCA professional documents PS15 Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery addresses this issue. Section 7 "Discharge of the Patient from the Day Care Unit" specifies the following requirements:

7.2.8 A responsible adult to take the patient home. For some patients it may be important to have an adult escort as well as the vehicle driver.

7.2.9 Discharge should be authorised by an appropriate staff member after discharge criteria have been satisfied.

7.2.10 Written and verbal instructions for all relevant aspects of post-anaesthetic and surgical care must be given to the patient and the accompanying adult. A contact place and telephone number for emergency medical care must be included.

In addition, sections 3.1, 3.2, and 3.3 apply as below.

3.1 A responsible person able to transport the patient home in a suitable vehicle. A train or bus is usually not suitable.

3.2 A responsible person staying at least overnight following discharge from the unit. This person must be physically and mentally able to make decisions for the patient's welfare when necessary.

3.3 Ensuring that the patient and/or responsible person understands the requirements for post-anaesthetic care and intends to comply with these requirements particularly with regard to public safety.

When is it OK to leave the hospital after handover to post-anaesthesia care unit?

Another matter that has recently been the source of frequent inquiry from nursing staff, hospital administrators and jurisdictional authorities is in regard to how long anaesthetists should remain at a facility after handing over to post-anaesthesia care unit (PACU) staff.

This issue is addressed within PS53 Statement on the Handover Responsibilities of the Anaesthetist. Section 3.2 is particularly relevant as problems often arise as a result of poor or inadequate communication. Effective communication between anaesthetist and PACU nurses will often avoid issues.

3.2 Care of and responsibility for the patient following sedation, major regional analgesia or anaesthesia is shared between the nursing staff, the anaesthetist and with the practitioner performing the procedure. There must be effective communication between all health professionals sharing care of the patient.

Section 4.4 addresses the requirement for availability after the handover.

4.4 The anaesthetist must be readily available to deal with any unexpected problems or alternatively ensure that another nominated anaesthetist or other suitably qualified medical practitioner is available and has access to the necessary information about the patient.

Dr Peter Roessler
ANZCA Director of Professional Affairs (Professional Documents)

LIFE ON THE FRONTLINE

Serving as an anaesthetist in the defence force brings personal and professional rewards, as well as service to country, as several College reservists explain to Meaghan Shaw.

"Thank God! I'm nearly home." One of the greatest rewards for air force reservist and anaesthetist Wing Commander Alex Douglas when repatriating soldiers injured in Afghanistan is hearing their relief once they know they're in safe hands and heading home.

As an aeromedical retrievalist, often she's the first person outside the wounded soldiers' warzone they have encountered, talking in a familiar Australian accent, and reassuring them they are going to be safe.

"They can see you're a doctor and you're going to take them home," she says. "And that sense of relief and, 'Wow, I'm nearly back' is very touching ... It's a gift I get and I'm very fortunate to have it."

Dr Douglas is one of about 75 anaesthetists in Australia and New Zealand who are involved in the defence forces, ready to assist in conflicts and disasters. Despite serving in often harrowing and dangerous conditions, their shared experiences reveal the rewards of service to their country, enhanced and improved clinical skills, and strong bonds of friendship and teamwork.

Many have served in Afghanistan, working in two-to-four month rotations as anaesthetists or intensivists at the NATO hospital in Tarin Kot in Uruzgan province where the Australian Defence Force is based. Other deployments for many College reservists have included East Timor, Bougainville, the Solomon Islands, Bosnia, Kosovo, Rwanda, and Banda Aceh following the 2004 tsunami.

Tarin Kot is an isolated outpost in the middle of Afghanistan, with the nearest city and major medical facility in Kandahar, about 200 kilometres away. It experiences a huge variance in temperatures between day and night, and summer and winter, with forces during the summer fighting season facing temperatures climbing to the high 40s, while in winter the base can be iced over.

The small military hospital at the Tarin Kot base is built within armoured walls designed to withstand small-arms fire, rockets and mortars. It has two operating theatres, an intensive care unit and several resuscitation bays.

The anaesthetic and surgical team provide initial resuscitation, life-saving treatment and damage-control surgery, with casualties requiring extensive and prolonged management evacuated to the coalition military hospital in Kandahar.

The hospital's primary role is to tend to soldiers wounded in combat, including suspected Taliban fighters. However, most patients are civilians injured as bystanders to the conflict. Sadly, about 30 per cent are children, many injured by playing with unexploded ordnance or in roadside bombings, or targeted by the Taliban because they go to school or are suspected of sympathising with the coalition forces.

"The Taliban are absolutely indiscriminate and absolutely ruthless in their attacks on civilians," says navy anaesthetist Commander Paul Luckin, who is responsible for all the navy's anaesthetists, intensivists and emergency medicine specialists, and who served in Afghanistan in 2009. "It's very challenging looking after civilians, particularly children, with the type of blast wound and high velocity injury that you would expect to get in soldiers."

Air force anaesthetist Group Captain David M. Scott, the Director of the Air Force Health Reserve in Queensland, was in Afghanistan for two months in 2008 when he ran the operating theatre and intensive care unit alone, and estimated he dealt with about 170 traumas during that time – two-thirds involving local Afghans and half of those children.

"The majority of the locals we looked after were either people who were terrorised by the Taliban – so had been shot by the Taliban for whatever reason, for being perceived to be assisting the international security assistance force – or they were kids who'd been playing with ordnance, unexploded stuff left generally by the Russians," Dr Scott explains.

Opposite page from left: An Aero Medical Evacuation team helps Ashmore Reef explosion patients inside the C-17 Globemaster en route to the Royal Brisbane Hospital; (top) Dr Alex Douglas pins an Australian flag to the bedside of an Australian soldier wounded in Afghanistan; (bottom) Tarin Kot base. This page: the resuscitation bays at Tarin Kot; anaesthetist Dr Michael Corkeron checks on his patient during an evacuation from Germany to Australia.

"Penetrating trauma management is something that's very cutting edge and massive wounding and massive transfusion trauma management is something you get to do par excellence when you go to those countries."

"Or it was just routine car crashes, irrigation canal bank collapses, rural and agricultural types of injuries and burns – little kids getting burnt when they pour boiling water on themselves. So it was a real mix of that sort of stuff."

The opportunity to deal with rarely encountered injuries, such as blast wounds, multiple gunshot wounds and blast fragmentation wounds, benefits anaesthetists' clinical practice on their return home.

"I saw more gunshot wounds in two months than I had for the previous 20 years of my medical career," Dr Scott says. "Penetrating trauma management is something that's very cutting edge and massive wounding and massive transfusion trauma management is something you get to do par excellence when you go to those countries.

"It gives you a skill set when you come back home to your own country ... You go at it harder, you get more aggressive at managing the bleeding early and the outcomes for our patients, our civilian patients, are actually more positive.

"I had a motorbike rider up here in Lismore a couple of months ago who almost amputated his arm and his leg in a crash and I just went back to how we managed things like that in Afghanistan ... And the guy did really well, kept both his limbs, and he only had a short time in intensive care. Now I'm not sure I would have been so calm and so much under control with that sort of situation had I not had those experiences."

Dr Scott is now back in Afghanistan where the number of civilians being treated at the hospital is slowing as the local authorities boost their own capability and capacity in preparation for the handover of control to the Afghan people, with the Afghan national army running their own hospital in Kandahar with three intensive care beds.

But the defence force is mindful of maintaining its surgical capability, and over the past two years has set up a full-time military surgical team working at the Royal Brisbane and Women's Hospital comprising a general/trauma surgeon, anaesthetist, intensive care physician and emergency physician, who are capable of being deployed as a team at short notice.

Many advances in medical treatment have come out of recent conflicts, such as damage control resuscitation and surgery, including minimal debridement of ballistic wounds with frequent returns to theatre, massive blood transfusion protocols, the intravenous delivery of blood and fluids, and the development of novel haemostatic agents, dressings and tourniquets.

Army anaesthetist and intensivist Colonel Peter (Toby) Thomas says the damage control protocols were developed through necessity in war zones. Fewer operating tables and tight time pressures mean clinicians were able to do only the minimal amount of surgery necessary, which turned out to have better outcomes for patients.

"The importance of avoiding hypothermia and coagulopathy and acidosis in trauma patients is never more evident than when you're resuscitating somebody that's had both his legs blown off," Dr Thomas explains.

"In Afghanistan, we only had one operating theatre, so you have to get patients in and out quickly, you have to triage which patients need to go into the operating theatre first, and so you have to move quickly. What is required is a very high level of co-operation between the surgeon and the anaesthetist."

Army anaesthetist Major Marty Graves, who has just finished his FANZCA training, recalls one experience that highlights the level of co-operation that can take place.

"At one stage with one casualty we had five different surgical teams of two surgeons each working on the casualty at the same time: one team on each leg, one on a limb, and one team in the belly. It's rare to see such co-operation amongst our surgical colleagues," Dr Graves says.

"Even the use of whole and fractionated blood is truly cutting edge and Australian healthcare is now gaining from this experience with the changes in massive transfusion protocols here in Australia."

(continued next page)

LIFE ON THE FRONTLINE CONTINUED

ANZCA is involved in the development of frozen blood platelet technology, supporting through a research grant the work of Lieutenant Colonel Michael Reade, who has served as an anaesthetist in Afghanistan and is the first Professor of Military Medicine and Surgery at the University of Queensland's School of Medicine.

Professor Reade is working with the Australian Red Cross Blood Service to develop a pilot clinical trial in bleeding surgical patients to assess the efficacy and safety of technology that allows platelets to be frozen and stored for up to two years.

"Cryopreserved platelets have recently been given to Australian soldiers in NATO hospitals in Afghanistan, with seemingly good effect," Professor Reade says. "If this approach is found to be effective, there is a high likelihood that many lives will be saved and resources more efficiently managed, particularly in outer metropolitan, rural and remote Australian and New Zealand hospitals and among defence force personnel."

Anaesthetists tend to be high-achievers and those who join the defence forces are often among the highest of the high-achievers, with many also involved in other community organisations that have an ethos of service, such as St John Ambulance and lifesaving clubs.

Some get involved as medical students or junior doctors, wanting an extra component to their training. Others get involved as consultants, wanting to build a defence force component into their practice.

The reasons they get involved are varied and interesting. Dr Douglas was influenced by the television series M*A*S*H; Dr Thomas was recruited while an anaesthetic registrar in the operating theatre by a consultant surgeon who had served in Vietnam; Dr Luckin always had an interest in submarine and diving medicine and survival at sea; while Major Graham Sharpe, who is New Zealand's highest-ranked anaesthetist, was recruited in his mid-50s while sitting on a plane next to the then head of the NZ Defence Force, and now Governor-General, Lieutenant General Sir Jerry Mateparae.

The training involved varies from service to service, but can take up to two years of short courses and weekend training to ensure clinicians are clinically competent and safe in a military environment. The air force tends to have the shortest training time, with the army and navy providing more training for logistical requirements including, for the navy, helicopter underwater escape training.

There is also a military anaesthesia course run in Brisbane, using resources at both the Royal Brisbane and Women's Hospital and Ipswich Hospital, which teaches anaesthesia in austere environments, managing battle casualties and their complications, and includes using old-fashioned draw-over vaporisers. It emphasises improvisation and a return to basic skills.

Military involvement requires a change in mind-set for many anaesthetists, who need to accept any deployment is to support a military mission set by government policy, which determines which patients are treated. There also is a hierarchy and different rules and regulations to contend with.

Dr Sharpe, who joined the NZ army three years ago and has done several training missions setting up a mobile hospital in Tuvalu, Vanuatu and Samoa, says it has taken him some time to get used to giving orders.

"Once I was getting someone to do something and one of the NCO's whispered in my ear, 'Don't ask them, Sir. Tell them'," he recalls.

Dr Thomas says there have been many improvements to defence force support and logistics since his first deployment to Rwanda in 1994, when he was part of the first surgical team on the ground.

"There was abundant evidence of the mass killings, there were still bodies that hadn't been removed, there was an unbelievable smell due to dead bodies," he says.

It was his first exposure to patients injured by landmines and machetes, as well as a population where 30 per cent of the people were HIV positive, and many had AIDS-related illnesses such as tuberculosis complications.

"When I arrived back in Australia from Rwanda, I had one day off with my wife and family, and went back to work the next day. Now, everybody coming out of these areas have to be interviewed by psychologists, and debriefed about their experiences and given an opportunity to identify any particular difficulties."

These days people are better prepared before going, and there has been a steady improvement in equipment and supplies, especially access to clean water, light and power, which are needed for any operating theatre set-up.

A similarly bleak scene confronted Dr Scott and Dr Luckin in Banda Aceh, when they were part of the first western medical team to arrive in the Indonesian provincial capital four days after the devastating 2004 tsunami, which killed 160,000 in that province alone.

"There is nothing that prepares anybody, not matter how experienced, for a place where there are bodies lying in the gutters everywhere," Dr Luckin says.

"The stench of decay in Banda Aceh was awful. From the moment you arrived until long after you left, the smell was on your skin and in your nose and was just awful. I think for all of us the magnitude of Banda Aceh, the sheer scale of devastation and death was very hard to cope with."

The pair had limited drugs, essentially no equipment and half a cylinder of oxygen, and they took over an operating theatre in a so-called military hospital where they dealt with the very worst of casualties, who were all classified as ASA4-E or ASA5-E.

"In Banda Aceh, all of our patients had severe penetrating trauma, they all had grossly infected wounds, most of them had septicaemia, they all had aspiration pneumonia, they had lungs full of mucus, secretions, often blood, often pus," Dr Luckin says.

"They were desperately ill patients and Dave and I anaesthetised them with very little in the way of drugs or equipment."

As a small nation, Australia uses a tri-service model for surgical deployments, with expressions of interest sought from military anaesthetists when need arises. This means navy, air force and army anaesthetists find themselves working side by side for military operations, such as Afghanistan, and during peacetime disasters.

New Zealand has not sent a surgical team to Afghanistan, although some anaesthetists have worked with the Canadian surgical team, which had been providing service to New Zealand troops. New Zealand anaesthetists can join the forward surgical team of the Royal New Zealand Army Medical Corps or can become part of the Civilian Volunteer Health Service, which can be sent to disasters and around the Pacific.

Despite the tri-service set-up, the different services do maintain specialist roles. The air force is mostly involved in long-distance aeromedical retrievals, while the navy can set up a hospital on board a ship and anchor it offshore, such as it did during the Solomon Islands conflict.

Below from left: Queensland Ambulance vehicles line up at the airport to transport those injured in the Ashmore Reef explosion to hospital; (right) Dr David Scott with a patient inside a C-17 Globemaster.

"It might seem you're delaying your career or hurting your career, but the benefits you get out of the military far outweigh any of the negatives."

The army provides Australia's only field hospital and expects its doctors to develop command, logistic and administrative expertise alongside their clinical roles.

Dr Douglas, who was awarded the Medal for Gallantry for her service in Rwanda, nominates as her most memorable retrievals accompanying seven Australian soldiers who were shot in Afghanistan in 2011 when they travelled home from a staging post in Germany, and repatriating a large number of burns patients injured during an explosion on an asylum seeker boat off Ashmore Reef.

The Ashmore Reef explosion represented a logistical challenge to co-ordinate the concurrent movement of critically ill patients from Darwin hospital to the Royal Brisbane and Women's Hospital. It involved six ambulances in convoy, a police escort that cleared intersections for the party, and special access on to the airfield.

Other aeromedical retrievals from overseas can be a challenge because of the 24 to 36 hours it can take to get home, all the while continuing the level of care that would be expected in a hospital for critically wounded patients, which often includes intubation and ventilation.

Dr Douglas says this is compounded by the hazards of aircraft, such as electrical shocks, loud aircraft noise that can drown out alarms, the necessity to be seated during take-off and landing, and the different air pressure levels that affect physiology.

"There are enormous considerations – trapped gases, the fact that vibration disturbs clots, a patient who's traumatised will probably bleed, it's colder at altitude, it's noisy, fatiguing, lots of things to think about," she says.

"Then when you're at altitude, whilst you might know what the issues are, your capability to act on all of them is not as good as it would be on the ground, therefore making it even more adverse for you."

Despite the challenges, Dr Douglas describes it as "fun". "It's absolutely awesome. I get really quite animated when I think, yeah, I do this stuff and I love it."

Other College reservists share a similar enthusiasm for the rewards of service, despite the dangers involved in some deployments and the separation and anxiety from family.

Dr Graves says it is well worth joining up. "It might seem you're delaying your career or hurting your career, but the benefits you get out of the military far outweigh any of the negatives," he says.

Professor Reade says his attitude to teamwork has changed due to his military involvement, and his deployments have made him more tolerant of circumstances at home that he cannot change.

"If there was a lesson, it was that all you can do as a doctor is the best you can do, and I apply that to my civilian practice now as well," he says. "The rewards have been to work with a very close-knit and co-operative team of people who are focused on one job. You end up forming a real bond with the team members you're there with. And you do get the sense that you are actually achieving some good."

Dr Thomas says it is professionally rewarding to provide high quality surgery and anaesthesia to coalition soldiers and civilians and it is hard not to be tempted to help whenever possible, despite the strain it places on his very supportive family.

"My youngest son was at law school when I went to Iraq and he said if I ever did another deployment, he was going to take me to court and sue me for mental stress or something," Dr Thomas recalls with a laugh. "I think he was joking."

While the dangers of service in the Middle East are always present, the surgical team is relatively safe due to the hospital and sleeping accommodation housed in armour-plated containers.

"Life on a two-way shooting range is a bit of a challenge always," Dr Scott says with understatement. "But you just knuckle down and do your job. You don't really notice that sort of stuff."

He says the support given to the surgical team is overwhelming and, in some cases, unexpected.

He recalls a particularly hellish period at the end of his last rotation in 2008 when he helped repatriate to Australia wounded soldiers who had been ambushed by the Taliban. He survived on minimal sleep over several days.

