March 2012

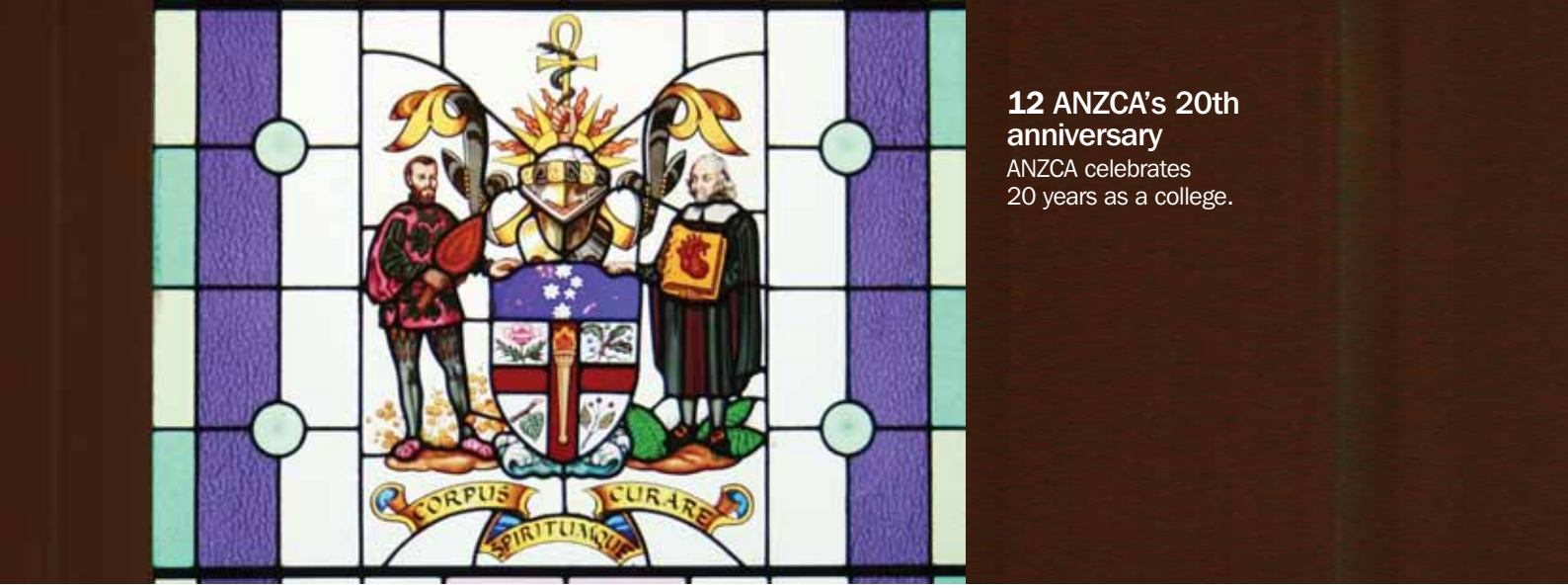
ANZCA BULLETIN

ANZCA
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

FPM
FACULTY OF PAIN MEDICINE ANZCA

This year ANZCA celebrates 20 years as a college

PLUS: A LOOK AT HOW CHRISTCHURCH IS COPING ONE YEAR AFTER THE EARTHQUAKE



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 some 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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In his Dean's message, Dr David Jones applauds the funding of an Australian system to track the prescribing and dispensing of opioids.

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President's message

Welcome to the first *Bulletin* for 2012! This is my last *Bulletin* message as the President of ANZCA. The President-elect, Dr Lindy Roberts, will take office following the annual general meeting to be held in May 2012 in Perth. Lindy started her training in the year that our College was formed – 1992 – and comes to the presidency with the vision, experience and commitment that will be crucial to the successful implementation of our redesigned curriculum. You can read Lindy's reflections on the start of her career, and how things have changed, in our feature on the 20th anniversary of ANZCA in this edition of the *Bulletin*. We've certainly come a long way since those early days, thanks to the talent and dedication of our Fellows, trainees and staff. I hope that you enjoy reading this special feature.

As this is my last message, I would like to reflect on the last two years and "What I know now that I didn't know before!"

The world outside anaesthesia

It's easy to become absorbed in the affairs of your own specialty to the exclusion of a broader understanding of how the health systems of our two countries work. On assuming office, I became ANZCA's representative on the Royal Australasian College of Surgeons' Council, the College of Intensive Care Medicine Board and the Committee of Presidents of Medical Colleges (CPMC). CPMC is a collaboration of the 15 Australian and Australasian specialist medical colleges. It receives reports from peak jurisdictional bodies and discusses issues such as ensuring the appropriate regulatory framework for medical education and practice, enough high-quality vocational training places, proper support for supervisors and the best quality and safety practices. As College president I also attended ANZCA New Zealand National Committee (NZNC) meetings and heard about the jurisdictional issues affecting anaesthetists and pain specialists there. The NZNC chair represents ANZCA on the Committee of Medical Colleges, the CPMC-equivalent in New Zealand.

So, what do I know now that I didn't know before about the world outside anaesthesia?

- In order to influence health policy, anaesthetists (and doctors in general) need to understand how our health systems work. This education should occur in medical schools, hospitals and specialist training programs. Our redesigned ANZCA curriculum includes learning objectives along these lines and I encourage trainees and their supervisors to make the most of these learning opportunities.
- ANZCA has a real opportunity to influence health policy at the highest level because the jurisdictions really do value input from doctors. Our exposure to all interventional specialties, acute care medicine and pain medicine gives us a broader understanding than most about the issues facing health. Because of our many policy submissions and the contributions of our delegates to meetings throughout Australia and New Zealand, ANZCA has a strong reputation on which we can build even further.
- The model for specialist medical training in our two countries is robust and cost-effective. However, we need to collaborate more with medical schools, the pre-vocational training sector, other colleges and health workforce bodies to ensure that the "training pipeline" is smooth and without any unnecessary cul-de-sacs or shortcuts.

The world inside ANZCA

Fellows usually contribute in areas of special interest or expertise within the College, be that training, fellowship affairs, research or quality and safety. The president, however, gets a bird's eye view of all College activities, as an ex-officio member of ANZCA's committees, sub-committees and working groups, a "frequent flyer" at conferences and workshops, and the chief point of liaison between the council and the staff. In addition, the president welcomes hundreds of new specialists to fellowship; thanks hundreds of examiners, conference organisers and committee members for their efforts; signs dozens of certificates of appreciation for supervisors; congratulates dozens of examination prize winners, research grant recipients

and medal recipients; and offers sympathy to the families of Fellows who have passed away, giving thanks for their contributions to our specialty. Finally, the president gets to know most of the staff, in particular the CEO and her team.

So, what do I know now that I didn't know before about the world inside ANZCA?

- I appreciate more fully the breadth of activity and the depth of dedication of our Fellows and trainees. Thanking people who have made a contribution is vital and we are continually improving the timeliness and completeness of this task. However, we need to explore further ways to make our sincere appreciation of all this work known to our Fellows – a project that is being undertaken by our Fellowship Affairs Committee and unit.
- Our staff value their work because they believe that they are contributing to a great cause: safe and high quality patient care. We need to take every opportunity to explain the clinical or training context of issues to our staff, in order to make their work even more efficient, effective and fulfilling. In parallel, Linda Sorrell, our CEO, will be contributing messages to the *Bulletin* and *E-Newsletter* with key news about our staff and their work. This will help us understand better all their efforts on our behalf.

Secret presidential business

You learn a lot about life as the president of a medical college. One of the lovely but secret jobs is writing letters of support for Fellows who have been nominated by their peers for an appointment to the New Zealand Order of Merit or Order of Australia. Some of our Fellows have contributed in wonderful ways to the profession and community, and it's great when this is acknowledged publicly. Another great job is sitting on interview panels for staff appointments and seeing the range of high-calibre people who want to work for us – a good sign of the health of our organisation. I've received a lot of messages of thanks and encouragement from people who have been helped by our work and a bit of advice about how to be a better person – all much appreciated!

Sometimes our Fellows' and trainees' performance does not live up to their best intentions: they run afoul of ANZCA's standards, workplace laws, medical registration bodies or community expectations and the president is asked for assistance or advice in a confidential capacity. More often than not, these Fellows and trainees have the content nailed, but could improve the way that they go about things and the way they interact with other people. As a result of this experience, I remain optimistic about peoples' motivations, and their ability to learn from their experiences and change ... and I'm also better at keeping secrets!

So, what do I know now that I didn't know before about secret presidential business?

- Sometimes, the people who struggle with their work performance or inter-personal relationships are not the ones you expect. We therefore need to make our expectations clear to everyone, through our *Code of Professional Conduct* and other resources; we need to provide more opportunities for up-skilling in communication, negotiation and leadership; we need to congratulate those who kick goals; and we need to be compassionate and supportive with those who continue to struggle.

In closing, I've really enjoyed my time as ANZCA President. I would like to thank the council, our former and current CEOs and their staff, the Fellows and the trainees for their support during my term. Twenty years after our formation in 1992, ANZCA is going strong!

Professor Kate Leslie
ANZCA President

How did we go with "ENGAGE"?

Embrace new training environments

- Twenty five Australian training posts in expanded settings (private, rural) for 2011 and 28 confirmed places for 2012. Applications are now open for places in 2013.

Negotiate and influence people

- More than 40 submissions to government and other bodies in 2011.
- Submission to Independent Health Pricing Authority on health reform.
- Submission to the Medical Board of Australia on doctors' health programs.

Get involved

- Curriculum Redesign Project involving more than 50 authors and hundreds of Fellows.
- Consultation for the ANZCA Strategic Plan 2013-2017 has begun with staff, Fellows and other internal and selected external stakeholders.

Advocate quality and safety

- Incident monitoring project (webairs) now up and running with 898 incidents collected.
- Six new or revised professional documents promulgated in 2011.

Give your support

- Fundraiser for Lifebox approved for the ASM gala dinner in May.
- Fellows donate more than $34,000 to the Anaesthesia and Pain Medicine Foundation in 2011 and donations in early 2012 are already higher than at the same time last year.

Educate yourself and others

- A growing library of audio and video podcasts including topics relevant to the ANZCA final examination, the online in-training assessment process and broad medical education.
- Clinical teachers' courses run throughout the regions.
- Twenty nine regional continuing medical education and special interest group events run from ANZCA offices in 2011 on behalf of ANZCA, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists.

CEO's message

In our first *Bulletin* for 2012, having now been at the College for six months, I believe the time is right to begin regular updates on our activities.

Over the past few months I have been visiting all the Australian regions and New Zealand to attend committee meetings and visit hospitals so I can hear directly what you believe to be the important issues.

Improving how we respond to your communications with the College is one project that is under way. We are in the process of establishing a service charter that will ensure Fellows and trainees are able to easily locate the correct staff member to help with queries and that these are responded to in a timely manner.

Revision of the ANZCA training program for the 2013 hospital year is a huge undertaking involving staff across the whole College working closely with a large number of Fellows involved in the project.

Key components of the revised curriculum are workplace-based assessments (WBAs) which are being introduced this year as a prelude to the requirements of the revised curriculum in 2013. In December we held a training-the-trainer workshop for 25 "WBA champions" who have been identified as key people to help disseminate information and provide workshops to our supervisors of training (SOTs) and other trainers about how WBAs work under the revised curriculum.

As part of the curriculum review we are revising all our policy documentation related to training and introducing a new training and accreditation handbook which will be the port of entry for all guidance information relating to the training program. The handbook will complement the curriculum and the consolidated regulation.

A new online training portfolio system is being developed to streamline the recording of information, including assessments and volume of practice requirements, for trainees and their supervisors.

FPM is also working on revising its curriculum for introduction in 2015 and has appointed a professional educationalist for the project.

ANZCA's strategic plan is being reviewed this year, timely given it is ANZCA's 20-year anniversary and a good opportunity to take stock of the progress to date, and to look at the College's future direction.

At present the project is focused on consulting with staff, Fellows and other internal and selected external stakeholders to inform an analysis of ANZCA's strengths and weaknesses, and identifying future challenges.

Council will consider this information as it decides on ANZCA's strategic priorities for the next five years. The revised strategic plan will be launched in August 2012.

FPM is also reviewing its strategic plan in alignment with ANZCA's planning process, and to join with ANZCA in considering the development and adoption of a shared vision and possibly a set of organisational values for the College and Faculty.

