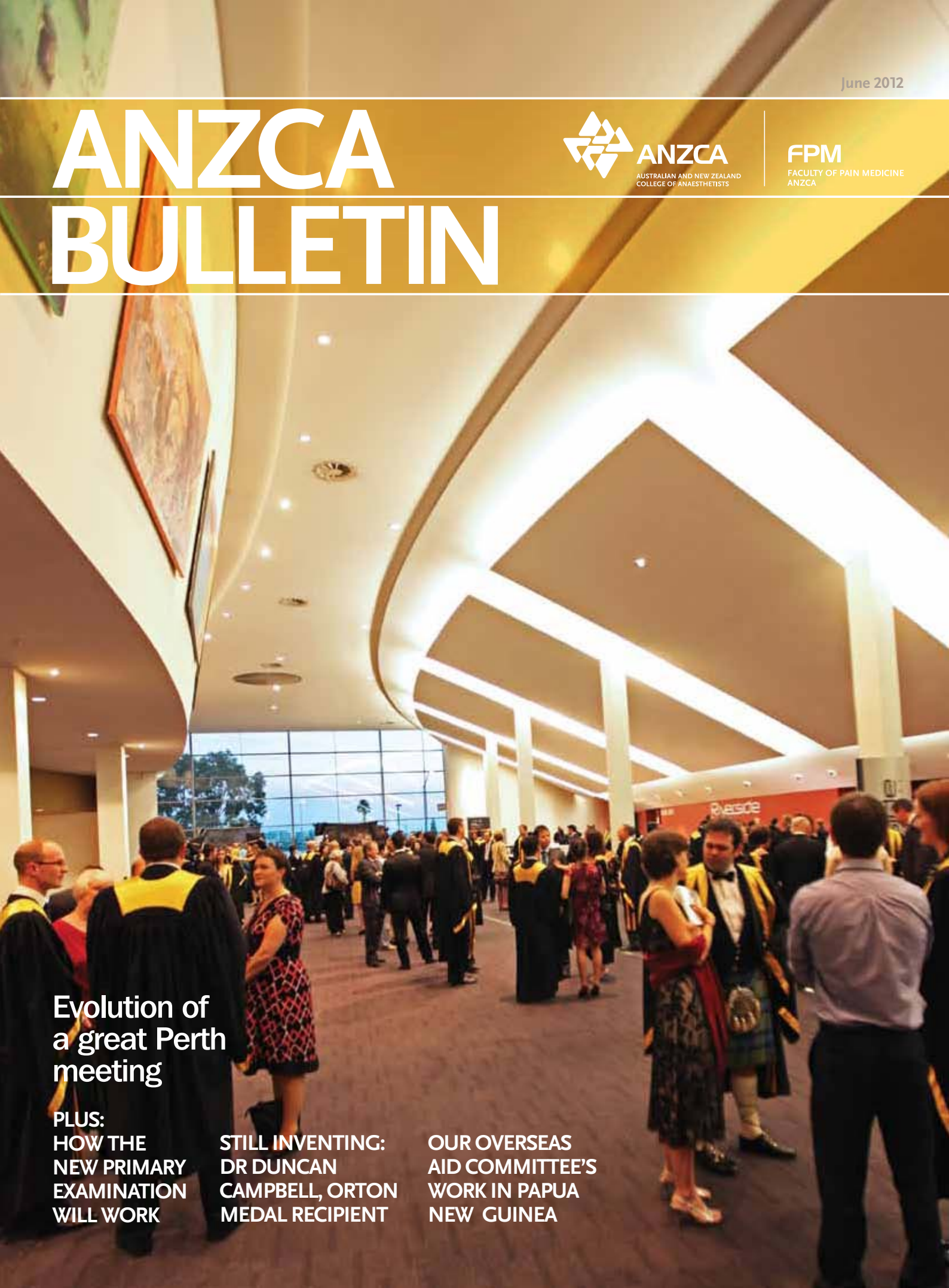


ANZCA BULLETIN



FPM
FACULTY OF PAIN MEDICINE
ANZCA



**Evolution of
a great Perth
meeting**

**PLUS:
HOW THE
NEW PRIMARY
EXAMINATION
WILL WORK**

**STILL INVENTING:
DR DUNCAN
CAMPBELL, ORTON
MEDAL RECIPIENT**

**OUR OVERSEAS
AID COMMITTEE'S
WORK IN PAPUA
NEW GUINEA**

20 Curriculum update

The primary examination will take on a new format under the revised curriculum.

24 Still inventing

Robert Orton medal recipient, Dr Duncan Campbell is still innovating.

12 Perth ASM a great success

More than 1500 Fellows and trainees attended the Perth meeting.

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.

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32 Titanic challenge

Victorian anaesthetist Dr Ashley Webb explains the effectiveness of a quit smoking program at Peninsula Health.

de
**ANESTESIA
Y
ANALGESIA**

DIRECTOR:
Prof. ALBERTO GUTIERREZ

54 Museum treasures

The Geoffrey Kaye Museum of Anaesthetic History has three new items of historical significance.



28 Teaching in PNG

The Overseas Aid Committee is doing a lot of work in Papua New Guinea.

Contents

4	President's message	37	NZ Anaesthesia ASM	62	The Anaesthesia and Pain Medicine Foundation
5	Chief Executive Officer's message	38	ANZCA and government: building relationships	64	New Zealand news
6	Acknowledging Professor Kate Leslie	40	Quality and safety	67	People and events
8	Letters to the editor	45	The dangers of self-inflating resuscitation bags	68	Australian news
9	Awards	46	ANZCA Trials Group meets at the annual scientific meeting in Perth	78	ANZCA Council meeting report
11	News	50	Successful candidates	80	Faculty of Pain Medicine
12	Perth ASM wrap up	54	Anaesthetic history: Museum receives valuable historical gifts from South America	86	Library update
19	New Fellows' Conference	55	ANZCA history and heritage update	88	Obituary
20	ANZCA's revised training program	56	The early development of anaesthesia practice in Queensland	89	Future meetings Australia and New Zealand
24	A mad idea – or several – is just what the doctor ordered	60	ANZCA in the news	91	life&leisure: "Savvy professionals can reap tax rewards", "Crossing the South Island the hard way" and "Rug up and explore with a wintry European adventure"
28	ANZCA contribution helps improve patient care in Papua New Guinea				
32	Tobacco and surgery: Issues of Titanic importance				
34	Lessons abound on a Dili adventure				

President's message



Dr Lindy Roberts
President, ANZCA

There are two particularly special aspects for me in taking over as president of the College at this time. The first is that the handover occurred at the recent successful ASM in my hometown, Perth. The second is that this year marks the 20th anniversary of ANZCA and it is also 20 years since I first joined the College as a trainee.

As the incoming president, I am like all our Fellows, driven by the notions of excellence, care and collaboration. An example of this is through leadership of the curriculum review process where we used a coalface-up approach, seeking the views of Fellows and trainees about the existing training program, to build a world-class curriculum that is nearly ready to be rolled out. We have another opportunity at this time as the College and its Faculty of Pain Medicine define the plans and direction for the five years from 2013 to 2017.

It is important that College leaders seek the views of Fellows and trainees and use that feedback wisely – the best leaders I have known have forged the directions of their organisations from listening to their constituents. As part of the planning for the next five years, there has been a series of ways in which Fellows and trainees have had a voice. These include the consultation process and hospital visits being undertaken by ANZCA Chief Executive Officer Linda Sorrell, the outcomes of the 2010 Fellowship survey, the 2011 New Zealand roadshow undertaken by Dr Vanessa Beavis, and the 2012 curriculum survey targeting heads of department, regional/national education officers, supervisors of training and trainees. Thank you to all who have shared their views.

So what are you saying? These are some of the key messages:

- Our core purposes remain training, education, accreditation, standards of clinical service delivery for all sections of our communities; services for Fellows such as continuing education, continuing professional development, the library and other resources; advocacy to the wider community and government in the interests of high quality patient care and safety; and promotion and support for evidence-based practice through research and education.
- As a College we have many strengths. These include the training program and the quality of our graduates, our growing educational resources, and publications. We are a credible, professional organisation that has the tremendous benefit of Fellows' capabilities and contributions; along with staff knowledge and resources.

- We can improve in a number of areas, particularly in our relationships with and services to our Fellows and trainees, including acknowledgement of and support for their contributions. Our main challenges over the next few years will be those of health sector and workforce reform; implementing the revised curriculum; ensuring that we remain an organisation that continues to deliver optimal value to its members; and fostering relationships with important partners. In some quarters, we need to strengthen our profile and role.

I am inspired by the call from Fellows for the College to remain a world leader, an organisation committed to excellence with a profile and membership services to match, using new technologies and communications to best effect. All these aspirations ultimately underpin the high standards of care we provide our patients.

Past presidents, deans and councils as well as the many Fellows and trainees who have contributed so much up to this point have given us all a solid foundation on which to continue building. I know we can respond to challenges and we will aspire towards an even stronger organisation over the next five years. We need to promote and maintain strong standards through successful rollout of the revised curriculum, and grow support for innovative research and ongoing development of resources for Fellows.

We need to work on building a sense of unity and ownership in our College through strengthening relationships between the ANZCA Council and the regions, ensuring a service-oriented approach throughout the College, and seizing ongoing opportunities for collaboration between the College and the Faculty of Pain Medicine. We must continue to foster strong relationships and strategic collaborations with governments, other colleges and the societies, and with training organisations in Hong Kong, Singapore and Malaysia. And we must ensure our organisation is sustainable into the future by continually developing efficiencies, relevance and effectiveness, the best staff and the best systems. I am confident that we will move from strength to strength.

Of course, there would be no College without the efforts of the many Fellows, trainees and staff who contribute at so many levels. The past 20 years has been marked by many significant achievements for the professions of anaesthesia and pain medicine, and I feel privileged to be taking over as the leader of a college that is in excellent shape. I have a great sense of optimism about our next 20 years and beyond.

Chief Executive Officer's message

The development of our ANZCA Strategic Plan for 2013-2017 is continuing apace.

Much feedback has been obtained through high-level consultation with internal stakeholders, including councillors, committees (including regional) and staff; and with external stakeholders such as other colleges, departments of health, universities and relevant government agencies.

Other sources of information have included recent fellowship and trainee surveys, the New Zealand hospital road show by former New Zealand National Committee chair and new ANZCA councillor, Dr Vanessa Beavis, and key points raised during my recent visits to hospital anaesthesia departments in Australia.

A total of 58 separate sets of feedback were received to six questions used to guide discussions and help inform ANZCA's strategic priorities for the five years from next year. Of these, 43 came from groups and individuals within ANZCA and 15 from external agencies, including from within departments of health, universities, and other colleges.

Following are the questions and the themes resulting from the responses.

What is ANZCA's core business? Training, education, standards; advocacy; research; communication.

What are ANZCA's strengths? Quality of services and graduates; communications and profile; Fellows' capacity and capability; organisational capacity and ways of working.

What are ANZCA's weaknesses?

Relationships with and services to Fellows and trainees; reliance on pro bono work of Fellows; profile and perceptions of ANZCA; organisational structure and ways of working.

Where should ANZCA be in five years' time?

The leader in anaesthesia training, recognised expert agency; a capable and innovative user of IT and communications technologies; provider of excellent services to members; good communicator with a strong profile.

What are ANZCA's main challenges in the next five years? Engagement with Fellows and trainees; good business practice in a tough environment; managing external influences (other providers, political change); curriculum implementation and continuing medical education/continuing professional development services; improving structure and ways of working.

There were also a number of themes that appeared across most or all of the questions including:

- The revised curriculum: An essential component in ongoing core business; a strength; a challenge, and critical to where ANZCA will be in 2017.
- Workforce: Mal-distribution of anaesthetists; training places, number of trainees, projected increase in demand, and funding changes for training.
- A need for support for rural anaesthetists and GP anaesthetists.

The ANZCA Council held a workshop in April and will be discussing the strategic plan again this month.

History and heritage

At the recent Perth annual scientific meeting, we filmed the first of several interviews with key College figures. These will form a collection of oral histories that will be available to the wider fellowship via the website.

This is part of our commitment to history under our History and Heritage Strategy, which was signed off by the ANZCA Council earlier this year. The strategy aims to meet 10 objectives over the next few years including actively capturing and documenting the history of the College and using information technology to improve accessibility.

We also have plans for a strong historic presence at next year's ANZCA annual scientific meeting in Melbourne and are committed to a new "anaesthetic history" section in each edition of the *ANZCA Bulletin*.

Other activities being undertaken include updating a booklet about the historic ANZCA-owned building, Ulimaroa, and other publications that highlight the history of the College.

For further information about the History and Heritage Strategy please see page 55.



Ms Linda Sorrell
Chief Executive Officer, ANZCA

Acknowledging Professor Kate Leslie



It is my pleasure to acknowledge our immediate past president Kate Leslie and her work as the leader of the College from May 2010 to May 2012. Kate's presidency has been marked by a clear vision, exceptional attention to process and outcomes, coupled with strong and decisive leadership.

Kate's efforts have been tireless and her style courageous. Through the vision of ENGAGE she urged us to embrace, negotiate and influence, get involved, advocate, give our support and educate.

There have been many achievements under Kate's leadership:

- Delivering a plan with our former CEO Mike Richards to strengthen our capability in areas such as education development, fellowship affairs, policy and communications.
- Recruiting our new CEO, Linda Sorrell, and putting in place a forward-looking relational and collaborative agenda.

- Leading the organisation to be ready for the rollout of the revised curriculum, ANZCA Curriculum Revision 2013.
- In collaboration with others, achieving a critical Medicare schedule change to fund trainees in private.
- Building activities and collaborations in overseas aid.
- Setting new standards of clarity for Fellows and trainee participating in College activities through terms of reference for ANZCA committees and leaders.
- Leading the charge for improving our approach to indigenous health.
- Confirming and codifying the crucial relationship between ANZCA and the Faculty of Pain Medicine by constitutional review.
- Strengthening relationships with our important partners notably the College of Intensive Care Medicine, the College of Surgeons and the Society for Paediatric Anaesthesia in New Zealand and Australia.

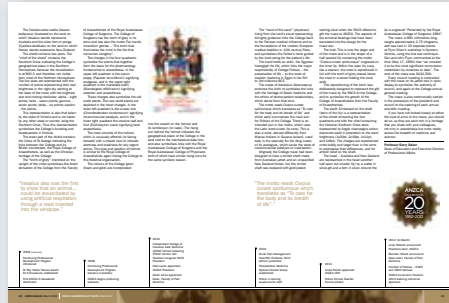
- Overseeing two highly successful annual scientific meetings – in 2011 held jointly with the Hong Kong College of Anaesthesiologists and this year in Perth.
- Reinforcing the College's commitment to preserving our history and heritage.

Through her ENGAGE strategy, Kate has achieved much. I, along with the ANZCA Council, am committed to continuing to work in all of these areas, as they are strengths for our College that are worth building upon.

Kate, on behalf of all Fellows, trainees and staff, thank you. We wish you well in your future endeavours.

Dr Lindy Roberts
ANZCA President

Letters to the editor



Celebrating our Coat of Arms

It is no exaggeration to say I was thrilled to see Professor Baker's exposition of the College Coat of Arms (*ANZCA Bulletin*, March 2012). Every feature rich with history and significance; their appearance, colour, position, shape, size, all telling the story of the College and our traditions of anaesthesia and intensive care in a spectacular symphony of colour and images. As the logo for a learned college I believe our Coat of Arms stands head and shoulders above every other Australian and Australasian professional college and is something of which every Fellow can be proud.

I turn to the article about the triangles. What contrived symbolism that is. The triangles have no soul and the many Fellows I have spoken to appear to have a similar view and are baffled by the supposed symbolism of the triangles.

Can I appeal to the new Council to review the decision to adopt the triangle logo? Let us make the most of what we have, our truly magnificent and inspiring Coat of Arms. Let us use the coloured version at every opportunity. Trainees should be made aware of its nature and design so they can draw inspiration from it.

Let us proudly display our inspirational Arms whenever and wherever possible.

Dr John Paull MB BS, Dip Ed, FANZCA
Consultant Anaesthetist (Retired)
Honorary Research Associate
School of History and Classics,
University of Tasmania,
Launceston, Tasmania.

Why does the College need two logos?

I was intrigued to read the descriptions of the armorial bearings or "crest", and the corporate logo, "the triangles", in the March 2012 *ANZCA Bulletin*. Barry Baker's exemplary article should be compulsory reading for all current and aspiring Fellows of the College.

The description of the logo, however, leaves a number of questions unanswered. That the logo design is "abstract and open to wide interpretation" reminded me of an occasion when I met with a senior staff member at Melbourne University. Without prompting, she commented on a College business card that depicted the corporate logo, saying that it appeared to represent an organisation that was unsure of its direction!

Why did the ANZCA Council feel the need to commission a new logo in 2008 in addition to one that was widely recognised and had been developed through a rigorous and well established process? Contemporary values are not obtained through the acquisition of a pretty design; they are obtained by action and achievements, thereby bestowing integrity on the name and reputation of the organisation.

We now have the confusion of two logos. The original armorial bearings, with so much embodied meaning, has been deliberately downgraded by the imposition of an abstract design of uncertain foundation.

The "rich burgundy colour" of the corporate logo supposedly denotes "quality, authority and a link to the traditions of the past". I find it difficult to ascribe such a range of attributes to a colour, more so as the logo appears in a range of colours in the same issue of the *Bulletin*.

Other Australian and New Zealand medical colleges use a single crest or shield, and display it proudly. It is time for the council to reconsider the merits of having two logos.

Dr Rod Westhorpe OAM, FRCA, FANZCA
Honorary Curator, Geoffrey Kaye Museum of
Anaesthetic History

Perth Hospital records

Thanks to Fraser Faithfull and Professor Garry Phillips for the article on the early days of the Faculty of Anaesthetists in Western Australia (*ANZCA Bulletin*, December 2011).

For the sake of the historical record I offer some minor corrections. The records of the Perth Hospital contradict the statement in the *Bulletin* that Dr B Burnside and Dr WH Nelson were the first honorary anaesthetists appointed to the hospital, commencing in 1918.



Although the record is incomplete, the minutes of the Perth Hospital Board¹ as early as 1906 record the nomination of a Dr Thurston to the post of honorary anaesthetist. In 1924 Gilbert Troup was appointed as an honorary assistant physician (not junior physician) to the Perth Hospital, and he was first appointed as an honorary anaesthetist in 1930 (not 1927)².

It is not clear when Dr Troup first worked at the Perth Children's Hospital; his own "personal information" held by the Australian Society of Anaesthetists gives the date as 1922 (the year of his graduation from Melbourne University), but according to the records of the hospital, his initial appointment there was in 1924³.

Dr Toby Nichols
Department of Anaesthesia
Royal Perth Hospital

References:

1. Minutes of board meetings of the Perth Hospital (held by Royal Perth Hospital Museum).
2. Annual reports of the Perth Hospital (held by Royal Perth Hospital Medical Library).
3. Jeanette Robertson, archives facilitator, Princess Margaret Hospital (personal communication).

Awards

Letters to the editor



ANZCA anaesthetic technicians and their colleagues in New Zealand.

Editor: I wish to expand on what Dr Michael Davis has written about early anaesthetic technician training in New Zealand (ANZCA Bulletin, March 2012). Efforts to institute formal training began in the 1960s and began at Christchurch Hospital and Green Lane Hospital, Auckland, in April 1977. The first examination for the Certificate of Proficiency was held in March 1979. Six candidates presented, four from Christchurch and two from Auckland. All passed. Training extended to other centres after that.

under the Health Practitioners Competence Assurance Act. I congratulate all those involved in achieving this important professional goal for our operating room colleagues. Throughout my anaesthetic career, I valued highly the support of the ANZCA. The process of developing the professional role of anaesthetic technicians is what I'd like to focus on, but much longer than the 11 years since the NZ Anaesthetic Technicians Society expressed "their wish to be covered by this legislation". I developed the first anaesthetic technician training course in New Zealand in 1978. 11 years ago, soon after I arrived in Christchurch as a full-time specialist for the Green Lane Canterbury Hospital Board, in order to complete the early history of technician training in NZ, it is worth reading from an early Department of Anaesthetics internal publication that covered the history of anaesthetics in Christchurch from 1978 to 1990.

which Doug Chisholm (Medical Director, Anaesthetics Services, CARE) was invited to do. Anticipating the establishment of proper training programmes, a public course was commenced... in Christchurch in 1978. The first formal course started the next year for the development of the NZ programme. Dr Eric Clayton from Hamilton was the first lecturer. As far as I know, at least two of those original five graduates were still working as anaesthetic technicians in Christchurch until recently.

Associate Professor (retired) Michael Davis, MB, BChio, MA (Canab.), FRCR(S), FANZCA, MD(SpAg), DipGHM, CertGHM(ANZCA) References: Davis MA, editor. Department of Anaesthetics 1978-1990. The changing face of anaesthetics in the public health system. Christchurch: Canterbury Anaesthetic Branch 1990.

Anaesthetic technicians in New Zealand

For the sake of accuracy, I wish to expand on what Dr Michael Davis has written about early anaesthetic technician training in New Zealand (ANZCA Bulletin, March 2012). Efforts to institute formal training began in the 1960s and began at Christchurch Hospital and Green Lane Hospital, Auckland, in April 1977. The first examination for the Certificate of Proficiency was held in March 1979. Six candidates presented, four from Christchurch and two from Auckland. All passed. Training extended to other centres after that.

Dr Basil Hutchinson, FANZCA, Auckland (Former chair, Anaesthetic Technicians' Board, NZ)

Dudley Buxton Medal of the Royal College of Anaesthetists

Professor Teik Oh has been awarded the Dudley Buxton Medal of the Royal College of Anaesthetists in recognition of his estimable services to the specialty. The medal was established in 1967 to provide an annual award of a prize for meritorious work in anaesthesia or in a science contributing to the progress of anaesthesia.

Australia Day Honours

Dr Andrew Kenneth Bacon has been awarded the Ambulance Service Medal (ASM), Victorian Ambulance Service, in the 2012 Australia Day Honours List.

Australian Queen's Birthday Honours

Associate Professor Malcolm Wright has been appointed a Member of the Order of Australia in the General Division, for service to intensive care medicine, as a clinician, teacher and administrator, and through advanced medical training programs in developing countries.

Dr David Henry McConnell has been awarded the Medal of the Order of Australia in the General Division, for service to medicine, particularly as an anaesthetist, through a range of executive and professional roles.

Dr Drew James Wenck has been awarded the Medal of the Order of Australia in the General Division, for service to intensive care medicine through advisory roles, and to the community.

New Zealand Queen's Birthday Honours

Sir Roderick Deane has been made a Knight Companion of the New Zealand Order of Merit (KNZM) for his contribution to business and policymaking, and for supporting the arts and disability sector for more than 30 years. Sir Roderick is on the board of ANZCA's Anaesthesia and Pain Medicine Foundation.

Dr James Judson, FANZCA, FCICM, received an MNZM (Member of the New Zealand Order of Merit) for services to intensive care medicine. Dr Judson works as an intensive care specialist at Auckland City Hospital's Intensive Care Unit.

Would you like a 2013 ANZCA Diary?

If you did not receive an ANZCA diary last year and would like a 2013 ANZCA Diary, please email communications@anzca.edu.au with your name and ANZCA ID number.

PLEASE NOTE: If you received a 2012 ANZCA Diary last year, you will automatically receive a 2013 diary.

Submitting letters

We encourage the submission of letters to the editor of ANZCA Bulletin. They should be sent to communications@anzca.edu.au. Letters should be no more than 300 words and may be edited for clarity and length.



Perth ASM wrap up

More than 1500 Fellows and trainees attended the Perth Annual Scientific Meeting in May. The scientific program included 13 plenary sessions, 178 concurrent session presentations, 47 workshops, 42 small group discussions and quality assurance sessions, and 59 ePoster presentations and was complemented by an excellent social program and other important ANZCA events, such as the College Ceremony.



Counting the many successes of the ANZCA ASM

The College has much to celebrate as the curtain goes down on an innovative and interesting annual scientific meeting in Perth.

We have put our glad rags in to be dry cleaned, filed away another conference handbook and reacquainted ourselves with our children. Now there is a chance to reflect upon the product of so many hours of planning; the days from May 12-16 during which the ANZCA Annual Scientific Meeting 2012 was held.

We selected the theme "Evolution: Grow, Develop, Thrive" a little over two years ago driven by the desire of the Regional Organising Committee to put together a meeting that had elements of old and new, in addition to practical aspects that would appeal to clinicians looking to develop and refine their practice.

Delegates were treated to the relaxing jazzy tones of songstress Nicki Pelecanos as the meeting kicked off with welcome drinks in the Riverview foyer of the Perth Convention and Exhibition Centre overlooking the Swan River. The welcome drinks are always a great way to reconnect with friends and colleagues and this year was no exception.

Beautiful blue skies greeted us on the opening day of the meeting, and we were welcomed by a representative of the Whadjuk Noongar people, Ms Ingrid Cumming, in a moving ceremony acknowledging the traditional owners of the land.

The academic program blasted off with interesting and thought-provoking plenary lectures delivered by the first female ASM Visitor, Professor Ruth Landau, and FPM Visitor Dr Daniel Bennett. They set the tone for the excellent plenary sessions over ensuing days. As the first session came to a close, a gasp of delight arose from the 1500 delegates as the curtain at the back of the stage drew back to reveal a healthcare industry exhibition, allowing access for delegates over the stage into the pavilion where morning tea was served.

Trainee delegates were joined by councillors and members of the academic fraternity from ANZCA and the Faculty of Pain Medicine at the Trainees' Luncheon at the Metro bar and bistro. The casual, relaxed mood gave a perfect opportunity to mingle.

Saturday night saw 177 new Fellows welcomed into the specialties while watched by family and friends at the College Ceremony. Always a special occasion, the

2012 ceremony will stand out in the minds of those present as they recall the personal and touching oration delivered by Australia's first indigenous surgeon, Associate Professor Kelvin Kong, who emphasised the importance of kinship within our profession by recounting the stories of three influential women in his life. The College Ceremony Reception, which followed, was a fitting way to congratulate the graduands, and showcased the exceptional food and wine that Western Australia has to offer.

Sunday started bright and early with a run into King's Park for about 40 fit and eager delegates and heralded another sunny day chock full of concurrent sessions, workshops and small group discussions, including the final day of the FPM program.

Plenary sessions by Professor Patrick Wouters exploring the wonders of the right ventricle and renowned pain expert and perioperative physician Professor Henrik Kehlet on the troublesome transition from acute to chronic pain set the scene. Internationally renowned communication experts, TRIAD, commenced a series of sold-out workshops focusing on difficult conversations and negotiation, which were well received by the attendees.

(continued next page)



Several heavily pregnant friends and family members gave up part of their Mother's Day to volunteer for the specialist echocardiography workshop by Professor Alicia Dennis, and Dr Alex Swann and his group ran a successful difficult airway workshop with true to life road-traffic trauma scenarios.

The healthcare industry was welcomed and thanked with a cocktail reception that evening as we mingled among our 61 exhibitors. We were entertained by local acoustic musicians 2fiveSoul as delegates socialised and browsed the exhibition. The artworks displayed in the rear of the area provided a pleasant diversion from an entertaining and informative exhibition hall. Special thanks go to Philips and all delegates for their patience as we awaited the untimely arrival of the USB keys containing the abstracts!

The short academic program on Monday included presentations by the Gilbert Brown Prize contenders and was followed by a plethora of choices for the delegates to experience some of the local Perth culture. A round of golf, a swim with the dolphins, a ride around the river or a day at Rottneet Island were enjoyed by families and partners.