He returned to his room, which he was sharing with an army colonel, whom he hadn't yet met.

"And I got back to find that my bags had all been opened, all the dirty clothes had been taken out, washed and dried and folded," Dr Scott recalls.

"This guy was an army colonel. I didn't know him from a bar of soap. I said, 'Wow, why did you do that?' And he said, 'I'm an intelligence officer and I know what you guys have been up to in the last 48 hours. I thought you might appreciate it'.

"There's not many places in the world where that would happen, is there?"

Involving clinicians in healthcare reform

"I talk about being a citizen of the healthcare system, not a victim of it."

A Churchill Fellowship looks at how clinicians can improve influence and improve the delivery of healthcare services, writes Meaghan Shaw.

When applying for a Churchill Fellowship, Newcastle anaesthetist Dr Tracey Tay had to make a two-minute pitch to a room full of unidentified people.

With no knowledge of their backgrounds, skill sets or professions, she had to assume they had no understanding of the healthcare system and her spiel had to go to the heart of how her research project would make Australia a better community.

"My essential pitch was if you're not consistently happy with healthcare in Australia, either for yourself or your community at large, and you were to redesign it, who would you want on the team?" she asks. "And currently there isn't a strong representation from clinicians in it at that high level."

Dr Tay works part-time as a senior staff specialist anaesthetist at John Hunter Hospital and Royal Newcastle Centre and her research last year has led to her working part-time at the NSW Agency for Clinical Innovation.

Her Churchill Fellowship investigated how highly performing organisations support clinician involvement in decision-making and leading change.

"I've always been interested in working out how doctors in particular can get a stronger voice into decision-making about priority setting and resource allocation in health at every level from hospital level and health service level all the way up to government and how we influence policy makers," she says.

Her research from late November to January last year took her to the UK, Denmark, Sweden and the US, and involved 35 interviews with 60 health experts.

In the UK, an interview with the Chief Executive of the Academy of Medical Royal Colleges, Mr Alastair Henderson, revealed

the historical background of how doctors and nurses ran hospitals with boards of management until a review by the Thatcher government in the early 1980s recommended involving people with more specialised management and financial experience.

As a result, there was a backlash by doctors who fled management structures in the UK, and Australia and New Zealand followed suit, leaving very few health services run by clinician CEOs.

But more recently, another review of the National Health Service in the UK identified a lot of waste in the system and problems with equity of access. Dr Tay says the resulting recommendations were for the involvement of senior clinicians in management positions. Now all Strategic Health Authorities in the UK have a medical director. "They're starting to say without doctors heavily involved at the beginning they're not going to get the reforms they need to see," she says.

In Australia too, the National Health and Hospital Reform process, instigated by former prime minister Kevin Rudd, recommended doctors have a much stronger role and voice in decision-making to ensure the most effective use of the health dollar.

Dr Tay's report shows the barriers to greater involvement by clinicians in management are a lack of leadership and management training and, especially for doctors, a lack of financial reward and prestige for taking on the extra responsibility.

But she views things differently and has found an emerging interest from clinicians wanting to get more involved.

"One of the things I've found around the world is a renewed desire to step up and make a difference in terms of the community that people want to live in," she says. "I think there are people who care enough, and for them it's not all about making large amounts of money."

Dr Tay says people who get involved get a sense of transparency and fairness about the distribution of health dollars.

"I talk about being a citizen of the healthcare system, not a victim of it," she says. "And I think a lot of people ... talk and act as though they are victims of the system, rather than a part of it. So that sense of belonging and sense of being part of a system that gives good healthcare overall is also a reward for getting involved."

Anaesthetists, in particular, are often found in the leadership arena, Dr Tay notes.

"It seems that we are people who are whole-of-system thinkers. Because in anaesthesia we're essentially a service specialty ... we learn how to work across specialties, we learn what the challenges are across specialties, we work very much as a team.

"So when it comes to understand whole of system, we're pretty good and I think we're over-represented at that leadership and management level. Managers tend to see us as largely sensible, calm people, which I think means we get a voice."

In Denmark and Sweden, Dr Tay found a more egalitarian, flatter management structure, with clinicians more engaged in the needs of the whole hospital rather than just their departments.

She says Denmark mandates leadership and management training for all clinicians and provides quarantined time for training activities. The UK also has developed a Medical Leadership Competency Framework, which mandates the same management curriculum for all medical schools, specialty training and deaneries (for prevocational training).

In Sweden, she visited Qulturum, a purpose-built facility within the grounds of the Ryhov County Hospital, where individuals or teams can spend six months or a year doing projects to redesign aspects of healthcare.

Similarly, the Kaiser Permanente's Sidney R. Garfield Innovation Centre in San Francisco is a giant warehouse with mock healthcare environments for working up new ideas and ways of doing things. The doctor-led organisation looks holistically at healthcare, building gardens and parks near communities struggling with obesity and running farmer's markets to encourage better eating as a way to influence the social determinants of health.

Dr Tay also visited the Institute for Healthcare Improvement in Boston, which developed the "Triple Aim" framework, which has three simultaneous objectives: improve the patient's experience of care, improve the health of the whole population and control costs.

Based on her research, Dr Tay makes four recommendations in her report, which are in summary:

"One of the things I've found around the world is a renewed desire to step up and make a difference."

- That all clinical education contains leadership and management training.
- That government and other health services include clinicians in planning, priority setting and resource allocation.
- That opportunities are created, particularly for junior doctors, for experiential learning in leadership and management.
- That healthcare organisations support clinicians to share responsibility and accountability for health outcomes, quality and cost with managers.

Dr Tay says the architect of the UK's management curriculum framework, King's Fund Senior Fellow, Mr John Clark, is now advising Health Workforce Australia on developing a similar national curriculum.

Western Australia and Victoria already have training programs in place for junior doctors to do a term attached to a service improvement project and there is strong interest from New South Wales to do something similar.

Dr Tay would also like to see clinicians and managers share key performance indicators so, for example, clinicians would be accountable for costs, and managers for education outcomes.

"Clinicians have to realise that we have to work with managers," she says. "The team that will change healthcare will consist of clinicians and managers. We both need each other to make change. So the sooner we understand managers and the sooner managers understand us, the quicker we'll get change."

- *Dr Tay encourages any anaesthetist with a passion for something to consider applying for the Churchill Fellowship, which considers a broad range of issues. "It's a wonderful opportunity and most Fellows find that it is a life-changing experience, as it was for me." She's happy to be contacted at Tracey.Tay@hnehealth.nsw.gov.au. Further information is available at www.churchilltrust.com.au.*
- *To hear more about Dr Tay's experiences, listen to the College Conversations CD with this edition of the* ANZCA Bulletin.

Ultrasound, chai and the Himalayas

A teaching week in Nepal delivers learning and enrichment for everyone involved, writes Dr Anthony Hull.

In spring 2012 I spent a week with the welcoming anaesthetic team at Dhulikhel Hospital, Dhulikhel, Nepal, teaching ultrasound-guided regional techniques. Having been in contact with the anaesthetists there, it was apparent that ultrasound-guided regional anaesthesia (and ultrasound-guided vascular access) was an area they were deficient in and were keen to develop. It seems that only two or three other anaesthetists in Nepal (who are in Kathmandu), are using ultrasound-guidance for regional blocks. Access to instruction or exposure to such techniques is extremely limited in Nepal, even more so outside of the capital.

Dhulikhel Hospital (www.dhulikhelhospital.org) is a unique health enterprise in Nepal. Founded by Dr Ram Makaju Shrestha, a local who obtained his medical degree in Vienna, Dhulikhel Hospital is a non-profit community hospital whose mission is to provide affordable, accessible and high quality healthcare. It has an all comers "service first, pay later" ethos, and runs quite differently to how a Nepali government hospital runs. Many patients can't afford to pay, and a significant amount of free treatment is funded out of a charity kitty. It receives no financial support from the Nepali government, but is funded by donor input and the re-investment of what fees are charged. The dedicated doctors and nurses are paid modestly. It's a busy place, with a happy, efficient and "can do" atmosphere.

It operates as an effective teaching hospital, in concert with the Kathmandu University Medical School, and also has a new and extensive dental school. The hospital covers a population of approximately 1.9 million people, though has already provided services to 50 out of 78 districts of the country.

Otherwise, apart from Nepal's government-funded public medical system, there is a growing private medical system that provides for the small minority who are able to pay high prices. The private system has an effect of draining more experienced medical staff from the public hospitals.

In Dhulikhel Hospital theatre, the default approach to regional LA blocks had been via stimlocation, using pre-loved and re-sterilised stimulating needles, performed pre or post-operatively. It was not unusual for the injection end-point to be that of neurological symptoms, particularly when there had been failure to evoke a motor response. The incidence of symptoms associated with systemic LA toxicity ranged between 4 to 10 per cent based on individual anaesthetist's estimations. Neurological manifestations were treated with benzodiazepines. There were no reports of progression to cardiovascular sequelae. Patients who received regional blocks had no routine follow up after departure from theatre, and catheter techniques had not been used.

There was a reasonable case for the introduction of ultrasound guidance into the local armamentarium, and teaching proceeded via hands-on practice and instruction. An ultrasound machine luckily lives in, and is allocated for, theatre use. The schedule was flexible to allow the busy theatre workload to continue unimpeded. The presence of nurse anaesthetic assistants enabled good attendance by the anaesthetists. The sessions initially focused on systematic sonographic imaging of plexuses and nerves on willing subjects, and progressed to performance of regional blocks on appropriate patients in the pre or post-operative setting. Also included were TAP blocks for sub-umbilical or full abdominal midline incisions.

We demonstrated how to achieve successful blocks by injection into neurofascial planes, with a margin of safety between needle and nerve. We discussed planning to avoid possible delays to theatre turnover with the use of a new technique.

The most readily available, inexpensive, and functional disposables (such as 22g quincke needles for TAP blocks) were determined. Some of the more generic aspects of regional anaesthesia were discussed selectively, including appropriate patient selection, day one post-operative reviews, LA dosing, and LA adjuvants.

An intralipid therapy flow chart was provided for copying and distribution to procedure areas where blocks occur, and intralipid availability was confirmed. A hard copy ultrasound-guided blocks resource is also now available for further self-guided progress.

The routine for central venous line placement at Dhulikhel Hospital was via the landmark guided subclavian approach. We covered imaging of, and CVC access via, the internal jugular vein route.

A week spent introducing a new method of performing regional anaesthesia is just a start. Just as the transition to ultrasound-guided regional anaesthesia practice among Australian anaesthetic departments took time, it also will be a gradual process in Nepal. There are also major resource and educational impediments to consider.

There are distinct benefits to be gained by incorporating this new technique into the routine of Dhulikhel Hospital anaesthetics department. Since I left Dhulikhel, there have been material improvements in block performance. The department has also managed (amazingly) to source another, more portable and user-friendly ultrasound machine. They hope to conduct an ultrasound regional block workshop, planned for early-mid 2013, at Dhulikhel Hospital, to be run by another anaesthetist from abroad.

I also gained distinct benefits while at Dhulikhel, among them the morning cups of Nepali chai overlooking the distant Himalayan range, being involved in an inspiring institution, and meeting a great bunch of Nepali doctors, nurses, and patients.

Dr Anthony Hull, FANZCA
New South Wales

"Just as the transition to ultrasound-guided regional anaesthesia practice among Australian anaesthetic departments took time, it also will be a gradual process in Nepal."

This page from left: Dhulikhel Hospital; Anaesthetist guinea pigs; Sometimes better not to know your own SpO2 (Gorak Shep, 5140 metres).

Raising the profile of paediatric pain

Despite recent advances, pain in childhood and adolescence remains under recognised, under estimated, under treated and under researched, writes Dr Meredith Craigie.

Children and adolescents experience a wide variety of pain, after injuries, surgery, burns and infections as well as associated with cancer and the effects of violence, including war and terrorism. It occurs regardless of where they live but the global differences in the provision of pain relief and pain management services are even more exaggerated for children than they are for adults. The membership distribution of the International Association for the Study of Pain (IASP) Special Interest Group on Pain in Childhood provides some insight into the interest of professional groups in pain in childhood. It seems incredibly small. In 2010, members of the Pain in Childhood SIG equated to only 4 per cent of the total IASP membership (Table 1); only half were doctors.

Publications concerning pain in childhood equate to only 11 per cent of the pain medicine research identifiable on Medline, Psychoinfo and OVID Nursing Database over the last 10 years. Most of this research has been in acute and procedural pain management culminating in the production of various guidelines such as the APAGBI guidelines for postoperative and procedural pain management[1] and the RACP Division of Paediatrics and Child Health guidelines for procedural pain management[2]. Research in children is challenging for a variety of ethical and developmental reasons. Animal research provides some insights; for example, the effects of injury at critical periods of early development, the timing of maturational switches in the function of key brain areas and the onset of pain sensitivity in adolescence with neuro-immune activation and NMDA-dependent central sensitisation[3,4,5].

Table 1: Membership of IASP Pain in Childhood SIG, 2010

Country	Members
USA	79
Canada	42
United Kingdom	20
Australia	18
Brazil	11
Netherlands	8
Sweden, Germany	7
France	6
Japan, India	5
New Zealand, Italy, Norway, Spain	4
Thailand	3
Belgium, Switzerland, Portugal, Mexico, Denmark, Israel	2
Finland, Ukraine, Costa Rica, Pakistan, Taiwan, Ireland, Kenya, South Africa, Bosnia & Herzegovina, Austria, Singapore	1

Adapted from the latest information available on IASP website.

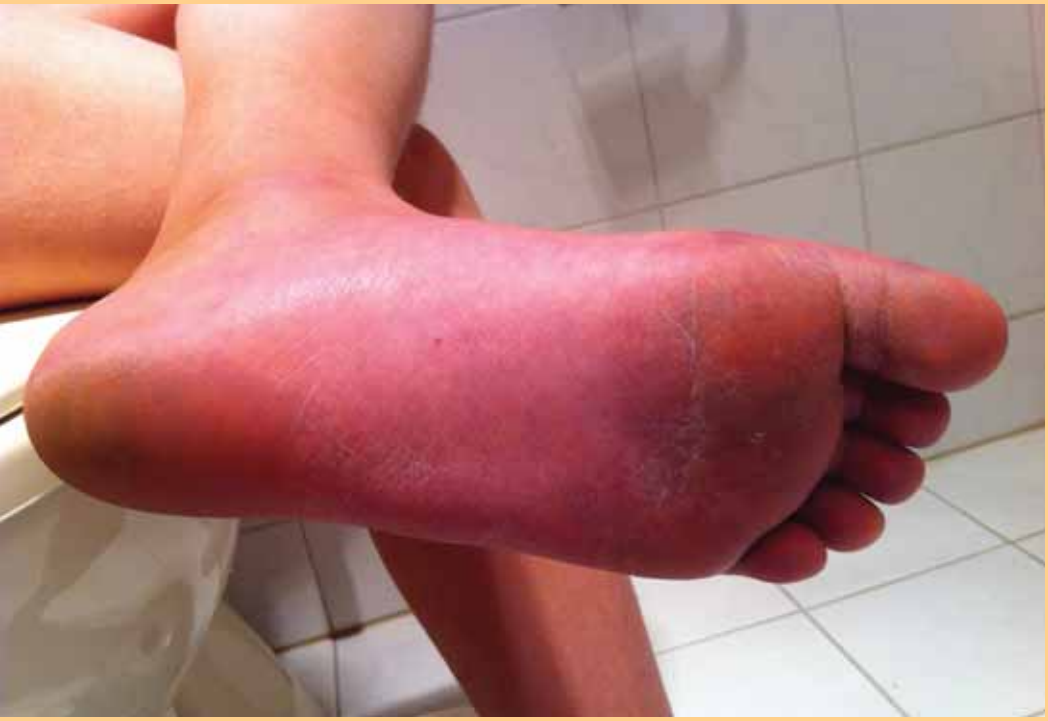
Table 2: Summary of prevalence rates and age differences by pain type.

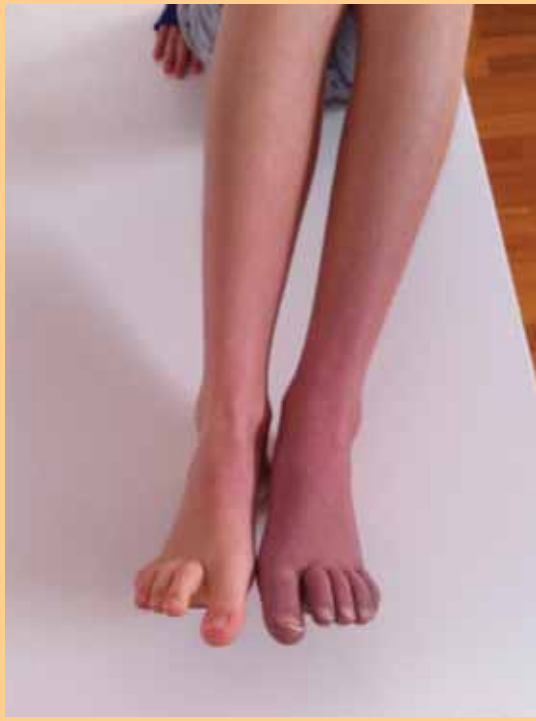
Pain type	Prevalence range	Age differences
Headache	8-82%	Older > younger
Abdominal pain	3.8-53.4%	Younger > older
Back pain	13.5-24%	Older > younger
Musculo-skeletal/limb pain	3.9-40%	Older > younger
Multiple pains	3.6-48.8%	Unclear
Other/general pain	5-88%	Unclear

Adapted from King et al. (2011).

Studies in neonates and young children suggest there are long-term ripple effects on somatosensory perception from pain during early development but the implications are not clear yet[6,7,8,9].