Another important project being co-ordinated by our policy team is the preparation of ANZCA's submission for reaccreditation to the Australian Medical Council (AMC) and the Medical Council of New Zealand. FPM is also preparing a submission for reaccreditation to the AMC. These important documents are an enormous undertaking involving many staff and Fellows. They will be submitted at the end of March with follow-up inspections planned for October.

Late last year our continuing professional development (CPD), information technology and communications teams redeveloped the online CPD portfolio to make it more user friendly based on feedback from Fellows. The CPD team is now working on a smart phone application that will enable Fellows to record their CPD activities using these mobile devices.

Finally, our events team is working hard with the Perth regional organising committee to bring you what promises to be a fantastic annual scientific meeting in May. If you haven't already registered, I encourage you to do so soon.

Linda Sorrell
Chief Executive Officer, ANZCA

Letters to the editor


NZ anaesthetic technicians can now register as health professionals

Re: NZ anaesthetic technicians can now register as health professionals (September 2011)
I was delighted to read the article by Susan Ewart, describing the "11-year process" that has resulted in anaesthetic

Editor's note

In the December edition of the *ANZCA Bulletin*, a quote in a letter submitted by Associate Professor Michael Davis on New Zealand anaesthetic technicians was inadvertently left out. This is the letter, republished in full with the missing, slightly abridged, quote included.

NZ anaesthetic technicians

I was delighted to read the article by Susan Ewart, describing the "11-year process" that has resulted in anaesthetic technicians in New Zealand now being able to register 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 many fine men and women who have worked alongside me in this capacity.

However, the process of developing the professional role of anaesthetic technicians to where it is today is, in fact, much longer than the 11 years since the NZ Anaesthetics Technicians Society expressed "their wish to be covered by this legislation". I developed the first anaesthetic technicians training course in New Zealand in 1978, 33 years ago, soon after I arrived in Christchurch as a full-time specialist for the then North Canterbury Hospital Board. In order to complete the early history of technician training in NZ, it is worth quoting from a 1990 Department of Anaesthesia internal publication that covered the history of anaesthesia in Christchurch from 1974 to 1990.[1]

"In the late 1970s…a national training committee was formed under the auspices of the Department of Health, on which Doug Chisholm [Medical Director, Anaesthesia Services, CAHB] was invited to sit. Anticipating the establishment of proper training programmes, a pilot course was commenced…in Christchurch modelled on the anaesthetic and basic sciences components of the UK Operating Department Assistants training programme. This Christchurch course became the basis for the development of the NZ programme. [Dr] Jim Clayton from Dunedin was the first examiner."

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, BChir, MA (Cantab.), FRCA(Eng.), FANZCA, MD(Otago), DipDHM, CertDHM(ANZCA)

Reference:

1. Davis FM, editor. Department of Anaesthesia 1974–1990. The changing face of anaesthesia in the public health system. Christchurch: Canterbury Area Health Board; 1990.


Is there a doctor on board?

A funny thing happened on the way back from the Hong Kong Combined Scientific Meeting (CSM).

On one flight, an asthmatic inadvertently took some peanut snacks and developed anaphylactic shock. His sister was frantic and called for the flight attendant. The flight attendant responded, informed the cockpit and

Re: "Is there a doctor on board?"

(*ANZCA Bulletin*, September 2011), and the subsequent letter from Dr Clarke (*ANZCA Bulletin*, December 2011) prompts me to relate an account of my own.

I was seated at the window in the end row on board an A330-220, which had just nosed into park on the tarmac in Launceston.

Looking out the window, I notice three men in yellow and, as I watch, one of them gracefully slides from walking to prone-on-concrete position.

Oddly, my first thought was, "Must be difficult for that person working around aircraft with epilepsy …"

As I watched, he did not move from the assumed prone-on-concrete position as his two comrades rallied. The more I watched the less he moved.

I indicated to the cabin crew that I wished to offer assistance.

"Oh, you can't; they're the men who bring the stairs to the plane," was the reply.

In-cabin phone communication to the front of the plane achieved two important objectives: the pilot requested stairs urgently and the senior cabin crew announced my imminent urgent egress.

I now know how a sheep dog feels as it runs along the backs of a flock of sheep all trying to flee the barking dog!

I was off the plane as soon as the stairs hit the fuselage, to find the gent had been rolled into an unconscious-patient position.

To my serious consternation, he exhibited no response, deepest cyanosis and no palpable pulses. My silent private response could be summed up in one word.

With an earnest request for formal help to the man in the yellow jacket with the secret service device in his ear, I proceeded with expired air mouth-to-mouth and a thump that should have woken something.

"Get the fire-ies" was my catch cry, assuming that they would arrive with flashing lights and oxygen, at least.

As I learned at an informal debriefing, the man with the secret service device in his ear could communicate with only the pilot of the aircraft to which his device was attached. [I thought that he could talk to the world].

Nevertheless that instigated a chain of communication from him to aircraft cockpit to Melbourne, to Hobart and finally to Launceston and thence to on-airfield Launceston Airport Fire Response.

After what seemed like 24 hours, the fire truck arrived and Deo Gratias, along with the senior medical emergencies instructor for Tasmania, and oxygen.

[When he offered to take over holding the face mask I said something like, "Sure, I've been practising for about 35 years if you could just help with the other bits." He was so calm, "Okay", and proceeded with the other bits.]

Meanwhile, the patient was responding and I could hear Ambulance Tasmania wailing up the highway. Never was I so glad to greet an ETT, and skilled paramedics.

A young plastics surgeon kept shaking my hand with congratulatory exuberance and a local ED RMO was delegated to brief them.

The next day in the intensive care unit [as a retrievalist/hanger on in ICU] I expressed to the gentleman patient, "K…. I've kissed you once and I'm not doing it again … Give up the fags!"

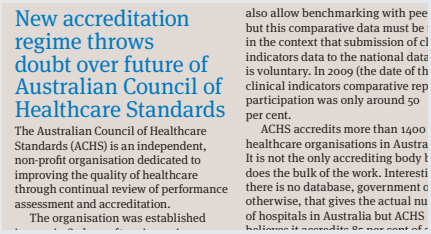
Lesson: Smash the closest fire alarm for oxygen-to-go at an airport!

Dr George Waters FFARCS
Acting Director, Anaesthetics and Intensive Care
Mount Isa, Queensland

Submitting letters

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

Awards



New accreditation regime throws doubt over future of Australian Council of Healthcare Standards

The Australian Council of Healthcare Standards (ACHS) is an independent, non-profit organisation dedicated to improving the quality of healthcare through continual review of performance assessment and accreditation.

The organisation was established

also allow benchmarking with pee
but this comparative data must be
in the context that submission of cl
indicators data to the national data
is voluntary. In 2009 (the date of th
clinical indicators comparative rep
participation was only around 50
per cent.

ACHS accredits more than 1400
healthcare organisations in Austra
It is not the only accrediting body t
does the bulk of the work. Interesti
there is no database, government o
otherwise, that gives the actual nu
of hospitals in Australia but ACHS

I wish to comment on the article "New accreditation regime throws doubt over future of Australian Council of Healthcare Standards" (*ANZCA Bulletin* December 2011).

The headline, while it may attract readership, is misleading in several respects. Australian Council of Healthcare Standards (ACHS) has advocated a national approach to standards since the establishment in 2000 of the commission's predecessor organisation, the Australian Council on Safety and Quality in Health Care, and to the review of accreditation (the Patterson review) initiated by the council in 2005.

The commission's national standards are built primarily on a "compliance model" around targeted areas related to clinical practice where sound best-practice evidence is available. What will ultimately be acceptable levels of compliance have not been determined; to some extent this is complicated by the mix of core and developmental requirements in those standards.

The ACHS Evaluation and Quality Improvement Program (EQuIP) takes a "whole of organisation" perspective, has a focus on outcomes and provides a perspective on performance.

ACHS has constructively contributed to development of the national standards. It has not simply accepted all the positions put to it, but has commented based on its experience and expertise. ACHS has been surprised at the lack of critical comment by other parts of the industry.

The article makes reference to ACHS' clinical indicators. They were developed as a tool supporting clinical review. However, there is in EQuIP a requirement to measure outcomes of care.

The ownership of ACHS by the industry and its independence are among its great strengths.

ACHS is not "threatened" by these changes. The challenge is to evolve its programs and practices to fit the new environment. We are doing this very successfully.

Adjunct Associate Professor Karen Linegar
President, Australian Council on Healthcare Standards

New Zealand New Year Honour

Dr Jeremy Cooper was made a Member of the New Zealand Order of Merit (MNZM) in the New Year Honours List for services to medicine.

Australia Day Honours

In the 2012 Australia Day Honours list the following ANZCA Fellows were awarded an Order of Australia honour:

Member (AM) in the General Division

Dr John Patrick Keneally: For service to medicine as a clinician and academic, to the specialty of paediatric anaesthesia and pain management, and through advisory roles with public health organisations.

Dr Harry Frank Oxer: For service to hyperbaric and underwater medicine, to medical education, and continuing service to St John Ambulance in Western Australia.

Medal (OAM) in the General Division

Dr Neil Thomas Matthews: For service to medicine in the field of paediatric critical care as a practitioner and academic.

Dr Rodney Neill Westhorpe: For service to medicine as an anaesthetist.


ne. To serve the community by fostering
ANZCA
CELEBRATING
20
YEARS
1992-2012
and quality patient
esthesia

Welcome to our feature on the 20th anniversary of our College!

Although the Faculty of Anaesthetists, Royal Australasian College of Surgeons (RACS) was established in 1952, it was not until 40 years later in 1992 that ANZCA was established. We owe a great debt of gratitude to RACS, to the pioneer anaesthetists who established the Faculty, and to the Fellows of the Faculty whose vision and persistence resulted in the formation of ANZCA. Anaesthesia care in New Zealand and Australia is now second to none in the world. We should also acknowledge the dedicated Fellows who established intensive care medicine and pain medicine under the auspices of ANZCA. Practice in these areas is world beating as well.

In this edition of the *Bulletin*, you can read the account of Dr Peter Livingstone, ANZCA's first president, on the establishment of the College; the reflections of Dr Lindy Roberts, ANZCA's President-elect, on her experiences as a trainee in 1992, and a timeline of ANZCA's milestones. We've certainly come a long way since those early days, thanks to the talent and dedication of our Fellows, trainees and staff. I hope that you enjoy reading this special feature.

Professor Kate Leslie
President, ANZCA

ANZCA timeline 1992 – 2012

1992

ANZCA founded February 7 with 2090 Fellows

Peter Livingstone appointed ANZCA President (until June)

Joan Sheales appointed College Registrar

The *ANZCA Bulletin* commences publication

The inaugural General Scientific Meeting of ANZCA held in conjunction with RACS at Canberra