Our delegates were able to recoup, plan for the next couple of days and enjoy some of the local attractions during an afternoon and evening of unplanned time. This also gave some of the Regional Organising Committee a chance to debrief and troubleshoot any issues for the final days of the conference and others to enjoy the fabulous wine dinner at Chez Pierre with 50 delegates and partners.

The last full day of the meeting presented a final opportunity to soak up the innovations of the meeting. The moderated ePoster sessions concluded in the morning and the Masterclass series reached a finale with excellent sessions on airways, coagulation and regional anaesthesia.

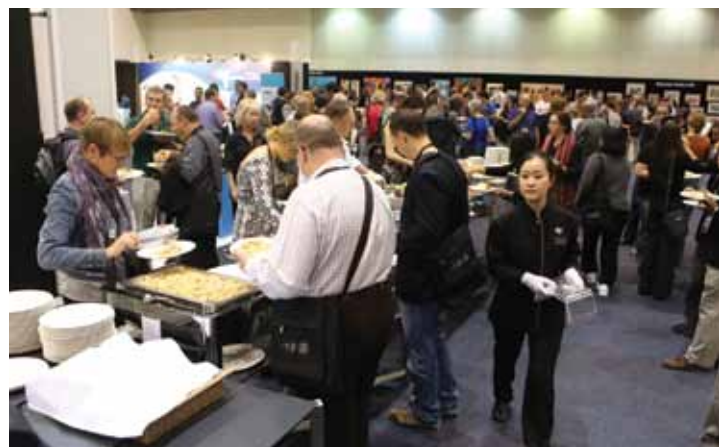
Anticipation mounted with the promise of glamour, mystery and Bond filling the twilight skies with the commencement of the gala dinner. Attended by 1000 delegates and their partners, social convenors Dr Charlotte Jorgensen and Dr Priya Thalayasingam outdid themselves in providing a night to remember; highlights include Professor Landau's movie-inspired toast and Dr Alan (Evil) Millard's entertaining mastering of the ceremonies.

We were feeling a little nostalgic by the time the final morning rolled around. The meeting concluded in great style (and with a great turnout) with TRIAD's Stevenson Carlebach delivering a session on the "neuroscience of negotiation" followed by a thought-provoking hypothetical session, chaired by medico-legal expert Dr Andrew Miller.

The closing ceremony saw the College presidency handed over by Professor Kate Leslie to Dr Lindy Roberts, both of whom epitomise Dr Robert's message of our College moving "from strength to strength".

Now, a few weeks later, the dust has settled and we haven't had to allocate rooms for any business meetings, troubleshoot menu disasters, or massage any budget figures. We have had a chance to reflect on what a privilege it has been to help co-ordinate such an extraordinary event; how lucky we've been to have enjoyed the tremendous support and goodwill of attendees, facilitators, volunteers and exhibitors; and what a fantastic team of people we have had the pleasure to work with over the last few years. A huge and sincere thank you to you all.

**Dr Tanya Farrell and Dr David Vyse,
Co-convenors, Perth ASM**



This page Clockwise from top: Perth ASM signage; Perth ASM Co-convenors Dr David Vyse and Dr Tanya Farrell; lunch in the healthcare industry area; the Opening Ceremony audience; view of the Opening Ceremony from the audio visual control area. **Opposite page** Clockwise from top: Question time in a plenary session; participants in the laryngoscope workshop; viewing an ePoster; Retired Fellows Lunch attendees.



“ Our aviator had a simple answer for the problem of fatigue – ‘Get more sleep!’ ”

Scientific program hits the mark with interest and innovation

The largest anaesthesia conference yet to be held in Perth, the 2012 ANZCA Annual Scientific Meeting offered 13 plenary presentations, 178 concurrent session presentations, 47 workshops, 42 small group discussions and QA sessions and 59 ePoster presentations.

It was gratifying to receive a great deal of positive feedback about the scope and quality of the scientific program from both the overseas invited speakers and delegates, the few complaints from the latter relating to the fact that they could not attend all the sessions that attracted them!

Much of the success resulted from the diversity of the program, which deliberately included many speakers from other medical specialties and non-medical disciplines, including intensivists, cardiologists, haematologists, microbiologists, surgeons, maternal and fetal medicine specialists, paediatricians, scientists and pilots.

The Masterclass series met the needs of those wishing to update or learn about current best practice; the Patient Blood Management sessions covered both new science and the successful Western Australian initiative into improved perioperative care of anaemia and evidence-based blood transfusion practices; and the Harvard-based TRIAD group

challenged and enriched our thinking in dealing with difficult conversations and the complexities of human behavioural responses.

The other key factor lay in the exceptional quality of the presentations. All credit is due to the more than 250 presenters and facilitators, starting with our featured invited speakers – Professor Ruth Landau, Professor Patrick Wouters, Professor Henrik Kehlet, Professor Joseph Neal, Associate Professor Andrew Davidson and Dr Dan Bennett – and finishing with a outstanding hypothetical session hosted by Dr Andrew Miller, the medical equivalent of Geoffrey Robertson and Billy Connolly.

In line with the theme of our meeting – Evolution: Grow, Develop, Thrive – we sought contributions from our invited speakers that covered new and developing areas of practice: pharmacogenetics, point-of-care monitoring, the application of ultrasound and echocardiography and advances in the management of acute and chronic pain.

The program emphasised the importance of our training and non-technical skills, with lectures and workshops devoted to the new ANZCA curriculum, research, communication skills, simulation and welfare. Our aviator had a simple answer for the problem of fatigue – “Get more sleep!” and our negotiation counsellor had a similar message – “Listen!”

The ANZCA ASM plays an important role in showcasing the growth of our understanding and knowledge through scientific endeavour. To this end, the Lennard Travers Professor, Associate Professor Andrew Davidson, clarified what is meant by “translation research” and the Gilbert Brown Prize session showcased our young achievers. These were complemented by the ANZCA Formal Project session, the Open Poster and Trainee Poster prizes; and the FPM Dean’s Prize and Free Paper session. Congratulations to respective ANZCA prize winners Dr Mary Hegarty, Dr Rohan Mahendran, Dr Paul Stewart and Dr Stanley Tay; and to the FPM Best Free Paper winner, Dr Sarika Kumar.

The introduction of ePosters appeared well received and offers greater scope to presenters than the traditional poster format.

Finally, we thank our colleagues who worked tirelessly to run a smooth meeting bursting with information and entertainment. Special mention goes to our amazing convenors, Dr Tanya Farrell and Dr David Vyse, and organising committee members Dr Soo Im Lim, Dr Liezel Bredenkamp, Dr Markus Schmidt and Dr Ed O’Loughlin, who were heavily involved in organising the scientific program.

Clinical Professor Tomas Corcoran and Professor Michael Paech, Scientific Program Co-convenors

Pain medicine meeting shapes evolution of healthcare

In a world where we are bombarded by negativity in the form of phrases such as “terrorism”, “global financial crisis”, “massacre”, “religious extremism”, “arms race”, “global warming”, “conflicts” and “power struggle”, one can take solace in occasions such as the recent 2012 ANZCA Annual Scientific Meeting, where the focus was “evolution”.

Evolution encapsulates the very purposes of existence and unites all living things, including human beings, irrespective of genetic background, upbringing socio-economic status, beliefs and occupation.

Conceived by Charles Darwin and popularised by Richard Dawkins, the concept of evolution challenges us to think rather than to believe and to never cease to question.

Pain medicine lends itself to the foundation of evolution, as all creatures will adapt to their environment to avoid and overcome pain. Pain, in an essence, drives us to better ourselves.

In the 2012 ASM, the pain component was designed to introduce new concept and to ask the hard questions – What are we doing now? Is it working? How do we decide what direction we need to take? – by focusing on outcomes.

The concepts were spearheaded by individuals who are the champions of asking these hard questions, including our invited speakers Dr Dan Bennett and Professor Henrik Kehlet. Such gatherings of dedicated scientists and visionaries alike represent a common ground of the desire to better ourselves and to engage in exchange of ideas without prodigious and bias, engaging in purposeful debate, to shape the future of pain medicine and the propagation and evolution of healthcare.

Dr Max Majedi
FPM Scientific Convenor

Delegates raise \$50,000 for Lifebox

Delegates at the ASM raised \$A46,142, including \$A35,654 at the Gala Dinner, for the Lifebox charity through the ANZCA ASM Global Lifebox Initiative that ran throughout the meeting,

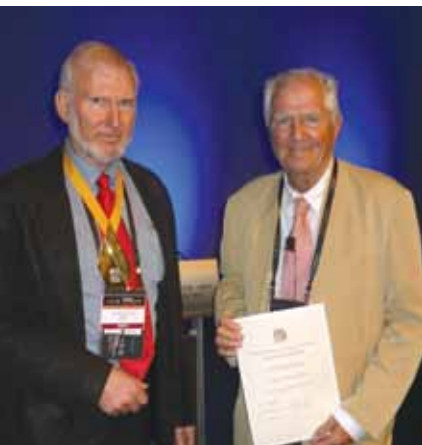
Delegates were given a pledge form in their satchels that could be used to make donations and at the Gala Dinner, each table was given a pledge envelope and guests were encouraged throughout the evening to donate to the cause.

The money will be used to buy pulse oximeters and education kits worth \$US250.

Each year, tens of thousands of lives are lost during surgery because operating rooms in many hospitals around the world don't have this simple piece of equipment that is standard in Australia and New Zealand.

An estimated 77,000 operating rooms in developing countries around the world don't have access to pulse oximeters, putting at risk about 35 million patients each year.

“ Delegates at the ASM raised \$A46,142, including \$A35,654 at the Gala Dinner, for the Lifebox charity



This page Clockwise from top: Dr David Jones with invited speaker, Dr Daniel Bennett; FPM new Fellows; Professor Henrik Kehlet presenting at an FPM session; (top) Dr Jones with FPM Free Paper winner Dr Sarika Kumar; (bottom) Immediate past Dean Dr David Jones with new Dean, Associate Professor Brendan Moore; Dr David Jones with invited speaker Professor Henrik Kehlet. **Opposite page** Clockwise from top: The College Ceremony; the College mace; a new Fellow is photographed; Robert Orton Medal winner, Dr Duncan Campbell; Orator, Associate Professor Kelvin Kong.



Snapshot

Full registrants: 1125

Day registrants: 68

Total attendees: 1782

New Fellows: 177

Sessions: 58

ePoster sessions: 6

Masterclass sessions: 12

Workshops: 47

Small group discussions (SGDs): 38

Quality assurance sessions: 4

Prize winners

Robert Orton Medal

Dr Duncan Campbell – For positively affecting the professional life of thousands of anaesthetists and the care of millions of patients by the invention of a fluidic ventilator that is widely known as “The Campbell Ventilator”.

Gilbert Brown Prize

Dr Mary Katherina Hegarty – “Does take-home analgesia improve post-operative pain after elective day case surgery? A comparison of hospital versus parent-supplied analgesia”

ANZCA Formal Project Prize

Dr Rohan David Mahendran – “Measuring cardiac output in the setting of different intra-abdominal and positive end-expiratory pressures: Comparison of trans-cardiac and trans-pulmonary thermodilution in a porcine model”

ASM 2012 Open Poster Prize

Dr Paul Anthony Stewart – “Ipsilateral comparison of acceleromyography and electromyography during recovery from non-depolarising neuromuscular blockade under general anaesthesia in humans”

ASM 2012 Trainee Poster Prize

Dr Stanley Tay – “Reduce volatile agent usage following introduction of Et-control system”

Renton Prize

Dr Katrina Pamela Pirie, May 2011

Dr On Yat Wong, September 2011

Cecil Gray Prize

Dr Jai Nair LePoer Darvall, May 2011

Dr Stuart Lachlan Hastings, September 2011

2012 named lectures

Mary Burnell Lecture

Professor Ruth Landau (ANZCA ASM Visitor), Seattle, US – “Pharmacogenetics and anaesthesia: not yet ready for prime time?”

Michael Cousins Lecture

Dr Daniel Bennett (FPM ASM Visitor), Colorado, US – “Opiophobia, regulation and risk management: developments in the USA, a cautionary tale”

Ellis Gillespie Lecture

Professor Patrick Wouters (ANZCA WA Visitor), Ghent, Belgium – “The right ventricle: more than a passive conduit?”

FPM WA Visitor Lecture

Professor Henrik Kehlet (FPM WA Visitor), Copenhagen, Denmark – “Progression from acute to chronic pain: what do we know and need to know?”

Australasian Visitors Lecture

Associate Professor Andrew Davidson (Lennard Travers Professor), Victoria, Australia – “Translational research in anaesthesia”

Regional Organising Committee Visitor’s Lecture

Professor Joseph Neal (Western Australian Organising Committee Visitor), Seattle, US – “Ultrasound – guided regional anaesthesia: a game-changer or just steady progress?”

Spreading the ASM word

Media activities occurred both internally and externally at the annual scientific meeting – via daily multimedia *ASM E-Newsletters* sent to meeting delegates and Fellows and trainees not at the ASM and through a very successful media program, which resulted in widespread coverage in print, on radio and TV in Australia and New Zealand.

The *ASM E-Newsletter* was distributed on the Friday before the ASM started (on the FPM Refresher Course Day) and each day of the meeting including Wednesday, the final day.

It featured a video interview with every keynote speaker plus audio recordings of each plenary lecture. Additional interviews with selected speakers also ran as well as photo galleries and media updates. All *ASM E-Newsletters* can be found on the ANZCA website under “Events/ANZCA annual scientific meetings”.

A total of 347 ASM-related media reports mentioned ANZCA, reaching a potential cumulative audience of more than six million in Australia and New Zealand with a value of more than \$700,000 in equivalent advertising dollars, according to a report from our media monitoring service, Media Monitors.

Nine media releases were issued, resulting in interviews with 17 speakers. Highlights included coverage of neurotoxicity for newborns, a possible genetic link to anaesthesia awareness, an update on oxytocin, new data on pregnancy complications associated with extremely obese women, the use of hypnosis in pain management, and developments in artificial blood.

The attendance of medical reporters from *The Australian* (News Ltd), *The Age* (Fairfax Media) and the Australian Associated Press wire service at the meeting resulted in 18 reports that were widely syndicated throughout Australia and New Zealand. This proved invaluable in terms of building our relationships with key media organisations not to mention raising the College’s profile – and that of anaesthesia and pain medicine – in the community.

For more details, please see “ANZCA in the news” on page 60.

Clea Hincks
General Manager, Communications
ANZCA



“ 347 ASM-related media reports mentioned ANZCA, reaching a potential cumulative audience of more than six million



Clockwise from top: Gala Dinner pre-dinner drinks; dancing at the Gala Dinner; more scenes from the Gala Dinner; the WA Regional Organising Committee.

New Fellows' Conference



Leaders – born or made? Leadership earned or learned? These were just some of the questions we wanted to explore during the 2012 New Fellows' Conference (NFC).

“Team Leadership in Anaesthesia” took place on May 9-11, prior to the Perth ASM. Our aim was to put together a thought-provoking program, showcasing aspects of anaesthetic leadership outside the usual theatre setting and, in the process, providing delegates with some new skills and ideas about leadership.

After gathering at the Perth Convention and Exhibition Centre, we had a three hour bus ride in the rain to the beautiful surrounds of Caves House in Yallingup, Western Australia.

To get tired legs moving, and to get to know each other, our first session was a series of team challenges. Figuring out the strengths and weaknesses in our teams to solve the various puzzles culminated in the teams having to cross an imaginary crocodile-infested ravine with two short planks, two milk crates and an iron bar. Everyone made it out alive to the other side. The “time machine challenge” record time previously set by the AFL Eagles team was well and truly smashed by our anaesthetists, a feat to remember by all.

This was followed by a relaxed sundowner, which included a wine tasting run by Howard Park Winery, before an informal sit-down dinner in front of a roaring fireplace strengthening new acquaintances.

Our second day commenced with early morning jogging and swimming for the superfit. The next workshop, presented by Anveeta Shrivastava and Wynand Hamman from Deloitte Consulting, took us through understanding cognitive types, and how individuals respond to different motivators and inspirations. We were able to type ourselves into the four categories of the Hermann-Brain Dominance Instrument, which were colour-coded, resulting in the group referring themselves by their “colour” for the remainder of the conference. After a scenario role play, we learnt about leadership and followership archetypes, and how an understanding of these allows for successful team interactions.

This stimulating workshop was followed in the afternoon by an interactive panel discussion session, with the aim of debating issues requiring anaesthesia leadership outside the theatre environment. Our esteemed panel consisted of Dr Mary Pinder, FICM Examinations Chair, Dr Justin Burke, New Fellows' Councillor, Dr Prani Shrivastava, Welfare SIG Chair, Dr David Scott, ANZCA councillor and councillor in residence at the 2012 NFC and Dr Emily Wilcox, the representative from the 2011 NFC.

Topics covered included how we deal with being a role model, a position of unconscious and unchosen leadership (leading to a discussion thread on the need to improve mentoring of new Fellows); how we deal with ethical issues arising from our responsibilities to act in our patients' best interest and be nice to our surgical colleagues; and whether we have created unrealistic expectations

in the community regarding the role of the anaesthetist. This was successful in stimulating debate and discussion, which continued after David Scott's talk relating the journey of his involvement in the College, into the Conference Dinner held at Cullen's Winery.

Cullen's Winery is a renowned organic winery in the region, with a long association with the medical community. Dinner was one of the highlights of the meeting, with a short talk from Vanya Cullen, Chief Winemaker at Cullen's, showcasing leadership in the winemaking industry with their sustainable biodynamic cultivation. A special tasting of some of their premium wines pre-empted a fantastic meal showcasing local produce.

Nearly everyone made it out of bed in time the next morning for Mary Pinder's workshop on debriefing after medical disaster. This involved small groups working together on various hypothetical scenarios to identify issues and learning how to design a debriefing plan.

After concluding the conference with the election of a representative for next year's NFC, we embarked on the bus trip back to Perth, with many noisy and excited conversations taking place among new friends and associates across the Australasian regions.

Dr Angeline Lee
Dr Irina Kurowski
New Fellows Conference Co-convenors

Above from left: New Fellows Conference delegates; Teamwork was needed to cross the (imaginary) “crocodile-infested ravine”.

ANZCA's revised training program

How the new primary examination will work

General overview

The broad aim of the new primary examination is to provide an integrated approach to learning.

While the candidate will still be learning about individual topics via the reference texts, the examination process, especially with regard to the oral examination, will not specifically aim to examine individual subject areas in isolation.

Rather the examination will aim to present candidates with a broad range of questions covering the scope of the various major topics. The exam can no longer be thought of as being distinct subject areas that will be examined individually. Subsequently, there will be no "passing" of individual subject areas possible in the new exam. A satisfactory performance in the examination overall is needed to ensure a pass in the primary examination. The allocation of marks will remain as it is now with the written and oral sections each worth 50 per cent toward the final mark.

Eligibility to sit

One of the crucial changes will be that only trainees occupying accredited training posts, who have completed six months of anaesthetic training, will be allowed to sit the primary examination.

This will make the exam process much more relevant for candidates since, in the past, no experience in anaesthesia was required. This meant examiners had to be very cautious in framing questions so they did not have a specific clinical anaesthetic focus to ensure no candidate was disadvantaged.

Now that has changed and questions will tend to have a more clinical focus wherever possible. That does not mean the examination is changing focus – it is not – it will remain an assessment of basic sciences applicable to the conduct of clinical anaesthesia and pain management.

Syllabus in general

The examination team has been through the new learning objectives, which are collected together in appendix three of the master curriculum document (found at www.anzca.edu.au/trainees/

curriculum-revision-2013) and matched them to the old primary examination syllabus. Statistics have been removed from the new curriculum, although the format in which they are to be assessed is still to be determined. There have been other minor changes but, in general terms, most of the other components of the old primary examination syllabus have been translated into the new learning objectives.

There has been additional material added in the form of about 30 learning objectives dealing with anatomy, equipment and safety. These have been transferred, as it were, from the final examination program and are all appropriate for early year trainees. While this extra material may at first seem daunting, it is all very applicable to the conduct of anaesthesia and mirrors many of the procedures that basic trainees will be involved in.

Written

The written component, consisting of a multiple-choice question paper and a short-answer question paper, will remain. However, the format will change to bring it in line with the style of the final examination and consist of a single multiple-choice question paper of 150 items, and a single short-answer question paper of 15 questions. Each of these will cover physiology, pharmacology, clinical measurement, safety, anatomy and equipment. In order to be invited to the oral examination, the candidate must achieve a minimum of 40 per cent in each paper.

Oral

This is where the major changes will occur. To start, there will be three vivas, each with two examiners lasting 20 minutes each. While this may appear to candidates as making life even harder than before, in fact, the opposite is the case. By having three vivas, each of which will cover four subject areas, the candidate will have a chance to talk about 12 different topics.

This change is necessary in order to assess the additional material that has been added to the learning objectives while, at the same time, maintaining the depth of knowledge needed. It also means that if a candidate performs poorly in one, or even two topic areas, there is still a good chance of being able to pass the

vivas overall. Each viva will be integrated in format. The material being covered in the vivas will be examined in detail each day to ensure that candidates are being assessed on a wide range of topics and the candidate is not being re-assessed on the same material during the different viva sessions.

Each of the vivas will differ in content. While the vivas will indeed be "integrated", there should be no expectation that each viva will contain equal amounts of material from all parts of the syllabus. Indeed some vivas may have a leaning towards one broad aspect, such as physiology with some questions on other learning objectives included throughout, while others may be broader, for example covering pharmacology, physiology and anatomy topics in the one viva.

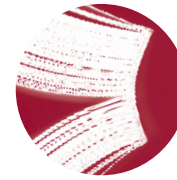
Resources and feedback

One of the strengths of the primary examination has been that examinable material has always been based on the objectives provided in a syllabus (or what are now learning objectives) coupled with a prescribed set of recommended texts.

Every question asked in the primary examination must have a direct reference back to one of the recommended texts. This will continue into the new primary examination. The list of recommended texts will soon be published on the College website, once approval has been obtained. It is also our intention to post on the website a selection of integrated viva questions, written by the current examination panel, which can be used for practise in trial viva settings, so candidates can get a feel for the new oral examination format.

Lastly, the Primary Examination Sub-Committee is aware that the College has placed a limit on the number of attempts that may be made to sit the primary examination. We are looking at ways to provide high quality feedback to unsuccessful candidates so they can improve their performance in subsequent attempts.

Associate Professor Ross MacPherson
Chairman, Primary Examination
Sub-Committee



Sample viva questions for the new format primary examination

A number of sample viva questions have been written by members of the Primary Examination Sub-Committee. These questions are available on the College website in the Curriculum Revision 2013 section - www.anzca.edu.au/trainees/curriculum-revision-2013.

The viva questions are designed to give candidates some practice in the type of integrated vivas that will be used in the new primary examination. The best way to utilise the sample questions when preparing for the examination is outlined online.

The College aims to increase the number of sample questions over time.

Fundamental to anaesthesia: the ANZCA Clinical Fundamentals

Among a number of innovations in ANZCA Curriculum Revision 2013 will be the introduction of seven ANZCA Clinical Fundamentals.

These fundamentals have been developed to define the range of clinical knowledge and skills required for specialist anaesthetic practice, and will be taught and experienced throughout the curriculum, particularly within the first four years of training, in parallel with the ANZCA Roles in Practice.

The seven ANZCA Clinical Fundamentals consist of:

- General anaesthesia and sedation.
- Airway management.
- Regional and local anaesthesia.
- Perioperative medicine.
- Pain medicine.
- Resuscitation, trauma and crisis management.
- Safety and quality in anaesthetic practice.

These areas define the fundamental aspects of anaesthetic practice, and clearly indicate the major areas of expertise that are required by all anaesthetists for specialist practice as an anaesthetist regardless of the clinical areas in which they work.

The specific learning outcomes, expected to be achieved for these ANZCA Clinical Fundamentals, have been defined and grouped to the various periods of training (introductory, basic and advanced training) where they build from basic knowledge and skills to more advanced levels as the trainee progresses. Log on to the ANZCA website to read more about these learning outcomes: www.anzca.edu.au/trainees/curriculum-revision-2013/pdfs/anaesthesia-training-program-curriculum.pdf.

The development of the ANZCA Clinical Fundamentals derived from a desire to define more accurately the core elements that make up and distinguish the practice of anaesthesia regardless of the areas in which anaesthetists work.

“No longer is (pain medicine) a subject to be ticked as Module 10 and forgotten!”

Past emphasis on surgery

Previously, considerable emphasis had been placed on describing anaesthesia according to the surgery for which it is used. This has under-emphasised many important expert contributions made by anaesthetists to other areas of medicine, as well as failing to recognise the universal application of many aspects of anaesthetic knowledge and skills.

Airway management

Airway management is a good example of where all branches of medicine readily acknowledge the pre-eminence of anaesthetic skills and knowledge. Training and education in airway management in the revised curriculum will no longer be somewhat haphazard by “association” with anaesthesia for surgery. As a clinical fundamental it will become the focus of the training itself.

The curriculum review undertaken in 2008-10 recommended that there be improved emphasis on other core areas of anaesthesia, including perioperative medicine, pain medicine and regional anaesthesia. These areas were perceived to be under-represented in the training program. This particularly applies to perioperative medicine and to pain medicine.

Pain medicine

In the existing ANZCA curriculum, pain medicine was included as a specific module (10), which could be experienced as a single block of activity, as well as a component of another module (1). It was commonly not perceived by trainees as being integral to their training as anaesthetists.

By incorporating pain medicine as an ANZCA Clinical Fundamental, the revised curriculum emphasises the intrinsic importance of pain medicine to all activities undertaken by anaesthetists. It thus demonstrates that the knowledge and skills of pain management are learned and applied across the whole training period and cannot be studied in isolation.

(continued next page)

ANZCA's revised training program continued

No longer is it a subject to be ticked as Module 10 and forgotten! The importance of early, adequate and ongoing management of acute pain to minimise the development of chronic pain syndromes must be integral to every anaesthetic; and the ability to provide the best clinical care for chronic pain patients who need concurrent therapy through the perioperative period is essential.

Perioperative medicine

Similarly, perioperative medicine is emphasised throughout training to enable the whole patient to be managed as part of the perioperative process, and not just to be swotted up for the final examination! This ability to assess and medically manage patients throughout the perioperative period is what provides the most compelling argument as to why anaesthesia is best managed by medical graduates.

Regional anaesthesia

Patients will benefit from recognition in the revised curriculum that regional anaesthesia is a very important alternative or adjunct to general anaesthesia in many areas of practice. The advent of good compact ultrasound imaging has improved the safe application of regional anaesthesia, and this technology has helped in the resurgence of this form of anaesthesia, which has considerable benefits for the perioperative care of patients.

Crisis management

Anaesthetists have been integral to the development of the team management of the critically ill, especially in advanced life support and trauma teams.

Anaesthesia itself can be associated with the management of life-threatening crises such as anaphylaxis and malignant hyperthermia. The knowledge and skills required of anaesthetists to manage the crises that may occur in their practice, and to contribute to the team management of the critically ill have been defined in the resuscitation, trauma and crisis management fundamental.

Safety and quality in anaesthetic practice

The issues of safety and quality in anaesthetic practice have not previously been gathered together and highlighted for training, though anaesthetists have for over 60 years led the medical profession in these aspects of practice. Anaesthetists were the first to systematically investigate deaths that may have been due to their own clinical management of the patients; anaesthetists were also the first to introduce knowledge generated from aviation experience to improve crisis management and implement safety algorithms; and similarly anaesthetists were the first within the medical profession to use high fidelity team simulation exercises to improve the safety and high quality of anaesthetic delivery. It is appropriate to acknowledge this role in anaesthetic practice by introducing the safety and quality in anaesthetic practice fundamental.