What we do know is that chronic pain in later childhood and adolescence is common. The landmark study by Perquin et al. found that chronic pain affected 25 to 35 per cent of children with a significant rise during adolescence[10]. More than 50 per cent of children reported recurrent pain in the previous three months, more than half in multiple sites and 25 per cent fulfilled the definition of chronic pain. It was more frequent in 12 to 15-year-old girls. Approximately 5 per cent had moderate to severe pain. More recently, a systematic review of studies of pain prevalence by King et al., found that there were widely inconsistent findings[11] (Table 2). They suggested that at least some types of pain may become chronic in childhood and be predictive of pain persisting into adulthood. Contributing factors included socioeconomic status, parental education, mental health status and time spent watching television. They concluded that there was a need for better studies of prevalence to understand the developmental trajectories, which may then allow identification of children at risk and early intervention. Prevalence studies have not been done in Australia and New Zealand.





In the clinic setting, complex regional pain syndrome, headache, abdominal pain and fibromyalgia dominate presentations[12]. Girls present more frequently than boys, similar to the community incidence. A study published by Walker et al. this year investigated the predictors of long term outcomes for 843 children experiencing functional gastrointestinal disorders with associated chronic pain and psychiatric comorbidities in adolescence and adulthood[13]. They performed cluster analysis and found a cohort of children who had evidence of central sensitisation that could be identified at baseline assessment. This has clinical and public health significance because it was these children who were at significantly higher risk of poor outcomes and therefore, should receive intensive specialised treatment.

However, it is not clear what constitutes the ideal treatment in many instances. Adult practices are often extrapolated to paediatric practice with limited evidence of efficacy. New slants on the traditional multidisciplinary approach are being tried with some promising results[14]. However, studies on treatment programs are few and the cost of persistent pain in childhood is high. In 2004 in the United Kingdom, Sleed et al. identified the costs for adolescents attending a pain management clinic with those attending a rheumatology clinic[15]. They estimated the average overall cost of pain to be around £8000 (approximately $A12,500) per adolescent per year. However, the costs for adolescents in pain were three times more than the rheumatology group. Parents and siblings required additional healthcare services secondary to the impact of the adolescent's pain problem on the wider family, adding to the costs. Estimates of lost earnings were up to £7250. This extrapolated to a national economic burden of approximately £6800 million per year. Amazingly, there has not been any further update on these estimates despite some major international pain initiatives recently. Neither the 2011 Institute of Medicine blueprint from the US nor the Australian National Pain Strategy provides any cost analysis of the impact of persistent pain in children and adolescents[16,17].

Dedicated funding for all paediatric pain services across Australia and New Zealand remains elusive. The Faculty of Pain Medicine acknowledged children as a special group and established the Paediatric Pain Working Party but only 5 per cent of Faculty Fellows work in this field with three recognised training positions in paediatric pain medicine.

(continued next page)

This page: Images of a 10 year old girl with Complex Regional Pain Syndrome (CRPS) following a minor trauma of her foot being shut in a car door and a subsequent re-injury playing netball.

Raising the profile of paediatric pain
continued

This year, the Australian Pain Society established the Pain in Children SIG, drawing together the small number of practitioners from the various paediatric medical, nursing and allied health disciplines. Hopefully pooling resources will benefit all. Research output mostly comes from the established groups in Sydney and Melbourne plus some from Auckland. Recent publications include articles on service provision of acute pain management for children, the emerging issue of children on long-term opioids and putting some science into paediatric pharmacology[18,19,20].

Despite recent advances, pain in childhood and adolescence remains under recognised, under estimated, under treated and under researched. More translational research from animals to humans and from children to adults is desperately needed to understand when and how to intervene. Strong advocacy is required both for improved access to multidisciplinary pain management services for children and adolescents as well as research funding. Most important of all, though, is raising the profile of pain in childhood within the healthcare professions as well as the broader community to enable better understanding, early intervention and better outcomes for children and their families.

Dr Meredith Craigie, FANZCA, FFPMANZCA
Chair, Faculty of Pain Medicine Paediatric Pain Working Party
Faculty of Pain Medicine Board member
Chair Faculty of Pain Medicine Examination Committee

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Old school in the New Hebrides: the Vanuatu experience

Resource limitations don't slow the medical staff – or the babies – at Vila Central Hospital.

In August 2012, I travelled to Vanuatu for a week with funding provided by the ANZCA Overseas Aid Trainee scholarship under the supervision of Dr Matthew Howes, a staff specialist from the Mater Mothers' Hospital in Brisbane.

We were based at the Vila Central Hospital in Port Vila, the capital city on the island of Efate, providing relief anaesthetic services during the Pacific Society of Anaesthetists conference in Fiji.

Vanuatu is a south Pacific nation comprising some 80 islands approximately 2400 kilometres east of Cairns. The islands are tropical and located in a region of active tectonic plate movement known as the "Pacific ring of fire". Earthquakes and volcanic activity are common and we experienced a quake measuring 5.1 on the Richter scale during our stay.

Vanuatu is country of contrasts; luxury cruisers moor in the harbour while a few streets away families live in very humble circumstances. Despite the poverty, it has been dubbed "the happiest country on earth" and the national people (known as Ni-Vanuatu or Ni-Van) greet you with a happy "hello" and a bright smile.

Due to geographical and linguistic separation, the islands display an amazing diversity of culture. Residents speak more than 100 distinct languages and there are many dialects. The official languages are French, English and Bislama (or Vanuatu pidgin English). Most hospital staff spoke English, but for many patients Bislama was the common tongue. It was interesting to discover that the term "anaesthetist" is not only a mouthful in English but also in Bislama. While the surgeon is known as the "katem man" (the cutting man), there are several variations for "anaesthetist". For example, I could be called "dokta blong makem man i silip gud" (the doctor who makes you have a good sleep) or this could be expanded to "dokta we i stikim man o i givim gas blong makem bodi i ded blong dokta i save katem" (loosely translated as "the doctor who either sticks you [for example, spinal] or gives you gas so that look dead in order for you to be operated on").

The hospital at Port Vila was once located on a small island in the harbour, a five-minute boat ride from the mainland. Today the island is home to the Iririki resort, however, if you look carefully you can see what remains of the former hospital. More than 30 years ago it was decided to move the hospital to the mainland, which by all accounts was a good idea. The current Vila Central Hospital comprises several single-storey buildings with separate wings for medical, surgical, obstetric and paediatric patients. The hospital is in a particularly poor area with many slum dwellings nearby. There are always groups of people milling around and kids kick a football on the open grassed area near the entrance.

Immediately it is evident that this is like no hospital I have worked in before. The two operating theatres are old and patched up. Everything from the beds, lights, diathermy, drapes and gowns appear to be from a bygone era and bring back fond childhood memories of watching M*A*S*H. There is a distinct lack of order and the meticulous sterility we are accustomed to in western hospitals. The anaesthetic machines seem more cluttered. The ampoules are hard to read and even harder to break; a file beside the anaesthetic machine is used for this purpose. There are no colour-coded drug stickers and multi-dosing of drugs is common to avoid wasting scarce resources. There are sharps everywhere, no needleless injection systems. Sharps bins are makeshift containers, such as used water bottles or cardboard boxes. Many "single use" items are recycled, including Hudson masks and oxygen tubing. The ward charts, drug charts and anaesthetic records are bland and there

is no comprehensive correct-site surgical procedure. Many patients do not know their date of birth and it is not uncommon to see numerous variations of names on a patient's chart.

Despite the obstacles and shortcomings everyone works well together to get the job done. The hospital staff are delightful and the patients are tough, tolerant and very grateful. By necessity, the junior doctors are much more hands-on than in Australia. It is not out of place for an intern under supervision to remove an appendix or perform a tubal ligation.

The clinical work was interesting and challenging. The caseload included a large number of paediatric and obstetric cases. During the week there were 77 births at the hospital – a lot considering there were only two midwives on duty! These deliveries included four emergency caesareans (no elective caesareans) and one vaginal delivery in the operating theatre (just saved from the scalpel). Two perineal tears also were sutured in theatre. Interestingly, there are no labour epidurals. Actually, there seems to be no pharmaco-analgesia for labour at all.

As well as the clinical aspects, I was able to attend one of the newly established obstetric morbidity and mortality meetings. The obstetric department recently established a high-risk obstetric clinic, which means there are fewer obstetric anaesthetic "surprises". I was also involved in running an interactive, clinically based teaching session for junior doctors on the topic of obstetric emergencies. Our time in Vanuatu also provided much needed support and shared experience with the two hard-working anaesthetic assistants – Michael Kalotrip and Joseline Phatu.

Overall, I found my time in Vanuatu to be of great value. The work was varied, challenging and rewarding. The hospital staff and patients were a delight to work with and care for. It was interesting to use different anaesthetic agents and techniques and I was left with a greater appreciation of our own medical system and the responsibility we have to use our resources wisely.

Dr Stephen Smith, FANZCA
Cairns Base Hospital, Cairns
ANZCA Overseas Aid Trainee scholarship winner

The ANZCA Overseas Aid Trainee Scholarship was established to support a final-year ANZCA trainee to develop their understanding of the challenges of providing anaesthesia and/or pain medicine in developing countries. Further information about the scholarship is available on the ANZCA website or by contacting overseasaid@anzca.edu.au.

"I could be called "dokta blong makem man i silip gud" (the doctor who makes you have a good sleep) or this could be expanded to "dokta we i stikim man o i givim gas blong makem bodi i ded blong dokta i save katem" (loosely translated as "the doctor who either sticks you [for example, spinal] or gives you gas so that look dead in order for you to be operated on."

Opposite page from left: Vila Central Hospital; Public health message: "Breast milk from mother is the best (number one) food for your baby".

This page from left: Some of the hospital's theatre staff on our last day; Theatre1: Arch bars to fractured mandible.

To resuscitate or not to resuscitate?

Anaesthetists have a duty to intervene when a patient has an adverse reaction to anaesthesia. But what if the patient requests otherwise?

It is increasingly common for patients with significant chronic disease to participate in advanced care planning. This is a process whereby a patient, in consultation with healthcare providers, family members and important others, makes decisions about his or her future healthcare, should he or she become incapable of participating in medical treatment decisions. Such programs have demonstrated a positive impact on the quality of end of life care[1].

A frequent component of advanced care planning is a "not for resuscitation" (NFR) order (also known as a do not attempt resuscitation order), which may be documented in the hospital records of patients whose underlying medical condition is severely compromising their quality of life, or is so debilitating as to make resuscitation attempts futile.

If the order is at the patient's request, attempting to resuscitate the patient from an imminent or established cardiorespiratory arrest related to their underlying disease would be against the patient's wishes, and could subject them to a loss of dignity and privacy that they had actively sought to avoid. It would not comply with the Good Medical Practice codes or guidelines of the Medical Board of Australia or the Medical Council of New Zealand[2,3]. Moreover, in the unlikely event that the resuscitation was successful, it may cause harm or prolong or increase the patient's suffering. For these reasons, all clinicians involved in the patient's care should respect an NFR order.

But what if the cardiorespiratory arrest (or imminent cardiorespiratory arrest) was not directly related to the patient's underlying medical condition? What if it were instead related to a recognised and reversible side effect of a drug administered for an unrelated condition? Or worse, what if the wrong dose of the drug – or even the wrong drug – had been administered? What if the patient already had intravenous access, airway protection and monitoring in place, and was likely to respond rapidly to resuscitative efforts without loss of privacy or dignity? Should resuscitation be withheld in these circumstances?

Providing anaesthesia for patients with NFR orders in place raises these and other questions. Several professional societies and organisations have guidelines on the decision to suspend or modify NFR orders in the perioperative period and the issue has been discussed in recent articles and editorials[4-13]. Various health departments and hospitals also publish guidelines to which anaesthetists can refer. However, the issue is complex and there are ethical and legal implications and it can be difficult for anaesthetists to know how to proceed.

This article simplifies the complex issues. It is not a comprehensive review, but a summary of common features found in the guidelines. It offers a framework for compassionate and responsible care.

Most guidelines on this issue highlight the importance of communication[4-7], which can be considered under the headings: explanation, clarification, informed consent, reassurance and documentation. Others focus on the importance of "re-evaluation" or "required reconsideration" of NFR orders, which also would involve these steps[8,9].

Explanation

While the patient's wishes must be respected, allowing a reversible side effect of an anaesthetic drug to hasten death is not an option for any anaesthetist. Therefore, to relieve anxiety and avoid misconceptions, it is essential to explain what anaesthesia entails. Patients (or their next of kin or legal guardian if they are not competent to provide informed consent) should be advised that general anaesthesia requires intravenous access, airway protection and the administration of intravenous fluids and/or drugs that may be required to counteract the known dose-related haemodynamic and ventilatory side effects of anaesthetic agents.

Major regional anaesthesia and heavy sedation require similar safety interventions. It is important to emphasise that managing these side effects is a part of anaesthesia and cannot be neglected or abrogated without a severe risk to the patient. If, at the request of a patient, an anaesthetist does not reverse a known haemodynamic or ventilatory side effect of an anaesthetic agent, the result could be fatal and may constitute assisted suicide. Moreover, there is the rare possibility of a more severe adverse reaction to anaesthesia, which may require cardiopulmonary resuscitation (for example, anaphylaxis, high neuraxial block). The anaesthetist would feel required to treat any anaesthetic-caused adverse reaction of this nature from the induction of anaesthesia to discharge from the post-anaesthesia care unit.

There is another view that patients are entitled to refuse treatment even for iatrogenic complications and that treatment decisions should be "defined in terms of patients' clinical goals and preferences"[12,13]. In the authors' opinion, this should not extend to reversible anaesthetic side effects and complications.

On the other hand, it should be explained to the patient that the management of most side effects of anaesthesia is typically rapid, effective and painless, and usually involves only the administration of vasoactive agents and/or intravenous fluids by their anaesthetist. Even chest compressions and defibrillation can be done in a controlled manner. A resuscitation team is not required to apply additional monitoring or insert extra lines without detailed knowledge of the patient's condition and wishes.

The point of contention, however, will be the differentiation between a major cardiovascular or respiratory event (including cardiorespiratory arrest) related to anaesthesia, and an event that is attributable to the patient's underlying condition. If there were any doubt, the anaesthetist would be required to attempt resuscitation until an anaesthetic cause had been excluded. If the arrest was due to the patient's underlying condition rather than an anaesthetic side effect, resuscitation would be much less likely to be successful; causes related to the patient's underlying condition would in most cases soon declare themselves.

Prolonged resuscitation attempts would not be justified, irrespective of the cause of the adverse event, due to the patient's previously expressed wishes and the futility, given the patient's reduced cardiopulmonary reserve and/or poor prognosis.

Clarification
In the event that consideration is being given to maintain any aspect of the NFR orders during the period in which the patient is under the influence of an anaesthetic drug, the anaesthetist must first clarify the following:

1. Has the patient provided written informed consent to the NFR order and is he or she competent to confirm their preference for NFR orders in relation to their underlying condition to continue during the perioperative period?
2. If the NFR order is part of an advanced care directive, did the advanced directive have provision for the possibility of unforeseen circumstances such as the need for surgery and anaesthesia?
3. Is the patient's medical condition or prognosis the same as or worse than at the time of their signing of the NFR order?

If the answer to any of the above questions is no or is not known, then it will not be possible to ensure that the patient's wishes are current in relation to NFR orders. Under these circumstances, we believe NFR orders should be suspended during the peri-procedure period unless there is legal advice to the contrary. Decisions relating to children may be particularly difficult in this regard9. Importantly, family members cannot insist on maintaining NFR orders without valid informed patient consent. However, the patient's next of kin or legal guardian should be entitled to receive the same explanation and reassurance if they are making decisions on the patient's behalf. **Informed consent**
Before proceeding with anaesthesia, the patient (or their next of kin or legal guardian if they are not competent to provide informed consent), as for all patients, must be made aware of the risks of anaesthesia and the measures that will be undertaken to minimise these risks. They should be informed that the risks are almost certainly increased by the patient's underlying condition, and that death may occur despite optimum management. Nevertheless, consenting to anaesthesia should include consent to the management of reversible anaesthetic side effects and adverse reactions.

Once informed, the patient, if competent, must then declare their wishes in relation to resuscitation for non-anaesthetic causes of cardiorespiratory arrest. Patient preferences for limitations on resuscitation from any cause (including anaesthetic causes) of cardiorespiratory arrest should also be documented, such as declining postoperative ventilation, haemodynamic support or intensive care. A purpose-designed form may be useful in this situation.

While there should be a separate consent form for the surgery or procedure, ideally the surgeon or proceduralist and the anaesthetist should meet with the patient together, so that all parties are aware of the risks and options, and the management plan and the patient's wishes are clear to all.

Reassurance
As for all patients, patients with NFR orders should be reassured that their anaesthesia will be as safe as possible and that they will receive adequate pain relief following their procedure and optimal management of anaesthetic side effects. In addition they should be reassured that their wishes in relation to NFR orders will be respected. If they have provided informed consent to have the NFR orders maintained throughout the perioperative period, then any attempts at resuscitation will be limited to the management of adverse effects known (or suspected) to be caused by anaesthesia. They will NOT receive resuscitation from a cardiorespiratory arrest considered to be unrelated to the anaesthesia or surgery. They should also be reassured that regardless of cause, resuscitation attempts will not be prolonged into the postoperative period, such that they would require postoperative ventilation, haemodynamic support or intensive care, counter to their requests.

Documentation
In addition to the written informed consent, a brief summary of the discussion with the patient or their next of kin should be documented in the patient's medical record.