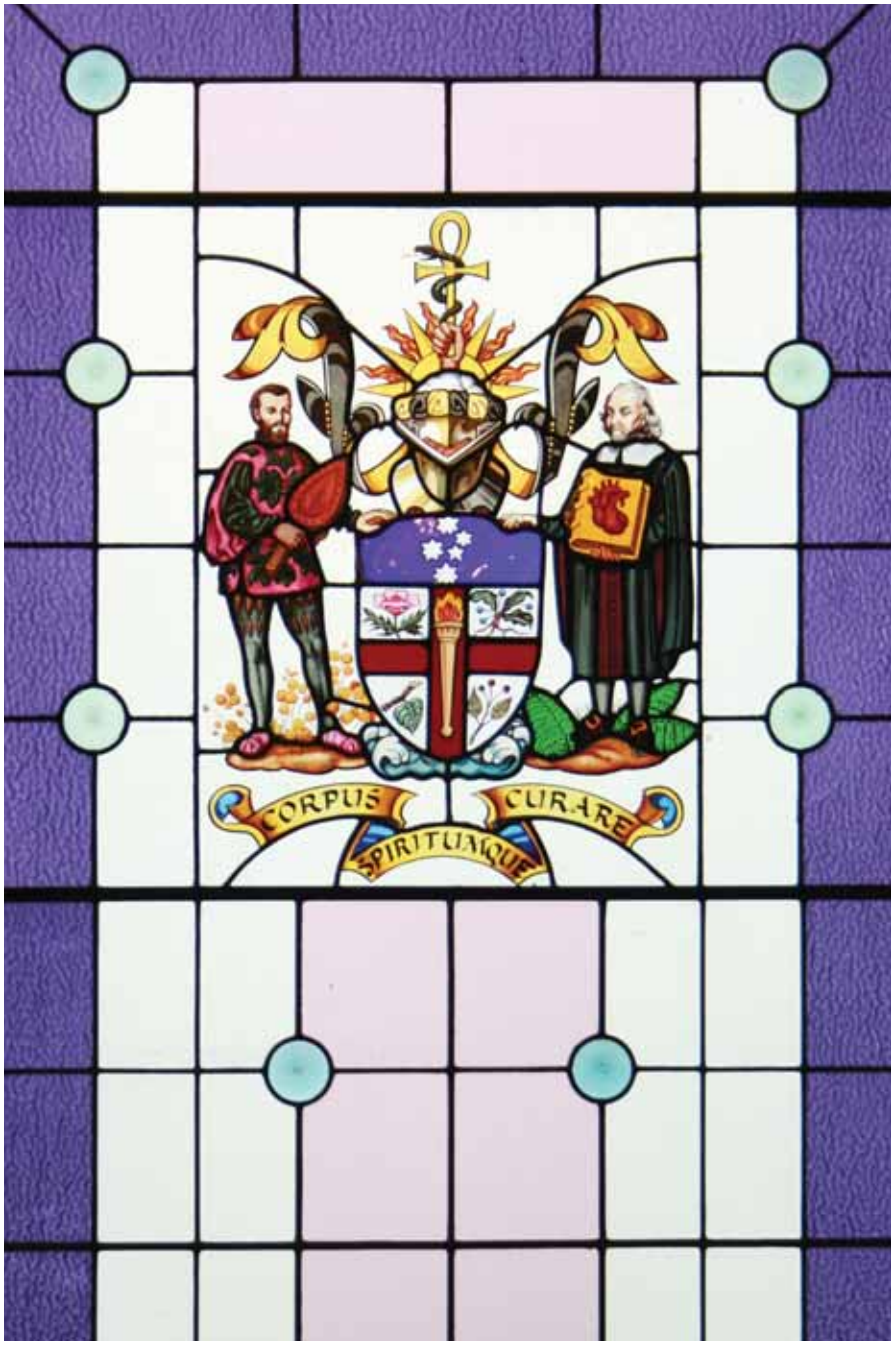
1992 (continued)

Michael Hodgson appointed ANZCA President

Rural Anaesthesia Special Interest Group established

Neuroanaesthesia Special Interest Group established

College armorial bearings authorised



In the beginning – how ANZCA was formed

ANZCA's first president, Dr Peter Livingstone, reflects on the beginning of the College.

Late in the afternoon of Friday February 7, 1992, the Dean's office received notification that the Australian Securities and Investments Commission (ASIC) had approved the Memorandum and Articles of association of the Australian and New Zealand College of Anaesthetists and issued a certificate of incorporation. This then was the completion of the first step in the legal process of the establishment of our College, a journey that had commenced almost two years earlier.

These two years had been taken up by exploring the possibilities and the pros and cons of separation from the Royal Australasian College of Surgeons (RACS), within which our Faculty of Anaesthetists had existed for some 42 years, in what had been very much a cooperative and harmonious existence. We as a faculty had been left by the RACS to determine and develop our own standards, examination system and granting of our fellowship. Both organisations benefited from each other in the process.

1992 (continued)

Inaugural meeting of Interim Board, Faculty of Intensive Care, ANZCA held November 4 in Melbourne. Geoffrey Clarke, Dean

* The Acute Pain, Cardiovascular and Thoracic Anaesthesia (renamed Cardiothoracic, Vascular and Perfusion in 1994) and Day Care Anaesthesia special interest groups were established in 1990. The special interest groups are jointly managed by ANZCA, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists.

1993

ANZCA Foundation established

Medical Education Special Interest Group established

Research Special Interest Group established

Michael Davies appointed ANZCA President

ANZCA opens New Zealand office in Elliott House, Wellington (moves to EMC House in 2007)

1993 (continued)

Ulimaroa, 630 St Kilda Road, purchased

Faculty of Intensive Care founded, Geoffrey Clarke appointed Dean

The final General Scientific Meeting held in conjunction with RACS in Adelaide

Over the years immediately preceding the establishment of ANZCA, there were moves from some quarters towards the formation of our own College (some would say that there were suggestions to that effect long before) and the board consulted with regional committees and Fellows through the faculty's bulletin. Other organisations made comment on this matter too.

What happened to make the Board of Faculty move in the direction of separation from the RACS and establish our College?

Over many years, many Fellows had expressed a wish to have our own College as a step towards more recognition in the community as specialists in our own right, a matter of status if you wish, and there was a view that formation of a College might assist.

Our tenure of space within the RACS building was becoming difficult to maintain, there was a natural desire on the part of the RACS to spread their influence and provide for as many of their functions and subspecialties as possible within the confines of the Spring Street Melbourne building in the interest of cohesion within their college and, although these difficulties were handled amicably, the Board of Faculty could see that the Faculty would need its own accommodation.

The most important factor, and the factor that forced the board's hand, came with legal advice that although the Faculty had controlled its own assets and finances, set entry and annual subscriptions, examination fees etcetera, Faculty assets were part of RACS assets. Furthermore, should the Faculty stay within the RACS and contribute to a building program at that site, our assets would still belong to the RACS.

The process of separation then began, with the cooperation of the RACS Council and its president, Professor Tom Reeve, followed later by Mr John Hanrahan. As this process developed it became obvious that if we were to become a separate legal entity, which was essential to protect our assets, then it was natural and reasonable to change our name to form a College. The options of inclusion of New Zealand Fellows seemed sensible because the board was endeavouring to keep the structure as near as possible to that of the Faculty, but a new and separate entity, and to leave further changes for a future Council to determine.

The work involved in this separation was enormous and I, as the dean at the time, thank all the members of the board, the registrar, advisors and administrative staff, who all gave everything to this process. It is a great tribute to the good nature of those involved that this was achieved without rancour and, often, with good humour.

ANZCA's first president, Dr Peter Livingstone

This final event (approval by ASIC) was celebrated at the board (now ANZCA Council) dinner on Friday February 7 1992 at the Melbourne Club and the ANZCA Council met for the first time the next morning. Now, we needed to search for a new home.

I think that all Fellows of the College and its faculties would agree that this was a turning point in our speciality in our two countries and it is one of which I am immensely proud. I earnestly hope all Fellows share this pride.

"Many Fellows had expressed a wish to have our own College as a step towards more recognition in the community as specialists in our own right."

1994

College relocates to St Kilda Road in February. Ulimaroa officially opened by the Governor General

ANZCA's first independent annual scientific meeting held at Launceston

College mace presented to ANZCA as a gift from RACS

1995

Neville Davis appointed ANZCA President

Maintenance of Professional Standards (MOPS) introduced

1996

Garry Phillips appointed ANZCA President

Maintenance of Standards Programme (MOS) approved

Anaesthesia training – 20 years on

President-elect, Dr Lindy Roberts began training in anaesthesia the year the College was formed. She describes her journey.

Nineteen ninety-two, the year that the College was founded, was also my first year of anaesthesia training. So the first 20 years of ANZCA are also the first of my anaesthesia career, and it is interesting for me to think about how far we both have travelled.

Most days, training seems a very distant memory, compounded by geographical distance (trained in Queensland, now living in Western Australia) and a hectic life. However contact with junior colleagues at work and with my involvement in two significant curriculum changes (in 2004 and 2013) inform this personal reflection on anaesthesia training, and how things have changed.

When I graduated from Queensland University in 1988, my career plans were vague at best. I was impressed and also slightly intimidated by those who seemed to know exactly where they were heading (mostly those who wanted to be surgeons). Medical student exposure to anaesthesia was limited to a couple of weeks during the surgical rotation in the sixth year of my undergraduate bachelor of medicine, bachelor of surgery (MBBS). Although I'd really enjoyed this experience – in a small department of a regional hospital where I'd been encouraged to do supervised procedures such as my first spinal anaesthetic – it had been brief.

Dr Lindy Roberts is congratulated on becoming an ANZCA Fellow by Dr Richard Walsh.

The seven-week elective term in anaesthesia during my intern year was a highlight. One-to-one supervision by consultants and the teaching they provided seemed such a luxury after long hours on the wards with limited contact with seniors, apart from busy registrars who were usually studying for exams. I liked the fact that anaesthesia seemed to attract the eccentrics, those who thought outside the box and those with a problem-solving mentality, although they did seem to have terrible taste in clothes. I didn't accept the widely expressed view that anaesthesia is for those who can't or don't want to communicate – as I observed the need for sensitive and effective interactions with patients during highly stressful periods in their lives, along with the importance of working collaboratively as part of the theatre team. I also witnessed the impact of bad behaviour.

In those days, there was only one week of annual leave during internship, and work hours were long. When the opportunity for a decent holiday came in second year, I went trekking in Nepal and it was there, sitting under a huge rhododendron, that I made the decision to become an anaesthetist. Later, working as a resident in the pain clinic and palliative care, I discovered a passion for pain medicine. Particularly, I liked some of the contrasts between the work in anaesthesia and that of the pain specialist, and thought the combination would be a good balance.

On my return from Nepal, I made initial approaches to directors of anaesthesia departments to see how to become an anaesthetist. Getting the primary exam, I was told, was a pathway to a certain place on the training program. There was one dispiriting experience where I was asked, quite gruffly I thought, whether I "really wanted to do anaesthesia". I'm not sure I accurately read the intention of these words, probably just meant to test my motivation, but their clumsy delivery remains a strong memory. To this day, it serves as an important lesson to be careful about the inadvertent messages that junior doctors can receive, even if they are not intended.

> "I have strong memories of delirious celebrations that followed the announcement we had passed."

1997

One Grand Chain (volume one) published

Alan Duncan appointed Dean, Faculty of Intensive Care

Welfare of Anaesthetists Special Interest Group was established

1998

Richard Walsh appointed ANZCA President

Diving and Hyperbaric Medicine Special Interest Group was established

First mortality report, *Anaesthetic mortality in Australia 1991-1993*, published

1999

Faculty of Pain Medicine founded, Michael Cousins appointed Dean

Felicity Hawker appointed Dean, Faculty of Intensive Care

Obstetric Anaesthesia Special Interest Group established

So, with another second-year resident, I began studying physiology and pharmacology, mostly in blissful ignorance of what was required, working with a pile of old exam papers and some textbooks from the reading list. We attended an excellent short course, joined by a third study buddy with an eye for a bargain. This saw our hapless trio living for two weeks in a cheap-as-chips, conveniently located, besser brick janitor's flat on the rooftop of the Victorian Eye and Ear Hospital in mid-winter with a couple of small bar heaters. I think it was sheer hard work that got us through. The next year I was on the training program.

My first four training years were spent in the Brisbane Southside Hospitals, with rotations through Greenslopes, the Mater, the Princess Alexandra, the Prince Charles and Toowoomba Base hospitals, along with a six-month swap with a UK trainee from the Royal Gloucestershire Hospital. For my provisional fellowship year, I relocated to Perth to complete the pain medicine certificate (a forerunner to Faculty of Pain Medicine training).

Frankly, I'm not sure I really knew much about the College. I sat the primary examination at the Royal Australasian College of Physicians offices in Sydney and my first visit to the College in Melbourne was to sit my final exam. My lasting impressions of that experience are of other candidates (of both genders) in dark suits, along with the black and white tiles in Ulimaroa. These caused a rising tide of (preconditioned) anxiety when I returned to the College later as a Fellow. I have strong memories of delirious celebrations that followed the announcement we had passed. Also I can picture one of my study group crying in the foyer and being consoled by Joan Sheales with reassurance that she would pass next time – when hers were tears of joy at her success!

So what has changed? Working hours were longer than they are now, especially during the overseas post, but the casemix was interesting and subspecialty exposure was excellent. Many aspects of training were less formal, for example there were no modules and no in-training assessments. In some, but certainly not all, hospitals I hardly knew my supervisors of training, as there was no requirement for regular meetings. Although I received lots of encouragement, I had little formal feedback (I assumed this meant things were going okay). Despite this, many consultants and more senior trainees were very supportive, offering practice vivas and great teaching in theatre (then, as now, this was variable).

Of course there were fewer centralised resources and nothing electronic – no internet, no smart phones, no search engines. Training was all paper-based, no ANZCA website, no online journals, and it was much less easy to access information. More broadly, there was no formal pathway for trainee input into decision-making, unlike currently where the ANZCA Trainee Committee is represented on all the bodies that oversee developments and decisions about training. There was no Welfare of Anaesthetists Special Interest Group. This was formed after I finished training. Awareness of trainee and Fellow health and welfare issues was far less apparent. Despite this, I was well trained and mentored by dedicated teachers, many experts and great role models – fortunately, some things don't change!