Thus the ANZCA Clinical Fundamentals were developed to expand on areas where there were perceived deficiencies in the 2004 curriculum. Most importantly, they focus the attention of trainees, supervisors, Fellows and other Colleges on the main areas where anaesthetists are trained and educated to be clinical leaders.

Tutors

To implement these clinical fundamentals, the College plans to have clinical fundamental tutors within teaching departments for each ANZCA Clinical Fundamental. In small departments, some Fellows may need to tutor more than one fundamental. We hope that there are enthusiastic anaesthetists with particular interests and expertise for each of the ANZCA Clinical Fundamentals in each department. These tutors will lead the way in making the learning experience for trainees satisfying and educational. Above all, they will support their trainees so that they obtain the best possible clinical experience to develop essential knowledge and skills in these clinical fundamentals. This support may require greater opportunity for regional anaesthesia in hospitals where this activity is not strong; the development of simulation situations, for example, for specific rare airway management scenarios; improved perioperative assessment procedures prior to and following anaesthesia; and carefully supervised acute pain rounds with strengthened links to services for patients with persisting pain.

Enhanced curriculum

There are many challenges in developing the full potential of these ANZCA Clinical Fundamentals, but the enthusiasm that Fellows have displayed for this concept means we are confident this initiative will considerably enhance the curriculum. The ANZCA Council is extremely proud and excited to be part of the delivery of ANZCA Curriculum Revision 2013 with its innovative ANZCA Clinical Fundamentals. We believe it will enhance considerably the training and education of our trainees.

Professor Barry Baker

Dean of Education, ANZCA

A mad idea – or several – is just what the doctor ordered

Dr Duncan Campbell proves ageing is no barrier to a lifetime of medical innovation. He spoke to Meghan Shaw.

Remarkably, Dr Duncan Campbell, 81, who nearly 40 years ago invented the Campbell ventilator which became the standard for hospitals around Australia and New Zealand, is still inventing.

In January this year, he took out a patent for a non-invasive cardiac output monitor that can determine cardiac output using optical sensors.

It's the latest in a stream of inventions by the indefatigable octogenarian, who last month was presented with the Robert Orton Medal at the ANZCA Annual Scientific Meeting in Perth for his contribution to anaesthesia, in particular for the invention of his eponymous ventilator.

"I thought they had forgotten about me long ago!" was his initial response when learning he was to be honoured.

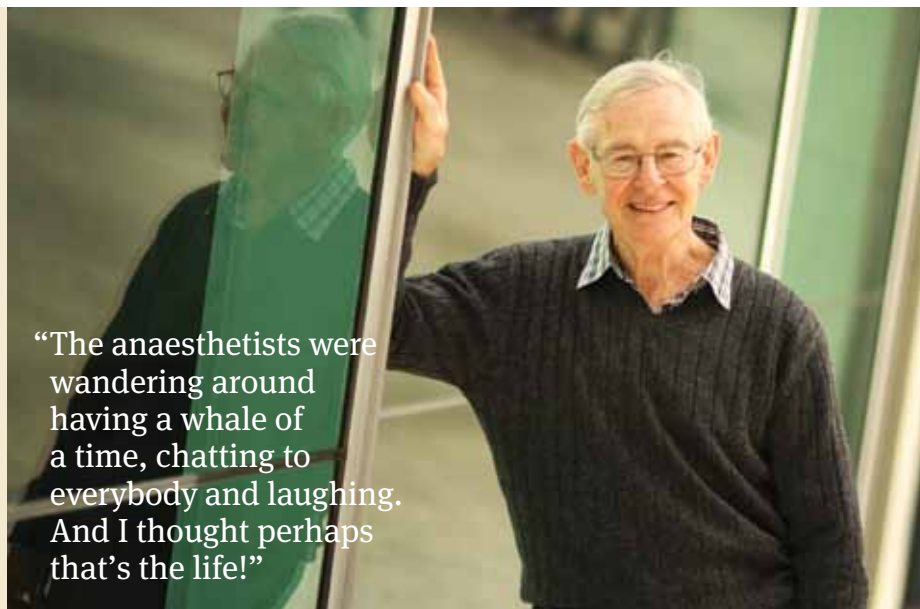
With a wry sense of humour and turn of phrase, Dr Campbell recounts a remarkable life from a childhood in Iran and India, to serving in the army during the Malayan Emergency, working with IVF and laparoscopy pioneer Dr Patrick Steptoe, and creating a series of anaesthetic-related innovations.

An interest in the wireless at a young age, and a desire to take things apart to see how they worked, perhaps can be seen as the spark that set off his passion for invention.

He was conceived in India, born in Britain, and spent his infancy in India and early years in Iran, where his Scottish father was the vice consul.

Incredibly, he knows the date of his conception because his mother, from Yorkshire, was quite the correspondent and wrote to a friend the day he was conceived saying: "Today, I started Duncan".

His earliest memories are from Zahedan, Iran, near the border of Pakistan and Afghanistan, where his father once fired a revolver into the air to frighten an intruder in the dead of the night.



"The anaesthetists were wandering around having a whale of a time, chatting to everybody and laughing. And I thought perhaps that's the life!"

He recalls the intruder tearing around the compound in distress because his accomplice, waiting on the consular wall to pull him up with a rope, disappeared at the sound of gunshots, taking the rope with him.

By the beginning of World War II, Dr Campbell was back in Britain and educated in London, the Lake District and the Kings School in Canterbury, before delaying national service by studying for an intermediate bachelor of science degree in agriculture – an interest prompted by his parents running a farm.

His agricultural studies led to a desire to study medicine – his father was delighted – and his first job after qualifying was as a house surgeon at Charing Cross Hospital, where he contemplated his future.

"I didn't really relish the idea of going into general practice," he recalls. "I thought something hospital orientated would be more interesting. And I was always intrigued by the fact that while I was stuck holding retractors and things for the surgeons, the anaesthetists were wandering around having a whale of a time, chatting to everybody and laughing. And I thought perhaps that's the life!"

At his second house job at the Metropolitan Hospital, London, Dr Campbell became friendly with the registrar anaesthetist who took him

under his wing until the registrar had a confrontation with the night porter and was dismissed.

"He was marched in front of the administrator who said, 'Good night porters are far more difficult to get than anaesthetists. Goodbye!'" Dr Campbell says, saddened at the memory.

His second attempt to defer national service failed when he told the army board the reason was to study anaesthetics.

"They laughed and laughed and said, 'The army's short of anaesthetists. You'll have no trouble at all getting an anaesthetic job in the army. Off you go.'"

Doubtful he'd be posted as a trainee anaesthetist anywhere more exotic than the north of Scotland, Dr Campbell suggested the Far East and ended up in Singapore, where he was also appointed blood transfusion officer. His ploy to encourage commanding officers and adjutants to set an example and give blood proved highly effective as well as entertaining for the troops.

After only a year's training, he was promoted to captain, graded clinical officer in anaesthetics and sent as the sole anaesthetist to the Kluang military hospital in (then) Malaya, about 120 kilometres north of Singapore.



“The parting words were, ‘We’re only a phone call away’, which wasn’t much help,” he says.

In Kluang, Dr Campbell met his wife, Mary, who was a nursing sister at the military hospital. They subsequently had two sons – one of whom is an anaesthetist and the other a dentist.

Kluang was also where he played his part in a hospital-inspired truce between the British and communist terrorists, which perhaps led to a cessation of hostilities in that area.

At that time, injured terrorists who were sent to the civilian hospital didn’t survive the night because the locals detested them so much they slit their throats.

As part of a goodwill gesture, the military hospital started taking problem cases from the civilian hospital, including the terrorists.

The first time this happened, only Dr Campbell and the surgeon were on duty. Short of staff and wards, they patched up the unarmed terrorists, and sent them to share the ward where the British were recovering.

The terrorists were astonished to wake up as they expected to be given a lethal injection and were discovered the next day by the returning commanding officer playing a card game, pontoon, with the injured British soldiers.

Dr Campbell says the terrorists were reluctant to return to their jungle units

after their recovery and apparently told their comrades they didn’t want to fight the British, who had become their friends.

“And do you know, there was one other skirmish when another lot of terrorists came in and after that, none. Absolutely nothing. We never had any more terrorists,” he says. “And I wonder very much whether it was to a large extent associated with the fact that we actually demoralised them with our treatment.”

Returning to England, Dr Campbell did his formal anaesthetic training after which, for interview practice, he applied for a job as an anaesthetist in charge of the anaesthetic services for the Oldham group of hospitals on the outskirts of Manchester.

“So absolutely blasé, I went up for this interview,” Dr Campbell recalls, expecting to be roasted for wasting the interview panel’s time by applying for such a senior job when he wasn’t even a consultant.

At the interview, he was asked by panelist Dr Patrick Steptoe what he knew about pneumoperitoneum and if he, like other anaesthetists, would be worried about pushing gas into the peritoneal cavity.

“I said, ‘Well I’d be worried if it was air, but if it was carbon dioxide or oxygen, I’d be quite happy because you wouldn’t get an air embolus with that,’” he replied.

(continued next page)

“An interest in the wireless at a young age, and a desire to take things apart to see how they worked, perhaps can be seen as the spark that set off his passion for invention.”

Opposite page from left: Dr Duncan Campbell; Dr Campbell and his son, Dr David Campbell, who was presented as a Fellow at the Perth ASM; and Dr Campbell inspecting the latest ventilators at the Ulco stand at the Perth ASM.

A mad idea – or several – is just what the doctor ordered

continued

Astonished to get the job, he worked alongside Dr Steptoe as the specialist developed the technique of laparoscopy.

Dr Campbell was still working at the hospital as Dr Steptoe began procuring human eggs from ovaries using a laparoscope, a precursor to IVF treatment, but moved to Australia nearly a decade before the first live birth in 1978.

Living along the Pennines, where it gets cold, wet and windy, Dr Campbell got fed up with the miserable weather.

One day, having dug out the snow that had blocked his driveway and garage, only to have the wind fill it up again, he turned to his wife and said: “Mary, where can we go where it doesn’t snow?” Her response was “What about Australia?” and a glance through the *British Medical Journal* revealed an anaesthetic staff specialist job advertised at the Royal Prince Alfred Hospital in Sydney.

He got the job and moved in 1969. One of his first duties was to design an anaesthetic tray that could store the daily supply of anaesthetic ampoules.

Flicking through the Yellow Pages, he found an advertisement for Ulco Engineering, which made specials to order and was willing to do medical work. They took on the production of the anaesthetic tray, and so began Dr Campbell’s long and productive association with the company and its managing director, John Uhler.

His next invention was a pneumatic lifting trolley, operated by two carbon dioxide cylinders, which could lift patients off the bed, transport them, and lower them onto the operating table. It could tilt patients up and down, and also had a radiotranslucent sheet to enable X-rays to be taken.

Ulco made a prototype, trials were conducted and a few were sold to Australian hospitals, but demand and profit margins were low and production ceased.

But his next invention hit the jackpot.

For some time, even before he came to Australia, Dr Campbell had been frustrated with the ventilators available and wanted to design a robust and versatile ventilator for theatre use that could be used on all ages, with the parameters – pressure, volume, flow and time – all controlled by the anaesthetist.

First he needed to find an alternative



to an electronic control system as, at that time, there was considerable concern about the dangers of micro and macro shock in the operating theatre, as well as possible explosive hazards from flammable anaesthetics.

His breakthrough came when, literally inspired by rocket science, he learnt that long-range rockets used a system of fluidic controls to withstand severe vibrations and magnetic forces.

Having sourced through Ulco some miniature fluidic control modules, in 1973 Dr Campbell made his first prototype. “It took up a lot of space with a mass of spaghetti-like tubing connecting the various components, but it worked,” he says.

He crammed all the workings into a plastic lunch box and took it to Ulco and various manufacturing companies to gauge their interest. Commonwealth Industrial Gases (CIG) was tempted and said they’d get back to him. He’s still waiting.

The main obstacle to production was that the mass of tubes made assembly too complicated. But inspired by transistor radios, where all the wiring was replaced by circuit boards, he designed a template so that channels could be engraved on a board for mounting the fluidic elements. The channels could then be sealed with a back plate to eliminate connecting errors.

He returned to Ulco and Mr Uhler was hesitant but said he would make

a prototype for \$1100 – a substantial amount of money – during the company’s quieter periods.

“I scratched my head and thought about it, and said, ‘Ok,’” Dr Campbell recalls.

With the manufacture of the first machine under way, he went to the Australian Society of Anaesthetists’ (ASA) meeting in Hobart in 1974 to present a paper on the ventilator.

On the plane back to Sydney, he sat beside Dr John Keneally, who was working at the Children’s Hospital, then at Camperdown. He was interested in a ventilator that was suitable for both children and adults.

“I said, ‘We’re making it so that it’ll ventilate anything from a mouse up to an elephant,’” Dr Campbell says.

Unknown to him, Ulco was captured by his enthusiasm and made a second machine at the same time as the first, which was completed in April 1975.

The first was used by Dr Campbell and has since been donated to the ASA’s Harry Daly Museum. The second was trialed and then sold to the Children’s Hospital.

Associate Professor Greg Knoblanche was then a registrar at the Children’s Hospital and the Royal North Shore. He told Royal North Shore’s director of anaesthetics Dr Ted Morgan about the ventilator, and the hospital promptly ordered four. The Children’s Hospital bought another, and the soon-to-be-opened Baulkham Hills Private Hospital also bought four.

“All without any advertising at all,” Dr Campbell proudly explains.

His description of the ventilator was published in *Anaesthesia and Intensive Care* in February 1976.

Improvements were made to the ventilator over the years: negative expiratory pressure was eliminated as it was never used; the bellows configuration was changed from hanging to rising; a disconnect alarm was incorporated; and the fluidic controls were replaced by improved and more manageable electronics with a visual display.

The absence of mechanical moving parts, precision engineering and attention to detail resulted in a ventilator with long-term reliability and legendary success.

By the time Mr Uhlir retired and sold the company in 2003, more than 3400 of the ventilators, including the updated electronically controlled EV500, which is still affectionately known as the Campbell ventilator, had been made and sold. A recent inquiry to the company revealed the figure is now more than 4000 and, despite a trend toward integrated anaesthesia machines and ventilators, they’re still being sold, with more than 1000 units still in use in Australia, New Zealand, throughout the Asia Pacific, the Middle East, Africa and Greece.

Spin-offs included a horse ventilator; an anti-DVT system using an inflatable sleeve to perfuse legs, which was not commercially viable; a kidney perfusing system, which was successful until research showed kidneys left on ice did better than perfused kidneys; a system for measuring airways resistance; a new ventilator alarm giving almost immediate indication of a disconnect; and a project for recycling volatile anaesthetics for hospitals.

His last project with Ulco was for a system of working out cardiac output, but Mr Uhlir reluctantly pulled the plug on the proposal because he was selling the company and the project would take a further two-to-three years to get to market.

Dr Campbell sold the patent for the system to Edwards Laboratories in the US.

But he kept thinking about it. “At the back of my mind I was always a bit worried about the fact that this was an invasive procedure requiring arterial cannulation in order to get cardiac output. And I suddenly realised that it could be done entirely non-invasively. You could do it optically, with optical sensors. I tried it out, and it worked.”

He took out a new patent in January and the project is in the pipeline, but he’s wary about talking about it because he thinks people will say he’s mad – although he’s used to that.

“They told me I was pretty mad about the ventilator,” he recounts. “I said, ‘I’m going to have a ventilator with no moving parts whatsoever’. They said, ‘Oh, you’re mad’. I said, ‘No. There will be not a single mechanical moving part’. They said, ‘How will it work?’ I said, ‘Very nicely!’”

Meaghan Shaw
Media Manager, ANZCA



“The absence of mechanical moving parts, precision engineering and attention to detail resulted in a ventilator with long-term reliability and legendary success.”

Opposite page: A younger Dr Duncan Campbell with a Campbell ventilator. This page: Dr Campbell taking possession of the first Campbell ventilator.

ANZCA contribution helps improve patient care in Papua New Guinea



The Overseas Aid Committee is working to assist the delivery and quality of anaesthetic services in Papua New Guinea (PNG), writes Meaghan Shaw.

Papua New Guinea has so few anaesthetists you can count them. There are only 15 consultant anaesthetists working in government hospitals, for a population of seven million.

In addition, there are about 100 non-medical trained anaesthetic scientific officers providing the rest of the country's anaesthetic services.

Coupled with health spending of about \$A50 per person and a paucity of basic anaesthetic equipment and drugs, the contrast with Australia and New Zealand couldn't be starker.

For Dr Lisa Akelisi-Yockopua, one of PNG's few consultant anaesthetists, a recent visit to Perth's annual scientific meeting was an "eye opener", giving her an insight into the latest anaesthetic advances and exposing her to an array of new equipment in the healthcare industry exhibition area.

"Obviously we do need a lot of equipment up in Port Moresby," she says at the Perth meeting. "Seeing the display of different equipment here, it's like, 'Oh, wow. It's so different'."

Dr Akelisi-Yockopua is in her second year out of training and came to Australia as a guest of ANZCA's Overseas Aid Committee. She has been selected for the ANZCA International Scholarship and is hoping to pass her English language test soon so she can come back to Australia and work with Adelaide anaesthetist, Dr Chris Acott, who specialises in head and neck surgery.

She also wants to specialise in anaesthesia for head and neck surgery – an area of need in PNG, which has a high incidence of head and neck cancer due to betel nut chewing and smoking. PNG also has other developing country health problems such as chronic tuberculosis, leprosy and HIV.

The sessions Dr Akelisi-Yockopua attended at the ASM – including a resuscitation update, difficult airway session, updates on opioids and reversal drugs, and a fiberoptic intubation workshop – were incredibly useful.

"I just can't express how appreciative I am," she says. "This is a great opportunity for any of us who haven't been to such a conference. It will be very nice for my other colleagues who (can learn from me). I'm very fortunate to come to this conference where I'm exposed to so many things which I didn't expect, and also meeting up with the other consultants from overseas."

Since 1993, ANZCA has been involved with training in PNG through the efforts of Professor Garry Phillips and a PNG senior lecturer in anaesthesia, Dr Harry Aigeeleng. This has included funding two educational visits to PNG each year, at the invitation of the University of PNG.

Dr Michael Stone, from the Royal Prince Alfred and St Vincent's hospitals in Sydney, went to PNG earlier this year for a week to train the anaesthetic scientific officers and anaesthetic registrars.

The anaesthetic scientific officers typically start their careers organising equipment for anaesthetists and doing general cleaning duties before undertaking a one-year diploma in anaesthetic science. Often they have a nursing background. They provide the bulk of the anaesthetic services in the country, especially in the provincial hospitals.

The anaesthetic registrars undertake a four-year masters in medicine course to become consultant anaesthetists.

Dr Stone provided tutorials and lectures on subjects such as airway skills, rapid sequence induction, failed intubation, defibrillation, advanced life support, paediatric syndromes and crisis management, aided by mannequins donated by the College.

It's the second trip to PNG for Dr Stone, who was encouraged to do the teaching visit by new Overseas Aid Committee



Chair, Dr Michael Cooper, who had previously taken part. Both were partly inspired to work in PNG having been to school with native Papua New Guineans.

Dr Stone says of the 100 kina (about \$A50) per capita spent on health each year by the PNG government, only a miniscule amount ends up in the anaesthetic budget.

“Consequently, there is a shortage of simple things like drugs such as suxamethonium and analgesics; halothane is the only volatile anaesthetic agent; there’s shortages of simple equipment like spinal needles, so spinal anaesthesia is provided using a standard cannula to give a spinal injection; and the gas supply runs out frequently,” he says.

Coupled with this, the standard of secondary school education in PNG is lower than Australia, mortality rates are high, and any death can potentially lead to the risk of payback from disgruntled relatives due to the country’s strong wantok system of allegiance and obligation to extended family.

Given this, Dr Stone is impressed with the students who he finds to be conscientious, motivated and hard working.

“They make up for educational and resource deficits through enthusiasm,” he says. “I take my hat off to them that, despite working under incredibly difficult circumstances and often having high

anaesthetic morbidity and mortality, they still come back to work each day and continue to work hard for their patients and the community.”

A former chairman of the Overseas Aid Committee, Dr Wayne Morriss, says ANZCA supports a range of initiatives for PNG, with the other annual educational trip to PNG undertaken by fellow committee member Dr Roni Krieser, who provides basic science teaching for trainee medical anaesthetists.

In addition, ANZCA helps organise an anaesthetic refresher course in Port Moresby in September every second year, when a large proportion of anaesthetic staff from PNG can gather in one place.

At the upcoming course this year, the committee will distribute about 40 Lifebox pulse oximeters provided through a \$10,000 ANZCA donation to the Lifebox initiative, which provides low-cost oxygen monitors to developing countries, alongside associated resources and training to raise the safety of surgery.

ANZCA also will provide about 40 packs of textbooks and electronic learning resources sourced by Dr Cooper as part of ANZCA’s educational initiative. A further 10 packs will be distributed to other developing countries supported by ANZCA.

“For a small investment, we can make quite large changes in anaesthetic practice, patient safety, all these things.”

Above from left: Dr Lisa Akelisi-Yockopua, from Port Moresby, who came to Australia and attended the ASM as a guest of the Overseas Aid Committee; Port Moresby General Hospital; Training in PNG; A tray of drugs.

ANZCA contribution helps improve patient care in Papua New Guinea continued



Dr Morriss says small donations of this kind can help reduce the gap between anaesthetic practice in Australia and New Zealand, and our closest neighbours, such as PNG.

“For relatively little expenditure or little resource, we can make a huge benefit,” he says. “We work very hard to get maximum bang for buck. So for a small investment, we can make quite large changes in anaesthetic practice, patient safety, all these things.”

Beyond PNG, the committee is also looking at overseas development opportunities in other countries.

This includes a new initiative, the inaugural ANZCA Overseas Aid Trainee Scholarship, which was recently awarded to Dr Steven Smith from the Mater Mothers’ Hospital in Brisbane.

This scholarship provides support for a final year ANZCA trainee to accompany a visiting team to a developing country and improve their knowledge and understanding of the challenges of providing anaesthesia and pain medicine in the developing world. Dr Smith plans to visit Vanuatu later this year.

The committee also supports the teaching of the Essential Pain Management course, which aims to improve knowledge of pain in developing countries, provide a simple framework for managing pain, and explore ways of overcoming local barriers which include lack of staff, inadequate pain knowledge and the scarcity or absence of analgesic drugs.

The course was developed and piloted by former Faculty of Pain Medicine dean Dr Roger Goucke and Dr Morriss in PNG in 2010, and has been taught in Fiji, the Solomon Islands, Vanuatu, Micronesia, Cook Islands, Mongolia, Vietnam, Rwanda and Tanzania, with plans to introduce it to Spanish-speaking Central America later this year and other parts of Asia. It has been translated into Mongolian, Vietnamese and Spanish.

Dr Morriss says the Essential Pain Management course is an example of starting with important principles and building on the basics of practice.

“The message of the course is extremely simple so that facilitates early hand-over to local instructors,” he says. “But the course is also very flexible so people can layer on as much complexity as they like.”

Overall, he says the Overseas Aid Committee has achieved a lot in its two years of operation, ensuring ANZCA is “an outward-looking rather than inward-looking College” and providing benefits for all areas of the College.

“It increases the relevance and profile of the College internationally and ensures people are gaining skills from an anaesthetic and teaching point of view,” Dr Morriss says. “From an individual point of view, people often do it for altruistic reasons. And, from a regional point of view, we think that it’s also good to be good neighbours.”

Meaghan Shaw
Media Manager, ANZCA

“We work very hard to get maximum bang for buck. So for a small investment, we can make quite large changes in anaesthetic practice, patient safety, all these things.”

Above from left: Learning to use equipment; An emergency trolley.



TOBACCO AND SURGERY: ISSUES OF TITANIC IMPORTANCE

On April 15, 1912, the RMS Titanic sank with loss of more than 1500 lives¹. A century later, it remains one of the worst peacetime maritime disasters, caused by failings that continue to both shock and fascinate the world¹.

In Australia and New Zealand, 20,000 people die annually from tobacco-related disease, equivalent to the RMS Titanic sinking in the Tasman Sea every month².

Like the Titanic disaster, regulatory failure contributes to this tobacco death toll. For example, some tobacco products contain additives, such as ammonia, that increase the addictiveness of nicotine (by increasing its unionised fraction) without the manufacturers being required to state this on the packaging^{3,4}.

Gender and class inequity occurred in the Titanic death toll. Ninety two per cent of second-class male passengers died compared to 3 per cent of the female passengers in first class¹.

Class and gender inequity occurs with the tobacco death toll too. The poorest 20 per cent of Australian men are 1.8 times more likely to face premature death compared with the wealthiest 20 per cent. This is due largely to socio-economic differences in smoking prevalence⁵.

Many patients quit smoking before surgery, particularly those having cardiac surgery, cancer surgery and other major operations⁶. Surgery can promote quitting and quitting itself improves surgical outcome, including significant reductions in wound infection and cardiovascular complications⁷. Despite this, evidence suggests that preoperative clinics do not systematically provide adequate smoking cessation care to patients having elective surgery^{8,9}. Such organisational failures may be costing lives in the same way that systemic failings led to unnecessary deaths in the icy Atlantic waters more than 100 years ago.

Clinicians dropping the ball on smoking cessation

Prior to August 2011, Peninsula Health provided little organisational support to encourage smokers to quit before elective surgery. A survey of pre-admission services in Victoria, NSW and the ACT showed we were not unusual in this regard³. Our waiting-list patients were sent a brochure entitled "About your anaesthetic", which included just two lines about smoking on page three:

"Give up smoking at least six weeks before your surgery to give your lungs and heart a chance to improve. You need to let the surgeon and anaesthetist know if you smoke."

The “chance” for cardiovascular improvement appeared not to motivate most patients, who continued to smoke until the day of surgery. Perhaps many believed their lungs and heart were fine. Perhaps others would be motivated if told their chance was increased by 30 to 100 per cent for a range of major morbidity including surgical site infection, pneumonia, myocardial infarction, stroke and septic shock¹⁰. Whether patients “need to let the...anaesthetist know” about their smoking or whether it is our responsibility to ask is a point that could be argued. However an audit of preoperative assessments in the UK showed smoking status was documented in less than 25 per cent of cases so perhaps there is a need for smokers to volunteer the information¹¹.

The existing brochure was weak and 50 per cent of surgical patients who smoke did not recall receiving this limited advice¹². Fewer than 40 per cent of smokers were aware that smoking increased anaesthetic complications or made wound infections more likely¹³. Clinicians were not talking to their patients about smoking either. Only 9 per cent of smokers were told to stop by an anaesthetist and 25 per cent by a surgeon¹². Surgeons advised quitting smoking in only 6.5 per cent of patients in a previous study at a Melbourne teaching hospital¹⁴. Clinician behaviour in this regard may be influenced by concerns that cessation just prior to surgery increased respiratory complications, although this is increasingly recognised as medical myth that has persisted far too long^{2,7,15}. In taking advantage of the “teachable moment” that surgery provided for smoking cessation, it appeared that clinicians had dropped the ball.

Stop before the op

From August 2011, all smokers entering the Peninsula Health waiting list were sent a locally developed quit pack, which addressed the deficiencies identified above. This was marketed as the “Stop before the op” program.

It consisted of a colour brochure detailing how quitting before surgery could reduce postoperative morbidity/mortality and improve long-term health if staying quit. A referral form for Quitline was included together with a reply-paid envelope to our anaesthetic department. The brochure advised signing and posting this form, which would be faxed to Quitline.

It advised that Quitline is staffed by smoking cessation specialists who offered a standard service of six free telephone counselling sessions that would at least double the chances of long-term abstinence compared with trying alone². Quitlines in all Australian states and New Zealand offer a similar service. Prior to “Stop before the op” less than 2 per cent of smokers having surgery had used Quitline in the past year.