In most cases this process is likely to be satisfactory to all parties. In the event that the patient (or the next of kin or legal guardian if the patient cannot provide informed consent) refuses any form of resuscitation despite the explanation and reassurance provided, then it may not be possible to provide anaesthesia for the procedure. Making stipulations on the extent of resuscitation (for example, procedure specific), such as no chest compressions or no defibrillation, may place an anaesthetist in a difficult position if they must attempt to reverse an inadvertent iatrogenic cause of a cardiorespiratory arrest, which if untreated could lead to an anaesthesia-related death. Treatment decisions should be based on the likely cause of the arrest while emphasising that, irrespective of cause, resuscitation attempts will not persist postoperatively against the patient's wishes. Hospitals or departments could develop guidelines to assist in this process.

In summary, NFR orders should not be automatically suspended during anaesthesia, but patients should still receive the safest possible anaesthesia, including the treatment of common anaesthetic side effects and rare adverse reactions. There should be extensive explanation and reassurance to allay patients' anxiety about inappropriate resuscitation and clarification and documentation of patients' wishes. Attention should then focus on providing the safest possible anaesthesia and ensuring that the patient is as comfortable and pain free as possible in the postoperative period.

Professor Neville Gibbs, FANZCA, MD, Chair of the ANZCA Mortality Sub-Committee

Associate Professor Larry McNicol, FRCA, FANZCA, Chair of the Victorian Consultative Council on Anaesthesia Mortality and Morbidity

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To resuscitate or not to resuscitate?
continued

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AURORA – a clinical registry

The concept of a registry is simple – it is a place where records are kept.

Clinical registries systematically and uniformly collect information from people who undergo a procedure, are diagnosed with a disease or use a healthcare resource.[1] The American Heart Association defines a clinical registry as a prospective observational database of a clinical condition, procedure, therapy or population, in which there are no registry-mandated approaches to therapy and relatively few inclusion and exclusion criteria.[2] This is very different to the conduct of a controlled-clinical trial where rigid filters in the form of inclusion and exclusion criteria are often applied before sampling can occur. This process of exclusion generates internal validity but may limit application of results to a broader population.

Despite these limitations, the randomised controlled trial (RCT) is the gold standard for determining if a therapy is efficacious. The focus of clinical registries is to capture real-world clinical practice, for example native hospital behaviour, in large patient populations independent of the environment of a controlled clinical trial.

Clinical registries are important for monitoring and benchmarking the quality of clinical care and are critical for clinical practice improvement. Clinical registries can serve multiple functions such as public health surveillance and for performance assessment. They can be used as vehicles for quality improvement, to evaluate trends in clinical practice and to monitor the safety and efficacy of a drug or device in phase four studies.[2,3] Determining if best practice and evidence-based guidelines are being adhered to or if the results of RCTs apply in routine practice (effectiveness study) are further valid uses.

There are many examples of successful clinical registries or databases from surgery,[4] intensive care,[5] and internal medicine.[6]

The Australian and New Zealand Registry (AURORA) is an example of a clinical registry established to determine the quality and safety of our contemporary practice of peripheral regional anaesthesia. The project began in 2006 during a period in which regional anaesthesia was evolving because of increased use of peripheral regional anaesthesia and ultrasound-guided techniques.

In previous studies peripheral nerve blocks (PNB) were performed using nerve stimulator technology and therefore the results did not apply to a new clinical technique. Existing literature included studies using self-reporting methodologies that were considered inadequate to guide risk disclosure.[7] Monitoring the quality and safety of regional anaesthesia is important for informed patient consent, clinical decision-making and because regional anaesthesia is often considered the alternative anaesthetic technique by many patients and anaesthetists.

The public perception of risk associated with anaesthesia is primarily related to the extremely rare risk of death due to general anaesthesia. Overall, the risks of general anaesthesia tend

to be more easily understood and thus accepted by patients. An anaesthetist may recommend regional anaesthesia but a patient's preconceptions may influence how receptive they are to an alternative technique. An additional burden is therefore placed on the clinician wishing to perform a regional technique when new potential benefits and complications are provided to patients.

AURORA results

Detailed methodology, outcome definitions, follow-up pathway and preliminary results of this project were published in 2009.[8]

During 2006-2012, approximately 35,000 peripheral nerve blocks (PNB) have been captured to the registry. Ultrasound-technology was used in 81 per cent of peripheral nerve blocks during this period. Peripheral nerve block was an effective technique for enhancing early postoperative recovery with the median pain scores in post anaesthesia care unit (PACU) being zero in all peripheral nerve block categories except for trunk.

Overall 65 per cent of patients required no analgesia, 23 per cent intravenous opioid analgesia and 8 per cent oral analgesia respectively. A total of 48 per cent of patients were ready to depart the PACU within 30 minutes.

Patient-rated outcomes indicate that patients were satisfied with the information provided to them and interactions with their anaesthetist. However, there is room for improvement because a significant proportion of patients reported moderate or severe pain following recession of peripheral regional anaesthesia.

During the study period of January 2007 to May 2012 inclusive, there were 22 episodes of local anaesthetic systemic toxicity (LAST) (13 minor; eight major and one cardiac arrest) from 25,336 peripheral nerve blocks. Overall, the incidence of LAST was 0.87 per 1000 peripheral nerve blocks. AURORA has demonstrated that ultrasound guidance may be protective for LAST. When peripheral nerve block was performed with ultrasound technology the incidence of LAST was reduced compared to techniques not using ultrasound. This finding was consistent using multiple analytical techniques and may represent the first statistical evidence that ultrasound guidance improves safety during peripheral nerve blocks.[9]

The incidences of late and long-term peripheral nerve block-related nerve injury were 0.6 and 0.30 per 1000 peripheral nerve blocks regardless of technology used. These incidences were calculated from a denominator comprising the total number of brachial plexus, femoral and sciatic nerve blocks. Fortunately, in most cases the long-term outcome for these patients was favourable.

In this study there was no significant difference in the incidence of late or long-term peripheral nerve block-related nerve injury when peripheral nerve block performed with ultrasound was compared with no ultrasound. Many observers would consider it plausible that peripheral nerve block-related nerve injury would be reduced when ultrasound-guided techniques were compared with techniques not employing ultrasound technology.

The major value and use of ultrasound-guided peripheral nerve block includes dynamic visualisation of needle placement and avoidance of nerve trauma. However, in addition to physical trauma there are other potential mechanisms including direct local anaesthetic toxicity. A randomised controlled trial comparing ultrasound-guidance with techniques not employing ultrasound would require a prohibitively large number of patients if permanent nerve injury were the primary outcome.[10,11]

The AURORA results indicate that if a difference in nerve injury truly exists when ultrasound guidance is compared with non-ultrasound techniques a sample of at least 30,000 per group would be required. It is now accepted that ultrasound guidance has not reduced the incidence of nerve injury caused by peripheral nerve block.[10] Even if a larger registry had an appropriate sample size, it would be very unlikely to contain a large cohort of peripheral nerve block not performed using ultrasound technology. Furthermore, the clinical presentation of PNI, its investigation and ascertainment of etiology is complex. In many clinical presentations of perioperative nerve injury it is impossible to be absolutely confident of the cause. Distinguishing

anaesthetic, patient and surgical causes of nerve injury are notoriously difficult, if not impossible in some instances.

Some consider that regional anaesthesia introduces a non-essential procedural risk into the already complex perioperative environment. The AURORA results clearly demonstrate that the incidence of serious complications attributable to peripheral nerve block is extremely low. When the infrequency of serious complications documented in this study is combined with the proven efficacy of ultrasound-guided peripheral nerve block,[11] it is difficult not to promote its routine use for peripheral nerve block. The evidence for the efficacy of ultrasound-guided peripheral nerve block is robust for commonly performed upper and lower extremity peripheral nerve block, but less definitive for trunk blocks.

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AURORA – a clinical registry
continued

The future

Fortunately, serious complications associated with regional anaesthesia are infrequent or rare. This, however, introduces the first challenge – the requirement for large sample sizes. The second challenge is to distinguish outcomes directly attributable to peripheral nerve blocks from other causes.

The development of a clinical registry with well-defined outcomes provided a framework for assessment of quality and safety of contemporary peripheral nerve block. This registry and its collaborative infrastructure provide an opportunity to develop what this author has described as a virtual department of anaesthesiology.[12]

If large enough, this entity would comprise centres with distinctly differing practice patterns providing the basis for a pseudo-randomised clinical trial. Ideally these practice patterns would include some of the almost continuous stream of newly described techniques. As creative and innovative as these new techniques often are, they should be tested for clinical effectiveness and safety before their widespread use is promulgated. Registries provide an important mechanism to do what other industries routinely do to stay competitive – continually monitor its products for quality and take steps to improve when indicated. Some experts have called for a registry for every medical condition and invasive procedure.[13] AURORA is a registry for peripheral nerve block.

In anaesthesia, we should be looking for efficient mechanisms to add value to our daily professional activities. Recording and reporting outcomes from routine care is one method of doing so. Competition from alternative anaesthesia providers and modes of local anaesthetic delivery[14] should prompt us to examine ways of adding value to what we do. A significant proportion of our population requires anaesthesia services every year and therefore we should treat anaesthesia as a public health issue. Collecting data from routine care and collaborating in multi-centre registries as virtual departments of anaesthesiology provide us with an opportunity to extend our repertoire and become public health physicians.

Registries provide an infrastructure for measuring and reporting key outcomes crucial to any improvement. This registry provides both a template for such a research infrastructure and demonstrates a low incidence of serious morbidity that others can benchmark their practice against in virtual departments of anaesthesiology. Because, this project now collects outcome data from Australia, New Zealand, Malaysia and the United States, it has been renamed the International Registry of Regional Anaesthesia. The collaborators and hospitals that have contributed to this project are located at www.regionalanaesthesia.wordpress.com/collaborators.

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Preoperative care – a "consumer's perspective"

The following is an edited extract from a letter to the ANZCA chief executive officer by an informed patient. The letter details her preoperative experience and highlights difficulties that may be faced by patients attempting to communicate with their anaesthetist prior to surgery. The issue is more common in the public health sector. Of course similar frustration is often also felt by the anaesthetist, who may not have the chance to adequately assess preoperatively a patient with a complex medical history.

Dear Ms Sorrell,

I am writing to you to outline a gap I have become aware of in how anaesthetists relate to consumers.

The gap emerged from my own experience of having an anaesthetist attend me for two operations. I have multiple chronic conditions so any operation causes concern and raises questions such as "is it going to upset my conditions which are stable at the moment?" I wanted to play an equal part with my health team in ensuring that my outcome was as good as it could be. People in the health environment say having the consumer at the centre of care benefits all and this is what I wanted.

I visited the specialist members of my health team who manage my chronic conditions and asked them to speak with the surgeon, which happened and that worked very well, but I could not access the anaesthetist for the same preoperative consultation. I was given an appointment for a pre-admission clinic a week before surgery and I saw an anaesthetist, but not the specialist who was going to give my anaesthetic. He tried to answer my questions but it was not very satisfactory because he was not the doctor attending the operation. He suggested I phone a number 24 hours before my operation to speak with the anaesthetist rostered to my surgery, but I wanted my questions answered before deciding whether I would have the operation. The anaesthetist did not have rooms so was unavailable until the morning of the operation. I eventually left a message and the anaesthetist phoned me at home on a Sunday and we began working together as a team.

The surgeon, the anaesthetist and I made up a team and they changed the way they did things to give me a better outcome. I was happy with the contract we drew up among us to manage my situation. I had an incredible outcome, the operations were successful and there was no change in my chronic conditions.

The health system encourages people to be more involved in their care and to play an active role in making health decisions. Consumers can only do this if we have easy access to the doctors and some knowledge that will help us make the right decisions for our care.

I am sure that anaesthetists would be willing to answer consumers' questions but I believe that consumers are unaware of how they can arrange a consultation prior to surgery. The increase in day-surgery procedures means consumers may not be seen by the anaesthetist before the day of their operation. This limits their ability to make informed decisions about whether to have an operation.

At the pre-admission clinic, I did not want to consent to the operation until I had my questions answered by the anaesthetist who was to give my anaesthetic, but I was expected to do so anyway. This was difficult for all involved. I did not give up and I was happy with the outcome.

Could there be discussion on how the interface between anaesthetists and consumers can be improved to provide a preoperative consultation process? Can we ensure that consumers know how to connect with their anaesthetist to assist them to make informed decisions?

This may be a new way of thinking about the relationship between consumers and anaesthetists, but the health system continues to say "put the patient at the centre of the care". By encouraging consumers to become knowledgeable and skilled at self-managing their chronic conditions, we also encourage them to ask questions and to contribute to decisions about their healthcare.

Regards,
(Name withheld)

Of note, the author does not at any stage refer to herself as a patient but as a "consumer". She reflects on the "contract" that exists between herself and her treating physicians. These are terms that we are not familiar with using in medicine but are no longer the sole domain of business and law.

Gratifyingly, she recognises the importance of the anaesthetist in optimising her outcome and the potential impact of anaesthesia and surgery on her underlying chronic conditions. She also has an acute understanding of the importance of a healthcare team. However, her experience was not optimal and serves to highlight the challenges of delivering patient centered care in a health system under significant fiscal constraints.

Whilst "easy access to doctors" providing the primary care is always going to be problematic in the public sector, staffing preoperative clinics with physicians who are able to comprehensively answer questions based on potential anesthetic plans should allow the patient to give informed consent for a procedure. Consideration needs to be given to the best way of establishing lines of communication with the primary anaesthetist. Meeting consumer demands for more comprehensive information about anaesthesia and perioperative management should be attainable.

The College has developed two relevant professional documents, *PS07 Recommendations for the Pre-Anaesthesia Consultation* and *PS15 Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery*. These reinforce that the intention of the medical team should always be to "put the patient at the centre of the care". This is not a new concept but the inevitable increase in day of surgery admissions and day surgery procedures in higher risk patients provides ongoing challenges. We must be aware of the increasing pressures and develop strategies to address them.

Dr Phillipa Hore, FANZCA
Communication and Liaison Portfolio
Quality and Safety Committee

Tribute to Dr Patricia Mackay

The inaugural meeting of the Quality and Safety Committee of the Australian and New Zealand College of Anaesthetists was held on Sunday May 4 in 2006. Dr Patricia (Pat) Mackay, retired anaesthetist and Emeritus Consultant to the Victorian Consultative Council for Anaesthetic Mortality and Morbidity, was one of 11 participants. The committee was the outcome of the combined recommendations of two taskforces established by Professor Michael Cousins during his presidency: the Data Taskforce (chaired by Dr Michelle Joseph) and the Integrated Approach to Quality and Safety Taskforces (chaired by Pat). Thus Pat was not only present from the beginning of the Quality and Safety Committee, she was substantially responsible for its creation.

During the six-and-a-half years that she served on the committee, Pat's astute mind, practical focus, encyclopaedic knowledge of matters medical, and consistent willingness to accept tasks however onerous, have made an enormous direct contribution to the committee's activities. In addition, Pat has made a substantial and very positive contribution to the collegial and effective way in which the committee has functioned.

During its first year, Pat argued strongly that an experienced and senior administrator would be essential if the committee were to succeed. Pauline Berryman was appointed (followed by Giselle Collins and now by Karen Gordon-Clark). Pat's wisdom has been very evident through the contributions of Pauline and Giselle. Fellows, notably Pat, contribute a great deal of their time to the College pro bono. Competent support from College staff is absolutely essential if the considerable value of that time is to be realised. This is perhaps better understood today than it was in 2006 and, in this, as in so many things, Pat was characteristically forward thinking.

The Quality and Safety Committee has placed considerable emphasis from the outset on communication. Pat took on the communication portfolio and established the quality and safety section within the College *Bulletin* that has now become a keynote feature of this publication. Although various Fellows have contributed, it has been Pat's energy, commitment, and editorial skill that has made the quality and safety section the widely read and important part of the *Bulletin* that it has become. Pat was also very quick to capitalise on the opportunities offered by the College's e-newsletter.

Patricia Mackay was born in New Zealand. She graduated from Otago University, Dunedin, in 1949 and her postgraduate training in anaesthesia was undertaken in New Zealand, Australia and the UK. She was appointed to the Department of Anaesthesia at the Royal Melbourne Hospital in 1954 and since then has pursued an outstanding career in Australia, in anaesthesia, intensive care and pain medicine (Pat established the first acute pain service in Victoria). She became Director of the Department of Anaesthesia at the Royal Melbourne Hospital in 1984, and held this position until 1992.

Pat's considerable organisational and administrative abilities were underpinned by a commitment to the promotion of research and teaching. In the ASA she has held the roles of secretary and treasurer, and was president from 1966 to 1968. She has been an examiner for the Faculty of Anaesthetists and made many contributions to ANZCA, including membership of the welfare of anaesthetists group, and culminating in her outstanding service on the Quality and Safety Committee.

In 1991, Pat was appointed by the Victorian Minister of Health to the position of Chair of the Victorian Consultative Council for Anaesthetic Mortality and Morbidity (VCCAMM). Her work on this council has promoted the highest standards of anaesthesia and peri-operative care through adverse event reporting and systems improvement, and this has reaped benefit locally, nationally and internationally. Pat's tireless and effective pursuit of patient safety has continued to this day, and has earned her an international reputation and the respect of all who have had the privilege of working with her. She has published more than two dozen papers in peer reviewed journals (several under her maiden name of Wilson) and has been a frequent invited speaker at national and international scientific meetings.

Pat has been recognised as a foundation member of the Australian Patient Safety Foundation and as a life member of the World Federation of Anaesthesiologists. In 2000 she was awarded the ANZCA Medal (pictured above right), in 2001 the Centenary Medal of the Order of Australia and in 2008 an OAM.

At the same time as achieving all of these things, Pat, with her husband Ian (an immunologist), raised five children. It is not surprising that, in 2002, she was made Woman Doctor of the Year by the Australian Medical Association. Pat is an outstanding role model for all doctors (not just anaesthetists) in Australia and New Zealand – both men and women.