I had some inspiring senior colleagues and several remained dear friends after I became a Fellow. Memories of how they treated me still inform my dealings with trainees. Probably my strongest and enduring bond is with members of my study group. Like many cohorts,

Dr Lindy Roberts in Nepal where she decided she would become an anaesthetist.

we studied for and sat (and passed) both exams together. The many hours spent practising questions, arguing intensely about what and who was right, supporting each other through the tension (and occasional crises) in personal lives that the stress of exams imposed, and the life change of finally passing, created friendships that endure to this day.

Dr Lindy Roberts
President-elect, ANZCA

"In second year, I went trekking in Nepal and it was there, sitting under a huge rhododendron, that I made the decision to become an anaesthetist."

2000

Teik Oh appointed ANZCA President

Critical Care in Unusual Environments (renamed Anaesthesia and Critical Care in Unusual and Transport Environments in 2005) Special Interest Group established

Simulation and Skills Training Special Interest Group established

Effective Management of Anaesthetic Crises course introduced

2001

ANZCA House opened

Richard Willis appointed ANZCA President

History of Anaesthesia Special Interest Group established

ANZCA's Education Development Unit formed

2002

Joint Faculty of Intensive Care Medicine (JFICM) founded with the Royal Australasian College of Physicians, Felicity Hawker appointed Dean

Leigh Atkinson appointed Dean, Faculty of Pain Medicine

Neil Matthews appointed Dean, Joint Faculty of Intensive Care Medicine in October

Rich history of anaesthesia depicted

Originally the mace was developed during medieval times as a weapon wielded by one arm from horseback. Therefore the shaft was long with a heavily studded head, and such maces developed a fearsome reputation, which made them an excellent symbol for power.

Following the introduction of gunpowder the usefulness of the mace as a weapon declined but its symbolism for power and authority survived. Ceremonial maces became larger with more decoration and were made of precious metals such as silver and gold. The ANZCA mace was gifted to the College by the Royal Australasian College of Surgeons (RACS) at our College's first annual scientific meeting in 1994, when their then president, Dr David Theile said, "as a demonstration of our part in your history and a permanent expression of our good wishes for your future". The design of the mace was greatly assisted by Joan Sheales, the then College Registrar (now titled chief executive officer), and is based around a lily to symbolise the creation of the new college of anaesthetists, as the lily in Greek lore symbolises birth.

The mace design also incorporates much of the symbolism from the College's armorial bearings which were designed to represent the Australian and New Zealand origins of the College; its geographical region and the domicile of its headquarters; its derivation from the Faculty of Anaesthetists, Royal Australasian College of Surgeons, and the links particularly in intensive care with the Royal Australasian College of Physicians; its closeness to the basic sciences of anatomy, physiology and pharmacology; and the relationships which exist between the new and old worlds.

The armorial bearings were designed by a College's Coat of Arms Subcommittee, which met between September 1991 and September 1992 and consisted of Barry Baker (chair), Peter Livingstone (dean/president), David McConnel (councillor), Peter Jones (RACS) and Joan Sheales (registrar/CEO), and later Michael Hodgson (president).

The Duke of Norfolk as Earl Marshall of Her Majesty's College of Arms authorised the armorial bearings on December 1, 1992, and they were officially granted on May 10, 1994. The subcommittee members were very pleased to be notified that, because of the design and its detailed justification, these arms were granted in the minimum time – an exceedingly rare occurrence.

The armorial bearings consist of the "supporters", which were chosen as famous historical figures whose work was vitally important in changing not only medical knowledge, but the way in which people thought about that knowledge.

"The Duke of Norfolk as Earl Marshall of Her Majesty's College of Arms authorised the armorial bearings on December 1, 1992."

2003

Anaesthetists in Management Special Interest Group established

Online journals available to Fellows

2004

Curriculum 2004 commences

Michael Cousins appointed ANZCA President

One Grand Chain (volume two) published

Jack Havill appointed Dean, Joint Faculty of Intensive Care Medicine

Milton Cohen appointed Dean, Faculty of Pain Medicine

Clinical Teacher Course piloted

ANZCA website created

ANZCA Trainee Committee established

2005

Mike Richards appointed ANZCA CEO

Acute Pain Management: Scientific Evidence (second edition) published

ANZCA Trials Group formed

Andreas Vesalius is on the left. He published his seminal work *De Humani Corporis Fabrica* in 1543 from Padua, Italy. This publication changed anatomy because it overthrew, after 1400 years, Galen's dogma (largely based on the anatomy of apes and monkeys) with human cadaver dissection, and by instituting the scientific approach of challenging dogma with direct experience. Vesalius also was the first to show that an animal that had ceased to breathe could be resuscitated by using artificial respiration through a reed inserted into the windpipe – in the coat of arms he is holding a bellows to signify this act. The bellows also signifies the experimental scientific basis of the specialty following Vesalius' lead. His view is outward looking to signify his broad academic outlook, and to indicate the widespread place of artificial ventilation in anaesthesia and intensive care.

William Harvey, who lived in England but who had studied in Padua, is the other supporter and is depicted holding a book with a heart etched on the cover. The heart and book represent the contribution made by Harvey in 1628 when he published *De Motu Cordis*, which for the first time described the circulation of blood through the lungs and around the body. The book also symbolises the College's respect for academic learning.

Harvey looks towards Vesalius to explain that the discovery of the circulation depended on prior anatomical description by Vesalius and others (that is physiology followed anatomy), and also because Harvey studied in the Italian medical schools.

These two supporters represent the heritage of the specialty based as it is on respiratory and cardiovascular physiology together with anatomy.

Corporate logo – "the triangles"

In 2008, ANZCA commissioned the design of a contemporary corporate logo to complement the College coat of arms on ANZCA livery. The logo is now used, along with the crest, on all ANZCA hard-copy and electronic documents, and on our website. The two symbols presented together signify the historical and contemporary values of ANZCA and the confidence of our organisation as we move forward.

The logo was inspired by the triangular board room table at ANZCA House in Melbourne, but the overall design is abstract and open to wide interpretation. The designers, Streamer, commented that the overall effect of the overlapping geometrical shapes is one of precision and exactitude, reflecting the sciences that underpin the profession. The two sets of overlapping forms may reflect our two countries and the three sets the foundations of our College - anaesthesia, intensive care medicine and pain medicine. The multiple and connecting triangular elements pointing in different directions allude to the multidisciplinary nature of the College.

The "triangles" remind me of a high mountain range reflected in a deep ocean, requiring us to be courageous, intrepid and visionary in all the things we do. They evoke a journey where the summit will be reached through careful steps and by dogged persistence. The rich burgundy colour denotes quality, authority and a link to the traditions of our past, but in essence the logo is modern and forward-looking and that's what I like about it!

Professor Kate Leslie
President, ANZCA

ANZCA
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

The place of pharmacology, which is the third scientific base for the specialty, is addressed by use of the botanical specimens in the "charges of the shield". The supporters stand on land separated by water, which forms the "compartment of the arms".

These separate lands signify not only the countries of Australia and New Zealand, but also the separation of the new world of Australasia from the old world of Europe (and the not-so-old world of North America where anaesthesia was first demonstrated and broadcast to the world in the mid-19th century).

The sea also indicates the significance of sea travel in the transmission of the introductory news about anaesthesia from North America to Europe and eventually to Australia and finally New Zealand.

(continued next page)

2006

Walter Thompson appointed ANZCA President

Roger Goucke appointed Dean, Faculty of Pain Medicine

Richard Lee appointed Dean, Joint Faculty of Intensive Care Medicine

Regional Anaesthesia Special Interest Group established

New Fellow first elected to Council

2007

ANZCA Foundation officially launched

Airway Management Special Interest Group established

Trauma Special Interest Group established

ANZCA Code of Conduct introduced

2008

Leona Wilson appointed ANZCA President

Penelope Briscoe appointed Dean, Faculty of Pain Medicine

Vernon Van Heerden appointed Dean, Joint Faculty of Intensive Care Medicine

Review of the curriculum commenced

The Cootamundra wattle (*Acacia baileyana*) illustrated on the land on which Vesalius stands represents Australia and the silver fern or ponga (*Cyathea dealbata*) on the land on which Harvey stands represents New Zealand.

The shield contains two parts. The "chief of the shield" contains the Southern Cross indicating the College's geographical place in the Southern Hemisphere because the constellation is at 600 S and therefore not visible from most of the Northern Hemisphere. The five stars are represented with the number of points representing their real brightness in the night sky starting at the base of the cross with the brightest star and moving clockwise: alpha – eight points; beta – seven points; gamma – seven points; delta – six points; epsilon – five points.

This representation is also that taken by the state of Victoria and is not taken by any other state or country using the Southern Cross. Thus this representation symbolises the College's founding and headquarters in Victoria.

The lower part of the shield contains the Cross of St George indicating the links between the College and its British counterpart, the Royal College of Anaesthetists, as well as the Christian heritage of the College.

The "torch of glory" imprinted on the upright of the cross symbolises the direct derivation of the College from the Faculty of Anaesthetists of the Royal Australasian College of Surgeons. The College of Surgeons has the torch of glory in its arms and has also the motto *Fax mentis incendium gloriae* – "The torch that illuminates the mind is the fire that consumes vainglory".

The charges in the four quadrants symbolise the plants that together form the basis for the pharmacology fundamental to anaesthesia. In the upper left quadrant is the opium poppy (*Papaver somniferum*) signifying analgesia, and in the upper right quadrant is the mandrake plant (*Mandragora officinarum*) signifying sedation and anaesthesia.

These charges also symbolise the old world plants. The new world plants are depicted in the lower charges. In the lower left quadrant is the curare vine (*Chondrodendron tomentosum*) signifying neuromuscular paralysis, and in the lower right quadrant the cocaine leaf and fruit (*Erythroxylum coca*) signifying local anaesthesia.

The crest consists of the helmet, which is unusually affronté (or facing forward) with a closed visor to indicate alertness and readiness for any urgent action. This type and position of helmet is similar to the Royal College of Anaesthetists again linking the College to this fraternal organisation.

The colours of the College gown (black and gold) are incorporated into the wreath on the helmet and its lambrequin (or cape). The rising sun behind the helmet indicates the geographical place of the College in the east next to the international date line; and also symbolises links with the Royal Australasian College of Surgeons and the Royal Australasian College of Physicians both of which have similar rising suns for the same symbolic reason.

"Vesalius also was the first to show that an animal... could be resuscitated by using artificial respiration through a reed inserted into the windpipe."

2008 (continued)

Continuing Professional Development Program introduced

Dr Ray Hader Trainee Award for Compassion established

First *ANZCA E-Newsletter* distributed

2009

Continuing Professional Development Program became mandatory

ANZCA begins producing podcasts

2010

Independent College of Intensive Care Medicine (CICM) formed replacing JFICM. Vernon Van Heerden inaugural CICM President

Kate Leslie appointed ANZCA President

David Jones appointed Dean, Faculty of Pain Medicine

The "hand of the carer" (physician) rising from the Lord's cloud representing Almighty guidance links the College back to the Parisian medical influence and to the foundations of the modern European medical tradition in 12th century Paris, and symbolises the Fellow's hand guided by the Lord caring for the patient's life.

The hand holds an ankh, the Egyptian hieroglyph for life, which links the major responsibility of College Fellows – the preservation of life – to the roots of western medicine in Egypt in the 5th to 3rd millennia BCE.

The snake of Asclepius (Aesculapius) entwines the Ankh to symbolise the links with the heritage of Greek medicine and the ethics of doctor-patient relationships, which derive from that time.

The motto reads *Corpus curare spiritumque* which translates as "To care for the body and its breath of life" and which aptly summarises the main aim for Fellows of the College. There is an intended pun in the motto, which uses the Latin word curare (to care). This is also a word, derived differently from Macusi Indians in Guyana (wurari), used daily in the specialty for the drug curare or its analogues, which cause the state of neuromuscular paralysis or curarisation.

Originally the College mace had been designed to have a timber shaft made from Australian jarrah and an unspecified New Zealand timber, but this timber shaft was replaced with gold plated sterling silver when the RACS offered to gift the mace to ANZCA. The aspects of the armorial bearings that have been translated into the design for the mace are:

The butt: This is now the larger end of the mace and is in the shape of a half opened lily containing the motto "Corpus curare spiritumque" engraved on the inner lip. Within the open lily cusp, like a stamen, the crest is reproduced in full with the torch of glory placed below the crest in a sense holding the crest aloft.