The new brochure included links for other support options such as face-to-face counselling offered by Peninsula Health Community Health.

During the six-month pilot program, 650 quit packs were posted to smokers entering the waiting list, resulting in 83 requests (12.8 per cent) for Quitline services. Other patients contacted the anaesthetic department to say they had quit without Quitline or saw a GP for help. Data was collected prior to the pilot shows that although some patients did quit while on the waiting list, this mostly occurred within a few weeks of surgery when there may be little benefit (see figure below). “Stop before the op” increased Quitline use more than fivefold and transformed quitting to clinically meaningful times of a month or more. Following this success, the program is now permanent with a slightly modified quit pack being sent to every waiting-list patient (smokers and non-smokers) as identification of smokers was time-consuming and sometimes difficult.

More lifeboats on the Titanic

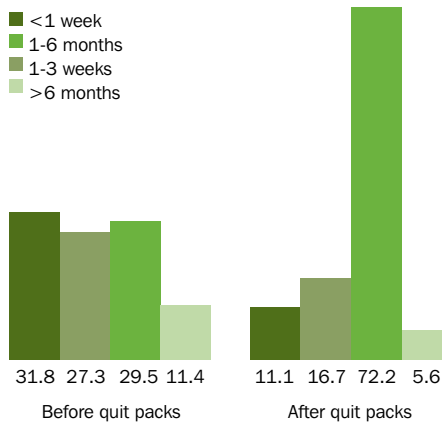
Since 1944, there have been more than 300 papers showing the adverse effects of smoking on surgical outcome, including increased risks of perioperative myocardial infarction^{10,16}. While it is appropriate to explore risk reduction strategies through research on beta-blockers (POISE), clonidine/aspirin (POISE-2) or nitrous oxide avoidance (ENIGMA-2), smoking cessation is a life-boat that is here and now.

Our responsibility is to ensure that all patients are offered the chance to get in the lifeboat if they choose.

Dr Ashley Webb

Frankston Hospital, Victoria

Distribution of quit durations before surgery following implementation of “stop before the op” quit pack: increased % of clinically meaningful quit times (>1 month)



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Lessons about on a Dili adventure



Volunteer anaesthetist, Dr Jane McDonald, in Timor Leste

I flew into Dili from Darwin at 8am on Saturday. When we landed, a blast of warm and humid air hit me as I stepped off the plane. I noticed immediately the smell of burning wood from hundreds of outdoor cooking fires, reminding me of bushfires back in Australia.

This was my first trip to Timor Leste and I was travelling with ear nose and throat surgeon Dr John Curotta and nurse Danielle Doughty. We were volunteers coming to provide specialist ear nose and throat surgery through the Royal Australasian College of Surgeons (RACS). I carried a large padlocked bright orange case with me, containing a smorgasbord of anaesthetic drugs provided by RACS.

We were cleared through customs and then met by Dr Eric Vreede, a specialist anaesthetist and team leader of the Australia-Timor Leste Assistance for Specialised Services (ATLASS) program, which is funded by AusAID.

Timor Leste is a small country only 640 kilometres north-west of Darwin, and is one of Australia's nearest neighbours. Colonised by the Portuguese in the 16th century, the predominantly Catholic population is made up of people of Malayo-Polynesian and Papuan descent.

The population is just over one million, though a high birth rate means it is increasing rapidly. In 1974 Timor Leste was invaded by Indonesia and years of violence followed, culminating in a massacre of Timorese in 1991. This was a turning point, and an international peacekeeping force was sent in until order was restored.

In May 2002, Timor Leste became an independent sovereign state. Years of fighting have destroyed much of the country's infrastructure. The new president was military-fatigued and bearded ex-Fretilin guerrilla leader Jose Xanana Gusmao. In 2003, Gusmao

met Fidel Castro at a non-aligned nations meeting in Kuala Lumpur and on hearing of the young nation's poor social indicators of life expectancy and infant mortality, Castro offered "a thousand doctors". Timorese students have since been training in Cuba on scholarships and more than 200 doctors have graduated and returned to Timor. Also the Cuban Government has set up a faculty of medicine within the University of Dili, which has been running since 2005. This has been the biggest Cuban health assistance program outside Latin America.

Since 2001 RACS has been providing surgical services through the Australian East Timor Specialist Services Project (AETSSP). This has included facilitating a continuous surgical service at Dili's Hospital Nacional Guido Valadares (HNGV) through the provision of a long-term general surgeon, anaesthetist and emergency medicine physician. Local doctors have had their training strengthened in areas of general surgical practice and there has been the development and implementation of a certified 12-month training course for 15



nurse anaesthetists. ATLAS is building on these achievements.

After arrival, Dr Vreede looked after our team. We collected a hire car and headed towards our hotel. The roads were chaotic and crowded with tooting cars, buses, motor scooters, pedestrians and dogs, competing with each other for right of way over the narrow and rough roads.

We left our bags at our accommodation and made our way to Dili's hospital to find a large crowd of almost 500 patients waiting to be seen by the ear, nose and throat team from Australia.

Communication is difficult in Timor. The official languages are Portuguese and Tetum though few people speak Portuguese. Many people also speak Bahasa Indonesian. There are many Cuban-trained doctors who speak Spanish, and some Chinese doctors who speak only Mandarin. An interpreter helped us with the patients at the ear, nose and throat clinic.

Mr Samento Faus Correia, the local co-ordinator and interpreter for RACS, wore a bright red Mao cap, which gave him an appropriate air of authority. He controlled the crowd and organised the

patients efficiently so Dr Curotta could see as many as possible. I became an "acting ear, nose and throat registrar" making notes and writing prescriptions. Australian volunteer and ear-care nurse Julie Sousness was able to triage patients with the help of a surgical registrar trained in Fiji who worked at the hospital.

There was a high incidence of chronic ear infection and associated complications. There were also patients with chronic sinusitis, various untreated congenital abnormalities, sensorineural deafness, vocal cord problems and allergic rhinitis. Several patients had oropharyngeal cancers caused by chewing betel nut, and one patient had juvenile nasopharyngeal angiofibroma causing severe epistaxis.

We managed to see 280 of the patients and identified 65 that would benefit from surgery. Unfortunately, we could not see the rest. Prioritisation is difficult. We chose to concentrate on ear surgery and gave priority to younger patients, those with bilateral tympanic membrane perforations, and those needing mastoidectomies.

(continued next page)

“Several patients had oropharyngeal cancers caused by chewing betel nut.”

From top left: A view of Dili Harbour; Dr Jane McDonald (left) puts a patient to sleep with the help of local Ear Care Nurse Julie Sousness acting as interpreter; Halothane vapouriser; Dr John Curotta reviews a patient on the ward post-operatively.

Lessons abound on a Dili adventure continued



We operated on 20 patients over the next week, aged from two to 32 years, performing mostly mastoidectomies for cholesteatoma, and myringoplasties. The average age of patients treated with surgery was 14 years. All surgical patients were in otherwise good health, though they were notably small in stature compared with the Australian population. The heaviest patient was a man of 30 who weighed just 52kg.

Oxygen and halothane were available, but no other gases or volatile agents. Suction was provided by means of a portable electric pump. Drugs and some anaesthetic airway equipment came with us, provided by RACS.

Nearly all patients I left to breathe spontaneously. The available monitoring was pulse oximetry, ECG and BP. There was no capnography. My anaesthetic assistants were Timorese trained, but did not speak English, so communication was a problem. Medical students attended many of the sessions, though teaching was also handicapped by language difficulties.

The cost of our trip was assisted by the generous efforts of the Rotary Club of Balwyn Victoria. We hope we have improved the lives of a few Timorese people by our visit. It has definitely provided an opportunity to mentor Timorese trainees.

Dr Jane McDonald
Westmead Hospital and Children's
Hospital at Westmead

“All surgical patients were in otherwise good health, though they were notably small in stature compared with the Australian population. The heaviest patient was a man of 30 who weighed just 52kg.”

Above from left: Final year Timor Leste medical students, trained in Cuba, watching Australian ENT surgeon Dr John Curotta do a mastoidectomy. Danielle Doughty (volunteer with the ENT team) is scrub nurse; Dr John Curotta (back to camera) examining patients at the ENT clinic. To the left is Danielle Doughty. A patient who had surgery on a previous trip, in the green shirt, named Colito, acts as interpreter.

NZ Anaesthesia Annual Scientific Meeting

By combining with a specialist international conference, this year's NZ Anaesthesia Annual Scientific Meeting is able to offer an exceptional line up of about 100 international speakers covering a wide range of generalist and specialist topics.

Scientific Co-Convenor Professor Alan Merry says the combined conference has attracted the best anaesthesia faculty yet seen in New Zealand – and one that means there will be something of interest for all anaesthetists and trainees.

The usual NZ Anaesthesia ASM is being held in Auckland between November 14-17 along with the 2012 International Congress of Cardiothoracic and Vascular Anesthesia (ICVA).

"Combining with ICVA has enabled us to attract an excellent international and Australasian faculty," Professor Merry says. "I consider it the best we have ever had for a New Zealand conference, and they will be providing a first-class generalist stream." Speakers in the general stream come from the US, New Zealand, Australia, Germany and Canada.

Professor Merry is one of a team of scientific program advisors who have put together a comprehensive program under the theme "What becomes of the broken hearted? Outcomes and how to change them". It has a broad-ranging general stream, a specialist ICVA stream and a third stream that straddles the two. Registrants are able to attend any session in any stream.

The combined conference is being hosted by ANZCA and the New Zealand Society of Anaesthetists in association with the Society of Cardiovascular Anesthesiology (SCA), which is US-based but with an international membership of over 6000 cardiac, thoracic and vascular anaesthesiologists. Its ICVA congress is held in different venues around the world every two years. This is the first time it has been held in Australasia.

Topics in the general stream include perioperative management of stents, transthoracic echo for non-cardiac anaesthetists, dynamic monitoring for non-cardiac surgery, goal-directed therapy in non-cardiac surgery, and fast track anaesthesia and outcome. Some of the other subjects covered include



airway management, trauma, obstetrics, paediatrics, acute and high risk patients, risks in older patients, operating room efficiency, simulation and outcome, intubation skills and perioperative assessment.

Professor Merry says the quality of the faculty overall is exemplified by the keynote speakers – Dr Richard Dutton from the US, Professor Scott Beattie from Canada and the NZSA Visiting Speaker, Dr Paul Baker, from Auckland.

Dr Dutton is an attending anaesthesiologist at the University of Chicago and the newly-appointed Executive Director of the Anaesthesia Quality Institute, which runs the National Anesthesia Clinical Outcomes Registry.

Dr Dutton has been involved in myriad research endeavours for the past two decades and has shared his professional expertise at more than 200 grand rounds and national and international symposiums, specifically addressing such issues as haemostatic resuscitation, massive transfusion and factor VIIa in civilian practice.

Dr Dutton will present a Saturday morning plenary session on "Outcomes: how to measure them and change them: perspectives from AQI", as well as speaking on "Trauma – anaesthesia and outcomes" in one of the concurrent sessions.

In his plenary session, Professor Scott Beattie from Canada will present on "What becomes of the broken hearted – angina: stents, coronary surgery and modern medical management". In a human factors concurrent session, he will speak to "Perioperative assessment – how does it change outcome?"

Dr Beattie is a professor in the Department of Anesthesia, University of Toronto, Faculty of Medicine and works in the Department of Anesthesia and

Pain Management at the Toronto General Hospital, University Health Network.

He is recognised internationally as an expert in the area of cardiac anaesthesia.

The NZSA Visiting Speaker, Dr Paul Baker, has 25 years' experience as a consultant anaesthetist at Starship Children's Health in Auckland. He is also a senior lecturer in the Department of Anaesthesiology, University of Auckland. His research interest and MD thesis is "Improving the safety and management of the difficult airway".

In 1996, Dr Baker founded the AirwaySkills course, which has taught hundreds of anaesthetists, intensivists and emergency physicians in New Zealand and Australia. He is also the developer of the Orsim bronchoscopy simulator.

Dr Baker will present a plenary session on "Education in airway management" and a paper on the "Quality and safety of airway equipment".

The combined NZ Anaesthesia ASM/ICVA conference begins on Wednesday November 14 with various satellite symposiums covering general and cardiac topics during the day, and the welcome reception in the evening. It opens formally on Thursday morning, with the conference dinner held on Friday evening.

For the full program and other speaker details, and to register, go to www.iccva2012.com. Early bird registration is open until September 5. Abstract submission for the moderated poster session, NZSA Ritchie Prize and NZSA Trainee Prize is open until July 31.

The NZ Anaesthetic Technicians Society conference is running in parallel with the NZ Anaesthesia ASM/ICVA conference.

Susan Ewart
NZ Communications Manager, ANZCA

ANZCA and government: building relationships

ANZCA continues to work with the Australian and New Zealand governments which both handed down their budgets in May.

Australia

Aged-care boost in budget

The Australian government's 2012-13 budget, released in May, was consistent with previous commitments made to the healthcare system. The biggest ticket item in the recent budget was a \$3.7 billion dollar aged-care package, with additional support for dental health, the National Bowel Cancer Screening Program, health infrastructure projects, as well as ehealth.

The government's commitment to ehealth was expanded with additional funding to support the roll out of the Personally Controlled Electronic Health Record (PCEHR) over the next two years. Health Minister Tanya Plibersek has taken a number of opportunities to promote the PCEHR as a cost-effective method for managing the health information of Australians, in the lead up to the system's launch on July 1.

Recent ANZCA submissions

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

- Medical Board of Australia's consultation on the board funding external doctors' health programs.
- The Australian Institute of Health and Welfare's consultation on National definitions for elective surgery urgency categories.
- The Australian Health Workforce Ministerial Council's Development of National Criteria under the National Registration and Accreditation Scheme.
- Health Workforce Australia in response to its proposed Health Professionals Prescribing Pathway in Australia.

ANZCA's past submissions, including the College's accreditation submission to the Australian Medical Council, can be found at www.anzca.edu.au/communications/submissions.

ANZCA recently met with representatives from Health Workforce Australia regarding the ongoing health workforce 2025 study into the supply and demand of medical practitioners with a focus on the data on the anaesthesia workforce. The College is providing input into a report for Australian health ministers due later in the year.

Specialist Training Program

The Specialist Training Program (STP) has made significant achievements over the past four months. All funding agreements with hospitals have been finalised, most hospital reports have been received, and payments have been made to support the training positions. ANZCA has been developing systems to streamline the processes involved in managing the 37 training positions across anaesthesia, pain medicine and intensive care medicine.

The College has made it a priority to develop networks with STP staff from other colleges, in order to share knowledge and experience, in addition to continuing to engage with government on training in expanded settings. The 2013 STP application round has recently closed. ANZCA, including the Faculty of Pain Medicine, received 23 applications, which were assessed for funding. The Australian Department of Health and Ageing will assess the College's assessment, as well as those made by the relevant health jurisdictions. The results of the application round are expected later this year.

ANZCA is working with regional/rural/remote area sites through the Rural Support Loading Grant (RSL) to assist these sites to meet costs of supporting trainees. All inquiries regarding the RSL and the 2013 STP application round should be directed to the STP project manager at stp@anzca.edu.au.



New Zealand

Health in the 2012/13 budget

The New Zealand government's 2012-13 budget was delivered on May 23. Health Minister Tony Ryall announced an increase of \$101 million for elective surgery and cancer services. One of the goals of the funding is an increase in 4000 elective surgeries per year. Other areas of interest include directing funding to reduce the waiting time for imaging and diagnostic tests, and IT improvements to support faster access to results. The government also earmarked an additional \$143 million for disability services. In a so-called "zero budget", the reallocation of funding still favours Vote:Health.

Physician assistants

Health Workforce New Zealand (HWNZ) has released the summative evaluation from its demonstration of the physician assistant (PA) role at Middlemore Hospital, where two PAs trained in the United States joined surgical teams for one year. Based on the results of that demonstration, HWNZ is now progressing with the trial of the PA role in primary care. The New Zealand office is working with HWNZ to ensure that the College is kept up-to-date with the PA project, and is providing advice to HWNZ on the new role from an anaesthesia perspective.

This project is an example of HWNZ's approach of rapid project development and implementation.

ANZCA is developing a position statement on physician assistants and other alternative providers. The results of the Middlemore Hospital trial and other trials will be used to inform this process.

CPD for general registrants

The Medical Council of New Zealand (MCNZ) has developed a continuing professional development (CPD) program for doctors who are not vocationally registered or who are not participating in a vocational training program, known as "general registrants". The program is designed to strengthen the CPD requirements and monitoring of general registrants' ongoing education.

The Chair of the New Zealand National Committee, Geoff Long, ANZCA's Chief Executive Officer, Linda Sorrell, and the New Zealand General Manager, Heather Ann Moodie, met with MCNZ to propose that general registrants working only in a specialist area (such as anaesthesia) and participating in an accredited college program are able to fulfil MCNZ's requirements. Following agreement by MCNZ, work is now underway to ensure the CPD program meets MCNZ's requirements by March 2014.

Submissions

New Zealand's drug purchasing agency, Pharmac, has sought the input of the New Zealand National Committee into the development of its Preferred Medicines List. Submissions have been compiled on anaesthetic, analgesic and antiemetic agents, and on fluids and electrolytes.

Recent submissions also include advice to the Health Quality and Safety Commission, the Ministry of Health, and Health Workforce New Zealand on technical workforce planning and development, including anaesthetic technicians.

John Biviano

General Manager, Policy
ANZCA



Australian and New Zealand Anaesthetic Allergy Group

Anaesthetists know that anaphylaxis during anaesthesia is a potentially life-threatening crisis. The event is often traumatic both for patient and anaesthetist.

It is also clear that anaesthesia is increasingly delivered in a wide variety of settings.

Busy anaesthetists need readily available information regarding management and referral centres for these patients to ensure subsequent anaesthesia is safe.

Furthermore, anaesthetists involved in subsequent care need clear guidelines about which anaesthetic agents can safely be used.

The Australian and New Zealand Anaesthetic Allergy Group (ANZAAG) was established in response to these challenges. ANZAAG members are specialists with an interest in the management and diagnosis of allergy to anaesthetic agents.

Members have been recruited through the network of specialists regularly working in this area. ANZAAG comprises 68 members, including 50 anaesthetists, 15 immunologists, one technical specialist and one perioperative physician, to date. The group represents 28 testing centres throughout Australia, New Zealand and Hong Kong.

ANZAAG arose from a concept developed by New Zealand anaesthetists involved in the management and investigation of patients who experienced anaphylaxis during anaesthesia.

The New Zealand group first met in the early 1990s and rapidly demonstrated the benefits of a network of specialists including anaesthetists, immunologists and technical/laboratory specialists involved in this area of care. It was apparent that a similar Australasian group could deliver benefits throughout the region.

ANZAAG has since developed a structure to reflect the inter-collegiate nature of the members of the group. The executive members of ANZAAG will form a sub-committee of ANZCA's Quality and Safety Committee to ensure a close working relationship between the two bodies.

The current executive of ANZAAG includes the chair, Dr Michael Rose (specialist anaesthetist, Sydney), ANZAAG co-ordinator Dr Helen Crilly (specialist anaesthetist, Gold Coast), immunologist representative Dr Katherine Nichols (consultant immunologist and pathologist, Melbourne) and anaesthetist representative Dr Peter Cooke (specialist anaesthetist, Auckland).

The group first met in May 2010 and has met twice a year since. ANZAAG meetings focus on education and developing resources to aid colleagues in the event of allergic reactions associated with anaesthesia.

ANZAAG is finalising a number of draft documents that will be available from a website that will launch at the ANZCA annual scientific meeting in Melbourne next year.

The aims for ANZAAG are:

1. To work towards best practice and safety in relation to the treatment, investigation and prevention of anaesthesia related anaphylaxis, working with other agencies nationally and internationally.

2. To foster information exchange, standardisation of practice and good working relationships between anaesthetists, immunologists, allergists and technologists involved in the follow up and investigation of patients who experience perioperative anaphylaxis in Australasia.

3. To foster critical inquiry and other research in the area of perioperative allergy and in the long term, to support these endeavours by establishing a research database of anaesthetic-related allergy within Australasia.

4. To provide and maintain web based resources including Australasian guidelines for the management and investigation of anaesthesia related anaphylaxis and to advise on referral and investigations after such an event.

5. To seek opportunities to keep anaesthetists, immunologists and allergists updated regarding the subject of anaesthesia related anaphylaxis.

ANZAAG will hold its annual general meeting and educational symposium from March 16-17, 2013 at the Princess Alexandra Hospital in Brisbane. The educational component will be open to all anaesthetists and immunologists and will focus on areas of interest in anaesthetic drug allergy.

Anaesthetists with a special interest in anaesthetic drug allergy management are invited to join the group. For further information please contact Dr Helen Crilly at hcrilly@onthenet.com.au.

Dr Helen Crilly
ANZAAG Co-ordinator

Anaphylaxis to drugs during anaesthesia

From January 1993 to December 2011, the Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM) reviewed 164 cases of adverse drug reaction. The actual number of cases may be higher and the true frequency for any drug is unknown in the absence of accurate denominator data.

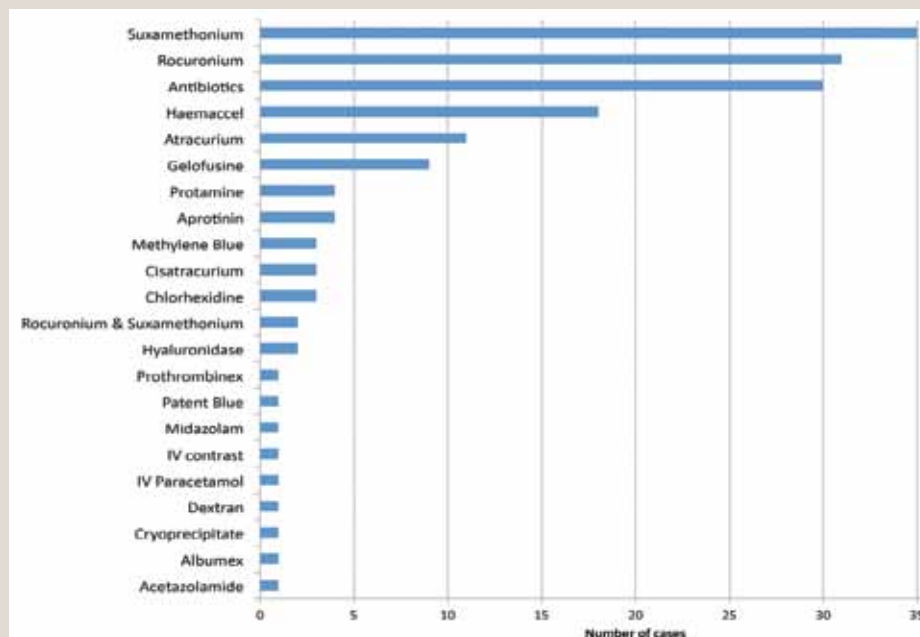
1. Reactions to neuromuscular blockers:

- Life threatening anaphylactic reactions to muscle relaxants comprises the highest risk. It is suggested that whenever unexpected hypotension is encountered during induction, it is wise to consider anaphylaxis and institute treatment with adrenaline, even if the diagnosis is in doubt.
- Hypotension may be the only clinical feature but cutaneous signs (rash, blanching, pallor) coughing or bronchoconstriction (increased airway pressure, difficulty with ventilation, hypoxia) may also occur.

- All anaesthetists should be prepared to initiate an emergency call to obtain immediate support for co-ordinated crisis management in any case of suspected anaphylaxis.
 - Review of these cases revealed that delayed diagnosis, failure to rapidly escalate adrenaline dose and co-existent cardiac disease were associated with increased risk of mortality.
2. Reactions to intravenous antibiotics can also be severe and life-threatening. In the case of cephazolin, careful inquiry should be made about previous hypersensitivity reactions to cephalosporins and penicillin. A history of major allergy to penicillin should be a contraindication to the use of cephalosporins as there is some evidence of cross reactivity.

Associate Professor Larry McNicol
Chair, VCCAMM

Figure 1: Intraoperative Drug Anaphylaxis 1993-2011



Quality and safety

continued

Comment on VCCAMM Report on Anaphylaxis

- The total number of cases investigated is almost certainly a fraction of those occurring over the period 1993-2011. This number of cases would be seen by a single busy anaesthetic allergy investigation clinic in approximately 18 months rather than 18 years. This is probably due to the lack of mandatory reporting of anaesthetic anaphylaxis.
 - There is no doubt that muscle relaxant anaphylaxis has been and remains the principle cause of anaesthetic anaphylaxis. The proportion of reactions to each relaxant is dynamic and will have changed during the investigation period. It is unusual that all muscle relaxants (for example vecuronium and pancuronium) are not listed here, presumably due to imperfect reporting of these events although by 1993 many anaesthetists had changed to rocuronium in preference to older agents. Thus it is important that this table is not seen as a true reflection of the relative risk for perioperative anaphylaxis.
 - The statement that “it is wise to consider anaphylaxis and institute treatment with adrenaline, even if the diagnosis is in doubt” is excellent, and could easily be bolded.
- Hypotension may be the only feature, but it is also worth noting that bronchospasm may be the only feature. Anaphylaxis should be considered in cases of severe and/or unexpected hypotension, bronchospasm, as well as when one or more of these is present with skin signs (rash, erythema, urticaria) or angioedema. In cases when the diagnosis is unclear, treatment should be instituted and mast cell tryptase assays taken to help investigations later.
 - The statement “All anaesthetists should be prepared to initiate an emergency call to obtain immediate support for co-ordinated crisis management in any case of suspected anaphylaxis” is excellent. Training/drills for anaphylaxis management should be routinely practised.
 - It should be noted that it is the treating anaesthetist’s responsibility to arrange follow-up testing by an expert in anaesthetic allergy investigation. Significant morbidity, including further episodes of anaphylaxis, have occurred with failure of referral and investigation of perioperative anaesthetic anaphylactic reactions.

- Cross-reactivity between cephalosporins and penicillins has been the subject of great misunderstanding over the years. While cross-reactivity does exist (particularly between penicillins and first generation cephalosporins) it is uncommon. Cross-reactivity is related more to similarities between the side chains of antibiotics than the beta lactam ring itself. It should be remembered that there is potential morbidity involved with the avoidance of the most appropriate antibiotic. The best approach in patients with allergy to penicillins or cephalosporins is to obtain clarification of exact antibiotic sensitivity by an immunologist with expertise in this area of testing. In a setting where such an opinion is unavailable and delay inappropriate, cross reactivity should be assumed if the reaction to the penicillin or cephalosporin was anaphylactic, involved evidence of angioedema, or significant cardiovascular or respiratory compromise.

Dr Michael Rose
Chair, Australia and New Zealand
Anaphylaxis Allergy Group



Methylene blue and serotonin reuptake inhibitors – an update

Mixing methylene blue and SRIs triggers severe toxicity

An informed understanding of serotonin toxicity with methylene blue has not changed since my previous comment in 2008¹. The seriousness and accuracy of the previous warning has been borne out by subsequent international reports of severe reactions and a few deaths. For those who wish to refresh their memory about methylene blue and serotonin toxicity there is a summary in my most recent review², as well as updated information on my website (Google “Gillman methylene blue”).

The story of interactions between monoamine oxidase inhibitors (MAOIs), which includes methylene blue, and drugs that possess significant serotonin reuptake inhibitor (SRI) capacity, mostly antidepressants,³ has confused not only the profession, but also the regulatory authorities. For instance, various sources incorrectly warn against mirtazapine, nortriptyline, bupropion etc, which do not have any SRI action and pose no risk. That is confusing and may precipitate unnecessary disruption or rescheduling of operations.