On Friday November 9, 2012, Pat attended her last meeting of the Quality and Safety Committee. Quality and safety in anaesthesia can only be built on the foundation of sound clinical expertise and experience, and through effective administrative and organisational skills. Pat brought all of these attributes to the committee, and a great deal more. In thanking her, Associate Professor David Scott, the chair, emphasised that this was her last official contribution. There can be little doubt that calls will continue to be made on Pat's unrivalled knowledge, expertise and wisdom.

Professor Alan Merry
Former Chair, Quality and Safety Committee

Anaesthetists can lead the way in surgical safety practice

Anaesthetists can lead the way by using the WHO surgical safety checklist in operating theatres, the Chair of New Zealand's Health Quality & Safety Commission (HQSC), Professor Alan Merry, says.

"Anaesthetists are integral to ensuring safety in theatre, and we're looking to them to help ensure the checklist is used to best effect," Professor Merry says. "It's about making sure the basics are right so the skill and expertise that characterises our surgery, anaesthesia and nursing is not wasted."

The surgical checklist provides a list of crucial checks that have serious consequences if missed, but also encourages members of clinical teams to introduce themselves, and to discuss the operative plan and any concerns they have before starting a procedure.

"Overseas studies suggest this initial conversation can make a difference if a member of the team subsequently notices something amiss while an operation is under way, and is debating whether to speak up."

Mistakes such as wrong-site surgery are still reported but should never happen, says Professor Merry, and the checklist helps to prevent such errors. It should stimulate discussion within the theatre team, rather than being used as a simple tick-list.

Professor Merry says just over 300,000 publicly-funded surgical operations are carried out annually in New Zealand. The commission will be working with the sector to help teams use the checklist effectively and get the most out of this tool.

Each year, the HQSC releases a report on serious and sentinel events[1] (SSEs) in district health board hospitals, most recently in November. The reports aim to encourage transparency and a just culture.

"It gives us a picture of where things are going wrong, and enables us to put in place systems to reduce harm," Professor Merry says. "But it is also much more than that. It is a promise to patients that these tragic events will be robustly reviewed, to ensure appropriate care and treatment was provided, and where indicated, to improve systems and processes of care."

Reporting also provides a safeguard for clinicians.

"By identifying and fixing systems failures, we give clinicians greater confidence that they will be supported by the systems around them to practise safely."

For the 2011/12 year, district health boards (DHBs) reported 360 serious and sentinel events. Ninety-one patients died (86 in 2010/11), although not necessarily as a result of the adverse event. Serious and sentinel events included 170 falls, a 13 per cent decrease from the 195 falls reported the previous year; 111 clinical management events, up from 105 in 2010/11; 18 medication errors, down from 25 the previous year; and 17 suspected in-patient suicides.

There was an overall decrease in serious and sentinel events, specifically falls, for 2011/12.

"This decrease is very good news," says Professor Merry. "It represents a lot of hard work by DHBs to both report and prevent adverse events. However, we have seen an increase in the number of cases of delayed treatment and suspected in-patient suicides."

He says that in 2011/12, DHBs reported 17 suspected in-patient suicides. The commission has looked at the DHB reviews of these deaths and found there is no clear trend evident – either in terms of whether numbers are increasing, or common factors.

"Each of these suicides has been subject to a robust process of review to ensure appropriate care and treatment was provided, and to improve systems and processes of care to reduce the chances of such a tragedy occurring again," he says.

In 2011/12, 17 cases were reported to the commission describing events in which system failures resulted in delays in the diagnosis of cancer or in a similar serious outcome. There were 13 such events in 2010/11, eight in 2009/10, nine in 2008/09 and seven in 2007/08 – indicating a likely increasing trend.

Professor Merry says the HQSC will look at measures to reduce the likelihood of these events.

"The importance of following up needs to be top-of-mind for clinicians at all times."

He says a national reportable events policy has introduced a change to the way serious and sentinel events are reported to the commission.

"Previously, there was no requirement for DHBs to report the outcome of a review to the commission, meaning lessons from events were often not shared. There is now a requirement for organisations to report to the commission the key findings and recommendations of reviews of events that occurred from July 1, 2012. Future SSE reports will be able to discuss in greater detail issues such as contributory causes and what has been learnt from the events."

Serious and sentinel event results for individual DHBs are posted on DHB websites. For a copy of the full report, summary document, and questions and answers about serious and sentinel events, visit www.hqsc.govt.nz.

Susan Ewart
NZ Communications Manager, ANZCA

Reference:

1. A serious adverse event is one that leads to significant additional treatment but is not life-threatening, and has not resulted in a major loss of function. A sentinel adverse event is life-threatening or has led to an unexpected death or major loss of function.

Dean's message

The Faculty of Pain Medicine has begun 2013 with a focus on the activities that also finished 2012. The year's agenda has been firmly established with 2013 shaping as the year of the curriculum redesign. The planned introduction of our revised curriculum in 2015 will entail great commitment and a sustained effort over the next two years.

The guiding principles of the curriculum redesign are based on the outcomes of the "blueprinting" process the Faculty conducted over the past two years. The blueprinting process documented the core skills and attributes unique and essential to a specialist pain medicine physician. The revised training scheme will ensure our trainees are taught and examined in a way that will deliver the quality specialist we need for the future.

This year has begun with a successful series of meetings across New Zealand and each Australian state. The information evenings allowed the Faculty to explain early proposals for the new curriculum and gave Fellows an opportunity to provide critical and constructive feedback. The rigorous debate that occurred during these visits has strengthened the basis of the new curriculum.

This project is the Faculty's most significant and ambitious undertaking since the curriculum was developed 15 years ago. It will require active input from Fellows to be successful, especially those who have direct contact with trainees.

The proposed changes will affect all Faculty Fellows in teaching hospitals and all future trainees. It is essential that Fellows have an early, accurate and thorough understanding of the proposed new curriculum, associated fee structures and training implications.

In the most basic sense, a profession is defined by the sacrifices required during training and examinations to obtain the qualifications of that profession. The introduction of training and examinations for pain medicine in the late 1990s gave definition to the Faculty and to the qualification of FFPMANZCA. This qualification has grown in prestige over 15 years to its current state of recognition as a standalone speciality in Australia and New Zealand. The review and redesign of our training curriculum will continue to define our speciality and to maintain the quality of our fellowship.

The recent publication of a report into the administration of the National Health Service (NHS) in a region of the UK serves to remind us of the importance of the third pillar of our five-year strategic plan: "Build Advocacy and Access".

An alarming but recurring theme in recent years is the vulnerability of healthcare to the competing political agenda of cost saving.

Eminent US opinion leader Dr Daniel Carr has published his foreboding insights on this topic, in a series of articles and addresses themed "When bad evidence happens to good medicine". Dr Carr warns of the increasing political misrepresentation of medical statistics and meta-analysis to improperly justify drastic limitations on health expenditure. He warns that the ambitious, clinical agenda to achieve an evidence-based medicine approach frequently is improperly represented to limit health funding where politically convenient.

In today's political context of necessary austerity we need to be – more than ever – aware of misrepresentation of evidence and deliberate undermining of our professional and clinical requirements to justify politically driven cost cutting.

In this regard, our plight is international. The *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, published in February, was damning in its condemnation of the "saving-at-all-costs agenda of the Mid Staffordshire NHS Foundation Trust".

The inquiry was empowered to investigate the serious failings of the foundation trust, whose mandate was delivery of healthcare in that region of the UK.

In the words of the report, "the story it tells is first and foremost of appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider trust board". It makes further reference to "tolerance of poor standards and disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care".

In Australia and New Zealand, we must all be vigilant and firm in our advocacy for patient care, when the motives of hospital administrators may lead them to be reckless with the interest of good healthcare in order to meet targets based solely or primarily on their fiscal performance.

We can look forward with optimism to both the challenges and potential achievements of the year ahead.

Associate Professor Brendan Moore
Dean, Faculty of Pain Medicine

Admission to fellowship of the Faculty of Pain Medicine

By examination:

December 5, 2012
Dr Tipu Aamir, MRCPsych, NZ
Dr Jayne Berryman, FANZCA, Qld
Dr Jenny Jin, FAFRM (RACP), NSW

December 24, 2012
David Louis Sommerfield, FCARCSI, Vic

January 21, 2013
Andrew Douglas Powell, FANZCA, NSW

This takes the total number of Fellows admitted to 337.

Vale James Strong AO

ANZCA and FPM have been saddened by the untimely death of James Strong who was the chairman of Painaustralia since its establishment in 2011.

Mr Strong had a long association with College and the Faculty, having been an inaugural member of the board of the ANZCA Foundation (as it was then called) in May 2005 and contributing to its change into the Anaesthesia and Pain Medicine Foundation in March 2011 before resigning to take up the chairmanship of Painaustralia.

The College and the Faculty are integral members of Painaustralia, the not-for-profit non-Government organisation established to pursue implementation of the Australian National Pain Strategy as articulated at the National Pain Summit in March 2010. Mr Strong contributed his considerable experience and skill to the establishment of Painaustralia and to its impressive advocacy work to date in a difficult climate. He was a champion of the plight of people in pain and did much to bring this to the attention of policymakers and the philanthropic community. His expertise, charm and insight will be missed.

Mr Strong was a prominent businessman in Australian circles, having been a board member and chief executive officer of Qantas, chairman of Woolworths Limited and of Insurance Australia Group as well as of other well-known companies. He was also a devotee and supporter of the arts, being at one time chairman of the Australia Business Arts Foundation and the Sydney Theatre Company.

We extend to James Strong's family our condolences and warmest thanks for his contributions to "our" world.

Associate Professor Milton Cohen
Director of Professional Affairs, FPM
ANZCA/FPM representative, Painaustralia

FPM Board meeting report

February 2013

Report following the meeting of the Faculty of Pain Medicine Board held on February 25

The president-elect of the Australian Pain Society, Dr Malcolm Hogg, met with the board in February to discuss areas of co-operation and collaboration.

Dean-elect: Associate Professor Brendan Moore was re-elected unopposed as dean-elect.

Honours and awards

The board noted with pleasure that the following were appointed members of the Order of Australia in the Australia Day honours list in recognition of distinguished contributions to their disciplines:

- Professor Jeno (Ben) Marosszeky, FAFRM(RACP), FFPMANZCA (NSW).
- Dr Alan Duncan, FANZCA, FCICM (WA).

Build fellowship and the Faculty

Corporate affairs

2013 board election: Nominations closed on February 1 for the one vacancy on the Faculty board. There being two nominations, a formal ballot will proceed. The ballot closes at 5pm on April 8.

FFPMANZCA logo: The board has approved a FFPMANZCA logo for professional use by Fellows on business cards, letterhead, slide presentations and email. This will be distributed in a CD format by mail and will also be downloadable from the FPM website.

Health Workforce 2025, Medical Specialties – Volume 3: The board recognised that this document influence the changing the landscape of medicine and will seek opportunities for pain medicine to be included in future iterations. The exclusion of pain medicine in the 2009 dataset was based on absolute numbers; the modelling was restricted to specialties with more than 500 members. The Faculty has subsequently highlighted to Health Workforce Australia (HWA) our expanding numbers and offered co-operation. HWA has been receptive to this offer and has sought information on the Faculty fellowship. The Faculty is considering a survey of Fellows to assist in providing information.

Terms of reference: An additional clause on financial reporting and planning has been added to all FPM committee terms of reference.

ANZCA museum: Pain medicine is to be represented within ANZCA's Geoffrey Kaye Museum and items or paraphernalia of historical interest will be sought.

Acknowledgement of past board members and deans: Academic dress for past FPM board members and deans is to be modified as a means of identifying individuals who have stood in high office in the Faculty. During their term of office, board members will wear badges of office, which will be relinquished upon retirement from the board.

Assessor

New Fellows: The following are congratulated on their admission to FPM fellowship. All new Fellows will be invited to present during the College Ceremony at the 2013 annual scientific meeting in Melbourne.

Tipu AAMIR	NZ
Jane Elizabeth BERRYMAN	Qld
David Louis SOMMERFIELD	Vic
Andrew Douglas POWELL	NSW
Jenny Gao-Ge Adams JIN	NSW

International medical graduate specialists (IMGS): The board has approved guidelines for the accreditation of positions for substantially comparable and partially comparable IMGS applicants. It is proposed that suitable employment opportunities will not be restricted to Faculty accredited training units for those required to undertake a period of clinical practice assessment under supervision.

The board is reviewing all pathways to fellowship in order to align the standards required for trainees, Australian and New Zealand specialists and international medical graduate specialists.

Fellowship

Election to fellowship: Dr Michael J Kent, FANZCA (WA) and Dr Kym Boon, FRANZCP (Qld) were elected to fellowship of the Faculty of Pain Medicine.

Professional documents

PM6 Guidelines for Long Term Intrathecal Infusions (Analgesics /Adjuvants / Antispasmodics): The board approved a revised professional document, which is an amalgamation of PM4 (2005) *Guidelines for Patient Assessment and Implantation of Intrathecal Catheters, Ports and Pumps for Intrathecal Therapy* and PM6 (2007) *Guidelines for long intrathecal infusions (analgesics/ adjuvants/antispasmodics).*

Training unit accreditation:

Accreditation of Specialist Medical Training Sites Project: The Faculty provided a response to the Accreditation of Specialist Medical Training Sites Project interim report of December 2012. This project is looking at accreditation processes to see if a streamlined approach to accreditation can be developed across the colleges. A final report is anticipated by February.

Resources

2013 budget: ANZCA Council has approved the Faculty's 2013 budget to provide adequate funding to meet the requirements of expanding Faculty activities, including support for the Curriculum Redesign Project.

Build curriculum and knowledge

Education

Mentoring program: Subsequent to the development of the FPM Mentoring Program in May 2012, the board has endorsed mentoring guidelines for mentees and mentors. A mentoring database was also approved for publication on the website, and will be accessible by Fellows and trainees. It will list Fellows who have volunteered to be mentors with a short background on each, and their contact details. Fellows and trainees seeking a mentor will go to the database to select a mentor and make initial contact. Ongoing mentoring activities will be conducted in a manner that is at the discretion and privacy of the mentor and mentee. The program will be monitored every six months for quality assurance.

Trainee exit questionnaire: Faculty regulations have been amended to require trainees to submit an exit questionnaire for each individual unit at which the trainee has undertaken accredited training. The aim is to gain a longitudinal perspective and provide an independent means of bringing information back to board, an Australian Medical Council requirement.

Supervisor of training ratification: Dr Aston Wan was appointed supervisor of training for the Barbara Walker Pain Centre for Pain Management. Dr Andrew Powell was appointed supervisor of training for the Hunter Integrated Pain Service.

Curriculum Redesign Project: Consultation and communication for phase one of the Faculty's Curriculum Redesign Project (CRP) began in December. Members of the Curriculum Redesign Project Steering Group were involved in making five short videos to inform Fellows and trainees about the new curriculum framework and program, which will be introduced in 2015. The videos and the program overview document are available on the Faculty website.

Regional face-to-face forums were held from late January to mid-February to provide an opportunity for Fellows and trainees to clarify points and give feedback on the proposed curriculum framework. These forums provided valuable input.

A Curriculum Redesign Project e-newsletter has been developed to keep Fellows and trainees informed of developments.

Examination report: The 2013 Examination Report is available on the FPM website. This report has been restructured to provide more feedback to prospective examination candidates on what is expected of them. It includes instructions on what should be covered in a neurological examination for the long case.

Sensory testing guidelines: The board has approved guidelines (known as POST), developed by the Examination Committee, to outline standardised terminology, equipment and technique for Pain Oriented Sensory Testing during clinical examination for trainees.

(continued next page)

FPM Board meeting report continued

Allied Health Pain Management in Primary Care: The Faculty has made a submission to Bupa Health Foundation seeking funding for online education for Allied Health Pain Management in Primary Care, building on the joint initiative with the RACGP. An intent of co-operation from allied health groups and the Australian Pain Society was included with the submission. A response is expected in April.

Continuing professional development
Scientific meetings
2013 ASM and FPM Refresher Course Day and ASM – May 3 and May 4-8 – Melbourne

Sofitel on Collins, Melbourne. Theme: 'Selling pain science – communication and cultural competition'. Scientific convenor: Dr Michael Vagg.

2013 Spring Meeting – October 25-27. Byron at Byron Resort and Spa, Byron Bay. Theme 'Internal pain is not eternal pain'. Scientific convenor: Dr Michael Vagg.

2016 annual scientific meeting, Auckland Dr Jane Thomas, FANZCA, FFPMANZCA has been appointed as the Faculty's 2016 scientific convenor.

Research
Electronic persistent pain outcomes collaboration (ePPOC): Negotiations are well advanced between NSW Health, the Agency for Clinical Innovation (ACI) and Australian Health Services Research Institute (AHSRI), University of Wollongong. A three-year contract will see Professor Kathy Eagar and team at AHSRI providing the ePPOC manager, statistical support and also high-level strategic input. Key deliverables will include piloting the benchmarking process in NSW and simultaneously working on a business case for expansion of the program across Australia and New Zealand.

Pain device implant register: The dean met with ANZCA's Director Policy, John Biviano, to commence development of a high-level business plan as a basis for seeking industry funding to support the proposed pain device implant register.

Steps to be taken include:

- Development of a business plan for industry funding.
- Professional management to develop product literature and PowerPoint presentations for hospital and clinician orientation and initiative.
- Establishment of a pilot in thee hospitals. It will be important to make this an Australian and New Zealand concept and New Zealand input will be sought.
- Lobby for perpetual funding (beyond the pilot phase) for a national register, including project management costs.

Development of this initiative by the Faculty would be a world first for an independent body to hold and control an implant register for pain.

Build advocacy and access
Relationships
Australasian Faculty of Rehabilitation Medicine: The AFRM Musculoskeletal Medicine, Pain Medicine and Occupational Rehabilitation Special Interest Group is putting on two workshops at the Australasian Faculty of Rehabilitation Medicine (AFRM) annual scientific meeting, one on pain related topics. Educational opportunities are being developed through the special interest group for AFRM fellows, who are increasingly being asked to conduct pain management programs.