This repositioning of the torch was deliberately designed to represent the gift of the mace by the RACS to the College, and to symbolise the growth of the College of Anaesthetists from the Faculty of Anaesthetists.

The shaft: Embossed on the shaft (stem of the lily) is a representation of the shield containing the four quadrants and with the chief containing the Victorian Southern Cross stars represented by Argyle champagne-colour diamonds sized in proportion to the stars' brightness (1x20pt, 2x16pt, 1x11pt, and 1x6pt). The charges are represented more boldly and larger than in the arms to emphasise their differences, and for artistic relief on the shaft.

The head – Australia and New Zealand are represented in the head (another half open but smaller lily) by a wattle in silver-gilt and a fern in silver. Around the lip is engraved "Presented by the Royal Australasian College of Surgeons 1994".

The mace is 960 millimetres long, weighs approximately 2.75 kilograms, and was cast in 19 separate pieces at Flynn Silver's workshop in Kyneton, Victoria, using the lost wax technique. Dan and John Flynn commented at the time (May 17, 1994) that "we consider it to be the most significant commission undertaken by ourselves to date". The cost of the mace was $A34,500.

Every council meeting is conducted with the mace on its jarrah rest in open display to symbolise the authority of council, and again at the College annual general meeting.

The mace is also ceremonially carried in the procession of the president and council to the opening of each annual scientific meeting.

If you have not looked closely at either the coat of arms or the mace, you should do so, as they are each rich in a heritage that you share with your colleagues, not only in anaesthesia but more widely across the breadth of medicine and science.

Professor Barry Baker
Dean of Education and Executive Director of Professional Affairs

"The motto reads *Corpus curare spiritumque* which translates as 'To care for the body and its breath of life'."

2010

Acute Pain Management: Scientific Evidence (third edition) published

Perioperative Medicine Special Interest Group established

Online in-training assessments start

2011

Linda Sorrell appointed ANZCA CEO

Online Clinical Teacher Course piloted

2012 (to March)

Lindy Roberts announced President-elect, ANZCA

Brendan Moore announced Dean-elect, Faculty of Pain Medicine

Number of Fellows – 5300 and 2000 trainees

ANZCA Curriculum Revision 2013 learning outcomes approved

The Anaesthesia and Pain Medicine Foundation

Foundation donors help researchers to save lives

The quality, innovation and diversity of the research conducted by ANZCA and Faculty of Pain Medicine Fellows has contributed significant advancements to the practice of anaesthesia and pain medicine in Australia, New Zealand and around the world.

In 2012, ANZCA research grants will again support several important research projects, which aim to extend the boundaries of medical knowledge and pave the way for advancements that will lead to further reductions in the number of patients who suffer post-surgical complications and persistent pain. The research is often complex and difficult, but the results are immensely rewarding: more people will return to pursue happy, fulfilling lives with their families, and more lives will be saved.

These research grants have been highlighted in many ANZCA publications, including the December 2011 issue of the *ANZCA Bulletin*. That the Anaesthesia and Pain Medicine Foundation funds most of ANZCA's research grants after selection by the ANZCA Research Committee is less well known.

The capacity of the foundation to fund vital research and education projects is greatly assisted by people who support it through their generous donations. In giving to the foundation, these donors not only support scientifically rigorous research. They support the life-saving outcomes that the research ultimately delivers.

Excellence in the standards of training, education and clinical practice in anaesthesia and pain medicine cannot deliver outcomes beyond the realms of current medical knowledge. Therefore, continuous improvements in outcomes and effective resource use rely heavily on a commitment to producing new knowledge from quality research. With the specialty still alarmingly low on the list of recipients of federal funding, it is vitally important to develop supplementary funding sources dedicated to research in anaesthesia and pain medicine, such as the Anaesthesia and Pain Medicine Foundation.

In early 2012, the foundation conducted an internal review and drafted strategic recommendations for developing its long-term capacity to support the life-changing research projects being conducted by Fellows of the College and the Faculty of Pain Medicine. Vital areas of focus will include greater engagement with Fellows, more communication highlighting the activities of the foundation and the research program, working to improve awareness of the College and anaesthesia and pain medicine, and a broadening of engagement with other philanthropic organisations and donors.

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, the Anaesthesia and Pain Medicine Foundation on **+61 3 8517 5306** or email **rpacker@anzca.edu.au**.

ANAESTHESIA IN TASMANIA

SPECIAL REPORT: HEALTH REFORM AND ANAESTHESIA DEVELOPMENTS IN TASMANIA

In this issue of the *ANZCA Bulletin* we conclude our series on anaesthesia in state and territory jurisdictions.

UNIQUE MIX OF CHALLENGES AND REWARDS KEEPS ANAESTHESIA STRONG

DR SIMON MORPHETT,
IMMEDIATE PAST CHAIR,
TASMANIAN REGIONAL COMMITTEE

On a cool December day with threatening skies and occasional drizzle, I set out with three other doctors on what is to be a 12-day adventure across Tasmania's remote south-west wilderness area. Our planned route is largely untracked and we will encounter no one else for the entire time. The start of such a remote walk is only 90 minutes from Hobart. A very kind friend manages to deposit us at the start of the walk and still make it back to work in Hobart on time that morning.

If I had to name what it was that has attracted me to live and work in Tasmania, it is the unparalleled accessibility of activities like this. Such a walk offers many rewards and challenges, expected and unexpected. Likewise, anaesthesia in Tasmania offers significant rewards and challenges and for similar reasons.

I have read with great interest the series of features in the *ANZCA Bulletin* on anaesthesia and pain medicine in the different states and territories and Tasmania is the last of these. Numerous issues sound very familiar. In particular, Dr Carmel McInerney's article on anaesthesia in the ACT (*ANZCA Bulletin*, December 2011) struck a chord, which is not surprising given the similarity of scale.

Tasmania is a small state, having only recently achieved a population milestone of 500,000, a source of some pride to our politicians at the time. I find this somewhat mystifying given that population growth (or decline) is manifestly due to so many factors outside their control.

Tasmania is also a poor state, referred to a little uncharitably as "the mendicant state" by Western Australian Premier Colin Barnett – another mystifying political statement that seems to imply an economic ranking that is somehow the result of political management rather than incidental mineral wealth. In any event, I prefer the term "revenue-challenged" a more acceptable modern, political representation.

Finally, there is the problem of geography. Beyond the obvious fact of being an island, the Tasmanian population is among the most decentralised in the country and Tasmanians have traditionally been able to access a relatively broad range of medical services at a local level, something seen as no longer sustainable by a succession of state governments.

The three factors of size, resource limitation and geographical idiosyncrasy influence anaesthesia in Tasmania but not by any means in a purely negative way. The attractions of the wilderness, the benefit of living and working in a smaller, more friendly community and, not least, more opportunity to become involved with various non-clinical activities and have a greater influence over your own working life have attracted and retained particular people within this state and so shaped anaesthesia.

I will provide a general overview of these factors but should first point out one of the principle features of anaesthesia in this state has been the amount of overseas aid activity that occurs. The instigator had of course been Dr Haydn Perndt. A notable aspect of this has been the development in Tasmania of two courses – the Remote Situations, Difficult Circumstances and Developing Countries Anaesthesia (RSDCDCA) course now more simply called the Real World Anaesthesia course and the Military Anaesthesia course. The defining (and it appears unique) feature of these courses is that they provide participants with hands on delivery of draw over anaesthesia to patients. Such a thing involved consent and cooperation from patients, other anaesthetists, surgeons, hospital administration and the Medical Council of Tasmania. Arguably this may only have been achievable with the combination of Tasmania's manageable health system size and Haydn's enthusiasm. Starting in Hobart with a RSDCDCA course, the format was skillfully adapted to suit military anaesthesia by Dr George Merridew and subsequently the Military Anaesthesia

(continued next page)

ANAESTHESIA IN TASMANIA
CONTINUED

course was run in Launceston with the same unique features. Having established the precedent, these courses continue to be run and have now been conducted in several locations both interstate and in New Zealand.

As for other overseas aid work, Dr Stephen Swallow offers an amusing summary of the development of what is now called the "Global Outreach" division of the Department of Anaesthesia at the Royal Hobart Hospital. A working environment that is extremely supportive of overseas aid activities is a feature of Anaesthesia throughout the state and indeed it is not possible to comprehensively cover all that occurs.

THE SIZE AND SCOPE OF ANAESTHESIA IN TASMANIA

Over the past 15 years, the number of specialist anaesthetists and trainees in Tasmania has increased considerably. Certainly the Royal Hobart Hospital Anaesthetic Department has more than doubled in size since I first joined it as a second-year registrar in 1997. There are currently 97 active Fellows in Tasmania. To give perspective, this is about a third of the number in South Australia and just 9 per cent of the number in New South Wales.

The public sector is effectively divided into three regions (each about to become more autonomous under new federal government health reforms). The southern region is serviced by the Royal Hobart Hospital (RHH), the northern region by the Launceston General Hospital (LGH) and the North West by the North West Regional Hospital (NWRH).

The NWRH now consists not only of the hospital in Burnie but has taken on the running of the Mersey Community Hospital (located at Latrobe near Devonport) as a second campus. This follows on from the state government's attempts to remove most acute care services from the Mersey and the subsequent controversial purchase of this hospital by John Howard's federal government in August 2007 just prior to an election (for the nominal sum of one dollar).

For many years, it had been difficult to recruit adequate numbers of trained specialist staff (including anaesthetists) to the Mersey Community Hospital and this problem remains. However, it is still open with the Tasmanian state government now effectively running a hospital owned by the federal government. This is discussed more under health reform.

Each of these three main hospitals is accredited by ANZCA for training and together they make up the rotation that is the Tasmanian Anaesthesia Training Program. It is possible to undertake all training required for FANZCA within Tasmania. Statewide there are approximately 30 anaesthetic registrars employed.

Of these, 16 positions are designated "rotational", this number being largely determined by the opportunity for adequate exposure to the necessary clinical experience in the subspecialty areas of cardiothoracic anaesthesia, neuroanaesthesia and paediatric anaesthesia.

Provisional Fellows, junior trainees awaiting a rotational position, non-vocational trainees (from ICU, emergency medicine and rural general practice) and a few international medical graduate specialists take up the remaining positions.

As a group, module supervisors and supervisors of training have elected not to increase the numbers of rotational trainees as this would involve shortening the subspecialty rotational blocks to less than their current three months and there was a strong feeling that although minimum training requirements might continue to be met, quality of training would be overly compromised.

Thus, overall, the number of trainees is small compared to other rotations but this means there is little danger of a trainee becoming "lost in the system". The quality of teaching and training across the state is currently extremely good. Individually, the hospitals have the following features:

- The NWRH has 160 beds (bed numbers for all hospitals taken from the website of the Tasmanian Department of Health and Human Services and is a tally of all beds including day stay outpatient services such as chemotherapy and dialysis and rehabilitation services).

  The anaesthetic department has nine full-time equivalent (FTE) consultant positions covered by five staff specialists and seven visiting medical officers (VMOs). There are two additional staff specialists at the Mersey Community Hospital (one currently filled by an international medical graduate specialist) but this does not cover the service requirement at that campus, some of which is covered from Burnie and the remainder by locums.

  There are six trainee positions of which two or three are designated "rotational".

  In terms of consultant staff, Dr Debbie Wilson is very actively involved in undergraduate and postgraduate education. She is ANZCA supervisor of training for the NWRH, involved in an ANZCA curriculum authoring group and in charge of the University of Tasmania Rural Clinical School in Burnie. In her spare time she is also on the Tasmanian Regional Committee.

  Dr Mark Reeves is on the ANZCA Council, is a primary examiner and actively involved in research. Thus trainees receive excellent exposure to practice in a small regional centre with very strong consultant leadership.

- The Launceston General Hospital is a 300-bed hospital that provides a wide range of surgical services including major upper gastro-intestinal and occasional vascular work.

  It is undergoing extensive redevelopment with an expanded emergency department and three-room endoscopy suite completed and a planned increase to nine operating theatres.

  The works will include an expanded recovery and new anaesthetic department office and educational facilities. There are 13 full-time staff specialist anaesthetists, nine VMOs and seven registrars. Three of the registrar positions are designated rotational.