One particular aspect of the (usually postoperative) presentation of serotonin toxicity warrants attention. Anaesthesia itself is not only an effective treatment for the central nervous system and core hyperthermia of serotonin toxicity, but also tends to modify and disguise signs and symptoms in the immediate postoperative period. Body temperature tends not to be elevated for a few hours postoperatively, but can then rapidly rise. In one recent case such a patient died of hyperthermia, despite energetic

cooling efforts⁴. Monitoring of core temp is essential, and judicious use of 5-HT_{2A} antagonists to treat hyperthermia may sometimes be required as a life-saving measure.

There is no firm evidence as to which of the available 2A antagonist candidates is best. The choice may depend on the history and condition of the patient, the required speed of onset (sub-lingual, IMI or IV) and the experience of the doctor.

The possibilities are cyproheptadine (PO only), chlorpromazine (IMI/IV), risperidone (IM), olanzapine (sub-lingual), droperidol (IMI/IV), but not ziprasidone, because it has significant SRI potency). As a guide, all these drugs would be expected to produce significant blockade at the 5-HT_{2A} receptor in “usual clinical” doses⁵.

Evidence supports the proposition that in Australia, in contrast to other countries, we have been successful in avoiding the toxic drug interaction of serotonin toxicity.

No cases have been reported to the Therapeutic Goods Administration (personal communication, March 2012), and all inquiries to me about methylene blue toxicity have been from Europe and USA. There have been none from Australia.

I would like to think that it is at least partly because of the attention that Australian anaesthetists have given to the evidence that has been presented. Congratulations are due not only to the medical profession, but also to the manufacturers of methylene blue in Australia (Phebra), who included a specific warning about serotonin toxicity on my advice. In contrast, warnings from national agencies (US Food and Drug Administration and the British Medicine and Healthcare Products Agency), and in the package inserts, are either absent or imprecise.

Conclusions

Mixing methylene blue with serotonin reuptake inhibitors predictably and frequently causes severe and potentially fatal serotonin toxicity: discontinuation of SRIs, with appropriate washout periods before using intravenous methylene blue, is a high priority and should probably be considered mandatory. The situation with smaller doses of methylene blue via other routes is uncertain. Oral absorbency is good and proposed uses of methylene blue, such as chromo-endoscopy, may generate blood levels sufficient to provoke serotonin toxicity⁶.

Dr P Ken Gillman, MRC Psych

Dr Gillman is a retired clinical psychiatrist with a special interest in neuropharmacology.

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ECRI alerts

The ECRI Institute is a non-profit organisation that issues alerts from four sources: the ECRI International Problem Reporting System, product manufacturers, government agencies including the US Food and Drug Administration (FDA) and agencies in Australasia, Europe and the UK as well as reports from client hospitals.

Some alerts may only involve single or small numbers of cases, there is no denominator to provide incidence and there is not always certainty about the regions where the equipment is supplied.

This section can only highlight some of the alerts that may be relevant. It is the responsibility of the hospitals to follow up with the manufacturer's representatives if they have not already been contacted.

Flow rate inaccuracy in Bayer MR tubing sets used with Continuum pumps (designed for use in MRI environments)

Bayer MEDRAD Continuum MR infusion system tubing may exhibit variations in flow when used with Continuum infusion pumps. There has been a recall of the tubing and continuum pumps that have been calibrated with the tubing.

Accurate delivery of critical medications in the MR environment is difficult without appropriate pumps. Although it is possible to use "regular" volume or syringe pumps sitting outside the field and to connect to the patient with several extension tubing sets, the compliance and length of tubing may affect rate accuracy and responsiveness to rate changes. Other MR conditional pumps are available.

Cassette test failure alarm on loading of Hospira PlumSet Administration Set onto pump

Hospira has recalled its 104-inch Lifeshield Primary PlumSet Administration Sets. A cassette failure alarm may occur when these sets are loaded onto the pump, possibly due to failure in welding of the cassettes. The cassette cannot and should not be used. The main potential adverse outcome is a delay in administration of the required therapy.

Luer connection leak in COBE spectra blood warmer systems (Caridian BCT)

If specific directions are not followed, a leak may occur at the return luer connection to an elevated blood warmer potentially resulting in air entrainment into the system.

Caridian BCT has inserted an addendum to the labelling: "When connecting a blood warmer tubing set to the return line, ensure that the tubing connection is tight. Put the luer connection no higher than 50cm above the return access to prevent the possibility of air entering the tubing".

Dr Phillipa Hore

Communications and Liaison Portfolio
Quality and Safety Committee

General alerts

Coronial alert

An Australian coroner investigating the death of a patient undergoing repair of a clavicle recently highlighted his findings that a screw had been inadvertently inserted into the right subclavian vein.

There was considerable haemorrhage, which was aggressively managed, but the patient did not improve and could not be resuscitated. The possibility of concomitant air embolism was a late diagnosis, probably due to the concentration of the surgical and anaesthetic team on managing the haemorrhage.

While not critical of the team, the coroner sought to highlight the possibility that whenever a large vessel is perforated, other causes of refractory resuscitation such as air embolism should be considered as well as the hypovolaemia that results from massive haemorrhage.

Dr Patricia Mackay

Communications and Liaison Portfolio
Quality and Safety Committee

Green armbands in ophthalmic surgery

Australian anaesthetists should be aware patients who have vitreo-retinal surgery get a green wristband if they have had gas instilled in the globe of the eye.

The band remains on until the surgeon considers the gas has completely gone, usually 4-6 weeks. The administration of nitrous oxide under these circumstances may be a potential risk to the eye and should be avoided.



Safety of Anaesthesia latest report

ANZCA's *Safety of Anaesthesia, a review of anaesthesia-related mortality reporting in Australia and New Zealand 2006-2008* is now available on ANZCA's website under resources. A web booklet version will be available soon and published in an upcoming *ANZCA E-Newsletter*. For queries please contact ANZCA's Quality and Safety Officer on qs@anzca.edu.au.



The dangers of self-inflating resuscitation bags

Self-inflating resuscitation bags are essential but rarely used adjuncts to the anaesthesia machine, a vital back up when the oxygen supply or anaesthesia machine fails. They are also essential items of equipment in the post-anaesthesia care unit (PACU), on cardiac arrest trolleys and in emergency departments.

However, a number of hazards are associated with the use of these bags, both re-usable and disposable models, many of which will be well known to anaesthetists and intensivists.

Dr Jane Torrie, the Director of the Simulation Centre for Patient Safety in Auckland, has identified an issue with one particular bag and reports:

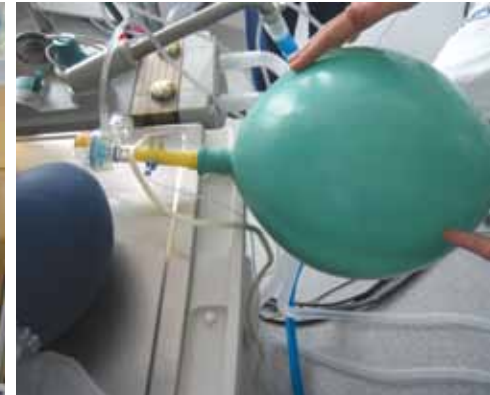
“Our usual bag valve mask product stocked in our university medical simulation centre was recently replaced with the L670 BVM single use product made by Allied Healthcare, Missouri, and imported by Care Medical.”

“During teamwork research over three days in late February 2012, we videoed 25 teams (anaesthetist, post-operative care nurse and anaesthetic assistant) managing highly-realistic simulated cases of deteriorating patients in a post-operative care area. All team members were clinically experienced and work in large local medical institutions where similar bag valve mask systems are stocked and used.

“The research team observing the cases noticed that in 11 out of 25 cases (44 per cent), a member of the team disconnected oxygen tubing from the manikin’s oxygen face mask and connected it to the manometer port of the L670 BVM after removing the white port cap. In all 11 cases, none of the team members detected the error during the remainder of the simulated case, and the oxygen was delivered at maximum flow rate (12-15 lpm) into the port for several minutes.

“The research team felt that barotrauma was a possibility in these cases, so at the end of the research simulations we connected a two-litre test lung bag to the L670 BVM, connected oxygen tubing to the manometer port and turned gas flows to 12 lpm.

“It was apparent that the test lung bag expanded alarmingly to a volume



of several litres and that there was no pressure relief system functioning to protect patient lungs from O₂ supply pressure in this device configuration. A photo is attached. This behaviour could also be reproduced using a brand new L670 BVM found in an operating room at Auckland City Hospital, but not consistently. There is no visible difference between the two BVMs.

“Patients whose lungs are ventilated via a closed system (endotracheal tube) would be at high risk of life-threatening lung barotrauma if the L670 manometer port was connected to oxygen tubing.

“It is obvious that this connection error will also reduce the inspired O₂ in most cases, as the reservoir bag does not fill despite high O₂ flow rates. A second photo is attached demonstrating this.

“While we are aware that this is not the intended configuration of the L670, we observed a large proportion of experienced healthcare professional teams, who were using it for the intended purpose, actually assemble it in a hazardous configuration. Even more concerning, the error was not apparent to them and thus was not corrected.”

The problem was reported to Medsafe (the authority responsible for regulating therapeutic products in New Zealand), which did not think it appropriate to take formal action as it understood this particular product had already been withdrawn from the market; the issue was one of incorrect use rather than device failure; and there had been no adverse events arising from such incorrect use of this or similar products.

Despite this, MedSafe is keen that word of this potential hazard is distributed to all anaesthetists.

This is a timely reminder that there are many hazards associated with these bags. Some hazards – such as the facility

for incorrect assembly rendering them useless and foreign material such as vomit accumulating in the old black Ambu bags – have largely been eliminated, or at least reduced by improved design.

A further series of problems is associated with the use of a filter between the bag and the patient. This is, of course, unnecessary if a disposable bag is used but several brands of re-usable bag are still available. This is not the forum to discuss the pros and cons of disposable devices but some of the hazards are as follows:

- High pressure oxygen could be connected to the CO₂ monitoring port of the filter resulting in exactly the same issues that Dr Torrie had in the simulation centre.
 - The same port can be left open or even broken off, resulting in a large leak and totally inadequate ventilation.
 - The filter can be blocked by patient secretions.
 - There are other disposable devices with ports between the bag and the patient.
- All anaesthetists should be aware of these problems and take the following actions:
- Check the self-inflating resuscitation bags in your clinical area frequently.
 - Never use a filter with a disposable device.
 - Make sure the O₂ tube is connected to the end of the bag away from the patient. (It should be stored in this configuration, which will prevent the last minute incorrect assembly experienced by Dr Torrie’s subjects.)
 - Educate nursing and other staff at every opportunity on the safe use of these devices.

Dr Joe Sherriff, FANZCA
ANZCA’s National Quality and Safety Officer, New Zealand

ANZCA Trials Group meets at the annual scientific meeting in Perth

Perth meeting

One of the important core activities for the ANZCA Trials Group is the annual scientific meeting. This year, the Perth meeting included two trials group scientific sessions, the annual trials group lunchtime meeting and a trials group executive committee meeting.

For the first time since the 2011 Palm Cove research workshop, the newly formed ANZCA Research Co-ordinators' – Special Interest Group (ARC-SIG) met at lunchtime on May 12 at the Perth Exhibition and Conference Centre. The 11 participants, led by Sofia Sidiropoulos, discussed terms of reference for future meetings and a program for the breakout sessions for the forthcoming ANZCA Trials Group Strategic Research Workshop in Palm Cove on August 10-12.

All co-ordinators were partially supported to attend by the National Health and Medical Research Council grant for the Peri-operative Ischaemic Evaluation-2 Trial (POISE-2 trial).

Associate Professor David Story chaired the first ANZCA Trials Group scientific session on Saturday morning. Professor Steve Webb, the chair of the Australian and New Zealand Intensive Care Society-Clinical Trials Group (ANZICS-CTG), opened the session with a talk on what is new in intensive care research. Professor Matthew Chan followed with a presentation on his work with the neuro-vision pilot study. Professor Julia Fleming wrapped up the session with a presentation on intra-guanethidine for Raynaud's syndrome: a pilot study. Both Professors Chan and Fleming were recipients of the ANZCA Trials Group Pilot Grant Scheme, and were awarded grants of \$5000 last year.

The chair of the ANZCA Trials Group, Associate Professor Tim Short, chaired the second session, "Methods and

madness in clinical trials", on Tuesday afternoon. Professor Paul Myles gave an informative talk on equipoise in clinical research. Professor Myles was followed by Dr Nolan Mc Donnell, who demystified the mysterious with a presentation on superiority, non-inferiority and equivalence trials.

The ANZCA Trials Group sessions at the annual scientific meeting follow an update/methodology/results format and Professor Stephen Schug finished the session with a presentation on measurement tools in acute pain research: is there room for improvement?

The annual ANZCA Trials Group lunchtime meeting followed and was attended by more than 30 participants from Australia, New Zealand and Hong Kong, including research co-ordinators associated with trials group research. Professor Tim Short chaired the meeting. Professor Myles opened the discussion on how future research could be better funded especially for investigator-initiated research, as well as updating the attendees on research activity associated with ANZCA multicentre research.

Most of the lunchtime meeting was assigned to a POISE-2 investigator meeting, chaired by the national co-ordinator for Australia and New Zealand, Professor Kate Leslie. She informed the meeting that POISE-2 is engaged with 33 sites across Australia, 10 are activated and 27 patients have been recruited to date. Professor Leslie thanked the investigators and co-ordinators at the meeting for their hard work and persistence in getting POISE-2 up and running in a difficult research environment. The Royal Adelaide Hospital (Dr Tom Painter and Sue Lang, and colleagues) was identified as having made an outstanding contribution to POISE-2, with 16 patients recruited to date. This site is also the largest contributor to the Aspirin and Tranexamic Acid for Coronary Artery Surgery Trial (ATACAS Trial). Congratulations to Tom and Sue and their colleagues!

Pilot grants

The ANZCA Trials Group is pleased to announce that the first pilot grant of \$A5000 for 2012 has been awarded to Dr Ben Olesnicky, Royal North Shore Hospital, NSW, for his project "Effect of Analgesic Regime on Outcomes Following Major Hepatobiliary Surgery – A Comparison of Epidural Analgesia and Intrathecal Morphine".

For more information of the ANZCA Pilot Grant Scheme, which is open to applicants all year, see: www.anzca.edu.au/fellows/Research/trials-group/pilot-grant-scheme.html

Publications

Leslie K, Myles PS, Chan MTV, Forbes A, Paech M, Peyton P, Silbert BS, Williamson E. Nitrous oxide and long-term morbidity and mortality in the ENIGMA Trial. *Anesth Analg* 2011; 112:387-393.

Graham AM, Myles PS, Leslie K, Chan MT, Paech MJ, Peyton P, E I Dawlatly AA. A cost-benefit analysis of the ENIGMA trial. *Anesthesiology* 2011 Aug;115(2):265-72

Myles PS; the ENIGMA Trial Investigators. Correspondence. *Anesthesiology*. 2012 Mar; 116(3):736

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.



Events

4th Annual Strategic Research Workshop, Sea Temple, Palm Cove, Qld, August 10-12.

Following a very successful workshop meeting in Palm Cove in 2011, the ANZCA Trials Group is returning to Palm Cove for its 4th annual consecutive meeting this year. The workshops bring together

experienced researchers as well as new and emerging researchers from Australia, New Zealand and Hong Kong. These meetings aim to present, mentor and encourage new ideas for multicentre research in anaesthesia, perioperative and pain medicine. Participants receive updates about existing research and are encouraged to engage in multicentre trials.

We also encourage anaesthesia research nurses and co-ordinators to attend.

ANZCA Research Co-ordinators' – Special Interest Group (ARC-SIG) has invited the Australian and New Zealand Intensive Care Society-Clinical Trials Group (ANZICS-CTG) Research Co-ordinators – Special Interest Group chair, Rachael Parke, from Auckland, to present at one of the breakout sessions.

Associate Professor Steve Webb, the chair of the ANZICS-CTG, is a guest

speaker along with biostatistician Dr Katherine Lee from the Clinical Epidemiology and Biostatistical Unit, Murdoch Children's Research Institute Melbourne. There will also be a POISE-2 trial investigators' meeting.

Participants are encouraged to bring along their ideas for future multicentre research. Please contact spoustie@anzca.edu.au prior to the workshop with the title and a one-page summary of your proposal(s).

More information can be found at: www.anzca.edu.au/fellows/Research/anzca-trials-group-events.html

Stephanie Poustie
ANZCA Trials Group
Research Fellow and Co-ordinator

Successful candidates

Primary examination

February/April 2012

One hundred and sixty four candidates successfully completed the Primary Fellowship Examination and are listed below:

Nathan Mark Oates	ACT	Craig Andrew McDonald	Qld	Kacey Nicole Williams	Vic
Ross Ingle Hanrahan	ACT	Daniel James Robertson	Qld	Marissa Ferguson	Vic
Adam Mark Hill	NSW	David Gutierrez-Bernays	Qld	Melinda Neroli Miles	Vic
Adelene Su-Chen Ong	NSW	David Liu	Qld	Murthi Sangeetha	Vic
Alison Beth Main	NSW	Desiree Vanguardia Perez	Qld	Nathalie Mei Gomes	Vic
Alyson Patricia McGrath	NSW	Jacqueline Yung	Qld	Noam Benjamin Winter	Vic
Aman Bamra Deep Singh	NSW	Joanne Lyn Cummins	Qld	Peter Doukas	Vic
Amardeep Singh	NSW	Jolyon Jay Bond	Qld	Ryan Basil McMullan	Vic
Ananth Kumar	NSW	Karl James Gadd	Qld	Sophia Cotton Bermingham	Vic
Andrew Mena Nikola	NSW	Kellie Maree Bird	Qld	Thomas Peter Sullivan	Vic
Ashokkumar Murugesan	NSW	Linh Tien Nguyen	Qld	Vanita Mohan Bodhankar	Vic
Christopher Michael Mason	NSW	Michael John Saba	Qld	Verity Rachel Sutton	Vic
Daniel Hernandez	NSW	Ohmar Aung	Qld	Vina Meliana	Vic
David Jack Zalcborg	NSW	Paul Robert Mills	Qld	Vincent Andrew Kun-Sai Yuen	Vic
David Sai-Wo Cheng	NSW	Peter Francis Correa	Qld	Ying Chen	Vic
Jang Cheu Cham	NSW	Rajdev Toor	Qld	Andrew Jin-Meng Lee	WA
Jessie Ly	NSW	Rebecca Helen Kamp	Qld	Anna Carter	WA
Joseph Peter Wilbers	NSW	Samuel Michael Bongers	Qld	Christine Siang-Yin Ong	WA
Karen Ann Hungerford	NSW	Sim-Wei How	Qld	Daniel Eric Anderson	WA
Karina Simone Berzins	NSW	Sorcha Eibhlin Evans	Qld	Ing-Kye Sim	WA
Lara Rybak	NSW	Stephen Chi-Wei Fung	Qld	Jan David Janmaat	WA
Leonid Pinski	NSW	Thomas Michael Walsh	Qld	Jen Aik Tan	WA
Lucy Rebecca Kelly	NSW	Victor Khi Lee	Qld	Mumtaz Anwar Khan	WA
Mahsa Mirkazemi	NSW	Wai-Mee Foong	Qld	Nathan Jon Curr	WA
Marcin Felix Teisseyre	NSW	Yee-Jen Jane Chia	Qld	Paul Anthony Cosentino	WA
Michael Patrick Reid	NSW	Adam Richard Storey	SA	Paul Matthew Ricciardo	WA
Nathan Andrew Moore	NSW	Alexandra Alison Bull	SA	Renuka Alakeson	WA
Nathan Roy Thompson	NSW	Ann-Maree Barnes	SA	Rohan David Mahendran	WA
Neil Lawrence Pillinger	NSW	James Arthur London	SA	William Henry Fellingham	WA
Penelope Gaye Taylor	NSW	Laura Jane Willington	SA	Ka-Hei Chong	HK
Peter Alexander Baird	NSW	Marni Calvert	SA	Maggie Wai Ying Tsui	HK
Phui Leng Chan	NSW	Richard Peter Champion	SA	Sen Yin Stevienne Tam	HK
Rebecca Jade McNamara	NSW	Richard Samuel Lumb	SA	Wai-Naam Wales Chan	HK
Rebecca Scott	NSW	John James Carney	Tas	Woon-Lai Lim	Mal
Sheung Hei Anthony Wan	NSW	Alireza Shangarffam	Vic	Abhishek Jain	NZ
Shirin Jamshidi	NSW	Amandeep Singh Sarai	Vic	Alison Jackson	NZ
Simon Christopher McLaughlin	NSW	Bishoy Moussa	Vic	Beau Curby Klaibert	NZ
Sunshine Kaya Austin	NSW	Bronwyn Calire Scarr	Vic	Chen Seong Ong	NZ
Trylon Matthew Tsang	NSW	Carolyn Sarah Varney	Vic	David Samuel Prior	NZ
Abigail Ngar-Yee Wong	Qld	Clara Anamaria Cotaru	Vic	Emily Claire Rowbotham	NZ
Behruz Mohammad Jamshidi	Qld	Damien Elsworth	Vic	Erica Ting-Yi Hsu	NZ
Catherine Ann Abi-Fares	Qld	Daniel Knox Joyce	Vic	Gemma Anne Malpas	NZ
Christian Van Nieuwenhuysen	Qld	Darragh Eoiw O'Brien	Vic	Graham Clifford Wesley	NZ
Christopher John Gorton	Qld	Dorothy Wai-Lin Chan	Vic	Heidi Joanna Mary Nelson	NZ
Christopher John Gorton	Qld	Fazian Zia	Vic	Jeremy Stephen Young	NZ
Claire Margaret Amy Manning	Qld	Gordana Ukalovic	Vic	Joesph Raoul McKerras	NZ
Clinton John Patricks	Qld	Gregory Michael Bulman	Vic	Julia Kate Taylor	NZ
		Harriet Clare Beevor	Vic	Katia Vanya Hayes	NZ
		James Austin McGuire	Vic	Madison Rosanna Elaine Goulden	NZ
		Jenny Clare Hewlett	Vic	Michael Richard Tan	NZ
		Joshua Anthony Szentel	Vic	Rochelle Amanda Barron	NZ
		Julia Kuchinsky	Vic	Ruth Elizabeth Brown	NZ
		Julie Yin Mei Chan	Vic	Sallie Elizabeth Malpas	NZ

Sathish Krishnan	NZ
Scott Yu-Chun Wu	NZ
Siew Ting Chin	NZ
Sophie Caroline Van Oudenaaren	NZ
Yiyi Zhang	NZ
Desmond Yu Mun Ho	Sing
Fung Chen Tsai	Sing
Lik Han Tee	Sing
Selene Yan Ling Tan	Sing
Stella Lin Ang	Sing
Xian'en Hope Ang	Sing
Zhi-Xiang Tan	Sing

Renton Prize

The Court of Examiners recommended that the Renton Prize for the half year ended June 30, 2012, be awarded to:

Ing-Kye Sim	WA
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Merit Certificates

Merit Certificates were awarded to:

Jacqueline Yung	Qld
Jen Aik Tan	WA
Julie Yin Mei Chan	Vic
Andrew Mena Nikola	NSW
Emily Claire Rowbotham	NZ
Yiyi Zhang	NZ
Jeremy Stephen Young	NZ
Julia Kuchinsky	Vic
Selene Yan Ling Tan	Sing
Daniel Eric Anderson	WA
Gregory Michael Bulman	Vic
Adam Richard Storey	SA
Thomas Peter Sullivan	Vic
Jolyon Jay Bond	Qld
Sangeetha Murthi	Vic
Alexandra Alison Bull	SA

Final examination

March/May 2012

One hundred and thirty five candidates successfully completed the Final Fellowship Examination and are listed below:

Hon Earn Sim	ACT
Adrian Boyn	NSW
Alexander Duthie	NSW
Andrew Alexander Lovett	NSW
Angela Suen	NSW
Arjun Nagendra	NSW
Brendan Alexander Irvine	NSW
Caroline Anne Jackson	NSW
Caroline Liana Fung	NSW
Christopher Charles Stone	NSW
Dinesh Harkishin Thadani	NSW
Elizabeth Mei-Ying Symons	NSW
Emily Ching-Ying Yeoh	NSW
Jia Jia Ye	NSW
Jonathan Douglas Minton	NSW
Marie Christiane Hadassin	NSW
Paul Mark Healey	NSW
Rachel Ruff	NSW
Ragu Nathan	NSW
Robert Patrick Heavener	NSW
Stanley L. Yu	NSW
Stephanie Wei Yin Fong	NSW
Stephen Jonathan Smith	NSW
Thananchayan Elalingam	NSW
Timothy Suharto	NSW
Wajdi Hadi Mohamad	
Ahmad Al-Salhi	NSW
Yasmin Vivian Celeste Zarebski	NSW
Alistair Grant Kan	Qld
Bradley John Smith	Qld
Brooke Jean Vickerman	Qld
Colin Thomas Brodie	Qld
Emma Lucinda Walters	Qld
Francesca Lee Rawlins	Qld
Jacqueline Annette Evans	Qld
Jeremy Luke Brammer	Qld
Joshua Surian Daly	Qld
Kellie Anne Oviden	Qld
Lisa Deecke	Qld
Lynda Glenys Veronica Allchurch	Qld
Minka Grenier	Qld
Mitchell Morse	Qld
Nurul Shamsidar Mohamed Bakri	Qld
Paul Francis Wigan	Qld
Paul Joseph Bennett	Qld

Paul Robert Nicholas	Qld
Peter David Koudos	Qld
Philip Lloyd Stagg	Qld
Torben Neal Wentrup	Qld
Wendy Julia Morris	Qld
William Thomas Meade	Qld
Yasmin Whately	Qld
Andy Sisnata Siswojo	Vic
Arvinder Grover	Vic
Benjamin Philip Jones	Vic
Chuan-Whei Lee	Vic
Daniel Hsin-Kai Liu	Vic
Gareth Iain Symons	Vic
Gauri Sangeeta Resch	Vic
Grace Mei Ling Seow	Vic
Herman Lim	Vic
Ian Thomas Chao	Vic
Jamahal Maeng-Ho Luxford	Vic
James Stuart Clark	Vic
Joseph Isac	Vic
Josephine Agnes Morrison	Vic
Kirsten Alice Bakyew	Vic
Lahiru Nipun Amaratunge	Vic
Lakmini Kamithri De Silva	Vic
Li Ann Teng	Vic
Mark Joseph Heynes	Vic
Martin N-H Hoai Nguyen	Vic
Matthew Garry Richardson	Vic
Melinda Kelly Same	Vic
Michelle Sue-Lin Chia	Vic
Nam Van Le	Vic
Nerida Frances Telec	Vic
Rachel Dilernia	Vic
Sina Mahjoob	Vic
Suet-Ling Goh	Vic
Suzanne Claire Whittaker	Vic
Timothy James Byrne	Vic
Trung Thien Du	Vic
Andrew Fah	SA
Andrew Norman Richard Wing	SA
Jeremy Thomas Sutton	SA
Kuan Lee Ng	SA
Michael Douglas Schurgott	SA
Nathan Trent Judd	SA
Vicki Anne Cohen	SA
Daniel John Aras	Tas
Mark Michael Alcock	Tas
Byrne Erik Redgrave	WA
Claire Louise Hinton	WA
David Andrew Kingsbury	WA
David Edward Bridgman	WA
David William Hoppe	WA

(continued next page)

Successful candidates

continued

Hamish Stuart Mace	WA
Marlene Louise Johnson	WA
Miles Earl	WA
Natasha Kamala Epari	WA
Riyad Adul Aziz Dawood	WA
Vanessa Greta Percival	WA
Wong Yoke Mooi	WA
Alastair James Ineson	NZ
Andrew Lynn Hamilton Childs	NZ
Benjamin Thomas Hayes Greenwood	NZ
Ching Wan Wu	NZ
Conrad Engelbrecht	NZ
David Heather Laurence	NZ
Geoffrey Paul Carden	NZ
Jaime Leigh O'Loughlin	NZ
James Edward Moore	NZ
Jeffrey Ian Reddy	NZ
Jennifer Anne Wright	NZ
Jeremy James Archer	NZ
Jin Hyuk Kang	NZ
Jonathan Colin Kersley Taylor	NZ
Joseph Charles Luke Taylor	NZ
Kathryn Frances Dawson	NZ
Lucy Rebekah Stone	NZ
Marsha Kim Heus	NZ
Nicolas William Rogers	NZ
Owen Callender	NZ
Phillip John Quinn	NZ
Po Che Yip	NZ
Rachel Clair Dempsey	NZ
Samuel Morrow Grummitt	NZ
Victoria Yien Freeman	NZ
Ku Ying Wai	HK
Ling Wai Yip	HK
Mak Wai Yin	HK
Or Yin Ling	HK
Tse King Yan Catherine	HK
Tsui Sin Yui Cindy	HK
Wong Tak Yee	HK

Fifteen candidates successfully completed the International Medical Graduate Specialist Exam and are listed below:

Namita Rakheja	NSW
Mahesh Ganji	NT
Caroline Collard	Qld
Sibi Kurian	Qld
Kajari Roy	SA
Nitin Nair	SA
Tharapriya Ramkumar	SA
Tilo Willy Klinger	Tas
Arnold Beeton	Vic
Adly Ariff Abas	WA
Andreas Rassamy Manopas	WA
Cristina Revenga Cilla	WA
Jesco Kompardt	WA
Raymond Sinnadurai	WA

Cecil Gray Prize

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended June 30, 2012, be awarded to:

Hon Earn Sim	ACT
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Merit certificates

Merit certificates were awarded to:

Andrew Norman Richard Wing	SA
Chuan-Whei Lee	Vic
Ian Thomas Chao	Vic
Jamahal Maeng-Ho Luxford	Vic
Lahiru Nipin Amaratunge	Vic
Marlene Louise Johnson	WA

ANZCA history and heritage update



ANZCA's history is highly valued among many Fellows and trainees who identify history and heritage as a tangible reminder of the high standards and achievements of previous generations.