Royal Australasian College of Surgeons (RACS) pain medicine section: An editorial by A Zacest and M Cohen has been published in the *Journal of Surgery*, coming out soon. Associate Professor Zacest will chair a neuromodulation session at the RACS Auckland meeting. Efforts are being made to engage with the local RACS organisers in Adelaide regarding pain education for surgeons to gauge the interest of general surgeons. Faculty Fellow Dr Thierry Vancaillie is establishing a surgical trainees' workshop in NSW and a similar initiative is being planned in South Australia as a useful way to establish interest and provide something tangible for trainees and surgeons. Opportunities for interaction with Neurosurgical Society of Australasia are very encouraging.

Pain societies: A teleconference meeting of executive members of the Australian Pain Society, New Zealand Pain Society and Faculty of Pain Medicine was convened in early February. Topics for discussion included co-ordination of future meetings, including a combined meeting in Sydney in 2017, and initiatives that would benefit from collaboration of the three organisations.

Professional
Australian Medical Council (AMC) re-accreditation: The Faculty has been granted accreditation of its training and continuing professional development programs to December 31, 2018. The annual report, due by March 12, is in development, including responses to the conditions and recommendations outlined in the AMC team's final report.

Pharmaceutical Benefits Advisory Committee: The FPM Director of Professional Affairs, Associate Professor Milton Cohen, and ANZCA General Manager Policy, John Biviano, met with Dr Suzanne Hill, chair of the Pharmaceutical Benefits Advisory Committee (PBAC), on February 5 to discuss opioid regulation. The meeting was positive, including a request for the FPM to articulate a guideline based on FPM professional document *PM1: Principles regarding the use of opioid analgesics in patients with chronic non-cancer pain*. A follow-up meeting is anticipated in June, once PBAC has reviewed 12 months of utilisation data, which will be available to them by the end of April.

The Faculty also responded to a request for a submission on the use of intranasal fentanyl.

Submissions: The Faculty contributed to the following submissions soon to be available on the ANZCA website.

- Australian and New Zealand Therapeutic Products Agency regulatory framework
- Department of Health and Ageing – Paediatric pharmaceuticals prescribing resource project.
- Cancer Council Australia – Cancer pain management guidelines.
- Health Workforce Australia – Draft Health Professionals Prescribing Pathway.

Essential Pain Management Sub-Committee: The College has established this sub-committee to improve pain management worldwide by working with health workers at a local level. The new sub-committee, which will report to the ANZCA Overseas Aid Committee, includes international members from the UK, Malaysia and Honduras to help advise on the best global approach to managing pain.

Fellows' publications: The board noted the following publications:

- *Australian and New Zealand Journal of Obstetrics and Gynaecology*
  - Stacey et al Persistent pelvic pain; rising to the challenge.
  - Evans, Editorial. Chronic pelvic pain in Australia and New Zealand.
- New Zealand Medical Journal
  - Shipton, E.A. Recognition of the vocational practice of the scope of pain medicine in New Zealand..

National Pain Strategy: Painaustralia had been asked to respond to the NSW Legislative Council General Purpose Standing Committee No 4 Inquiry into the safety and efficacy of cannabis for medical purposes. A measured response was provided to avoid any inference of support. The Faculty does not currently have a position on this issue and there is potential for this to be considered.

Employment of specialist pain medicine physicians: The board discussed its role in advocating for positions in pain medicine to be filled by appropriately qualified specialist pain medicine physicians. The board will advocate strongly to employing authorities and health departments that FFPMANZCA is the only qualification recognised by the Medical Board of Australia for registration as a specialist pain medicine physician and that FPM training is the only one with a clinical basis. The use of the terminology of "specialist pain medicine physician" will be encouraged in all new appointments.

Communications: A schedule for Faculty publications in 2013 is available on the Faculty website.

International visitors journey into the past at Geoffrey Kaye Symposium




The Geoffrey Kaye Symposium held at the College in Melbourne in January attracted many prominent and international guests. They saw the world famous Geoffrey Kaye Museum of Anaesthetic History collection firsthand and enjoyed a fascinating program, including a tour of Melbourne University's medical collections.

The museum hosted the Geoffrey Kaye Symposium as a satellite meeting to the 8th International Symposium on the History of Anaesthesia held in Sydney and gave many international anaesthesia historians their first opportunity to visit the College and the collection.

Geoffrey Kaye was an avid collector. When he established a teaching department at Melbourne University in the mid 1940s, he displayed his collection of anaesthesia devices to ensure that medical graduates received a firm grounding in anaesthesia. This collection became the core of the Geoffrey Kaye Museum, which now holds some 8000 objects. Geoffrey Kaye's display also included items of his own design and a range of equipment he had expertly sectioned for the benefit of his students.

The Geoffrey Kaye Symposium also gave an opportunity for the museum's honorary curators and staff to upgrade the permanent display and mount a temporary display in the boardroom. A new state-of-the-art display case was installed in the foyer of ANZCA House to showcase Geoffrey Kaye as an inventor, engineer and teacher.

The temporary display showed the depth of the museum's collection, with more than 80 mask inhalers on display. Designed for use with ether, chloroform or ethyl chloride, almost all dated from the 19th century.

Also on display were three significant books. Joseph Clover's casebook, from 1846-1853, an original copy of the *Illustrated London News* of January 9, 1847, showing the diagram of the ether inhaler that was copied by both William Pugh in Launceston and John Belisario in Sydney, when they administered the first anaesthetics in Australia in June 1847.

One of the College's Corporate Collection treasures, a 15th century Latin copy of Hippocrates, also was on display along with a selection of 2000-year-old Roman surgical instruments. The donor of the *Hippocrates* book, Professor Bernard Brandstater FANZCA, had brought the ancient instruments from his home in Loma Linda, especially for the occasion.

The existing permanent exhibition also is available for Fellows, trainees and their families and friends to visit during business hours. We invite Fellows and trainees attending the forthcoming annual scientific meeting in Melbourne to visit the Geoffrey Kaye Museum. In addition to the anaesthesia timeline, the central part of the display focuses on developments in pain medicine and monitoring, two areas in which anaesthesia has made great advances.

Dr Rod Westhorpe
Honorary Curator

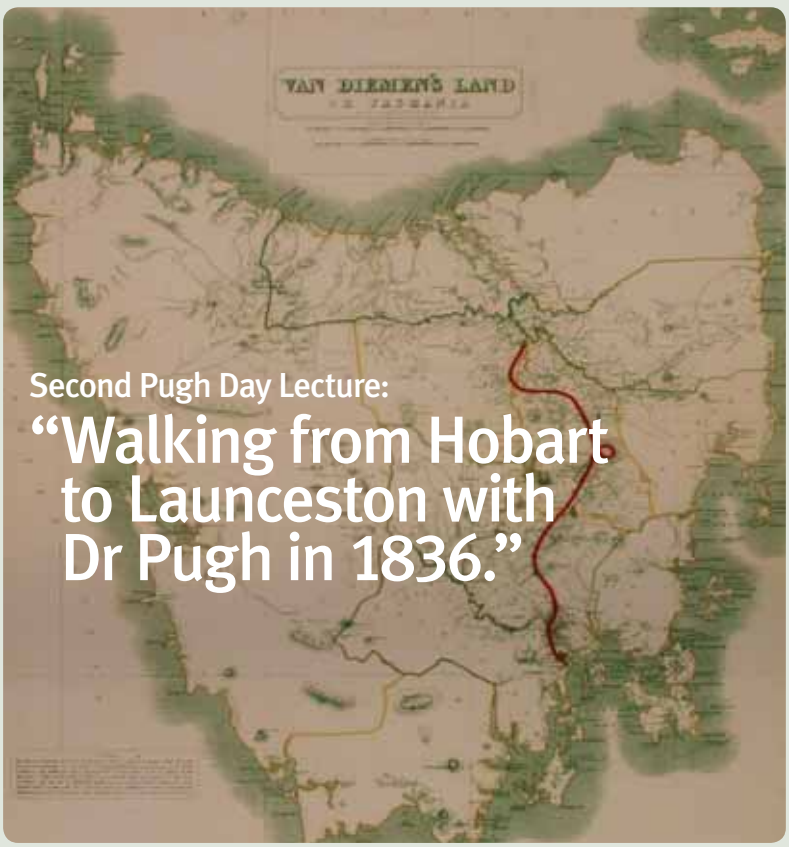
Dr Christine Ball
Honorary Curator

Maria Drossos
Museum Collection Officer

All inquiries, please contact Maria at museum@anzca.edu.au

This page clockwise from top left: Dr Jan Hofland, Dr Jean Allison, Dr Rod Westhorpe and Dr Joseph Rupreht; Dr Jean Bernard Cazalaa, Dr Dominique Simon, Dr Jacques Hotton, Dr Marguerite Zimmer and Dr Rod Westhorpe; Dr Christine Ball, Dr David Wilkinson, Dr Wulf Stratling, Dr Rod Westhorpe, Dr Joseph Rupreht and Dr Marten van Wijhe; Professor Bernard Brandstater, Mrs Ramona Bause, Dr George Bause and Dr Susan Vassallo and Ms Karen Bieterman.

Opposite page clockwise from top left: Mrs Victoria O'Brien, Dr Michael Cooper, Dr John Paul and Dr Des O'Brien; Dr Rod Westhorpe, Ms Mimi Westhorpe and Professor John Severinghaus; Mrs Jean Goulden, Dr Paul Goulden, Professor Barry Baker and Dr Anthony Kovac; Dr David Wilkinson, Dr Christine Ball and Dr Wulf Stratling.



Second Pugh Day Lecture:

"Walking from Hobart to Launceston with Dr Pugh in 1836."

SPEAKER: Dr John Paull MB BS, Dip Ed, FANZCA, consultant anaesthetist (retired) University Associate, School of Humanities, University of Tasmania, Launceston, Tasmania

VENUE: Meeting Room, Queen Victoria Museum and Art Gallery, Inveresk, Launceston Tasmania.

DATE AND TIME: Sunday June 16, 2pm.

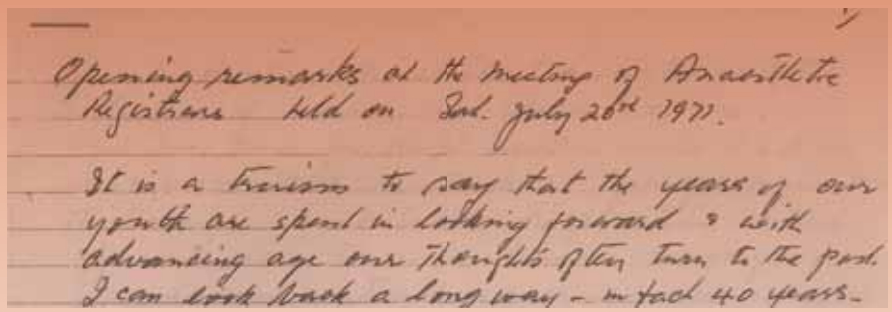
SUMMARY:

After a four-month voyage from England, Dr William Russ Pugh arrived in Hobart in December 1835. He visited Sydney and, after returning to Hobart, began a month-long walk to his ultimate home, Launceston, at the height of summer in February 1836. Bushrangers were a hazard along the dirt road and his diary describes the people he met and the conversations he had. Several of the homesteads are still owned by descendants of the families he stayed with. Despite repeated advice from his hosts to abandon medicine and take up sheep farming, Dr Pugh reached Launceston and proposed to the woman he had met on the voyage from England. Pictures of the characters and their properties, then and now, illustrate the talk.

SPONSORSHIP:

This lecture, which commemorates Dr Pugh's administration of ether for a surgical procedure for the first time in Australia on June 7, 1847, is jointly sponsored by the Launceston Historical Society and the Launceston General Hospital Historical Committee and Department of Anaesthetics.

Teaching change: the development of training in anaesthesia


Opening remarks at the meeting of Anaesthetic Registrars held on Sat. July 24th 1971.

It is a truism to say that the years of our youth are spent in looking forward & with advancing age our thoughts often turn to the past. I can look back a long way – in fact 40 years.

The first anaesthetic registrars meeting was held at the Royal Children's Hospital in Melbourne in 1971. Forty years later, Kester Brown opened ANZCA's registrars meeting in 2011, presenting a fascinating look at how specialty training has changed over time.

When Dr Kester Brown arrived in Australia in 1966, there was a paucity of teaching in Melbourne hospitals. If they managed to get time off from their clinical duties, registrars might attend basic science lectures at the University of Melbourne or the Faculty of Anaesthetists. It was very different to Dr Brown's own training in Vancouver, where anaesthesia residents had time set aside, free of clinical duties, for their teaching program.

In 1968, Dr Brown arranged a weekly half-day release for registrar tutorials at the Royal Children's Hospital, where he worked as an anaesthetist. The following year he began monthly meetings in the anaesthesia department. In 1970, as the Victorian education officer in the Faculty of Anaesthetists, Dr Brown came up with the idea of a registrars meeting and it was from these beginnings that a tutorial system emerged in Melbourne hospitals.

The first registrars meeting in July 1971 was planned for the Saturday following the Part II Course so that interstate doctors could attend. Registrars at the time were paid less than $10,000 a year so funds were obtained from companies marketing new drugs – Parke Davis (ketamine) and Abbott (methoxyflurane) – to support travel for interstate presenters.

Hospitals were asked to arrange for a staff anaesthetist to cover emergencies for the day so that the registrars could attend. The meeting was also well attended by specialist anaesthetists – there were few meetings in those days – and attendance was about 120.

The director of anaesthesia who had introduced registrar training to the Royal Children's Hospital in 1953, Dr Margaret McClelland, opened the inaugural meeting.

Dr Margaret McClelland

Dr McClelland had been a founding Fellow of the Faculty of Anaesthetists and president of the Australian Society of Anaesthetists and her handwritten notes deliver a valuable insight into the development of anaesthesia training over time.

"It is a truism to say that the years of our youth are spent looking forward and with advancing age our thoughts often turn to the past," Dr McClelland said.

"I can look back a long way – 40 years. In those days there were no anaesthetic registrars. All doctors were expected to give anaesthetics. The standard anaesthetic was an ethyl chloride induction followed by ether dropped on to a gauze-covered mask. This was not an easy anaesthetic to administer. It was feared and disliked by the patients, but with experienced anaesthetists the surgeons were given reasonable working conditions. However, many anaesthetics were given by resident medical officers, including those recently qualified.

"Teaching and supervision was frequently inadequate so that it is not surprising that some anaesthetics were stormy and increased the hazards of surgery. Preparation of the patient left much to be desired. There was no blood bank and often, particularly at night, we were expected to collect and cross match blood if it was considered necessary.

"Equipment was almost non existent. Machines, if any, were very primitive. There were no piped gases, suction was not readily available to anaesthetists and anaesthetic deaths were considered bad luck even though nearly half of them were due to inhalation of vomitus."

Dr McClelland mentioned the first Australian surgical anaesthetic by Pugh in Launceston on June 7, 1847, less than eight months after Morton's demonstration in Boston.

She discussed Edward Henry Embley, the first anaesthetist appointed to the Melbourne Hospital, who undertook what was one of the most comprehensive research projects at the turn of the last century – 286 experiments in dogs, done at weekends, which showed, among other information, that death with chloroform was due to cardiac and not respiratory causes.

The Hyderabad Commissions in India concluded that death was primarily respiratory. His results, published in three papers in the *British Medical Journal* in 1902, took up 20 pages.

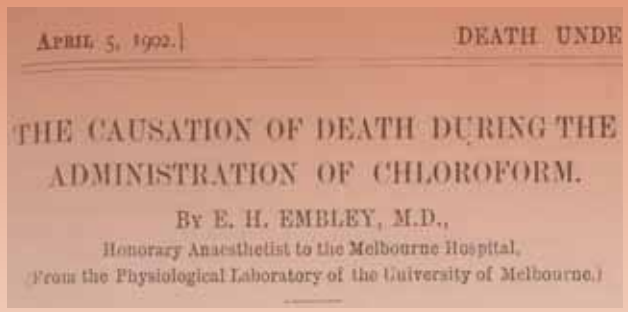
E.H.Embley

In the collection of ANZCA's Geoffrey Kaye Museum of Anaesthetic History, there is a certificate signed by Embley indicating that the student had undertaken six anaesthetics and achieved proficiency in administering anaesthesia.

According to Dr McClelland, those who wished to practise modern techniques in the immediate post-war years were frustrated by the difficulty in obtaining drugs, equipment and machines.

"Teaching and training became an important issue. The examinations for the Diploma of Anaesthetics started in 1948 in Melbourne and Sydney. The Faculty of Anaesthetists was founded in 1952."

By the time Dr Brown joined the anaesthesia department at the Royal Children's Hospital in 1967, much had changed.



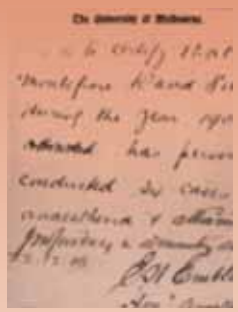
APRIL 5, 1902.] DEATH UNDE

THE CAUSATION OF DEATH DURING THE ADMINISTRATION OF CHLOROFORM.

By E. H. EMBLEY, M.D.,

Honorary Anaesthetist to the Melbourne Hospital.

(From the Physiological Laboratory of the University of Melbourne.)



Deaths associated with anaesthesia were uncommon. Recovery rooms had been introduced. Patients were usually seen the night before surgery and received pre-medication. Thiopentone (1934), muscle relaxants, IPPR, machines and anaesthetic assistants had come into being. By today's standards, monitoring would be regarded as simple but anaesthetists were skilled at clinical monitoring and assessment.