  The LGH is very popular for training as it is a friendly and supportive department with a core group of experienced anaesthetists who are well established there. For a number of years, it was the site of the Military Anaesthesia Course. In addition, Dr Colin Chilvers has taken on the role of regional education officer for the Tasmanian rotation.

- The Royal Hobart Hospital is a 490-bed hospital that provides all surgical services with the exception of paediatric cardiac surgery and solid organ transplantation.

  It is the major teaching hospital for the University of Tasmania medical school and the only tertiary referral centre in the state for cardiac surgery, neurosurgery, burns, neonatal surgery and level three neonatal intensive care.

Left: Royal Hobart Hospital.

The anaesthetic department now consists of approximately 28 FTE consultant anaesthetist positions (staffed by 38 people) and 17 registrar positions (10 or 11 designated rotational). A recent trend in the department has been the increase in the number of consultants opting for a mix of public and private work with many doing half and half, employed as a 0.5 FTE staff specialist.

This obviously complicates departmental administration but has had the very big advantage of retaining the majority of Hobart anaesthetists at least partly in the public sector.

Rotational trainees will spend at least two out of four years at the RHH. One of the characteristics of the RHH department is the amount of developing country work that occurs and this is covered by Dr Stephen Swallow's article.

Within pain medicine, another recent innovation has been the appointment of Dr Max Sarma, whose particular role is in the management of transitional pain patients. Dr Sarma's role has proven to be a major asset to the acute pain service and the wards, and is working towards achieving earlier discharge in these increasingly numerous "difficult" patients. Dr Sarma is also providing valuable education in pain management to our trainees.

HEALTH REFORM AND RESOURCE CONSTRAINTS

There are a number of issues surrounding the funding and organisation of health services in Tasmania that will directly impact on anaesthesia services.

In the immediate future is the impact of an $80-$100 million health spending cut imposed by the state government in their effort to return the state budget to surplus. As part of this, elective surgery is to be reduced, with the effective closure of two theatres at the LGH and two theatres at the RHH. It remains to be seen how this will affect anaesthesia training.

In addition, a large number of resident level positions have been removed including, those that rotated through anaesthesia, reducing our ability to expose and attract local junior doctors to specialty training.

Of even greater concern, the reduction in frontline positions is very widespread with all specialties affected and such a global reduction in service may not be easy to reverse when funds again become available. The cuts have led to renewed discussion in Federal Parliament with calls for a full federal takeover of Tasmania's hospitals. (www.abc.net.au/news/2012-02-09/20120209-federal-government-vows-to-watch-tasmanian-health accessed February 11, 2012)

In the near future is the implementation of reforms necessitated by the National Health Reform Agreement, to which all states are now signatories. In Tasmania we will have three separate Tasmanian health organisations (THOs) based around each of the three main hospitals and created by the Tasmanian Health Organisations Act 2011. Each will be a separate legal entity, fully responsible for its own operations and funding, one aim being to reduce the current large state health bureaucracy.

This poses several challenges. The first is making three small organisations in what is already a small state run efficiently. Many clinicians and indeed independent reviews[1] have felt that efficient and sustainable health service delivery in Tasmania requires a move towards more integrated statewide services.

However, while this has been a goal for some time it has not been achieved in many areas and there is a possibility that having competing organisations will drive efficiencies.

From an anaesthesia point of view, I see the main effect as being how we co-ordinate trainee appointments for our statewide rotational training rotation.

The second challenge will be the move to activity-based funding (ABF) that the agreement entails. Recent discussion with our new ANZCA CEO emphasised to me the absolute necessity of having full and accurate coding systems to access all available funding and the importance of education of all hospital staff necessary to achieve this.

As anaesthetists, we have been leaders in promoting hospital efficiencies (such as with ambulatory care units) and ABF has many similarities to the RVG, so we should be well placed to meet this particular challenge.

Finally, in common with some other states, Tasmanian public hospitals administer a "private patient scheme" (PPS), one of the features of which is to supplement medical staff salaries to make them competitive. In Tasmania, this is a very significant component of salary and critical to recruitment and retention of anaesthetists within the public sector. The move to ABF will make the private patient scheme more difficult to administer and may threaten its viability.

GEOGRAPHY AND ANAESTHESIA

As alluded to in the introduction, lifestyle and wilderness are a significant factor in attracting and retaining some anaesthetists to live and work in Tasmania. From a professional perspective, the isolation necessitates the provision of often tertiary level subspecialty services in a relatively small hospital environment. You are provided with a challenging and interesting array

(continued next page)

ANAESTHESIA IN TASMANIA
CONTINUED

of work in a setting that is friendly and in which you know or are acquainted with all the other specialists. Communication is pleasant and so when confronted with difficulties, help and advice generally easy to obtain.

Set against this is the question of what range of services is it reasonable to provide to the citizens of Tasmania? Two issues that limit this are important.

The first is skill availability and maintenance – how many particular procedures must a clinician perform to maintain competence and also therefore how many clinicians in a hospital should be doing that procedure? If only one is required or available, then is the service sustainable?

The second is simple economics – is the cost of the service justifiable in terms of overall public benefit? This second issue does not often intrude into the domain of the clinical anaesthetist, although maybe it should.

The first is also not commonly an issue as we practise most of our procedures frequently, although with the advent of credentialing, hospital administrations are much more aware of it.

Interestingly, it has arisen recently at the RHH in regards to paediatric anaesthesia. A recent increase in the number of paediatric surgeons and a highly functioning neonatal intensive care have led to requests to increase the scope of neonatal procedures that are performed at the RHH. Anaesthetists have been asked to reflect carefully on the extent of the paediatric anaesthesia service they will provide.

In the current economic climate, Tasmanian health organisations may have to look critically at more of the services they provide. While such decisions are appropriately made at an executive level, I believe clinicians, including anaesthetists, should seek active input to achieve the best outcome for the population.

Decentralisation of population in small centres necessitates a medical retrieval service. The Tasmanian Medical Retrieval Service is based in Launceston. It has the use of one fixed-wing plane through a contract with the Royal Flying Doctor Service. There is occasional usage of the Tasmania Police-contracted helicopter but this is rarely used for medical retrieval (other than neonatal) as it is based in Hobart and the retrieval service is based in Launceston.

Originally, this service was set up and run by Dr George Merridew out of the LGH anaesthetic department and without any additional allocation of funds. This eventually became unsustainable and for a number of years it has been well run by an emergency physician who was contracted for this purpose.

A dwindling number of anaesthetic staff remain involved but the service now relies heavily on locums. It is evident that the Tasmanian geography, with isolated west coast settlements and centralisation of some acute services needs a more effective retrieval service, both for critically ill patient transfer and for a co-ordinated primary medical response (which it has never had).

With this in mind, an independent review into the Tasmanian medical retrieval service was commissioned and carried out by Dr Peter Sharley in 2007. Dr Sharley's report contained 24 recommendations including a relocation of the service to Hobart to enable adequate staffing using existing hospital staff and increased usage of a Hobart-based helicopter service.

It comprised dedicated funding for staff, in particular a director and three senior registrar positions, one each based in intensive care unit, anaesthetics and emergency department.

The report was widely supported, especially from within the anaesthesia community and the government at the time agreed to implement all the recommendations. Unfortunately there has been no change to date. Within the spectrum of acute-care services in Tasmania that involve anaesthetists I feel the biggest problems are with the retrieval service.

In conclusion, it seems to me that none of the things I have outlined here are individually unique to Tasmania. The unique thing is the mix, the different rewards and challenges that result and the people that are attracted to that. At present, this mix is keeping anaesthesia in Tasmania healthy and growing.

Reference:

1. Professor Jeff Richardson The Tasmanian Hospitals System: Reforms for the 21st Century ("The Richardson Report") 2004 available online at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0004/8563/2004-06-Richardson-Report-v2.pdf (accessed February 2012)

From left: Smithton Hospital, North West Regional Hospital

REFLECTIONS ON GLOBAL OUTREACH ANAESTHESIA AT THE ROYAL HOBART HOSPITAL

DR STEPHEN SWALLOW,
ROYAL HOBART HOSPITAL, TASMANIA

I may be a bit too old to have a mentor who has not now retired. When I consider my position as the clinical lead for "global outreach" in the Department of Anaesthesia at the Royal Hobart Hospital and reflect on the major influences that have shaped my anaesthetic career, a few individuals stand out.

The professor of anaesthesia in Dunedin, New Zealand, in 1987 and 1988 offered me an opportunity to live in Australia or New Zealand and avoid a life of penal servitude in the National Health Service of the United Kingdom. Barry Baker invited a notable anaesthetist to Dunedin and subsequently to the Royal Prince Alfred Hospital as a visiting professor. The culmination of that visit was the Jobson Symposium.

In a small way, I am attempting to emulate this. In February, Professor Gautam Bajracharya from Bir Hospital, Kathmandu, Nepal, became our first visiting professor. He spoke about academic anaesthesia, anaesthesia training and research in Nepal at the Annual Tasmanian Combined Australian Society of Anaesthetists and ANZCA meeting in Launceston.

I arrived in Hobart on February 1, 1999, and was assigned an office. I was to share my office with a certain Haydn Perndt. Haydn was away in Kathmandu when I started work but returned two weeks later. We established a mutual interest in *Xena, Warrior Princess*. When I purchased a 1999 Xena calendar at a discount price to adorn the wall of our shared office, a bond formed between us.

A week later, I was conscientiously working on a Saturday morning when the door to our office was thrown open by a manic-looking, red haired, 13-year-old boy with crazy eyes. He was, clearly, planning to play computer games on his father's computer and expected the office to be empty. "I'm Haydn Perndt's son," he announced. That is pretty obvious, I thought.

Later in 1999, Haydn and George Merridew ran the first Remote Situations, Difficult Circumstances, Developing Countries Anaesthesia (RSDCDCA) course in Hobart. I met George, Steve Kinnear, Rob McDougall and many other significant contributors to overseas aid. The obvious father figure to all of them was a parsimonious Scotsman who preferred to travel by bus or tram rather than take a taxi. He did not like propofol because he thought that it was too expensive. I had met Kester Brown.

I first met Marcus Skinner in 1994 when I was working in Launceston. Marcus moved from Burnie to Hobart in 2010 to take up the position of director of anaesthesia at the Royal Hobart Hospital.

We already had a strong commitment to overseas aid or global outreach, whichever term you prefer. Haydn had run all of this, including a spell as chair of the Welsh Federation of Sea Anglers (WFSA) Education Committee from his study at home. Google WFSA if you don't believe me.

Dr Haydn Perndt has had considerable influence over a generation of anaesthetists at the Royal Hobart Hospital. He has worked tirelessly to oppose the actions of what he calls the "militarist, capitalist, fascist alliance". We have been made aware of the actions and consequences of ethical investors such as Haliburton. Capitalist profit is the surplus effort of the exploited proletariat. A prize goes to the first respondent to correctly name the author and the date of this quote. Haydn retired as a staff specialist in 2010 after handing over the directorship of the department to Marcus Skinner. Haydn now exists as the archetypal peripatetic grey nomad, continuing to work in less affluent countries.

Marcus further strengthened the support of the director of anaesthesia to our global outreach projects. He co-wrote the original *Primary Trauma Care* manual in 1995 and has worked extensively in developing countries, particularly Vietnam. He has allocated to me extra rostered time to develop our global outreach activities. In this way, what is often a voluntary activity done at weekends and after work, is now an officially sanctioned and legitimate activity of the anaesthetic department.

I see global outreach in our department as a small not-for-profit business. We are applying to potential donors for grants that will fund our activities. To this end, we are taking two Faculty of Business Corporate Internship Program students, one for two days per week and the other for one day per week for the 13 weeks of semester one this year. One student will work primarily on aspects of finance, obtaining tax-free gift recipient status, GST registration and affiliation with the University of Tasmania Foundation. The other will produce promotional material for us to show potential donors and market global outreach.

We are strengthening our ties with the Faculty of Medicine. We plan to take elective medical students with us on our overseas visits.

In 2010 and 2011, staff specialists, visiting medical officers and full-time specialists in private practice have taught Primary Trauma Care in Mongolia, China, Burma and Vietnam. We have provided anaesthetic services or taught on refresher courses and at societies of anaesthetists meetings in Nepal, Laos, Vietnam and the Solomon Islands. Anaesthetists from Nepal, Laos, Vietnam and the Solomon Islands have visited us. We have received financial support from the Rotary Club of Glenorchy and the University of Tasmania.