Consequently, the ANZCA Council signed off on a history and heritage strategy in 2011 that aims to meet 10 key objectives in capturing and documenting the history of the College while enhancing the Geoffrey Kaye Museum of Anaesthetic History, an internationally significant collection. The 10 objectives are focused around preservation, engagement, accessibility and relevance to Fellows and trainees.

In 2012, key activities to date have included the filming of three interviews with key College figures – Professor Emeritus Tess Cramond, Dr Duncan Campbell and Dr Nerida Dilworth. Dr Dilworth is a well-known retired paediatric anaesthetist from Western Australia, Dr Campbell designed the Campbell ventilator and was awarded the Orton Medal at the Perth annual scientific meeting and Professor Cramond is a significant historic figure in Australasian anaesthesia.

These engaging oral histories will be available to all Fellows via the ANZCA website during the second half of 2012, forming part of an ongoing series.

Other activities have focused on the implementation of robust historical collection and archiving policies that will provide guidance on the collection and maintenance of items of historical importance.

Work has also commenced on improving accessibility to the collection held by the College through the use of information technology. This is focused on providing a rich and interactive experience of material via the ANZCA website.

Also under way are plans for a strong historic presence at next year's ANZCA annual scientific meeting in Melbourne and the development of materials that highlight the history of the College.

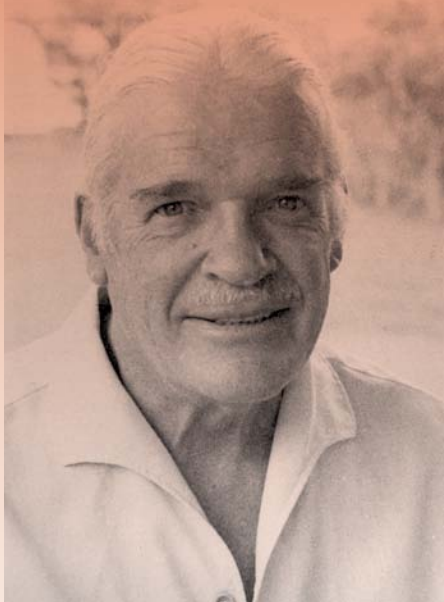
Mark Harrison
General Manager, Fellowship Affairs

Opposite page clockwise from top left: Group photo outside the Anaesthesia Museum of the Buenos Aires Anesthesia Association. From left: Dr Enrico Buffa, Dr Hector Venturini (Curator), Dr Rod Westhorpe, Dr Christine Ball, Dr David Wilkinson (WFSA President), Dr Douglas Bacon (Wood Library Laureate), Dr Alberto Varela (Director), and Dr George Bause (Curator, Wood Library Museum); Dr Christine Ball being presented with the Takaoka ventilator by Dr Enrico Buffa, Dr Alberto Varela (Director), and Dr Hector Venturini (Curator); A copy of the first issue of the Argentinian journal Anestesia y Analgesia, 1939.

This page from left: Filming oral histories are Dr Nerida Dilworth and Dr Wally Thompson; Dr Duncan Campbell and Dr Christine Ball.

The early development of anaesthesia practice in Queensland

This is the fifth article in a series about the foundation Fellows of the Faculty of Anaesthetists, Royal Australasian College of Surgeons. Professor Tess Cramond takes up the story as it unfolded in Queensland¹.



The first practitioner with a higher degree in anaesthetics to practice in Brisbane was Dr “Doggie” David Aubrey Davis, MB ChM (Syd) 1923, Diploma in Anaesthetics (DA), Royal Colleges of Physicians and Surgeons (RCP&S) 1939. There is a record of his having an appointment at the Brisbane Hospital as an Honorary Physician (1932-38).

Dr Horace Johnson completed physician training in Edinburgh as well as special training in anaesthetics and is also recognised as one of the founder practitioners in Queensland. He worked as honorary anaesthetist to the Mater Children’s Hospital in Brisbane from 1935 until the wartime period. As his resident in 1952, my interest in anaesthetics was nurtured by him. When Dr Johnson volunteered for the Australian Imperial Force (AIF), his anaesthetic practice was taken over by Dr Vera Madden (married name Watson) MBBS (Melb) 1935, who provided yeoman service to an overworked surgical community. She was the first full-time appointment in anaesthetics at Brisbane Hospital (1938-41). She went into private practice when Dr Horace Johnson volunteered for

the AIF, remaining in practice until her husband, Dr Donald Watson (orthopaedic surgeon), returned from active service in 1946.

Dr Madden was followed (1941-45) by Dr Agnes Coates Earl, MBBS (Syd) 1939 and, when she resigned, from 1945-49 by Dr Ray Robinson, MBBS (Qld) 1943, who obtained the two-part DA (Syd) 1951. Dr Robinson was to play a pivotal role not only as one of the “Queensland Girls”, but also in the development of paediatric anaesthesia at the Hospital for Sick Children and in thoracic anaesthesia at the Brisbane Hospital and later at the Princess Alexandra Hospital. She anaesthetised the first neonate to have surgery for repair of a tracheo-oesophageal fistula by Dr Morgan Windsor, and it was a memorable experience for me to have been the anaesthetic registrar helping her that night in 1954.

Dr Robinson was joined in 1947-49 by Dr Joan Dunn, MBBS (Qld) 1944. She completed her training in Oxford, obtaining the two-part DA, RCP&S (1951) – the first Queensland graduate to obtain a higher degree in anaesthetics.

She was appointed the first anaesthetics supervisor (later called director), at the Brisbane Hospital (1951-53). A superb, quietly efficient administrator, she had the unenviable task of providing clinical care, supervising and training junior staff and organising a new department. There was limited finance, facilities were primitive and the administration less than supportive. For Dr Dunn, there “were no problems, only solutions”. There were 20 operating theatres in eight areas of the three hospitals – the Brisbane Hospital, the Women’s and the Hospital for Sick Children.

Another woman whose re-entry to medicine after 21 years was to have a marked impact on the future of anaesthetics in Queensland was Dr Isabel McLelland, MB ChM (Syd) 1918. She was almost 50 before she retrained in medicine to give anaesthetics for her husband, gynaecologist Dr Hugh McLelland. Mrs McLelland, as she was always known, established the partnership which was later known as “The Queensland Girls”, interstate and overseas. She did much to foster the role of the specialist anaesthetist



“She managed even the most irritable surgeons superbly telling them to get on with the surgery for which they were trained – and giving them a score on her ‘grizzle graph’!”

providing excellent service for elective and emergency surgery. She was elected to membership of the faculty of anaesthetists but later declined election to fellowship on the grounds that fellowship was the accolade for those who did formal training and successfully fulfilled the examination requirements. It was my privilege to be invited to join the group – with Mrs McLelland, Dr Robinson, Dr Dunn and Judith Foote.

Dr Ruth Molphy, MBBS (Qld) 1947, was appointed registrar 1948-1950 and then proceeded to the UK, obtaining the two-part DA in 1952 before returning to the Brisbane Hospital as director of anaesthetics 1953-1963, and later as foundation director at the Prince Charles Hospital 1963-1983. Dr Molphy was an innovator. She built on Dr Dunn’s firm foundation and introduced the recovery room and the respiratory unit, the forerunner of the modern intensive care unit. She managed even the most irritable surgeons superbly telling them to get on with the surgery for which they were trained – and giving them a score on her “grizzle graph”!

The input of three remarkable women – Dr Dunn, Dr Robinson and Dr Molphy – moulded anaesthetic practice in Queensland. They were exceptionally competent clinicians, gentle and technically dextrous, ready to be innovative with new drugs and techniques. Importantly, they related well to patients, surgeons, nurses and other health professionals. So the precedent was set – women doctors make good anaesthetists! Appointment of women as anaesthetic registrars was accepted.

On the other side of the river, the first anaesthetics registrar at the Mater was Dr Patricia O’Hara (Lady Brennan) MBBS (Qld) 1950, in 1952, followed by Dr Gavan Carroll MBBS (Qld) 1952, who served in the position from 1954 to 1955. He undertook all the teaching of medical students until the appointment of Dr Sheila Power MRCS LRCP (Sheffield) 1957, DA 1959 as the first director, from 1963 to 1973.

The last two-part DA, RCP&S was held in 1953 and it was replaced by the two-part FFARCS. Both Dr Dunn and Dr Molphy were admitted to FARCS in 1954. The Faculty of Anaesthetists of the Royal Australasian College of Surgeons

was established in 1952 and Dr Dunn and her colleagues, including Dr Averil Earnshaw MBBS (Qld) 1950, DA 1953, were disappointed to miss out on early offers of foundation membership of the new faculty although many did in fact become foundation members.

It is apparent that many ex-servicemen had learnt anaesthetics under field conditions, working with surgical colleagues who were now in private practice and important in medical politics. It is not surprising that prominent ex-servicemen – Dr Arnold Robertson MBBS (Syd) 1936, Dr Hec Willson, MBBS (Syd) 1939, Dr Hugh Connolly MBBS (Qld) 1941, Dr Edward Muller MBBS (Qld) 1940, and Dr John Woodley MRCS LRCP 1940 – were sponsored for admission to the fledgling Faculty of Anaesthetists, RACS.

Dr Robertson and Dr Willson were admitted as foundation Fellows and Dr Connolly, Dr Dunn, Dr Win Fowles MBBS (Syd) 1939, Dr Molphy, Dr Muller, Dr Robinson and Dr Woodley, who graduated from the University College Hospital London, as foundation members².

(continued next page)

From left: Dr Arnold Robertson; Dr Joan Dunn; Professor Tess Cramond.

The early development of anaesthesia practice in Queensland

continued

Dr Robertson was the son of a distinguished ear, nose and throat surgeon and had a privileged education – the Armidale School, St Andrew’s College and the University of Sydney. He had blues for rowing and rugby. Initially a general practitioner in Queensland, he drifted into full-time anaesthetics practice because “he enjoyed it and was good at it”. He was appointed visiting specialist at the Mater and could be described as the founder of the specialty in Queensland. His war service was equally outstanding. He retired with the rank of Lieutenant Colonel, an OBE and several mentions in dispatches. He served on the Council of the British Medical Association and was its secretary in 1948. He became state representative to the federal executive of the Australian Society of Anaesthetists, and then its federal president in 1950-51, when he was convenor of the anaesthetics section of the Australian Medical Conference. In 1952 he decided to migrate to the United Kingdom, where he remained for 20 years.

Dr John Hector “Hec” Willson enjoyed a long successful career as a clinical anaesthetist, which included a post as Special Lecturer in General Anaesthesia, Faculty of Medicine and Dentistry, University of Queensland, and senior roles at the Mater and Brisbane General hospitals as well as visiting and consultant roles at Greenslopes Repatriation Hospital and Yeronga Military Hospital.

With the establishment of the regional committees of the faculty in 1956, Dr Willson, Dr Connolly and Dr Muller all accepted a role for a short period, but the driving forces were Dr Dunn, Dr Robinson and Dr Molphy, later supported by Dr Roger Bennett MBBS (Qld) 1945.

References:

1. Professor Cramond served as Dean of the Faculty of Anaesthetists, RACS, from 1972 to 1974 and has published a number of previous articles in the *ANZCA Bulletin* about outstanding women anaesthetists, including:
Obituary article - Dr Lillian Joan Dunn, published in the March 2002 edition, pp. 26-27
Obituary article – Dr Margaret Smith, March 2008 edition, pp. 16-17
Obituary article – Dr Agnes Mary Daly, March 2010 edition, pp. 98-99
Obituary article – Dr Ruth Molphy, June 2011 edition, pp. 106-107
2. Three doctors were added to the list of foundation members in June 1953: Dr William Ackland-Horman of South Australia, Dr Isabella McLelland of Queensland, and Dr Stewart Peddie of New Zealand. Please refer to the Register of Fellows and Members of the Faculty of Anaesthetists, Royal Australasian College of Surgeons, page 43 [held in ANZCA Archives].

“The input of three remarkable women – Dr Dunn, Dr Robinson and Dr Molphy – moulded anaesthetic practice in Queensland.”

ANZCA in the news



Post-op pain relief 'fails kids'

ADAM CRESWELL, *The Australian* May 15, 2012 12:03PM

PAIN specialists are warning that rising rates of day surgery for babies and young children are leading to many infants being sent home with inadequate pain relief after significant operations such as tonsil removal.

Many operations such as hernia repairs, ear surgery, tonsillectomies or plastic surgery to remove an extra toe or finger are increasingly being performed in a single day as hospitals try to cope with demand, leaving parents in charge of their child's pain relief at home.

But specialists at a national conference in Perth were told there was good evidence the advice being given to parents was inadequate, and many children were enduring unacceptable levels of pain sometimes for days after their operations.

Andrew Davidson, a senior staff specialist at Melbourne's Royal Children's Hospital, said a study at his hospital in 2009-10 found the median pain score among 50 children who had had a tonsillectomy remained at unacceptable levels for seven days after their procedures.



Other types of surgery, such as operations to repair hernias or fix undescended testes, caused elevated pain levels for two to four days, though these were mostly in the tolerable range.

Associate Professor Davidson told the annual meeting of the **Australian and New Zealand College of Anaesthetists** the advice at his hospital to parents was initially a three-dot-point sheet advising them to give their children paracetamol every four to six hours or a paracetamol-codeine mixture if more relief were needed.

But the RCH research showed that half of the 50 tonsillectomy child patients were taken back to their GPs over the following days after leaving hospital for extra pain relief or for suspected infection, and 12 per cent were readmitted.

While the push for greater day surgery was sensible, allowing children to recover at home away from the risk of hospital-acquired infections, Associate Professor Davidson said the risk was "you cost-shift the care on to parents who are not always well equipped to offer it".

Media coverage of ANZCA and the Faculty of Pain Medicine has reached a potential cumulative audience of nearly 10 million people (9,452,995 people) over the past few months, mainly due to media reports generated from the annual scientific meeting (ASM) in Perth.

Highlights of the ASM media coverage included outgoing president Professor Kate Leslie appearing on the new national Channel 10 breakfast show promoting the conference and talking about key topics, and the new ANZCA President, Dr Lindy Roberts, taking talkback calls on ABC 720 Perth's Drive program with host Russell Woolf.

Nine media releases were issued promoting the ASM, the Faculty of Pain Medicine Refresher Course Day and the Joint Trauma and Anaesthesia and Critical Care in Unusual and Transport Environments (ACCUTE) Special Interest Group meeting, which focused on mass casualties and burns.

Topics that generated the largest amount of media interest included Dr Bob Large from the Auckland Regional

Pain Service talking about the uses of hypnosis in analgesia and pain management; Professor Geoffrey Dobson from James Cook University explaining how he is developing a resuscitation fluid for injured soldiers inspired by hibernating hummingbirds; Associate Professor Andrew Davidson from Melbourne's Royal Children's Hospital talking about the increased risks of anaesthesia for newborns; Professor Jamie Sleight from New Zealand's Waikato Hospital explaining a possible genetic link to anaesthetic awareness; Dr Nolan McDonnell from Perth's King Edward Memorial Hospital for Women outlining increased complications associated with extremely obese pregnant women; Professor Amy Tsai from the University of California, San Diego, explaining how worms are being used to develop artificial blood; and visiting US Professor Ruth Landau talking about the "love hormone" oxytocin.

Seventeen speakers from the conference and associated meetings were interviewed and ANZCA greatly

appreciates their contribution. Full coverage from the meeting can be found on the ANZCA website under "Events".

Apart from the ASM, ANZCA also contributed to a 4000-word feature on chronic pain in the *Weekend Australian* (circulation 300,000) quoting Associate Professor Milton Cohen and Professor Michael Cousins, and a pain medicine career special in the *MJA Careers* section featuring FPM spokesmen. Also in the pain area, former FPM Dean, Dr David Jones, was interviewed by a NZ wire service about the need for New Zealand to follow Australia's lead on prescription opioid tracking.

A media release promoting publication of the *Safety of Anaesthesia: A review of anaesthesia-related mortality reporting in Australia and New Zealand 2006-08* received coverage, as did one about the Specialist Training Program funding secured by ANZCA, which was widely reported in regional and rural areas.

Meaghan Shaw
Media Manager, ANZCA



Media releases distributed by ANZCA since March this year

- \$50,000 raised to save lives in developing countries *(May 16)*
- Perth anaesthetist and pain expert new ANZCA president *(May 16)*
- Oxytocin: the love hormone's new role in pain relief *(May 14)*
- Primordial species could be the key to artificial blood *(May 13)*
- Post-operative nausea and vomiting: is there a genetic link *(May 12)*
- Hypnosis in pain management *(May 11)*
- Revolutionary pain service leads the way on pain relief *(May 10)*
- Hibernating hummingbirds inspire new resuscitation fluid *(May 10)*
- More than 1300 anaesthetists to attend key meeting in Perth *(May 8)*
- Anaesthesia remains extremely safe *(April 23)*
- Boost for rural health with extra specialists trained *(April 12)*
- ANZCA Bulletin* out now: ANZCA turns 20; NZ urged to adopt prescription opioid monitoring; Christchurch one year on – NZ release *(March 30)*
- ANZCA Bulletin* out now: ANZCA turns 20; training Mongolian skeptics; NZ urged to adopt prescription opioid monitoring – Australian release *(March 30)*

Since March this year,
ANZCA has generated...

- 67 print stories**
- 85 online stories**
- 170 radio reports**
- 44 television reports**

The Anaesthesia and Pain Medicine Foundation



Dr Roderick Deane appointed Knight Companion

Anaesthesia and Pain Medicine Foundation Board member Dr Roderick Deane, who joined the board in October 2011, has received the honour of appointment to the New Zealand Order of Merit as a Knight Companion. Sir Roderick was appointed by Her Majesty the Queen on the occasion of the celebration of the Queen's Birthday and Diamond Jubilee this year.

The significance of this honour is reflected in the fact it is one of just four Knight Companion appointments made to the New Zealand Order of Merit in this year's Queens Birthday and Diamond Jubilee Honours List.

Sir Roderick's senior level contributions to New Zealand in corporate and business leadership, public sector reform and central banking, particularly through his leadership during the currency crisis of 1984, are widely recognised for having significantly improved economic opportunities for all New Zealanders.

The appointment also reflects Sir Roderick's long-term commitment to the arts and his provision of assistance and leadership to charitable causes and organisations. Along with his participation on ANZCA's Anaesthesia and Pain Medicine Foundation Board, Sir Roderick's contributions have been a strong example of personal community service that helps to improve the quality of life through expanding economic, cultural, creative, and health and well-being opportunities.

Sir Roderick's contribution to the board of the Anaesthesia and Pain Medicine Foundation comes at a time of renewed effort to increase the foundation's fundraising, to increase support for scientific research, overseas aid and indigenous health. Improving support in these areas is vital for delivering better health outcomes to millions of New Zealanders, Australians and people in developing countries.

Give to the foundation's research funding appeal

As part of its fundraising program, the foundation recently sent an appeal to Fellows and the public in Australia and, pending the response, is planning a similar appeal in New Zealand. If you haven't responded already, please consider sending a contribution. Previous research by ANZCA Fellows has produced results and further grants far outweigh the small initial costs. Making a gift to the foundation is one of the best and most relevant philanthropic investments available!

Thank you to all Fellows who have already given generously. Gifts can be made by mail or by calling Rob Packer at the foundation on +61 3 8517 5306.

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

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.



Council of Medical Colleges (CMC)

At its March meeting, it was agreed that the Council of Medical Colleges (CMC) would continue with its enlarged secretariat, which will involve a 36 per cent increase in subscriptions phased in over two years. A CMC website is being developed to provide a conduit for information sharing and to progress matters between meetings.

At the May meeting, Professor Alan Merry, as Chair of New Zealand's Health Quality & Safety Commission, and Dr Leona Wilson, as Chair of the Perioperative Mortality Review Committee (POMRC), each gave updates on the work of the HQSC and POMRC, and outlined how colleges can help with this work, especially disseminating information arising from their reports.

HWNZ Executive Chair Professor Des Gorman (pictured above) spoke to the group about health workforce issues, noting that a shortage of nurses is a larger and more pressing problem than the shortage of doctors.

Professor Gorman said HWNZ was focusing on ways of improving what already exists, for example productivity improvements, addressing mal-distribution, and looking at the impact of models of care on the demand for doctors and other healthcare practitioners. The best mix of generalist and specialist skills remains on the HWNZ agenda, as does the development of a "flexible, redeployable workforce". A document on prioritisation of funding for medical disciplines has been released to district health boards and Professor Gorman said it would be sent to colleges in the near future.



Anaesthesia research

ARGONZ (Anaesthetic Research Group of New Zealand) is an informal association for New Zealand anaesthetists and trainees interested in furthering scientific and clinical research in anaesthesia. The group would like to collect information about current and planned research so that it can be made available to the anaesthesia community in case others can usefully contribute to that research. ANZCA has agreed to assist with this. As a first step, anyone who has a current research project (or an idea for a future project) is asked to email ANZCA's New Zealand office (anzca@anzca.org.nz) with the title of their research and a few lines explaining where they are up to and any difficulties they face.

NZ government news

More operating theatres for Middlemore Hospital

The Counties Manukau District Health Board, which administers Middlemore Hospital in South Auckland (pictured above), has received government approval for three new operating theatres and the replacement of 11 existing aged theatres. The new clinical services block will also include a 42-bed assessment and planning unit, an 18-bed high dependency unit, and replace the clinical sterile supply department.



New trauma network

The government has established a Major Trauma National Clinical Network to develop a national, strategic approach to the provision of major trauma services, from pre-hospital emergency care to rehabilitation and injury prevention services, and to co-ordinate major trauma service improvements.

The network's clinical leader is surgeon Mr Ian Civil, Director of Surgery at the Auckland District Health Board and the immediate past president of the Royal Australasian College of Surgeons (pictured above).

Faster broadband for rural hospitals

Under the second phase of rural broadband initiative contracts, 37 rural hospitals, including Thames and Taumarunui, as well as 10 health centres, will receive ultra-fast broadband. The faster links will allow rural staff to take part in training sessions being run in urban centres and enable clinicians to view immediately electronic information recorded across the country, rather than having to wait for reports or films to be sent.

Tobacco plain packaging

Cabinet has agreed in principle to introduce plain packaging for tobacco products in alignment with Australia. However, this is subject to the outcome of a public consultation process to be undertaken later this year.

People and events

Airway Management SIG Meeting



The third Airway Management SIG Meeting was held at the Mantra Erskine Beach Resort in Lorne, Victoria from March 9-11. The theme of the meeting was "Everything airways: Airway problems outside the OT" and the international guest speakers were Dr Josef Holzki (Germany) and Dr Paul Phrampus (US). The convenor was Dr Chris Acott and the co-convenors were Dr Zoe Lagana and Dr Louisa Heard. More than 250 delegates attended lecture sessions and workshops with 20 companies from the healthcare industry supporting the meeting. The next Airway Management SIG meeting will be held in 2014.

Trauma & ACCUTE Special Interest Group Conference



The joint one day Trauma and Anaesthesia and Critical Care in Unusual and Transport Environments (ACCUTE) SIG Meeting was held at the Parmelia Hilton Perth on Friday May 11, 2012. The meeting was well attended and covered a wide variety of topics under the general theme of "Mass casualty- burns". Guest speakers included Professor Fiona Wood, Mr John Kelleher, Professor Geoffrey Dobson and Lieutenant Colonel Michael Reade.

The next meeting of the Trauma SIG will be held in conjunction with the Airway Management SIG in Melbourne, June 2013.

Associate Professor John Moloney
Dr Allan MacKillop
Joint Convenors

Obstetric Anaesthesia Special Interest Group meeting



The 3rd Quadrennial Obstetric Anaesthesia Special Interest Group meeting was held at the Quay West Resort, Bunker Bay, following the 2012 ANZCA Annual Scientific Meeting. The location was on the edge of the renowned Margaret River Wine region and gave the delegates the opportunity to unwind after the ASM.

The theme of the meeting was 'high risk obstetric anaesthesia' and speakers included well-known anaesthetists from around Australia and New Zealand. Invited speakers included Dr Luke Torre (intensivist), Dr Nicole Staples (haematologist), Dr Andrew Miller (lawyer and anaesthetist) and Professor Yee Leung (gynaecologist). The program included a number of interactive sessions, workshops and PBLDs, which included practical tips and tricks for delegates.

There was a welcome reception at the resort and a wine tour, which visited well-known vineyards in the Margaret River. The social program also included a conference dinner at the Wise Vineyard.

Meeting delegates raised more than \$1000 for the Lifebox project through a series of raffles supported by the sponsors, adding to the success of this initiative from the ASM.

The meeting attracted 120 delegates and six healthcare industry representatives, all of whom took away new ideas and new friends and colleagues.

Thank you to all the delegates, speakers and workshop and PBLD facilitators for attending and contributing to the success of the meeting, a number of whom travelled a long way. A special thank you to Kirsty O'Connor from ANZCA, for her help with organising the meeting.

Dr Nolan McDonnell
Convener

Above clockwise from top left: Dr Paul Phrampus (US) and Dr Josef Holzki (Germany); Dr Andrew Heard, Dr Pierre Bradley and Dr Richard Semenov; Delegates at the 3rd Quadrennial Obstetric Anaesthesia Special Interest Group meeting; Professor Fiona Wood and Dr Kylie Hall; Lieutenant Colonel Michael Reade and Co-Convenor Associate Professor John Moloney.