In the 1960s and 1970s, intensive care was in its infancy. Prolonged nasotracheal intubation began in Beirut, Adelaide, Melbourne, Toronto and Gotenberg in the early 1960s and led to the development of intensive care. Much of what is taken for granted today had to be learned. Nasotracheal tubes bypass the humidifying mechanism in the nose so humidifiers were introduced. Which were more suitable – humidifiers or nebulisers, which produce minute water particles? Humidifiers eventually won.

In 1970, deep hypothermia to 18 degrees Celsius and then circulatory arrest was introduced for repair of congenital heart disease in infants. Before that, infants below 10kg had palliative surgery until they were big enough for corrective surgery.

More recently, new drugs, equipment and monitoring have improved medical practise and our affluent world has enabled surgery to progress to the standards we expect and deliver today. Training also has improved and registrars are fortunate to be training under one of the best systems in the world.

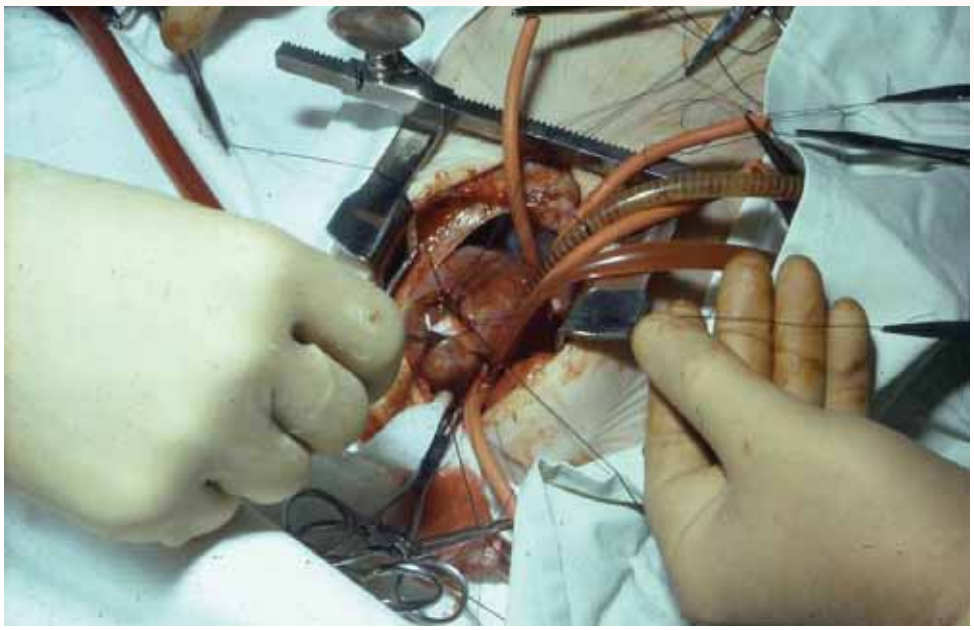
Many of those who contributed to these early registrar meetings have gone on to make significant contributions to our specialty, among them Dr Chris Evans, who won the prize at the first meeting. Dr Evans later became president of the New Zealand Society of Anaesthetists.

Dr Kester Brown, FANZCA
Former Director of Anaesthesia, Royal Children's Hospital, Melbourne

Opposite page from left: Dr Margaret McClelland; Dr McClelland's opening remarks at the meeting of anaesthetic registars in 1971.

This page above from left: Dr EH Embley; The first of three papers in British Medical Journal by Dr Embley; A certificate signed by Dr Embley indicating that the student had undertaken six anaesthetics and achieved proficiency in administering anaesthesia; Dr Chris Evans.

This page below from left: Surgery on arrested infant heart; 1960s Boyle machine with ether bottle.



ANZCA Trials Group

Introducing Anna Parker

Anna Parker joined the ANZCA Trials Group in November 2012, and is based at the Department of Epidemiology and Preventive Medicine, Monash University, Alfred campus. Her primary role is the co-ordination of the POISE-2 study, but she assists with all the trials group activities including the new studies in 2013, the RELIEF and Balanced Anaesthesia studies.

Anna is an experienced research administrator who has worked in the healthcare sector for many years. She holds a master of bioethics degree from Monash University and a master of arts from the University of Melbourne.

Before joining the ANZCA Trials Group, Anna was employed by the Research and Ethics Unit of Alfred Health, assisting researchers through the life of their project from submission preparation and monitoring of research conduct through to final reports and archiving.

A key aspect of her Alfred role has involved ensuring that research projects are adequately resourced, designed to achieve their research outcomes in a manner that is respectful and appropriate for the participant group and comply with necessary legislative and regulatory requirements, such as the Australian Code for Responsible Research Conduct and ICH/GCP.

Anna also has developed governance tools such as training, policies and communications to support the research goals. Prior to working at Alfred Health, Anna spent several years conducting educational research for a non-profit organisation, developing new qualifications and curriculum. Her early career was as an archaeologist working on excavations in Turkey, Syria and Jordan.

Guidelines for ANZCA Trials Group presentations and endorsement

The ANZCA Trials Group aims to promote, support, design and conduct multicentre collaborative research in anaesthesia, perioperative medicine and pain medicine. In keeping with these aims, the trials group has developed guidelines to assist researchers seeking formal trials group endorsement for their research studies.

The purpose of trials group endorsement is to ensure a consistently high standard of study design, conduct, analysis and dissemination and that research capacity and study feasibility are optimised.

Further, engagement with the trials group research community is an essential component of the endorsement process. To be eligible for endorsement, new and revised study proposals must be presented at trials group and/or ANZCA scientific meetings. Presentation at a trials group research workshop at an early stage of development is strongly encouraged. The study may be conducted in association with one or more collaborating institutions or research groups.

Proposals will be endorsed on merit and take into account the ANZCA Trials Group terms of reference, any relevant trials group research policies, the research strategy and the research capacity of the trials group.

The process for endorsement involves at least two reviews of the study where at least one reviewer will be a voting member of the trials group executive. Once endorsed by the trials group executive, the study management committee is responsible for obtaining resources and conducting the proposed study in accordance with the trials group terms of reference and relevant policies. Studies must be conducted with high professional standards and in compliance with codes of research conduct such as the National Health and Medical Research Council Australian Code for the Responsible Conduct of Research.

A study update must be presented at least once per year, preferably by presentation at a trials group meeting. Results of the primary study must be presented at a trials group or ANZCA scientific meeting, and it is preferred that this is the first presentation outside of the study investigators.

The guidelines also include a publication policy as well as information and requirements for submitting proposals to the trials group research workshops.

A copy of the guidelines for ANZCA Trials Group presentations and endorsement is available from trialsgroup@anzca.edu.au

ANZCA annual scientific meeting satellite start-up meeting for the Relief and Balanced Anaesthesia studies

The REstrictive versus LIbEral Fluid Therapy in Major Abdominal Surgery (RELIEF) and the Balanced Anaesthesia studies will start in 2013. Both studies received National Health and Medical Research Council grants and funding is available to conduct a start-up meeting in Melbourne at ANZCA House on Friday May 3, the day before the ANZCA annual scientific meeting.

The program includes informative sessions to assist sites that wish to participate in either or both studies. There will be a talk on good research practice, and lunch is provided. Funding is available for one research co-ordinator per site to attend the meeting. Please contact swallace@alfred.org.au for more information.

ANZCA annual scientific meeting trials group activities

The ANZCA annual scientific meeting is always a busy time for the ANZCA Trials Group. This year, our two sessions will be held on Sunday May 5, with our annual lunchtime meeting for investigators and research co-ordinators held between the sessions. The lunchtime meeting is open to all interested delegates.

ANZCA Trials Group 5th Annual Strategic Research Workshop

The 5th Annual Strategic Research Workshop of the ANZCA Trials Group returns to the Sea Temple Resort at Palm Cove this year and registrations are now open.

We are delighted to welcome Professor PJ Devereaux to the meeting. Professor Devereaux, who is from McMaster University Ontario, Canada, is well known to many in Australia as the lead investigator on Perioperative ischemic evaluation study-1 and Perioperative ischemic evaluation study-2 (POISE) trials. In addition, our popular statistical sessions are included in the program.

The workshops bring together experienced researchers as well as new and emerging researchers from Australia, New Zealand and Hong Kong. The meeting aims to present, mentor and encourage new ideas for multicentre research in anaesthesia, perioperative and pain medicine. Updates are also given of existing research activity, and participants are encouraged to engage in current multicentre trials. Submit your ideas for future multicentre research projects to the event co-ordinator: spoustie@anzca.edu.au

Anaesthesia research nurses and co-ordinators are encouraged to attend. More information about the meeting can be found at: www.anzca.edu.au/fellows/Research/anzca-trials-group-events.html

New publications

Glassford NJ, Myles P, Bellomo R. The Australian approach to peri-operative fluid balance. Curr Opin Anaesthesiol 2012; 25:102-110.

Leslie K. Myles P.S. Halliwell R. Paech M.J. Short T.G. Walker S. Beta-blocker management in high-risk patients presenting for non-cardiac surgery: Before and after the POISE Trial. Anaesthesia and Intensive Care 2012: 40: (2) 319-327.

Myles PS. Large randomized trials to overcome barriers to patient safety. Anesth Analg. 2012 Aug;115 (2):479-80

Survey research

In 2013 the ANZCA Trials Group developed a council-endorsed survey research policy, improved its participant sampling methods and updated its web pages on survey research on the ANZCA website.

It considered 23 applications for survey research in 2012, representing an increase of 76 per cent in applications. More than 10 of these were reviewed, approved and facilitated electronically by the trials group; some are still being reviewed.

The response rates for electronically facilitated survey research remains low; at worse it can be as low as 29 per cent while the highest response rate in 2012 was 49 per cent. The trials group strongly encourages Fellows and trainees to participate in survey research that they receive from the trials group. The trials group endeavours to review and assist survey researchers to ensure their research meets publishable standards before a survey is facilitated. Extra expertise is available to trainees. Further information can be found at: www.anzca.edu.au/fellows/Research/trials-group/survey-research.html

Stephanie Poustie
ANZCA Trials Group Co-ordinator

Anaesthesia and Pain Medicine Foundation

Becoming a patron now simpler and more rewarding

When it was established in 2009, the Anaesthesia and Pain Medicine Foundation's Patrons Program was designed to allow donors to make planned annual donations to support anaesthesia and pain medicine research and education, while offering visible recognition of donors' generosity. Joining required donors to commit to donations of $5000, $25,000 or $100,000 over a five-year term.

Last year the foundation simplified the program to make it easier to join. The five-year commitment is no longer needed – a new patron only needs to commit to give $1000 or more each year.

The recognition levels were retained, except that rather than commit to a predetermined level up-front, patrons are now recognised as follows whenever total giving reaches these levels:

- $5000 Presidents patron.
- $25,000 Life patron.
- $100,000 Governor.

Patrons continue to be recognised in the December issue of the *ANZCA Bulletin* and on the foundation pages of the ANZCA website.

From time to time patrons will also be invited to special events held to recognise the foundation's most committed supporters. A reception is being planned to coincide with the annual scientific meeting in Melbourne in May for donors from across Australia and New Zealand. Future events will be held in the regions and in New Zealand starting at ANZCA House in April.

December appeal

An appeal promoting the foundation was inserted with the subscriptions mailing in December. The response to date has been encouraging with almost $40,000 received, compared to just over $26,000 the previous year. This is an important boost to our capacity to fund research and overseas aid. Thank you to everyone who so generously donated.

Patron profile: Dr John Boyd Craig

From left: Dr John Boyd Craig; Clinical Associate Professor Nolan McDonnell, recipient of the 2013 John Boyd Craig Research Award for the project "Evaluation of the safety of intrathecal administration of magnesium sulphate in a sheep model".

In 1987, Dr John Boyd Craig donated $100,000 to generate future income to provide perpetual annual research grants for Fellows, especially for Western Australia-based pain medicine research.

In 2010, Dr Craig was made the inaugural governor of the then-ANZCA Foundation, in recognition of his financial contribution to research in the field of pain medicine and his strong commitment to the foundation's work to increase support for research and education in the specialties.

Rather than make a donation to support a single project, Dr Craig's vision was for the funds to be invested, producing earnings to fund research projects in perpetuity. Increasing capital growth would produce ever-increasing funding for research over the long term.

This vision was consistent with the objective of the Patrons Program, which is to allow committed supporters to make regular annual gifts to build the broader foundation corpus, thereby contributing to the total funds available to grant to Fellows for research and education projects each year.

Another important motivation behind Dr Craig's gift was to encourage others to make similar donations to increase the funding for research. With uncertainty around the level of future research funding available from other sources, his desire was to demonstrate that a growing corpus can provide a protected and secure source of funding for the research required by ANZCA Fellows to remain at the forefront of innovation in anaesthesia and pain medicine.

To honour Dr Craig's contribution, ANZCA created the annual John Boyd Craig Research Award, which is awarded each year by the ANZCA Research Committee to the chief investigator submitting the most suitable, highly ranked research project grant application.

After graduating in medicine from the University of Melbourne in 1942, Dr Craig served as a staff officer in aviation medicine with the Royal Australian Air Force focusing on anaesthesia until 1960. He subsequently practiced in Perth as a specialist anaesthetist before retiring in 1986.

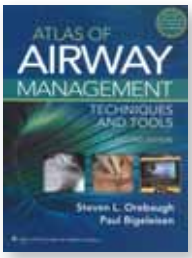
Dr Craig's keen interest in pain medicine was influenced by his father, a Gallipoli veteran whose leg amputation left him with phantom pain and sciatic neuralgia.

The foundation acknowledges and thanks all those Fellows who have given generously.

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**.

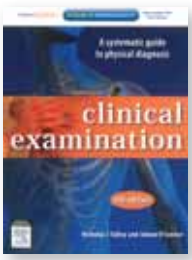
Library update

New titles



Atlas of airway management: techniques and tools / Orebaugh, Steven L; Bigeleisen, Paul E. -- 2nd ed -- Philadelphia, PA: Lippincott Williams and Wilkins, 2012.

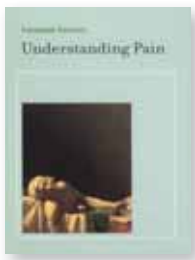
Pain-relieving procedures: the illustrated guide / Raj, P. Prithvi; Erdine, Serdar. -- 1st ed -- Chichester, West Sussex ; Hoboken, NJ: Wiley-Blackwell, 2012.



Clinical examination: a systematic guide to physical diagnosis / Talley, Nicholas J; O'Connor, Simon. -- 6th ed -- Sydney: Churchill Livingstone Elsevier, 2010.

SBAs and MCQs for the final FRCA / Tandon, Rakesh [ed]. -- 1st ed -- Oxford: Oxford University Press, 2012.

How to read a paper: the basics of evidence based medicine / Greenhalgh, Trisha. -- 4th ed -- Chichester, West Sussex: Wiley-Blackwell, 2010.



Understanding pain: exploring the perception of pain / Cervero, Fernando. -- 1st ed -- Cambridge, Mass.: MIT Press, 2012.

Pain 2012: Refresher Courses: 14th World Congress on Pain / Tracey, Irene [ed]. / IASP Scientific Program Committee. -- Seattle: IASP, 2012.

Smith's patient-centered interviewing: an evidence-based method / Fortin VI, Auguste H.; Dwamena, Francesca C.; Frankel, Richard M.; Smith, Robert C. -- 3rd ed -- New York: McGraw-Hill Medical, 2012.

Do you know the value of your College or hospital library?

It's official – your health library can help with professional development, health outcomes, innovation and due diligence. Health Libraries Inc (HLI) and the Australian Library and Information Association (ALIA) have produced a joint report, *Questions of life and death*, describing the value of health library and information services in Australia. The report is based on surveys carried out in August and September 2012, with responses from 250 library staff and users across the nation. The report shows how people use health library and information services and the impact this has on their work and study. Library and information service users were asked how they believed their use of the service over the past year had helped them. The report can be downloaded from the HLI (www.hlinc.org.au) and ALIA (www.alia.org.au) websites. For more information, please call Laura Foley, HLI, +61 6 8517 5305 or Sue McKerracher, ALIA, +61 404 456 749

Greater access to e-books

Fellows and trainees who have accessed online books such as *Miller's Anesthesia* and *Anesthesia Secrets* through *MDConsult* will be pleased to learn that the ANZCA Library now provides full unlimited access to all the subscribed resources, plus chapter PDF downloads for offline use.

Cambridge Books Online recently upgraded to a user-friendly platform that provides html and PDF access to the specialised anaesthesia collection, as well as other tools such as RSS feeds and improved accessibility.

A growing collection of online books can be accessed through the ANZCA Library website: www.anzca.edu.au/resources/library/online-textbooks

Watch this space as an exciting new collection of resources soon will be available to all ANZCA Fellows and trainees.

(continued next page)

New journal in the ANZCA Library

The ANZCA Library recently added the *Journal of Continuing Education in the Health Professions* to the online collection. *Journal of Continuing Education in the Health Professions* is the official journal of the Alliance for Continuing Education in the Health Professions, the Society for Academic Continuing Medical Education, and the Council on CME, the Association for Hospital Medical Education. It is a quarterly journal publishing articles relevant to theory, practice and policy development for continuing education in the health sciences. The journal presents original research and essays on subjects involving the lifelong learning of professionals, with a focus on continuous quality improvement, competency assessment and knowledge translation. It provides thoughtful advice to those who develop, conduct and evaluate continuing education programs.

Ask an expert ... for search assistance

Need updated information on a topic for an unusual case, presentation or paper and don't know where to start? The ANZCA Library has the expertise to perform literature searches and share the search strategy and results with you.

The Medline and Embase databases now have the functionality to allow the library staff to email the search strategy to you so you can continue or make changes to the search. The library also has EndNote bibliographic software on hand and can send results in a format that can go straight into your EndNote library.