Two of our pain specialist comrades have taught on the Essential Pain Management (EPM) course in the Solomon Islands and Tanzania. This year they are helping facilitate and teach the first EPM course in Vietnam and progressing EPM delivery in Tanzania, as part of an expanding EPM program in the Pacific, Asia and Africa.

We are one of many anaesthetic departments around Australia and New Zealand who are making significant contributions to the teaching of anaesthesia and pain management and the provision of anaesthetic services in less affluent countries in our region and beyond. The work is rewarding and long may it continue.

Scholar role to offer more choice

The new ANZCA scholar role will offer greater flexibility, more clarity and more options for trainees to develop research and teaching skills as part of the revised curriculum.

The scholar role will replace Module 11 and the formal project from next year, except where transition principles are in place for trainees who have completed Module 11 or are well advanced to complete Module 11 in 2013.

The new structure will give interested trainees an opportunity to engage in formal research, but will have other options for those less inclined towards research.

The Chair of the Assessment Committee, Associate Professor Jennifer Weller, says the new scholar role will be better defined and more meaningful, particularly for trainees who don't see themselves as researchers.

"It offers much more clarity about what they're expected to do," she says. "There will be some clearer guidelines around how they'll be assessed on the piece of work, and there'll be some options so people who don't want to take on a major project can divide it into smaller options."

Under the revised curriculum, trainees will have two options depending on their level of interest in research.

Those who aren't interested in completing a research project will be required to do three activities.

These are to critically appraise a paper published in a peer-reviewed indexed journal for external assessment (to be completed during basic training); to critically appraise a topic for internal evaluation and present it to the department (during advanced training or provisional fellowship training); and to complete an audit and provide a written report for external assessment (at any time during training).

Above: Chair of the Assessment Committee, Associate Professor Jennifer Weller.

Associate Professor Weller says the audit could be assessing your own practice or the practice of a hospital or hospital department, measuring and collating results, and developing ways to improve practice.

She says the idea is to ensure all trainees have some basic skills in interpreting research and evidence.

"They need to show some evidence that they're capable of critically appraising the literature so that if a paper comes out recommending something, they can look at the paper and say: 'Is there enough evidence in this paper. Is it robust? Should I actually change my practice because of what these people are recommending?'."

With the activities spread over the course of training, Associate Professor Weller says the intention is that trainees can build on their knowledge and not cram everything at the last minute.

"I think each of these activities is a manageable chunk that's not as difficult to approach as the formal project," she says.

For trainees who wish to do a research project, that option is also available. They can either complete a post-graduate course in research or a post-graduate course in teaching, make a significant contribution to a research project leading to publication in a peer-reviewed journal, complete a systematic review or critical appraisal of a topic that is of publishable standard in a peer-reviewed journal, or complete another approved activity in the area of research or teaching.

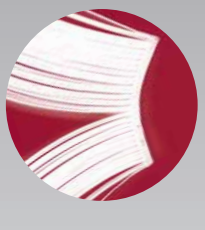
Prospective approval must be gained from the regional scholar role supervisor or director of professional affairs assessor for the planned project or course.

"I think it's really important for us to continue producing academic anaesthetists to take the profession forward," Associate Professor Weller says. "So instead of doing a collection of three things, a trainee can opt to undertake a bigger and more in-depth study or a systematic review of a topic area which would be something you could publish."

In addition to the two research options, all trainees will be required to show they are competent teachers by the end of advanced training. They will be required to teach a skill, and to facilitate a small group discussion or run a tutorial. These tasks will be evaluated by peers and the department scholar-role tutor, who will provide feedback and opportunities for reflection.

Associate Professor Weller says the teaching requirement was introduced because teaching is fundamental to how anaesthetists further the profession.

"The new generation of specialists learns from existing specialists," she says. "Every single anaesthetist will be involved in teaching so it's important that we have some understanding of what we're doing so we can do it better."



The scholar role is one of seven ANZCA roles, which are based on the CanMEDS (Canadian Medical Education Directives for Specialists) framework, and are designed to ensure trainees have a broad range of skills. In addition to being medical experts, trainees are required to have skills as a communicator, manager, collaborator, professional, health advocate and scholar.

The new curriculum framework defines the desired attributes of trainees for each of these roles. For the scholar role, a trainee at the end of training should be able to:

- Maintain and improve practice through ongoing learning.
- Critically evaluate information and its sources, and apply this appropriately to practice decisions.
- Demonstrate knowledge and skills appropriate to fostering scientific inquiry.
- Facilitate the learning of others.

These skills will be assessed through the scholar role activities, as well as multi-source feedback, the final examination, clinical-placement review questions (which will replace the in-training assessment) and clinical-based discussions.

Associate Professor Weller says the new arrangements are a good way forward.

"There's more flexibility in the scholar role," she says. "Hopefully, people find it more meaningful and better defined."

The Chair of the ACT Regional Training Committee, Dr Jennifer Myers, agrees: "The scholar role offers an alternate pathway for those who don't want to get involved in research and academia and I think that's a benefit of the new curriculum."

Meaghan Shaw,
Media Manager, ANZCA

At a glance – scholar role assessment

Core unit	Assessment
Basic training or advanced training	Teach a skill (with evaluation, feedback and reflection)
	Facilitate a small group discussion or run a tutorial (with evaluation, feedback and reflection)
Plus EITHER Option A: All three activities	
Basic training	Critically appraise a paper published in a peer-reviewed indexed journal for external assessment
Advanced training or provisional fellowship training	Critically appraise a topic for internal evaluation and present it to the department
Basic training, advanced training or provisional fellowship training	Complete an audit and provide a written report for external assessment
OR Option B: Select one and obtain approval	
Basic training, advanced training or provisional fellowship training	Complete a postgraduate course in research
	Complete a postgraduate course in teaching
	Complete a significant contribution to a research project leading to publication in a peer-reviewed journal
	Complete a systematic review/critical appraisal of a topic published in a peer-reviewed journal
	Complete another activity in the area of research or teaching

Transitioning to the revised curriculum in 2013

The ANZCA Council has approved the principles for transition to the revised curriculum ahead of the introduction of the revised curriculum in the 2013 hospital employment year. During 2012, the College will contact each trainee to review their training status and to confirm how they will be transitioned to the revised program. This process will be communicated to trainees during the first half of 2012.

Information relating to transition principles and the curriculum revision are available on the ANZCA website: www.anzca.edu.au/trainees/curriculum-revision-2013

Oliver Jones,
General Manager, Education Development, ANZCA

ANZCA and government: building relationships

Australia

Following a cabinet re-shuffle, Tanya Plibersek was appointed Minister for Health on December 14, 2011, with Nicola Roxon now Attorney-General. Previously Ms Plibersek was the minister for human services and social inclusion, while under the former Rudd government she was minister for housing and the status of women.

As Health Minister, Ms Plibersek has continued to push the health agenda set by her predecessor, with a focus on means testing the private health insurance rebate, governance of Medicare locals and initiatives designed to reduce tobacco use. The new minister has also recently announced funding for a national electronic records system designed to combat abuse of controlled drugs including prescription painkillers.

ANZCA's Policy Unit continues to engage with the Department of Health and Ageing under the direction of the new minister. To the end of February 2012, the College had made submissions to the Department of Health and Ageing on:

- Prescribing competencies framework project: Core competencies to prescribe medicines safely and effectively – Draft 1.7 for consultation.
- Evidence requirements for assessment of applications for the prostheses list: A discussion paper.

Other responses include:

- Consultation paper on Australian safety and quality goals for healthcare submitted to the Australian Commission on Safety and Quality in Health Care.
- Activity-based funding for Australian public hospitals: Towards a pricing framework submitted to the Independent Hospital Pricing Authority.

ANZCA's past submissions can be viewed at www.anzca.edu.au/communications/submissions.

Engagement continues through ANZCA representation at the Medical Training Review Panel and the Enhanced Medical Education Advisory Committee. Key issues include concern about the work of Health Workforce Australia on the supply and demand of medical practitioners – the data on specialist trainees will be reviewed due to data integrity issues. The Independent Health Pricing Authority is also under scrutiny from the various medical undergraduate, prevocational and vocational bodies given the absence of any meaningful accountability mechanisms for teaching, training and research.

Australian government grants – Specialist Training Program

The Specialist Training Program (STP) has made significant progress since the execution of the agreement with the Australian government in November 2011. ANZCA now has a program manager and project officer are now in place to manage the 37 training positions across anaesthesia, pain medicine and intensive care medicine specialties.

New multiyear funding agreements are being established between ANZCA and training settings across Australia and the first reporting requirements have been met.

The program also has a rural focus and acknowledges the additional costs associated with training in rural areas. Under the program, ANZCA manages a Rural Support Loading (RSL) grant to assist with the additional costs of supporting specialist training posts located in rural settings. Grants of up to $20,000 (ex GST) pro rata full time equivalent (FTE) per annum are available.

The Rural Loading Grant is open to all STP posts which are located in regional/rural/remote areas based on Remoteness Area Classification (RA) 2-5. Applications for the RSL open in April.

In addition, applications for the 2013 STP round opened on March 5. Interested facilities need to notify ANZCA of their intention to apply for funding and request a letter of support for their applications. 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

Developing networks with policy staff at other colleges and within the Ministry of Health remains a focus for the policy officer in NZ and is progressing well. There is a high degree of goodwill among policy practitioners and frequent opportunities to share information.

Submissions

The New Zealand office has made a number of submissions, the notable ones to Health Workforce NZ on their proposed "concept note" for a health workforce strategy for NZ, and on the prioritisation of medical disciplines for funding. The second generated a response saying that the funding framework would be substantially revised; however, no further details are available at this stage. It is due for implementation in the 2012-13 financial year.

Post-election environment

The new National-led government has continued, as expected, on the same path it followed during the last term, but with increased vigour.

The health targets (to July 2012) continue to focus on shorter emergency department stays, more elective surgery, shorter waits for cancer treatment, increased immunisation, more quit support for smokers, and better testing and services for those with cardiovascular disease and diabetes. The minister has also identified four health priorities:

- Strengthening the health workforce.
- Improving hospital productivity.
- Speeding up the implementation of the Primary Health Care Strategy.
- Improving value for money.

The briefing to the incoming minister (officials' advice to the minister and available on the Ministry of Health website) focuses on "accelerating the pace of change"; identifying seven possible directions for change, with rationale and policy options for each. They are:

- Moving intervention upstream.
- Meeting the diversity of needs within the population.
- Driving investment towards better models of care.
- Integrating services to better meet people's needs.
- Improving performance.
- Strengthening leadership while supporting frontline innovation.
- Working across government to address health and other priorities.

This all signals a continuation of the recent trend for rapid changes and introduction of new models of care and service delivery systems on short timeframes. ANZCA needs to be aware of the environment and ready to respond. In some circumstances (for example, the HWNZ strategy) we will discuss the implications of proposals with other colleges and societies.

John Biviano, General Manager Policy, ANZCA

Christchurch anaesthetists – working with the "new normal"

Christchurch anaesthetists, like the city's residents in general, speak now of their "new normal", which aptly sums up their situation where life goes on as usual in many ways, but against a backdrop of the effects of nearly 18 months of unprecedented seismic activity.

As at the end of February, they had experienced over 10,000 earthquakes* since 4.35am on September 4, 2010, when a 7.1 strength earthquake shook the city. It caused considerable damage to buildings and land though, incredibly, no deaths and only two admissions to hospital for injury. People were not so fortunate on February 22, 2011, however, when a 6.3 force quake killed 185 people, left hundreds with severe injuries and caused massive damage to buildings, land and infrastructure.

"Normal" now includes continuing aftershocks that have caused further damage and made insurance companies reluctant to finalise claims, leaving many owners in limbo as to what will happen to their property. There is virtually no city centre; hundreds of buildings, including many heritage landmarks, are being demolished and many of the rest are inaccessible. Businesses have had to move or have closed. Homes have been demolished or are too damaged to repair, or are inhabitable but damaged with repairs likely to take years. Streets are buckled or closed, making travel around the city slower and more difficult. Land has turned into liquefaction again and again, and whole suburbs are being abandoned. Closed schools share premises with others often some distance away. Infrastructure such as sewerage and water remains badly damaged in places.

This page: Christchurch's CBD with hundreds of empty spaces as the demolition of damaged building continues.

Opposite page: Christchurch citizens were eager to enjoy the instant shopping mall created out of shipping containers on the fringe of the CBD, most of which has been out of action for a year.