Queensland

Queensland Regional Report

Activity in Queensland continues at a high level and in the last three months has included:

- A week-long final exam preparation course.
- Primary and final practice viva sessions.
- Written and clinical exams.
- Two primary lectures.
- Two webinars and recording of four podcasts.
- A three-day foundation teacher course.
- The directors of anaesthetics meeting.
- The 15th Annual Registrars' meeting.

Once again, the Queensland Regional Committee would like to acknowledge the work of the dedicated and capable course convenors, lecturers and mock examiners who have offered trainees these valuable learning opportunities.

Committees have been elected for 2012-14. Office bearers will be advised in the next edition of the ANZCA Bulletin.

The selection and allocation process for 2013 hospital rotations has been reviewed and applications for placements closed June 4. Assessment is in full swing.



OPAL: Obstetrics, Paediatrics and Law

Dr Ben van der Griend is the keynote speaker at the Queensland combined ANZCA/Australian Society of Anaesthetists annual conference being held on Saturday July 7. Dr van der Griend is a paediatric anaesthetist at the

Christchurch Hospital. He has a strong interest in training and has set up a successful education program called PAT:CH – Paediatric Anaesthesia Teaching: Christchurch.

Dr van der Griend's presentation, "Is it safe to anaesthetise children?", will address the likelihood of a child dying or being harmed by anaesthesia and whether anaesthesia damages the developing brain.

The full conference program is available at on ANZCA's Queensland regional office website: <http://qld.anzca.edu.au>.

Opposite page from left: Adjudicators Dr Helmut Schoengen and Dr Brian Lewer; Dr Peter Moran and the formal projects officer for Queensland, Dr Kerstin Wyssusek; Dr Yasmin Whately receiving the Tess Crammond Award from Professor Tess Crammond; Formal project presenters Dr Conrad Macrokanis and Dr Satnam Solanki; Adjudicators Dr Helmut Schoengen, Dr Sanjiv Sawhney and Dr Brian Lewer; Dr David Goldsmith receiving the lucky draw prize from Stefan Dooney of Pert & Associates; Brian Pert of Pert & Associates with Dr Michael Steyn; Dr Chris Turnbull, Dr Robert Miskeljin and Dr Andrew Wilke; Dr Conrad Macrokanis receiving the Axxon Health Award from Dr Patrick See.



15th Annual Queensland Registrars' Meeting

The registrars' scientific meeting for the presentation of completed formal projects was held at the West End premises of ANZCA's Queensland office on Saturday April 28. This is a key annual event in the training of anaesthetists and offers registrars the opportunity to present their original research for their Formal Project at a meeting of their peers.

The standard of presentations was high and the winner, Dr Yasmin Whately, was commended by the adjudicators for the significant development to her skills, required to collect and analyse the pathology data needed to examine the contractile

function of cardiac tissue. Other prize winners included Dr Conrad Macrokanis, who received the Axxon Health Award for work on irukandji syndrome and Dr Brett Segal, who received the Australian Society of Anaesthetists Chairman's Choice Award for his analysis of single-shot anaesthesia.

Professor Tess Crammond presented Dr Whately with first prize, the Tess Crammond Award, and provided some sage words of encouragement and advice for trainees.

We thank our major sponsor, Pert & Associates, who made a strong case for the importance of sound financial management for consultants.

Australian news continued

Queensland continued



Foundation Teacher's Course

A Foundation Teacher's Course was held at the West End premises of ANZCA on April 18-20. Maurice Hennessey facilitated the course, assisted by Dr Kersi Taraporewalla, our resident educator of international specialist graduates. A total of 16 supervisors attended and were put to the test through lively discussions and problem-based learning activities.

The main focus of these discussions and activities was how to give relevant feedback that enhances the acquisition of knowledge and skills, particularly in relation to the soon to be implemented workplace-based assessments (WBAs).

The course also provided participants with an opportunity to engage with colleagues who were able to offer different views and opinions on the practice of assessment.

Clockwise from top left: Dr Rudolf van der Westhuizen sharing his experience with newly appointed supervisor Dr Aled Hapgood; ANZCA's Maurice Hennessey observes the activities during a session on delivering training at the Queensland Foundation Teacher's Course; Dr Maree Burke, Dr Julie Sherwin and Dr David Law practice the art of giving feedback; Dr Helen Davies with Dr Tim Scholz at the Queensland Foundation Teacher's Course.

South Australia and Northern Territory



Current medico legal anaesthetic controversies

On April 3, the SA & NT Continuing Medical Education Committee held “Current medico legal anaesthetic controversies” presented by Dr Andrew Miller. Dr Miller was an excellent speaker and received very positive feedback from the 40 or so attendees. Hot topics included information on mandatory reporting, anaesthetic case studies, epidural disaster case and the proposed National Disability Scheme. This initiated much discussion among the attendees and many stayed after the presentation to network and discuss.

Above clockwise from top left: Dr Douglas Fahlbusch, Helena Manis, Dr Andrew Miller and Megan Sheldon; Dr Lynne Rainey and Dr John Hughes; Speaker Dr Andrew Miller; WCH Queen Vic Theatre.

Western Australia



News from Perth

A medical careers expo was held on March 27 at the Burswood on Swan. The aim of the expo was to provide interns, residents, service registrars, international medical graduates and senior medical students with information regarding vocational training programs and career pathways. The evening was very busy and was attended by more than 200 junior doctors and senior medical students. Thank you to Dr Suzanne Myles, Dr Michael Veltman, Dr Joel Adams, Dr Jim Miller, Dr Bree Maciejewski and Dr Melissa Haque who helped out with inquiries regarding the anaesthetic training program in WA.

A supervisors of training workshop was held on the evening of April 26 at the WA regional office. The workshop focused on the workplace-based assessments (WBAs), which form part of the revised curriculum, and was presented by the WA WBA champions Dr Paul Kwei and Dr Ange Lee. Dr Jodi Graham also assisted with the workshop. Supervisors of training will now return to their departments and start teaching and recruiting assessors.

On May 11, the WA regional office hosted an ANZCA Teachers Course-Foundation level. The course was attended by 11 Fellows, some of whom were in Perth to attend the annual scientific meeting, which was held at the Perth Convention and Exhibition Centre from May 12 to 16. Maurice Hennessey from the ANZCA Education Development Unit convened the course and covered the following areas: planning effective teaching and learning, teaching in context and effective feedback. The feedback from the course was very positive.

The ANZCA WA annual general meeting was held at the Perth Convention and Exhibition Centre on May 14. Thank you to those who attended.

On the evening of May 14, Oliver Jones, ANZCA General Manager, Education Development, gave a presentation at the WA regional office about the transition of existing trainees to the new curriculum in 2013. About 25 WA trainees attended. WA's regional education officer, Dr Jodi Graham, was also on hand to answer questions. Thank you Oliver and Jodi.



Above clockwise from top left: ANZCA General Manager, Education Development Oliver Jones and WA Trainees; Attendees at the WA ANZCA Teachers Workshop; Maurice Hennessey and attendees at the workshop.

Tasmania



Tasmanian Joint ANZCA/ASA Meeting in 2013

The 2013 Tasmanian Joint ANZCA/ASA Meeting will be held from February 22-23 at The Tramsheds Function Centre, Launceston. For further enquiries, please contact: tas@anzca.edu.au

Australian Capital Territory



WBA workshop

The ACT regional office held a workplace-based assessment workshop on June 9, which was attended by delegates from hospitals in the ACT, Dubbo and Wagga Wagga.

As well as providing a valuable opportunity to learn about the assessment tools required as part of the new ANZCA curriculum, the workshop gave participants a welcome opportunity to meet with colleagues.

Preparations are underway for a difficult airways workshop to be held at the Hyatt Hotel, Canberra, on August 4.

Further information and registration forms will be available on the ACT website soon.

New South Wales



Part Zero: An Induction to Anaesthesia takes off

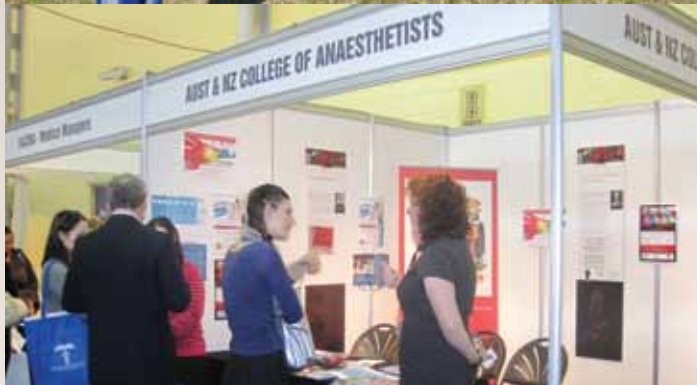
The 2012 Part Zero: An Induction to Anaesthesia course on March 10 proved a popular way to spend a quiet Saturday afternoon. Despite clear sunny skies outside, more than 100 interns, residents and registrars flocked to the Royal Prince Alfred's Education Centre to learn more about the exciting life of an anaesthetic registrar.

After a welcome by the NSW Regional Trainee Committee, the day kicked off with doctors Katherine Jeffrey, Simon Martel and Anand Pudipeddi reminding us what being an anaesthetic trainee is all about, and the various prestigious organisations a budding anaesthetic trainee can join. This was followed by Dr Pat Farrell covering "What is the College?", Dr Simon Martel highlighting the structure of training and the new ANZCA curriculum and Dr Michael Stone's famous exam tricks and tips lecture.

Afternoon tea was followed by a presentation by Dr Michael Bonning, of Beyondblue, who covered the topic of mental health and happiness. Dr Greg Downey discussed mentorship and Dr Ken Harrison, of Careflight, gave a guide to career choice (as well as his family photo album!) Dr Greg Knoblanche rounded off the afternoon with his presentation on the ins and outs of medico-legal defence.

Despite squeezing a lifetime's worth of information into five hours, morale remained high thanks to the entertaining and informative lectures. The day was rounded off with a question and answer session followed by drinks at the local. Thanks go to all the presenters, the 2011 Regional Trainee Committee, and to Tina Papadopoulos and Warren O'Harae from the NSW ANZCA office for all their work behind the scenes.

New South Wales



NSW Regional Committee

There is a significant and exciting “changing of guard” at the NSW Regional Committee this year. Six members are leaving the committee, including three former chairs, Jo Sutherland, Michael Amos and Richard Halliwell.

I thank these three dedicated people, who have more than 30 years of experience at regional committee level. They have given their time and experience to the College in many roles on the committee.

Also leaving is Tracey Tay, who has made a great contribution to the committee including as regional educational officer. Thanks also to Michael Rose and Kar Soon Lim, who have contributed particularly with formal projects and education over the past four years. I sincerely thank all these retiring members of the state committee for all the excellent work they have done.

This year presents the exciting challenge of the revised ANZCA curriculum. The NSW region also has a large number of hospital accreditation inspections ahead.

To help lighten the load, I welcome Andrew Armstrong, Michelle Moyle, Nicole Phillips, Michael Stone, Suyin Tan, Emily Wilcox to the committee. Please feel free to speak to any members of the committee about any issues or concerns.

Simon Martel and Carl D'Souza will represent the new Fellows, while we welcome Michael Wirth as Chair of the NSW Trainee Committee. Thanks to Lewis Holford who has handed over to Gavin Patullo representing the Faculty of Pain Medicine on the committee.

The NSW Regional Committee as always has the support of the NSW representatives at the ANZCA Council, Frank Moloney, Patrick Farrell and Michelle Mulligan, and this continues.

The committee welcomes the continued input of Carmel McInerney (ACT) and Michael Farr (Australian Society of Anaesthetists).

To conclude, ANZCA Curriculum Revision 2013 presents an exciting change to education within the College and this, combined with the usual workforce and accreditation requirements, will present some challenges to the new NSW Regional Committee. I look forward to the contributions of all members as I thank those who have contributed greatly in the past.

Dr Greg O'Sullivan, Director
Anaesthetic Department
St Vincent's Hospital

Australian Medical Association Careers Day

Members of the ANZCA NSW Regional Committee and NSW Trainee Committee attended the NSW Australian Medical Association Careers Day on May 5 at Sydney Olympic Park.

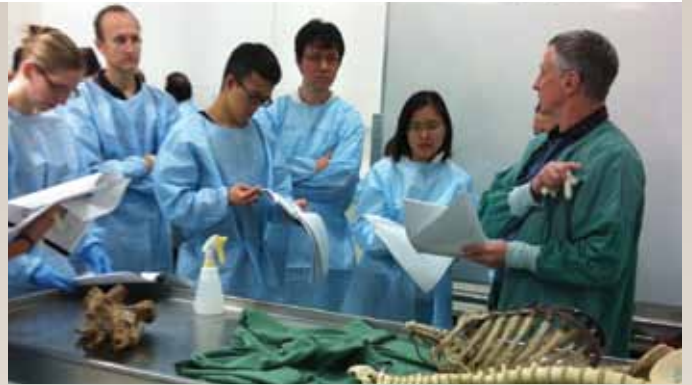
The day was designed to introduce the various career options available to junior doctors. Approximately 300 junior doctors and medical students attended the event.

The NSW ANZCA table was well attended and questions ranged from “How do I become an anaesthetist?” to “How do I pass the primary exam?” and “How do I get a trainee job?”. There were also many questions about the curriculum change and how it will affect training.

A highlight of the day was a retrieval demonstration by Careflight, who flew in to extricate an injured child from a mock-up playground accident. This generated great interest among attendees when it was revealed that anaesthetists are part of the retrieval team.

Many thanks to NSW ANZCA staff and doctors who gave up their Saturday to talk about anaesthetics.

Above clockwise from top left: Dr Richard Halliwell and Dr Greg O'Sullivan; Mock retrieval at the Australian Medical Association Careers Day; The ANZCA table.



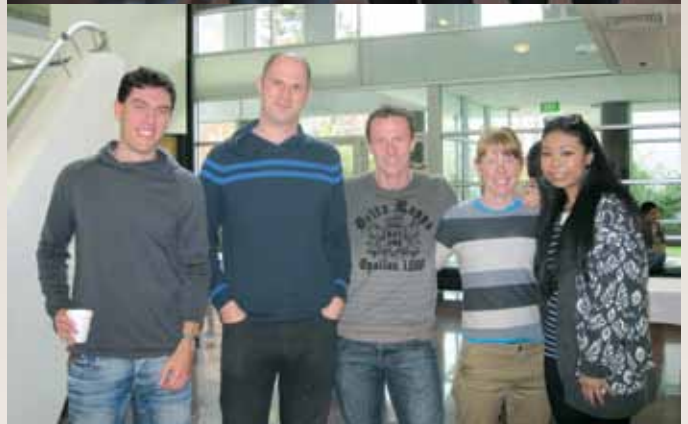
NSW Part II Refresher Course

The NSW Regional Committee again conducted a very successful Part II Refresher Course in Anaesthesia at Royal Prince Alfred Hospital from February 20 to March 2.

The course enabled candidates sitting for the final fellowship examinations a greater understanding of anaesthesia. It included seminars, panel sessions, demonstrations, lectures and informal tutorial. A highlight on the last day of the course was the anatomical workshop held at Department of Anatomy and Histology, University of Sydney, which enlists the help of seven lecturers in a hands-on workshop.

A special thanks to all the speakers who devoted a huge amount of time and effort in assisting the candidates to prepare for their final examinations, and especially to Dr Tim McCulloch and Associate Professor Gregory Knoblanche.

Victoria



Full-time Primary FANZCA Course

Our Course Coordinator, Minh Lam, has efficiently organised and run the Victorian Full-time Primary FANZCA Course from May 28 to June 8 at which we had a record attendance of 60 candidates.

As there was a change in some lecturers, the program was challenging but resulted in a very successful course.

I thank our participating lecturers and the mock viva examiners, both new and established, whose assistance and cooperation we could not do without. Their efforts are greatly appreciated and we look forward to their continued input.

As convenor, I thank the College for the use of their facilities and the staff for their cooperation and understanding in the event that the course caused any inconvenience or disturbance.

Dr Adam Skinner

Primary FANZCA Course Convenor

From top: Statistics lecturer Dr Craig Noonan (second from left) with trainees; Course convenor Dr Adam Skinner (second from left) with trainees.

ANZCA Council meeting report

April 2012

Report following the Council meeting of the Australian and New Zealand College of Anaesthetists held on April 21, 2012

Death of Fellows

Council noted with regret the death of the following Fellows:

- Dr Harold John White (NSW)
FANZCA 1992, FFARACS 1967
- Dr Maurice John Brookes (NSW)
FANZCA 1992, FFARACS 1968
- Dr Ronald Ernest Thiel (Qld)
FANZCA 1992, FFARACS 1966

College honours and awards

- Dr Leona Wilson has been appointed chair of the New Zealand Perioperative Mortality Review Committee.
- Dr Andrew Kenneth Bacon has been awarded the Ambulance Service Medal (ASM), Victorian Ambulance Service, in the 2012 Australia Day Honours List.

Education and Training

ANZCA curriculum project: Council approved in principle a preliminary draft of the ANZCA *Handbook for Training and Accreditation*, which will now be circulated for wider consultation. A further draft of Regulation 37 "Training in anaesthesia leading to FANZCA, and accreditation of facilities to deliver this curriculum" was also approved. Copies of both documents will be presented to June meetings of the Education and Training Committee and the council for approval.

Training program in Hong Kong, Malaysia and Singapore:

In light of the achievement of the original purpose for training in Hong Kong, Malaysia and Singapore being fulfilled with the development of internationally recognised training programs and qualifications in each country, the ANZCA Council decided not to implement the 2013 curriculum in Hong Kong, Malaysia and Singapore.

Trainees registered on April 21, 2012, will be supported to complete the current training program within a reasonable timeframe, with provisions for these trainees to be developed in consultation with the regional training committees of Hong Kong, Singapore and Malaysia. Support for and privileges of existing Fellows will continue. The council will work with anaesthesia leaders in Hong

Kong, Singapore and Malaysia to shape a new collaboration that builds on our shared history and supports our shared objectives over coming decades. More information is available as a link from the front page of the College website.

EMAC Course Subcommittee: Council approved the formation of an EMAC Course Subcommittee, which will oversee the accreditation of simulation centres for EMAC and provide advice to the Education and Training Committee and the ANZCA Council on trainee access to EMAC courses. In line with this decision, terms of reference have been developed for the subcommittee and Regulation 2 will be amended to reflect the disbandment of the Courses Working Group.

Training Accreditation Inspectors:

Council supported the development of a formal process for the appointment of training accreditation inspectors who are not councillors or members of the Training Accreditation Committee. They will be appointed for three-year terms and eligible for re-appointment three times (a maximum of 12 years). The process for appointments is outlined in the terms of reference for ANZCA Training Accreditation Inspectors.

Training Accreditation Committee (TAC) 2013 Working Group:

Council approved the establishment of an advisory body to review the changes and the implications for accreditation and to make recommendations to the Training Accreditation Committee about necessary changes. Terms of reference have been developed to assist in this process.

Time limits for recognition of outstanding AVT forms:

A time limit of May 31, 2012 has been placed on receipt of outstanding approved vocational training forms for training completed in 2009 or before. Trainees who do not submit relevant documentation by this date will lose accredited time for the relevant training terms. This is being communicated to individual trainees and their supervisors of training.

Dr Lisa Akelisi-Yockopua was supported to attend the 2012 ASM in Perth from the ANZCA scholarship fund.

Papua New Guinea: ANZCA will provide the best medical student with a certificate and \$100, the best diploma of anaesthesia

with a certificate and \$400, and the best MMed student with the Professor Garry Phillips Prize in the form of a medal and \$500.

Fellowship Affairs

New Fellows Conference: Council approved the following resolutions:

- (a) That new Fellows who attend the New Fellows Conference are eligible within five years of fellowship.
- (b) New Fellows will receive financial support to present at one annual scientific meeting only.
- (c) That the above recommendations are implemented from 2013 onwards.
- (d) That new Fellow representatives will be required to report back to their respective regional/national committees, by writing a report on the New Fellows Conference and presenting it to the regional or national committee.

Annual scientific meetings

2018 ASM: Canberra will host the 2018 Annual Scientific Meeting, to take place at the National Convention Centre from Friday May 4 to Wednesday May 9, 2018.

2014 ASM: Due to the redevelopment of the Sydney Convention Centre, the 2014 ASM will be relocated to Singapore and will be a co-located meeting with the Royal Australasian College of Surgeons Annual Scientific Congress from Monday May 5 to Friday May 9, 2014. Dr Nicole Phillips will be the convenor of the 2014 Annual Scientific Meeting and Dr Timothy McCulloch the scientific convenor.

Internal Affairs

Appointment of external representatives:

Council approved the following appointments:

- Dr Rowan Thomas – ANZCA representative to the Standards Australia IT-014-13 Clinical Decision Support Sub-Committee.
- Dr Phoebe Mainland – ANZCA representative to the Standards Australia mirror committee for ISO TC 210 (Quality Management and corresponding general aspects for medical devices).
- Professor Kate Leslie – Health Workforce Australia – Expert reference group for the expanding workforce scope initiative: advanced practitioners in endoscopy nursing

Indigenous Health Committee: In seeking to determine and monitor the numbers of indigenous trainees and Fellows in Australia and New Zealand and in line with a request from the Committee of Presidents of Medical Colleges Indigenous Subcommittee, questions derived from the census of both Australia and New Zealand will be included in the training application and subscription notices.

Terms of reference: Council approved the following terms of reference for Fellows and trainees occupying leadership roles within ANZCA: President; vice-president; honorary treasurer; councillors; committee, subcommittee and working group chairs; committee, subcommittee and working group members; chair of examinations; final and primary examiners; Training Accreditation Committee inspectors; international medical graduate specialist panel members; international medical graduate specialist workplace-based assessment assessors; and the annual scientific meeting officer. Copies of these documents will be made available on the ANZCA website shortly.

Australian federal not-for-profit sector reform: The CEO provided the ANZCA Council information about the establishment of an independent regulator, the Australian Charities and Not-for-profits Commission (ACNC), a new definition of 'charity' and other changes. The college will ensure it is prepared for these changes.

Regulations: Amendments have been made as follows with copies to be made available on the ANZCA website shortly:

- Regulation 2 – 'Committees of the Council' to include the EMAC Course Subcommittee and the Anaesthesia and Pain Medicine Foundation (regulation 34 was withdrawn).
- Regulation 4 – 'Examination Subcommittees and Courts' (this regulation will be withdrawn from the start of the 2013 Hospital Employment Year, with content to be distributed to regulations 2 and 37 and the terms of reference).
- Regulation 6.4 – 'Admission to Fellowship by Assessment'.

- Regulation 30 – 'Reconsideration and Review' to include a time limit of 3 months from the date of the decision to applications for reconsideration and review.

Quality and Safety Recategorisation of 'T' documents to 'PS' documents

During the work of the TE-Document Development Group, it became evident that the College's professional documents could be rationalised by reclassifying all documents in the "technical ("T")" category as "professional standards ("PS")". The proposed change in categorisation would apply to:

- To1 Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations.
- To3 Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice.
- To4 Guidelines on Equipment to Manage a Difficult Airway During Anaesthesia.

PS42 Recommendations for Staffing of Departments of Anaesthesia

A document development group will be established to review the document and develop an accompanying background paper. The following individuals have been appointed to the group: Dr Mark Reeves (lead; Tas), Dr Vanessa Beavis (NZ), Dr Kerry Brandis (Qld), Dr Peter Roessler (Vic) and Associate Professor Daryl Williams (Vic).

TE09 Guidelines on Quality Assurance in Anaesthesia

A document development group will be established to review the TE09 and, develop it into a professional standard and accompanied by a background paper. The Quality and Safety Committee will put forward to council the document development group's composition for approval.

PS16 Statement on the Standards of Practice of a Specialist Anaesthetist and TE06 Guidelines on the Duties of an Anaesthetist

A document development group will be established to amalgamate both documents into one professional standard and prepare an accompanying background paper. The following

individuals have been appointed to the document development group: Dr Rod Mitchell (lead; SA), Dr Justin Burke (Vic), Dr Alison Corbett (WA Regional Committee Vice-Chair), Dr Vaughan Laurenson (NZ) and Dr Peter Roessler (Director of Professional Affairs).

Retiring Councillors

This was the last council meeting for Councillor Dr Leona Wilson, the Faculty of Pain Medicine Dean Dr David Jones, and New Fellow Councillor Dr Justin Burke. The president thanked them for their contributions and wished them well for their future endeavours.

Dr Roberts acknowledged the many significant contributions made by Professor Leslie as the ANZCA president and wished her well for the future. Professor Leslie will remain on the ANZCA Council for the next two years as a councillor.

Dr Lindy Roberts will take office as the ANZCA President from the annual general meeting to be held at the Perth ASM in May 2012.

Professor Kate Leslie
President

Dr Lindy Roberts
Vice-President

Dean's message



It is a time of major change at Faculty of Pain Medicine Board, with the retirements of five board members, three of whom have served the maximum 12 years of board service allowable under the Faculty regulations.

Dr Carolyn Arnold (2006-12) and Dr Guy Bashford (2009-2012) are retiring board members not standing for re-election. They have both been significant contributors as chairs of Training Unit Accreditation Committee and Continuous Professional Development Committee respectively, as well as being major contributors to several Faculty committees and initiatives. The demands on board members can at times be onerous and the significant contributions of Drs Arnold and Bashford are very much appreciated.

In 1994, discussions began between leading thinkers of five participating medical colleges. These discussions ultimately resulted in the formation of the Faculty of Pain Medicine in 1998. An interim board was formed and later, in the year 2000, the first annual general meeting of the Faculty was held and the first board elected. Three members of that initial visionary group have continued to serve on the Faculty's board until May this year. Associate Professor Leigh Atkinson (dean 2002-04), Dr Penny Briscoe (dean 2008-10) and Dr David Jones (dean 2010-12) have been instrumental in the foundation and refinement of not only the Regulations and processes of the Faculty, but the spirit and culture that has delivered our identity and success. They have nurtured their "baby" through to its teenage years and now, like all good parents, must stand aside, watch and worry as the Faculty forges its own ongoing, destiny.

On behalf of the Faculty, I thank all five retiring board members for their invaluable contributions and wish them all the best for the future.

The imminent challenge to the incoming board this year is to ensure a smooth changing of the guard. The foundations we have inherited are solid and the future looks bright.

Associate Professor Milton Cohen (Faculty dean 2004-06), another foundation board member, continues in his role as Director of Professional Affairs and provides an ongoing valuable source of corporate knowledge of Faculty affairs at this important time of transition.

We welcome onto the board, Dr Melissa Viney and Dr Michael Vagg from Geelong and Dr Andrew Zacest, Dr Dilip Kapur and Dr Meredith Craigie from Adelaide. Professor Stephan Schug and Dr Kieran Davis will continue as co-opted members on the board from Western Australia and North Island of New Zealand respectively. The new members of the board bring new energy and vision and a feeling of optimism for the consolidation of achievements to date and to ensure growth and leadership in the Faculty.

Over the first four months of this year, the Faculty has engaged in a wide-ranging review and strategic planning initiative. Input was sought from external stakeholder groups as well as regional committees of the Faculty and from within ANZCA and the Faculty board. Two facilitated sessions were held in conjunction with the February and May board meetings, to review feedback and agree our goals for the future, to understand the challenges we face and plan the actions and activities required to achieve our goals. The second session was attended by all retiring and new board members and was useful to ensure a seamless transition of ideas and aspirations for the future.

I am pleased to report that the Faculty of Pain Medicine in Australia and New Zealand is strong and growing. Our relationship with ANZCA is strong and ANZCA's support remains invaluable. Our own professional, courteous and effective Faculty staff are led with distinction by Ms Helen Morris. My sincere thanks, personally and on behalf of the board for your ongoing support.