Contact the library to discuss your information needs: library@anzca.edu.au

New ECRI publications

Health Devices, Vol. 41, No. 11, November 2012

- Top 10 health technology hazards including:
  - Alarm hazards.
  - Medication administration errors using infusion pumps.
  - Air embolism hazards.
  - Inattention to the needs of paediatric patients when using "adult" technologies.
  - Inadequate reprocessing of endoscopic devices and surgical instruments.
  - Caregiver distractions from smartphones and other mobile devices.
  - Surgical fires.

Health Devices, Vol. 42, No. 1, January 2013

- A tool for addressing the top 10 technology hazards

Operating Room Risk Management

- Refusal of blood transfusions on religious grounds.
- Employee radiation exposure.
- Health literacy.
- Culturally and linguistically competent care.

Latest anaesthesia and pain medicine research

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

Bennett MH, Stanford RE, Turner R. Hyperbaric oxygen therapy for promoting fracture healing and treating fracture non-union. Cochrane Database Syst Rev. 2012;11:CD004712.

Moore RA, Derry S, Aldington D, Cole P, Wiffen PJ. Amitriptyline for neuropathic pain and fibromyalgia in adults. Cochrane Database Syst Rev. 2012;12:CD008242.

Williams AC, Eccleston C, Morley S. Psychological therapies for the management of chronic pain (excluding headache) in adults. Cochrane Database Syst Rev. 2012;11:CD007407.

Bohmer AB, Kindermann P, Schwanke U, Bellendir M, Tinschmann T, Schmidt C, et al. Long-term effects of a perioperative safety checklist from the viewpoint of personnel. Acta Anaesthesiologica Scandinavica. 2013;57(2):150-157.

Dexter F, Epstein RH, Wachtel RE, Rosenberg H. Estimate of the relative risk of succinylcholine for triggering malignant hyperthermia. Anesthesia & Analgesia. 2013, 2013;116(1):118-122.

Larsson J, Holmstrom IK. How excellent anaesthetists perform in the operating theatre: a qualitative study on non-technical skills. Br J Anaesth. 2013;110(1):115-121

Lee J, Lee J, Lim H, Son J-S, Lee J-R, Kim D-C, et al. Cartoon distraction alleviates anxiety in children during induction of anesthesia. Anesthesia & Analgesia. 2012;115(5):1168-1173.

Mai CL, Firth PG, Yaster M. History of pediatric anesthesia timeline. Paediatr Anaesth. 2013;23(1):1-2.

Upp J, Kent M, Tighe PJ. The evolution and practice of acute pain medicine. Pain Med. 2013;14(1):124-144.

Sheraton TE, Wilkes AR, Hall JE. Mobile phones and the developing world. Anaesthesia. 2012;67(9):945-950.

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

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

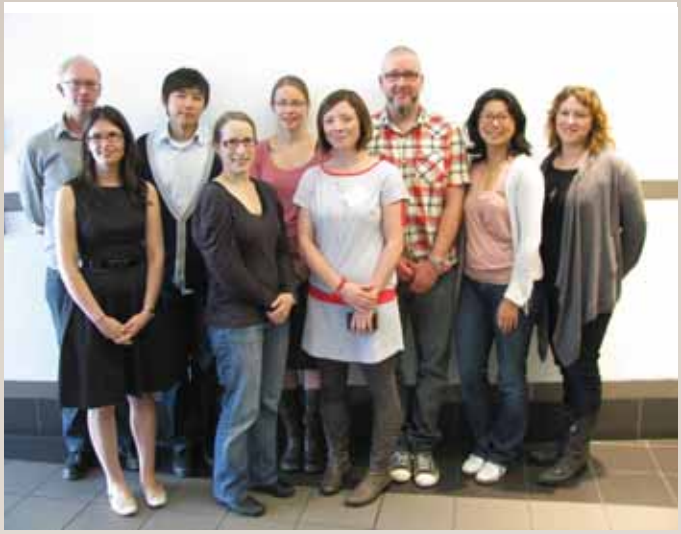
Contact the ANZCA Library
www.anzca.edu.au/resources/library
Phone: +61 3 8517 5305
Fax: +61 3 8517 5381
Email: library@anzca.edu.au

Singapore visit

Earlier this year, Dr Lindy Roberts (ANZCA President), Dr Genevieve Goulding (ANZCA Vice-President), Dr Mark Reeves (Chair, Training and Accreditation Committee) and Dr Kerry Brandis (ANZCA councillor) visited ANZCA-accredited hospitals in Singapore and Malaysia where they met with ANZCA trainees, supervisors of training and the Singaporean and Malaysian Regional Training Committees to support ANZCA training in these countries until mid-2019.

Above from top: Standing from left: Dr Ashokka Balakrishan, Dr Tiong Ing Hua, Dr Nivan Loganathan, Dr Rohit Agarwal, Dr Deborah Khoo, Associate Professor Raymond Goy, Dr Swapna Thampi and Dr Terry Pan from the National University Hospital, Singapore. Sitting from left: Dr Lindy Roberts (ANZCA President) and Dr Kerry Brandis (ANZCA councillor).

Standing from left: Members of the Singapore Regional Training Committee Professor Lee Tat Leang, Dr Terry Pan, Dr Goh Meng Huat, Associate Professor Eugene Liu with ANZCA councillor Dr Kerry Brandis. Sitting from left: Dr Mark Reeves (TAC Chair), Dr Lindy Roberts (ANZCA President), Dr Uma Shridhar, Dr Genevieve Goulding (ANZCA Vice-President), Dr Lim Suan Ling.



NZ Trainee Committee

December's New Zealand Trainee Committee meeting saw the incoming members of the 2013 committee join the 2012 members to ensure a smooth transition.

The meeting was held on the eve of New Zealand going live with ANZCA's 2013 curriculum and training portfolio system, the first region to do so, ensuring keen anticipation and an obvious area of discussion.

The valued contribution of the outgoing committee members (Dr Jonathan Taylor, Dr Rachel Dempsey, Dr Matt Levine, Dr Sarah Sew Hoy and chair Dr Sheila Barnett) was acknowledged and the new members were welcomed. The 2013 committee is Dr Olivia Albert (Auckland), Dr Rochelle Barron (chair, Wellington), Dr Ruth Brown (deputy chair, Christchurch), Dr Lizi Edmonds (Nelson), Dr Julia Foley (Auckland), Dr Michael Hamilton (Dunedin), Dr Chang Kim (Auckland), Dr Laura Kwan (Wellington), Dr Ghassan Talab (Auckland) and Dr Richard Walsh (Hamilton), with Dr Catherine Purdy (co-opted, Auckland) and Dr Kathryn Hagen (NZ Society of Anaesthetists' representative).

One of the committee's projects for this year is updating the *Anaesthesia Training in NZ Made Easy* handbook. Its focus will be on the experience of training to become an anaesthetist in New Zealand, rather than curriculum advice or duplicating information that is available on the ANZCA website.

The committee has already begun work on establishing a trainee welfare system. The welfare system will provide trainees with support by way of nominated welfare officers. Trainees will be able to contact a welfare officer in times of increased stress, if they are having difficulties or are feeling overwhelmed either in or outside the workplace. The recent survey as to what support already exists drew a 50 per cent response rate and those responses are now being analysed.

Above: Members of the 2013 NZ Trainee Committee, from left: Dr Richard Walsh, Dr Julia Foley, Dr Chang Kim, Dr Kathryn Hagen, Dr Rochelle Barron (chair) Dr Sheila Barnett (outgoing chair), Dr Michael Hamilton, Dr Laura Kwan and Dr Lizi Edmonds.

BWT Ritchie Scholarships

Each year, the NZ Anaesthesia Education Committee (NZAEC), a joint ANZCA/NZSA committee, can award BWT Ritchie Scholarships. The scholarship provides up to NZ$25,000 to assist New Zealand-based ANZCA, Faculty of Pain Medicine or College of Intensive Care Medicine trainees, who have passed their final exam, to gain overseas experience and bring it back to New Zealand.

Although applications have traditionally closed at the end of June, this year the deadline is October 31, which fits better with overseas university schedules. It also gives potential candidates, who must be nominated by their departments, time to research their proposed program of study before the award decisions are made.

But who was BWT Ritchie, whose legacy continues to benefit today's anaesthetists?

Brian William Thomas 'Tommy' Ritchie was born in South Canterbury in 1915. His early education was at The Pines in Timaru, a five-mile pony ride to and from school. His secondary school education was at Timaru Boys' High School, where he was head boy and captained the first XV rugby team and first XI cricket team.

Following in his father's footsteps, Tommy Ritchie he attended St John's College at Cambridge University in 1935, quite an adventure for a South Canterbury lad in those days, not least because of the six-week ocean voyage required to reach England.

He graduated in 1938 with a bachelor of arts with honours in natural sciences. While at Cambridge, Tommy Ritchie studied physics under Lord Rutherford, and was introduced to Albert Einstein while on a rugby tour to the United States (sponsored by Phillip Morris cigarettes!). He captained the St John's College rugby XV, tennis VI and the university XV on its US tour. During the latter, he may have been responsible (neither confirm nor deny) for blackening John F Kennedy's eye in the scrum when they overwhelmed Harvard 50-0.

After graduating, Tommy Ritchie studied clinical medicine at St Thomas' Hospital, London, qualifying MB BS in 1941. Various house appointments during the war led to the position of resident anaesthetist at St Thomas'.

The formation of the BWT Ritchie Scholarship may have been due partly to the fact that in those days no stipend was paid until a specialist was fully qualified; laundry facilities were provided but young doctors were expected to use 'private means' to survive.

Tommy Ritchie wrote: "The Second World War made our clinical studies somewhat abnormal as the bombing disrupted the functioning of the hospital with numerous evacuations to Surrey and the Home Counties. I often acted as chauffeur to the senior obstetric and gynaecological consultant while attending classes out of London and he would teach me while we weaved our way in and out of London during or after a blitz."

In 1944, the Emergency Medical Service (EMS) sent Dr Ritchie to the north of England, where he was appointed consultant anaesthetist at the Royal Victoria Infirmary in Newcastle as well as at Shotley Bridge Hospital, Freeman Hospital and as a clinical tutor at Newcastle University.

Rugby and cricket continued during the war: he captained St Thomas' Hospital XV and XI, the London United Hospitals XV and XI, played for the Barbarians and captained the North of England XV against Charlie Saxton's New Zealand Expeditionary Force XV.

While in the north-east, he met his future wife, Jessie Gilbert Carter, who was in the Women's Auxiliary Air Force as a senior cipher officer. They married in Oxford in 1946 in an 'austere' wedding due to rationing. After returning to New Zealand with his new wife, Dr Ritchie decided there were greater opportunities in England so returned to the north-east.

Simon (1948) and Julia (1950) were born before Jessie died in an automobile accident in 1951. A nanny, Miss Prue Blackley, was dispatched from New Zealand to assist with the young children and soon became Mrs Prue Ritchie. Jonathan (1956) and James (1959) followed.

When Dr Ritchie retired from the National Health Service in 1981, the couple returned to New Zealand and lived in Masterton. Tommy died in 1992, Prue in 1993. Both were predeceased by Julia, who died in a boating tragedy in Taiwan in 1990.

Dr Ritchie set up the BWT Ritchie Scholarship in 1991 with a $200,000 gift to a trust for that purpose – the capital to be retained with the net income on the capital to be used to fund the scholarships. Jonathan Ritchie has been an advisory trustee since the trust's inception, as were his parents until they died.

The first recipient was Dr Charles Minto of Christchurch, who undertook a provisional fellowship year at Stanford University. Records are not complete but at least 21 doctors have received scholarship grants since then and have studied mainly in the UK and USA, but also in Canada, Australia and South Africa.

Dr Ritchie clearly considered there were benefits in having New Zealand anaesthetists study overseas and returning to practice in New Zealand. The trust deed establishing the scholarship stipulates that the grant is intended to enable overseas experience but with the scholar expected to return to New Zealand for at least three years to work in anaesthesia or intensive care. At the time, intensive care training was overseen by ANZCA.

For information on the scholarship, see www.anaesthesia.org.nz (click the NZAEC link) or email nzaec@anaesthesia.org.nz.

Australian news

Queensland

Queensland Regional Report

The start of 2013 was plagued by rising waters in Queensland as high tides again flowed over the banks of the Brisbane River and on to the road at West End. Apart from power outages and hard-drive failures the Queensland regional office was safe and the year is off to a busy start.

The ANZCA Queensland Regional Committee, Faculty of Pain Medicine Queensland Regional Committee, the ANZCA Training Committee and the ANZCA/ASA Continuing Medical Education (CME) Committee have all convened their first meetings.

On February 6, the ANZCA Queensland Regional Committee hosted a welcome to 2013 reception to thank the many Fellows and trainees who volunteer significant amounts of time to support College training and CME activity, as well as healthcare industry representatives. The evening was well attended and thoroughly enjoyed, suggesting that there is likely to be strong support into the future.

The ANZCA/ASA CME Committee has been particularly active, with plans for the annual conference well advanced. The conference, titled 'Together everyone achieves more: Anaesthesia in the team environment", will be held on Saturday, June 22.

The first evening lecture presented by David McCormack was informative and created vibrant interaction.

The 2013 hospital year has begun and with it the revised curriculum. Queensland education officer Jeneen Thatcher has ensured that departments, supervisors of training and trainees are well prepared and supported.

Trainee events hosted to date include the GASACT course, the final exam preparation course and the last sitting of the old primary exam and the first sitting of the new primary exam. A webinar series focusing on introductory anaesthetic competencies also has begun. New trainees are encouraged to take advantage of this valuable learning opportunity.

Mark Gibbs honoured with Australia Day Achievement Award

The Queensland Department of Health has recognised 13 individuals and teams for their significant contribution to the improvement and delivery of health services in Queensland as part of Australia Day celebrations. In a ceremony held on January 25, Dr Mark Gibbs received an Australia Day Achievement Award from the Director General of the Department of Health, Dr Tony O'Connell.

Dr Gibbs was awarded for his "dedication and commitment to improving the standard, quality and capacity of anaesthetic services in rural facilities across Queensland".

In his role as chair of the SWAPNET Rural and Remote Work Group, Dr Gibbs conducted a statewide review of anaesthetic service capacity involving 30 rural facilities across Queensland throughout 2010 and 2011. The review developed 18 recommendations to improve the quality and capacity of anaesthetic services in rural areas.

Dr Gibbs then established and led two major projects:

- Standardised Anaesthetic Equipment Project, which delivered anaesthetic equipment worth $3million to 28 rural facilities last year.
- Rural Generalist Anaesthetic Introductory Program, a four-day program held in Toowoomba in the final week of January. This program provided 16 rural generalist trainees/registrars with the necessary training to enable them to be effective and less reliant on their supervisors from the day they start their anaesthetic advanced skills training/rural posting. The ultimate aim of the Rural Generalist Anaesthetic Introductory Program is to deliver high-quality GP rural generalists to rural hospitals in Queensland. The four-day program was officially opened and recognised by the health minister on Wednesday.

Dr Gibbs is the Director of the Department of Anaesthesia & Intensive Care at Ipswich Hospital, and is a member of several ANZCA committees, including the Queensland Regional Committee, Training Accreditation Committee and the GP Anaesthesia Working Group. He is also the rotational co-ordinator for the Queensland Anaesthetic Rotational Training Scheme (QARTS) and a former regional education officer.

Congratulations Mark!

Dr Mark Young
Chair, Queensland Regional Committee

This page from top: from left, Dr Jeneen Thatcher (education officer), Dr Kerstin Wyssusek (formal project officer) and Dr Masha Jukes (QARTS, southern rotational co-ordinator) at the Welcome to 2013 reception; from left, Sandy Shaw (regional manager), Dr Mark Young (regional chair), Professor Michael Steyn (regional committee member), Dr Paul Nicholas (Trainee Committee chair), Dr Genevieve Goulding (ANZCA Vice-President), Dr Charmaine Barrett (QRC secretary and treasurer) at the Welcome to 2013 reception.

Dr Betty Brenda Spinks 1920 – 2012

I feel honoured to be asked to write an obituary for Dr Betty Brenda Spinks.

Betty was born in London in March 1920 and died in Melbourne in October last year. Of particular importance was that Betty passed the inaugural final fellowship examination for the Faculty of Anaesthetists, RACS, in Melbourne in May 1956.

After schooling in Brighton, Victoria, and London, UK, Betty graduated MBBS Melbourne in 1943. She passed the part 1 DA (Melbourne) in 1946 after a residency in Hobart Tasmania, Royal Children's Hospital (Melbourne) and Fairfield Hospital, and she started her anaesthetic training in Melbourne. Dr L Travers and Dr K McCaul were her early supervisors. Registrar training commenced in Britain at Kings College Hospital and the Hillington Hospital. She completed her training as a registrar at the Queen Victoria Hospital and the Royal Melbourne Hospital. During this time she also undertook 18 months in general practice.

I had professional contact with Betty twice. As a junior resident medical officer at Footscray and District Hospital we did a three-month anaesthetic term and Betty was often my supervisor. I remember during an open insufflation anaesthetic for Ts and As, I stated that the patient was "getting light". Her immediate response was "get the patient deeper or the patient will vomit".

In 1969, I became a colleague as a visiting medical officer at Footscray and District Hospital. I was now able to appreciate that Betty was a meticulous anaesthetist and was always concerned about the welfare of the patient. She continued to specialise in ear, nose and throat anaesthesia.

Department meetings were held in the homes of the six visiting medical officers and Betty rarely missed a meeting. Her opinions were always sound. Betty also gave anaesthetics at the Peter MacCallum Cancer Institute and had a small private practice.

Over recent years she suffered from ill health and, with some difficulty, attended a combined ANZCA/ASA meeting in Melbourne to be awarded a 50-year membership of the Australian Society of Anaesthetists.

Dr Ian Rechtman, FANZCA
Victoria