The focus for the Faculty continues to be on building a strong and effective support network for our Fellows and to maintain the highest standards of training and examination towards the award of our fellowship. We have an ongoing responsibility to promote the specialty of pain medicine to increase our fellowship numbers to enable us to better meet community needs.

The important work towards recognition as a medical specialty in New Zealand remains a top priority. Progress remains steady and positive.

We are working with the Royal Australian College of General Practitioners to produce and deliver an innovative online education program to be launched later this year, jointly at the Faculty's spring meeting in Coolumberrig and the GP12 (RACGP) meeting on the Gold Coast. Sixteen Faculty Fellows and invited experts have contributed to the content of this educational initiative. These efforts to promote knowledge and understanding of pain medicine and management can be extended to wider audiences in the coming years.

We aim to build our knowledge and curriculum for the future. We have a vision to produce strong and reliable research. Co-operation across our fellowship to produce collaborative, or pooled data, presents an opportunity to contribute meaningfully as a Faculty to global scientific research. We are working steadily towards the establishment of national outcome data collaborations and registries. Pooling, accurately recording and analysing the effect and effectiveness of different treatment approaches will give us real and useful clinical direction to genuinely raise the level of treatment and care available to our patients in the community.

An understanding of the future challenges for the Faculty begins and ends in the community. The problem of persistent pain continues to be misunderstood and access to information and treatment is alarmingly inadequate. The resultant suffering of people in persistent pain remains unacceptable. We must continue to advocate strongly and co-operatively with our partner organisations, ANZCA, PainAustralia, the Australian Pain Society, New Zealand Pain Society and consumer and industry groups, to keep the management of pain, in all its forms, on the political agenda.

In my first address as Dean of the Faculty, I admit to feeling humbled and slightly overwhelmed. I am honoured to follow as dean, in the footsteps of people whose counsel I have cherished and whose work and achievements I respect and admire. I can only aspire to continue the quality of leadership to which this Faculty has become accustomed.

Associate Professor Brendan Moore
Dean, Faculty of Pain Medicine

Dr David Jones' farewell



As ANZCA celebrates its 20th birthday, the Faculty of Pain Medicine reached its teens. I have been privileged to be there since its conception and gestation via an ANZCA Joint Advisory Committee on Pain Management (JACPM, 1994-1998) then continue to serve on the Faculty Board as inaugural censor (subsequently assessor) since the Faculty's birth late in 1999 and through to being the sixth Dean. Now it is necessary for me to step aside.

I would like to acknowledge many fine people who have also been dedicated to seeing the Faculty grow from a good idea, then evolve and thrive into the peak training and assessment organisation that it is today.

In particular I pay tribute to Associate Professor Leigh Atkinson and Dr Penny Briscoe, both former deans who also now leave the board having completed maximum 12-year terms, and former dean Associate Professor Milton Cohen, who continues his valuable input as the Faculty's first director of professional affairs.

From the founding dean, Professor Michael Cousins, together with all other board members, these people have made a major contribution to this early genesis of the Faculty. In addition I acknowledge the strengthening relationship with ANZCA as the host College, which has made the venture possible. I would not like to belittle in any way all the other contributing specialists, but at the same time note that anaesthetists are present during the genesis of many long-term pain conditions, and have a very significant contributory role in working towards reduction of chronicity.

A new board with five new members has been empanelled led by Associate Professor Brendan Moore. This happens at an exciting time – especially to continue developing a realigned curriculum flowing from the blueprinting project, and also the time of settling the strategy directions for the next five years.

The priority directions include maturing of the project for outcome data collection and its evaluation, and development of future leaders and increased advocacy.

Since pain traverses most areas of health practice, it is important to have all health

professionals better educated, as well as the public in general. To that end, the Faculty is continuing to build new relationships. Primary care and gynaecology are two major fields where much persistent pain is encountered, and through the efforts of a former dean of Faculty, a new section on pain within Royal Australasian College of Surgeons connects to another large source of clinical cases.

It is significant that the Faculty's Visiting Speaker, Professor Henrik Kehlet, a world authority on persistent post-surgical pain, delivered his plenary on the transition from acute to chronic pain at the recent ANZCA ASM. The Faculty is multidisciplinary, and these examples illustrate the cross-specialty collaboration that is necessary to get all on the same page regarding persistent pain.

In partnership with the pain societies and PainAustralia, the task of improving access to services looms larger than most. Growing a skilled workforce is inextricably linked to this in that increased places for training are also needed.

There is growing unrest in Australia and New Zealand over what is appropriate regarding opioid prescribing, with much of what reaches the headlines lacking balance by only highlighting what is bad. Rarely, if ever, is there a mention of positive outcomes, which I can assert from experience do exist. Having the wisdom to know the difference comes to mind.

Much of what has been presented at scientific meetings recently (for example, fMRI studies, graded motor imagery, placebo and nocebo research) tell me that the organ of pain is ... the brain!

If I had to select a single theme about helping pain sufferers to cope and improve their lot, I would choose the relationship we must form with them as being paramount. We do not cure long-term pain, we frequently control some of it, but always we need to strive to provide comfort. That comfort requires a huge range of tools, including active listening, believing and acknowledging the person has a problem – although not an unsurmountable one – reducing the perceived threat from a pain condition, reassurance, and providing realistic expectations from health interactions for pain.

Stressors, such as the effects of not being believed, or uncertainty about the meaning of a particular pain regarding the patient's future and even life expectancy, are consistent with recent research on creating nocebo effects.

Dealing with these factors usually takes more than one interaction (that is, a relationship), and I ask whether we as specialists should be treating doctors (who do it) or consultant doctors (who tell other people what to do)? There may be some important style differences that alter outcomes – something for Faculty members to consider when it comes to evaluating outcomes data.

None of those arts of medicine methods exonerate us from having top-notch knowledge about all the scientific aspects of our specialty. But the art of communicating that meaningfully to the patient needs much thought and practice. It should be no surprise then that experienced practitioners are questioning within Faculty circles the duration we allocate for training. How much is enough?

Briefly I would like to mention something about the environment in which we operate. It is increasingly more politically correct, and a normal expectation, to provide information and gain informed consent. It certainly feels right to inform patients well – and is even expected by the law. But each month I encounter an example of another health professional undermining some aspect of what I thought was a job well done, usually an act by someone thinking they are doing their job well. For example, in a dispensing location reading to a patient each the side and adverse effects of a medication from the drug catalogue, or printing it from the computer and giving it to the patient. On the surface it may seem like the right thing to do, notwithstanding we (patient plus prescriber) might have discussed the *most likely* side and adverse effects before they departed the consultation. Patients return with reports like "it freaked me out". It may increase their fear of taking anything.

Research proves that active medications include placebo responses (a real response) contributing to their beneficial effects¹. Similarly pairing of dire/negative messages with effective agents undermines their efficacy (nocebo effect). And that happens for even the safest of medicines we use. What can you as readers contribute on how we can remain ethical, comply with legal requirements but also not undermine the efficacy of our tools? The science is there already.

I have learned innumerable lessons from those around me – practitioners of all types, patients and even a few politicians. I thank all those who have shared their wisdom, guidance, stories, secrets and tricks of practice, and those who entrusted me with stewardship of the Faculty and its board over my time as dean.

To conclude, as I wish the Faculty and its Fellows an even brighter future, I would like to leave you with a modified version of the plea (from Niebuhr): "Give us **Grace** to accept with serenity what we cannot change, **Courage** to change what must be changed, and the **Wisdom** to distinguish between them".

Dr David Jones
Immediate past Dean, FPM

Reference:

Tracey I. Getting the pain you expect: mechanisms of placebo, nocebo and reappraisal effects in humans. *Nature Medicine* (2010); 16:1277-1283.

News

2012 Examination

Examination dates

November 23-25, 2012 (Friday to Sunday)

The Auckland Regional Pain Service,
Auckland NZ

Closing Date for Registration:
Friday October 5, 2012

Pre-Examination Short Course

The 2012 Pre-Examination Short Course will be held from September 14-16, 2012 at ANZCA/FPM Brisbane Regional Office, West End Corporate Park, River Tower, 20 Pidgeon Close, West End, Queensland.

Closing date for registration:
Friday September 9, 2012.

Admission to Fellowship of the Faculty of Pain Medicine

By examination:

Dr Simon Aaron Cohen, FRACP
(New South Wales)

Dr Cornelis Abraham De Neef,
FACRRM (Victoria)

Dr Louise Kathleen Brennan,
FANZCA (Victoria)

Dr Brett Chandler, FANZCA (Victoria)

Dr Roderick Kenneth Grant, FANZCA
(Queensland)

Dr Jason Suk Hyun Kwon, FANZCA
(Queensland)

Dr James Chor Hoaw Yu, FANZCA
(New South Wales)

Dr Mohammed Saleem Khan,
FAFRM(RACP) (Victoria)

Dr Gopinathan Raju, MA (Malaysia)

Honorary Fellowship:

Professor Henrik Kehlet, PhD
(Denmark)

Training Unit Accreditation

Following successful reviews, Concord Repatriation General Hospital, The Royal Children's Hospital and Flinders Medical Centre has been re-accredited for training. After its initial review, Gold Coast Interdisciplinary Persistent Pain Centre has become an accredited training unit, bringing the number of accredited pain units to 28.

Dr Timothy Brake has been confirmed as the Supervisor of Training at the Kowloon East Cluster Pain Management Centre.

FPM Board meeting report

May 2012

Report following the Faculty of Pain Medicine Board meetings held on May 10 and May 13.

The Faculty of Pain Medicine Board met on May 10 in Perth and the new board met on May 13 to appoint office bearers and committee chairs. The chairs will confirm committee membership within the coming weeks.

At the new board meeting, Professor Ted Shipton (NZ) was elected FPM Vice-Dean, Professor Stephan Schug and Dr Kieran Davis were co-opted for a second term representing Western Australia and the North Island New Zealand respectively. Associate Professor David A Scott, FANZCA, FFPMANZCA (Vic) was confirmed as the co-opted ANZCA Council representative to the board. The board now comprises:

Associate Professor Brendan Moore
Dean

Professor Edward Shipton
Vice-Dean, Chair, Education Committee

Dr Meredith Craigie
Chair, Examination Committee

Dr Kieran Davis
Co-opted member North Island of New Zealand

Dr Ray Garrick
Royal Australasian College of Physicians representative

Dr Chris Hayes
Chair, Research Committee

Dr Dilip Kapur
Treasurer

Dr Frank New
Assessor

Professor Stephan Schug
Co-opted member, Western Australia

Dr Michael Vagg
Chair, Continuing Professional Development Committee

Dr Melissa Viney
Chair, Training Unit Accreditation Committee

Dr Andrew Zacest
Royal Australasian College of Surgeons representative

Associate Professor David A Scott
Co-opted member of ANZCA Council

The board congratulated Dr Frank Moloney (NSW) and Dr Michelle Mulligan on their re-election to ANZCA Council, and to Dr Vanessa Beavis (NZ) and Dr Gabriel Snyder (New Fellow councillor) on their election to ANZCA Council.

Dr David Jones, Professor Leigh Atkinson, Dr Penny Briscoe, Dr Carolyn Arnold and Dr Guy Bashford were farewelled at the FPM Annual Dinner on Friday May 11.

The Faculty Board will next meet in Melbourne on August 13.

FPM strategic planning 2013-17

The board, including new board members, held a second strategic-planning workshop in conjunction with the May 10 board meeting to continue developing a five-year strategy. A summary of responses from consultation with key stakeholders helped identify strategic goals for FPM to 2017.

Arising from the workshop, the Faculty's driving aim for 2013-17 is "Building strength". Key pillars of the strategy will be:

- Build the fellowship and the Faculty.
- Build curriculum and knowledge.
- Build advocacy and access.

Fellowship

Two new Fellows were admitted in March, six in April and two in May, including the award of honorary fellowship to Professor Henrik Kehlet at the College Ceremony in Perth. This takes the total number of admissions to 328.

Associate fellowship

The board resolved to rescind FPM Regulation 3.5: Admission to Associate Fellowship by Training and Examination. The board agreed that a single registerable qualification, FPMANZCA, will be awarded to persons who meet all Faculty training and assessment criteria. A prior specialist qualification "acceptable to the board" is one of the criteria. International medical graduate specialists applying for FPM training will be assessed on a case-by-case basis to determine the quantum of recognition of prior learning to be credited towards the Faculty's training time requirements. Regulation 3.1.1.6 will be amended to remove reference to a requirement for an Australian or New Zealand specialist qualification acceptable to the board.

International medical graduate specialists (IMGS)

The board approved the formation of an FPM IMGS Working Group to review ANZCA Regulation 23 with a view to adopting this regulation and to follow closely ANZCA's IMGS assessment processes adapted to pain medicine as the subject matter. The FPM working group will include representation from the ANZCA IMGS Committee and ANZCA's manager IMGS and accreditation. The board resolved that FPM IMGS assessment fees will align with ANZCA's.

Relationships

ANZCA

The following Fellows were nominated to represent the Faculty on ANZCA committees:

Dr Meredith Craigie
Examinations Committee/Chair, Examinations

Primary Examination Sub-Committee/Chair, Examinations

Final Examination Sub-Committee/Chair, Examinations

Professor Ted Shipton
Education and Training Committee/Chair, Education Committee

Dr Chris Hayes
Research Committee/Chair, Research

Dr Penny Briscoe
Fellowship Affairs Committee/ASM officer

Dr Frank New
IMGS Committee/Assessor

Dr Jane Trinca
Quality and Safety Committee

Associate Professor Roger Goucke
Overseas Aid Committee

Dr Melissa Viney
Training Accreditation Committee

Professor Stephan Schug
ANZCA Trials Group Executive

Dr Penny Briscoe/
Professor Ted Shipton
ANZCA Terms of Reference Working Group

Representation on ANZCA regional committees is to be confirmed following consultation with regional chairs.

Royal Australian College of General Practitioners (RACGP)

A steering group meeting for the joint FPM/RACGP GP online-learning project was held on April 27 in Sydney. Following development of the online content involving a number of Fellows, the project has now entered the review process and remains on track for a launch of a module at the FPM Spring Meeting in Coolom on September 29. The full active-learning module will be launched at the GP12 meeting on October 26.

Australian Pain Society/New Zealand Pain Society/FPM/ANZCA boards breakfast meeting

Faculty representatives attended an informal combined boards breakfast meeting during the Australian Pain Society Annual Scientific Meeting, which brought together key representatives of the Australian Pain Society, New Zealand Pain Society, PainAustralia, FPM and ANZCA. Another meeting of the group will be convened later in the year to discuss opportunities for closer collaboration to achieve the next steps to implement the National Pain Strategy.

Education

FPM curriculum revision

During April and May, research was done into educational approaches used by fields relevant to pain medicine. The findings of the research and a second version of the proposed curriculum framework were presented to members of the Curriculum Revision Sub-committee in a workshop in Perth on May 14. Two current trainees have joined the sub-committee and were present at the workshop. The latest version of the proposed framework includes two streams of learning and assessment: Stream A – Understanding of theory and Stream B – Clinical skills development. Additional workshops are planned throughout the year. Implementation of the new curriculum is planned for 2015.

(continued next page)

FPM Board meeting report continued

Retrospective credit of prior training

The board approved the establishment of a working party to develop criteria upon which to base decisions regarding the awarding of retrospective credit for prior training and experience in a manner that is reliable, available to relevant stakeholders, and based on the current understanding of the requirements of a specialist pain medicine physician. There will be collaboration with the planned IMGs Working Group.

Training unit accreditation

The Gold Coast Interdisciplinary Persistent Pain Centre has been accredited for pain medicine training. Concord Repatriation General Hospital, Royal Children's Hospital and Flinders Medical Centre have been re-accredited.

The board approved the revised Faculty professional document PM2 (2012) *Guidelines for Units Offering Training in Multidisciplinary Pain Medicine*. The revised document includes criteria for Tier 2 accreditation for units deemed by the Faculty Training Unit Accreditation Committee to have significant strengths in some areas of pain medicine practice, but not the breadth of practice required to satisfactorily meet the requirements of a comprehensive (Tier 1) training facility (as stipulated in PM2).

Continuing professional development

2012 ASM and Refresher Course Day – Perth

The Faculty's Refresher Course Day and ASM programs were a great success. The refresher course attracted more than 130 delegates and strong support from healthcare industry sponsors and exhibitors. The program provided insights into the importance of outcome measurement in pain management. The day was completed with a dinner at the Old Brewery overlooking the magnificent Swan River. The meetings attracted widespread media coverage and the *ASM E-newsletter* was well received. Thanks go to all who contributed in bringing this event to fruition.

The Best Free Paper Award was awarded to Dr Sarika Kumar for her paper titled "Total and free ropivacaine drug levels during continuous Transversus Abdominis Plane (TAP) block for postoperative analgesia after abdominal surgery: A pilot study".

The Dean's Prize was not awarded.

2014 ASM and Refresher Course Day – Singapore

Following the change of venue from Sydney to Singapore, the Faculty has appointed a Co-FPM Scientific Convenor, Dr Kian Hian Tan (Singapore), to work with Dr Lewis Holford. The Faculty is investigating potential venues for the Refresher Course Day in Singapore and opportunities for collaboration with the Royal Australasian College of Surgeons pain medicine section.

Professional Electronic Persistent Pain Outcomes Centre (ePPOC)

The project to develop a national benchmarking system for chronic pain has now been provisionally titled 'Electronic Persistent Pain Outcome Centre' (ePPOC). Development is planned in three stages; a funded planning stage; an initial pilot; larger roll out. Stage one is aimed at developing a sustainable business model for ePPOC. Once an approved business plan is developed and a funding module is secured, a pilot roll out involving six to eight centres is anticipated. This will enable initial implementation and system development. Once the benchmarking system is refined, a larger roll out will be launched.

Submissions

The Faculty's submission to the Australian Medical Council for ongoing accreditation was submitted March 2012 and can be viewed on the FPM website at www.fpm.anzca.edu.au/communications/accreditation-submissions.

The Faculty has recently contributed to the following submissions, which can be viewed at www.anzca.edu.au/communications/submissions/government-submissions-2012

- Health Workforce Principal Committee – Development of national criteria under the National Registration and Accreditation Scheme (NRAS) – April 2012
- Medical Board of Australia – Consultation on the board funding external doctors' health programs – April 2012
- Department of Health and Ageing – Evidence requirements for assessment of applications for the prostheses list: A discussion paper – February 2012
- Deputy Director General, Governance, Workforce and Corporate – Request for information to support NSW medical specialist modelling – March 2012

Finance

At the end of April, the Faculty remained in a positive position against budget.

2012 calendar

Dates for future board meetings:
August 13 (Melbourne)
October 29 (Melbourne)

Library update

New titles

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

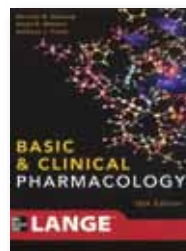


AAGBI core topics in anaesthesia 2012 / Johnston, Ian [ed]; Harrop-Griffiths, William [ed]; Gemmell, Leslie [ed]. / Association of Anaesthetists of Great Britain and Ireland. -- Oxford, UK: Wiley-Blackwell, 2012.

Alfred Hospital faces and places. Volume IV / Alfred Hospital; Alfred Healthcare Group Heritage Committee. -- Prahran, Victoria: *The Alfred*, 2010. *Kindly donated by the Alfred Hospital Heritage Committee*



Australasian anaesthesia 2011: Invited papers and selected continuing education lectures / Riley, Richard [ed]. -- Melbourne: Australian and New Zealand College of Anaesthetists, 2012. *Also available online through the ANZCA website*



Basic and clinical pharmacology / Katzung, Bertram G [ed]; Masters, Susan B. [ed]; Trevor, Anthony J. [ed]. -- 12th ed -- New York: McGraw-Hill, 2012.



Essentials of pain medicine / Benzon, Honorio T [ed]; Raja, Srinivasa N. [ed]; Fishman, Scott M. [ed]; Liu, Spencer [ed]; Cohen, Steven P. [ed]. -- 3rd ed -- New York: Elsevier Saunders, 2011.

More e-books available to Fellows and trainees

The ANZCA Library now provides access to over 25 online textbooks through Cambridge University Press, as detailed below:

- Anaesthetic and Perioperative Complications.
- Evidence-based Anaesthesia and Intensive Care.
- Basic Science for Anaesthetists, 2nd Edition.
- The Anaesthesia Science Viva Book, 2nd Edition.
- Anesthesia in Cosmetic Surgery.
- Core Topics in Airway Management, 2nd Edition.
- The Clinical Anaesthesia Viva Book, 2nd Edition.
- MCQs for the Primary FRCA.
- Core Topics in Neuroanaesthesia and Neurointensive Care.

- Anesthetic Pharmacology: Basic Principles and Clinical Practice, 2nd Edition.
- Core Topics in Endocrinology in Anaesthesia and Critical Care.
- Controversies in Obstetric Anesthesia and Analgesia.
- Physics, Pharmacology and Physiology for Anaesthetists: Key Concepts for the FRCA.
- Ultrasound-Guided Regional Anesthesia: A Practical Approach to Peripheral Nerve Blocks and Perineural Catheters.
- SBAs for the Final FRCA.
- Anesthesia Oral Board Review: Knocking Out the Boards.
- Anesthetic Management of the Obese Surgical Patient.
- Case Studies in Neuroanaesthesia and Neurocritical Care.
- Clinical Ethics in Anesthesiology: A Case-Based Textbook.
- Positioning Patients for Surgery.

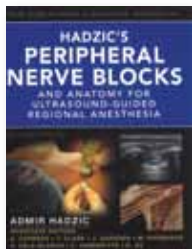
- Pharmacology for Anaesthesia and Intensive Care, 3rd Edition.
- Core Clinical Competencies in Anesthesiology: A Case-based Approach.
- SAQs for the Final FRCA.
- Morbid Obesity: Peri-operative Management, 2nd Edition.
- Anesthesia for the High-Risk Patient, 2nd Edition.

These e-books and many more can be accessed through the ANZCA Library online textbooks list or library catalogue: www.anzca.edu.au/resources/library/online-textbooks

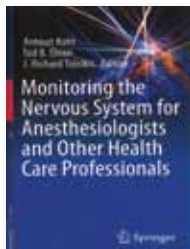
New ECRI publications

Health Devices, Vol. 40, No. 9, September 2011

- Best vital signs monitors. Health Devices, Vol. 40, No. 12, December 2011
- Evaluation of 10 intensive care ventilators.



Hadzic's peripheral nerve blocks and anatomy for ultrasound-guided regional anesthesia / Hadzic, Admir [ed]. -- 2nd ed -- New York: McGraw-Hill, 2012. *Also available online through ANZCA Library online textbooks list*



Monitoring the nervous system for anesthesiologists and other health care professionals / Koht, Antoun [ed]; Sloan, Tod B. [ed]; Toileikis, J. Richard [ed]. -- New York: Springer, 2012.



Ophthalmic anaesthesia / Kumar, Chandra M [ed]; Dodds, Chris [ed]; Gayer, Steven [ed]. -- Oxford: Oxford University Press, 2012.

History of anaesthesia VII: proceedings (7th : 2009 Oct. 1-3 : Crete): proceedings of the 7th International symposium on the history of anaesthesia / Askitopoulou, Helen [ed]. -- Herakleion: Crete University Press, 2012.



Neuroscientific foundations of anesthesiology / Mashour, George A. [ed]; Lydic, Ralph [ed]. -- 1st ed -- Oxford: Oxford University Press, 2011.

Stoelting's anesthesia and co-existing disease / Hines, Robert L. [ed]; Marschall, Katherine E. [ed]. -- 6th ed -- Philadelphia, PA: Churchill Livingstone, 2012. *Available online through ANZCA Library Online Textbooks list*

- Ventilator alarms and safety alerts. Health Devices, Vol. 41, No. 4, April 2012.
- Making connections: integrating medical devices with electronic medical records. Health Devices, Vol. 41, No. 5, May 2012.
- Interfacing monitoring systems with ventilators.
- Advanced ventilation features. Operating Room Risk Management updates.
- Basic Patient Monitoring during Anesthesia.
- Pre-Use Checklist for Anesthesia Units.
- Social Media in Healthcare.

Evidence-based practice corner

Hines S, Steels E, Chang A, Gibbons K. *Aromatherapy for treatment of postoperative nausea and vomiting*. Cochrane Database of Systematic Reviews 2012, Issue 4. Art. No.: CD007598.

Liakopoulos OJ, Kuhn EW, Slottosch I, Wassmer G, Wahlers T. *Preoperative statin therapy for patients undergoing cardiac surgery*. Cochrane Database of Systematic Reviews 2012, Issue 4. Art. No.: CD008493.

Derry S, Moore RA. *Single dose oral celecoxib for acute postoperative pain in adults*. Cochrane Database of Systematic Reviews 2012, Issue 3. Art. No.: CD004233.

Jones L, Othman M, Dowswell T, Alfirevic Z, Gates S, Newburn M, Jordan S, Lavender T, Neilson JP. *Pain management for women in labour: an overview of systematic reviews*. Cochrane Database of Systematic Reviews 2012, Issue 3. Art. No.: CD009234.

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Dr Ronald E Thiel

1934 – 2012



Ron Thiel was born and raised in Toowoomba, Queensland. He attended Toowoomba Grammar School from 1942-52 where he excelled both academically and on the sporting field. In his senior year, he was school captain, captain of school cadets, captain of the athletic team, president of school dramatic society and runner-up dux.

He commenced medical studies at the Queensland University School of Medicine in 1953. He was offered one of five state scholarships during his first year, but declined, perhaps because a scholarship required a seven-year commitment to the state health department after graduation. He later took up an army scholarship to assist with his education expenses. After graduation he was posted to Singleton and other bases for his requisite two years.

On returning to Brisbane, Ron worked as an anaesthetic registrar at Greenslopes Repatriation Hospital and the Royal Brisbane Hospital. He obtained his anaesthetic fellowship in 1966. (He was Fellow no. 303, which amused him considering his army background). He was awarded the prestigious Australian Society of Anaesthetists Gilbert Troup prize for his paper “The Myotonic Response to Suxamethonium”, which was published in the *British Journal of Anaesthesia* in October 1967.

Ron and his family moved to Cairns where he was the sole specialist anaesthetist for six years. Ron was the mainstay of anaesthetic practice, both public and private, during this period, with some GP anaesthetists to support him. Because of his enthusiasm and teaching ability, he was instrumental in encouraging many residents to undertake post-graduate anaesthetic training.

Ron was a perfectionist and this inevitably led to professional altercations (especially with surgeons), and accounts of these confrontations are now folklore. He developed a large dental surgery anaesthetic practice and was one of foremost practitioners in this field.

In the early 1970s, Ron developed what was probably the first day-surgery unit in Queensland approved for Medicare rebates. For many years this facility at Solander Medical Centre provided a low-cost alternative to inpatient stays, prior to the establishment of hospital day surgery units.

As the Cairns Anaesthetic Group expanded, Ron moderated his workload and in 1987 undertook a “tree change” to Malanda on the Atherton Tablelands. He commuted to Cairns several times a week and worked sessions at Atherton Base Hospital, again undertaking teaching duties with nursing and medical staff.

Ron retired from anaesthetic practice in 1998 and relocated to Brisbane, then to Kooralbyn Valley and finally to the Sunshine Coast. His retirement was marred by the onset of Alzheimer’s disease that, with his usual tenacity and stubbornness, he fought for 12 years, far outlasting his initial prognosis.

Ron had a very active life outside anaesthetics, with the emphasis on sailing and water sports. He will be remembered for his wicked sense of humour, a ready grin and sometimes-questionable jokes!

Ron is survived by his devoted wife Gaye, his children William, Carey and Gillian and their families.

Dr Robert J Shield