On the plus side, however, there is a burgeoning suburban scene with new cafes, bars and restaurants opening to serve the businesses that have relocated. Innovative use of shipping containers has seen a pop-up mall of 30 retailers open up on the CBD fringe. Earthquake damage is very localised and, with Christchurch's extensive hinterland, it is easy to escape the city. Christchurch's residents are upbeat, looking forward to the rebuild and former residents are returning to take up new opportunities.

The most recent *Lonely Planet* guide noted that while most of the bars, cafes and restaurants that it recommended in 2010 were no longer open, Christchurch was "re-emerging as one of New Zealand's most exciting cities". The guide said visitors should definitely spend a few days there.

Christchurch Hospital's Department of Anaesthesia has fared remarkably well over the last year, despite far from ideal working conditions. Clinical Director Dr Richard French says: "While the circumstances we have faced have often been tragic or very disturbing, we are not in despair."

While he believes everyone must have given some thought to leaving Christchurch, staff have not left in droves despite the damage to or loss of homes and other issues. Rather, turnover has been at normal levels for the usual reasons, with only one consultant leaving, and that was for family reasons in the UK.

Dr French says that while some trainees opted not to take up scheduled rotation positions in Christchurch, others – usually with an existing Christchurch connection – have chosen to move back from other training centres, often to be closer to family and friends and take care of property.

Even with a 30 per cent increase in positions, all posts are filled. "We are not swamped with applications but those we get are of a very high quality so the staffing situation is far from bleak."

The earthquake, he says, has been extraordinary clarifying in terms of shaking out any complacency.

"Previously, we were blessed in having a very attractive local environment that was a major drawcard in itself. The brutal truth is that now people may choose

not to come here because of the current environment. We can't delude ourselves. We have to make sure the department is offering the best training and the best working environment in Australasia, and that working here is pleasant and professionally satisfying," Dr French says.

"The future is extremely bright for the department and for the city, which is coping well. I can only influence the department so my philosophy is that this is an opportunity for us to take our department from being a good department to being a great department."

Looking back over the year, the Deputy Clinical Director and ANZCA's formal project officer in New Zealand, Dr Jennifer Woods, feels that as a group, anaesthetists may not have appreciated just how much impact the earthquake and its aftermath had on them psychologically.

"We concentrated on getting our work done and set aside our personal needs. Perhaps we should have been more open to accepting the help that was offered. At the time we boxed on because we thought we should and thought we were all ok, but with hindsight maybe we should have looked after ourselves more," she says.

"Each of the inconveniences is minor but cumulatively they do become stressful. However, we coped and I think that as a department we have done remarkably well, meeting all the government health targets."

Dr French, too, is proud of his team, who have stepped up to maintain service in difficult working conditions. The department's offices are currently disrupted by earthquake-related work – sheer wall testing and having the adjacent stairwell out of action for six weeks while it is fixed. Parking at the hospital is limited, with the public carpark closed due to damage and the staff carpark held up by scaffolding.

"While the circumstances we have faced have often been tragic or very disturbing, we are not in despair."

The loss of two wards at Christchurch Hospital has added pressure for a very prompt turnover of acute cases, so the case mix in theatres has changed.

The region has also lost four theatres – two at an inner-city private facility and two at the satellite Ashburton Hospital, an hour from Christchurch. Ashburton's theatres, which handle about 1500 cases a year, were closed last month after being assessed as an earthquake risk. Christchurch now has to handle those cases as well and private facilities are being used for some procedures, a situation that concerns Dr French, even though staff have responded well.

"We work in the public arena because of collegiality, the case mix and the opportunity to teach. That working environment is not mirrored in private practice. It is gratifying that people are willing to work in this way but I am conscious that we can't expect them to keep doing that. I need to be able to offer them a path forward."

(continued next page)

Earthquake statistics:

Within the first 24 hours of the February earthquake, there were 322 presentations to the Christchurch Hospital emergency department with 122 admissions to the ward. This represents fewer than four per cent of the documented 6500 earthquake-related trauma and illness. Three patients were declared deceased on arrival and one patient died following a failed resuscitation attempt in the emergency department.

Initially, theatre workload was relatively light with 30 general anaesthetic cases in the first 24 hours. The majority of cases (19) were orthopaedic. Three patients required six separate visits to theatre for bilateral fasciotomy of upper or lower limbs and then bilateral lower limb amputation.

In the following two weeks, the majority of the theatre case mix was orthopaedic trauma related to the earthquake. However, elective services were gradually reinstated over this time period. There were 258 theatre cases requiring 914 surgical procedures, of which 502 or 55 per cent were orthopaedic cases. Of the 11 neurosurgical procedures in this time, there were two traumatic spinal cases.

Dr Rachelle Mason, Christchurch Hospital

Christchurch anaesthetists – working with the "new normal"
continued

In this respect, the government's approval of a hospital rebuild is very important, he says.

In December, the government gave the Canterbury District Health Board the go-ahead to develop a business case for rebuilding the city's hospitals. The option being considered involves rebuilding most of the clinical wards at Christchurch Hospital including a new acute services wing. Minister of Health Tony Ryall said the earthquakes had made an already identified capacity problem a lot worse.

"The phrase the 'new normal' is becoming a bit of a cliché but it is true – you just adapt. There are some inconveniences but it is not unpleasant, Christchurch is still generally a nice place to live and work," Dr French says.

Susan Ewart, Communications Manager, NZ, ANZCA

**Paul Nicholls of the University of Canterbury's Digital Media Group has developed a Christchurch quake map to help people understand what people in Christchurch are experiencing. The map, at www.christchurchquakemap.co.nz, presents a time-lapse visualisation of the earthquake and its aftershocks.*

Above: Dr Bryce Curran (left) pictured with the Mayor of Christchurch Bob Packer. Dr Curran is holding the award he received for bravery in assisting with a double amputation in a collapsed building on the day of the earthquake in February last year. Photo courtesy of Linton Photography.

Bravery award

In some respects Dr Bryce Curran became the public face of the work performed by anaesthetists immediately after the earthquake on February 22, 2011 – for going into the collapsed PGC Building where he anaesthetised and then helped to amputate the legs of a man trapped by fallen concrete, while aftershocks continued. Initial reporting of that could have left an incorrect and poor impression of the anaesthetic care given and Dr Curran agreed to explain the facts in an ANZCA media release that garnered wide coverage.

This is not to detract, however, from the work other anaesthetists did in the field and the sterling work from the whole team at the hospital, working under extreme pressure as casualties flooded in – in theatres that had no heating and putting their resuscitation skills to maximum use in the emergency department, often working by torchlight.

Largely, over the last year, Dr Curran has been able to put his experience behind him, though the anniversary this February revived memories. "I saw some horrible things and the anniversary coverage brings it up. The memorial service was very useful – there was a wonderful sense of shared emotion, it was a unique event and probably a good thing for many people but now I am ready to draw a line in the sand and move on."

> "We have to make sure the department is offering the best training and the best working environment in Australasia."

He was given an award for bravery at that memorial service, along with the others who assisted with the double amputation, including Australian urologist, Dr Lydia Johns Putra from Ballarat (in Christchurch at the time for a conference), fire officer Scott Shadbolt and police officer Danny Johanson, who is also a paramedic. The team worked by torchlight to free Brian Coker, providing ketamine anaesthetic and amputating his legs with a Leatherman knife and a hacksaw.

"It was very nice to catch up with Lydia and debrief over a meal," Dr Curran said. "And also to find out the extent of Danny Johanson's role – he put the tourniquets in place and in fact helped with finally extricating Brian, which I had not realised until now as it was after I had crawled back out of the hole. It was absolutely a team effort."

While in some respects, his year has been about moving on, Dr Curran says living in a damaged home with a decision still to be made on whether or how it will be fixed, does leave one with the feeling of having your life on hold.

His experience has also deepened his interest in disaster response work, leading to him taking part in the Darwin-based AusMAT course last April, along with two other New Zealand anaesthetists, one of whom is Dr Maurice Lee, ANZCA's representative to the New Zealand Ministry of Health (MoH) for disaster planning.

Dr Lee says the Christchurch earthquake has given added impetus to the MoH's work on disaster response capability. "It provided a good reminder to look at ourselves and our capabilities." He says AusMAT is "a fantastic course that now sets the benchmark for anyone working in this area". – Susan Ewart.

Simulation for trainee selection

Selection of anaesthesia trainees is a complex but crucial undertaking. Each year, multiple selection centres across the ANZCA region conduct intensive and time-consuming recruitment programs designed to select the "best" trainees to our specialty.

While the selection process is slightly different in each state, all employ traditional selection methods such as written submission, references and interview. We would like to report on the 2011 selection process in Western Australia, in which the use of simulation as a selection tool was trialled for the first time.

Background

For many years, the WA anaesthesia training program has employed a centralised and standardised selection process, using curriculum vitae, a statement addressing selection criteria, references and a structured interview. In most cases, this process has been successful in selecting very good anaesthesia trainees. However, as trainee numbers increase, there are concerns that sometimes we don't get it right. As a result, alternative and additional strategies for trainee selection were considered. The role of simulation has been investigated in multiple centres around the world, and has been implemented in several deaneries in the United Kingdom[1,2].

In 2011 the WA selection committee trialled two additional modalities in their selection process – a short pre-prepared presentation as part of the interview station, and a simulation station. I co-ordinated the simulation station with Dr Belinda Lowe (also a consultant anaesthetist at Sir Charles Gairdner Hospital). The simulation station was designed to complement traditional selection techniques, but also to reveal information about candidate suitability that may not be elucidated from the written submission or interview.

Developing the simulation station

It was felt that the key strength of simulation in this setting would be to observe candidates' behaviour and non-technical skills within a high-pressure clinical situation. With these objectives in mind, assessment criteria were developed:

1. "Ability to think" – situational awareness/systematic approach/ logical thinking.
2. "Ability to act" – decision making/ implementation.
3. Communication and interpersonal skills.
4. Behaviour under pressure.
5. Appropriate medical management.
6. Global assessment.

Each of these criteria was given equal weighting, and was scored on a five-point scale from poor (one) to outstanding (five), giving an overall score out of 30.

Simulation scenarios were then designed to demonstrate these criteria. As anaesthesia experience was not a prerequisite, scenarios were medical rather than anaesthesia based, and involved common, ward-based clinical situations. Each scenario used medium fidelity simulation with Laerdal SimMan Classic or SimMan 3G mannequins. One of the assessors played the role of a nurse. Each scenario was designed to take approximately 10 minutes, and incorporated a period of initial assessment followed by a clinical deterioration. Each candidate was tested in two scenarios. Scenarios were trialled in advance, on simulation Fellows acting the role of junior doctors, to determine whether the desired assessment criteria could be observed.

Assessors were invited from each of the teaching hospitals in the Perth region. All were consultant anaesthetists familiar with simulation and with an interest in trainee selection.

Prior to their attendance at the simulation station, shortlisted candidates were emailed information about the process, including the nature of medium fidelity simulation and instructions to behave as they would in a normal clinical situation. When candidates arrived at the simulation station, this information was reiterated verbally and in writing.

Implementation of the simulation station

The simulation station was labour intensive. The two scenarios ran simultaneously in separate rooms, and each scenario employed three assessors – one as the nurse confederate, one as the console operator and voice of the mannequin, and one as a stand-back assessor. Assessors rotated through each of these roles, and each assessor independently marked each candidate. Assessors were encouraged to provide comments as well as scores for each of the assessment criteria. They were also asked to provide a "gut-feeling" assessment of whether they felt the candidate should be selected for the training program, on a scale from "definitely don't select" to "definitely select". In addition to the six assessors, two support personnel were employed to accompany candidates between the simulation rooms, and provide support and reassurance as necessary.

A total of 29 candidates were assessed in the simulation station over two days. All scenarios ran smoothly, with no major technical issues.

It was agreed among all assessors that the simulation scenarios provided very interesting and valuable information about the candidates and their suitability for anaesthesia training. The overall level of performance was high, and medical management was generally sound. The most discriminating assessment criteria were:

- The ability to stay calm and controlled under pressure.
- The ability to make decisions and act upon them.
- Interpersonal skills, particularly when making requests of the nurse (assessor).

As this was the first time that simulation for selection was being trialled, the results from the simulation station were only worth 5 per cent of the total mark for selection. However, it is felt that the qualitative information obtained from the subjective evaluations of the assessors was just as valuable as the quantitative results, and both quantitative and qualitative data will be correlated with subsequent clinical performance of appointed trainees.

Feedback

All candidates were asked to complete a feedback form after their simulation station, to determine their impression of the process. Most felt the simulated scenarios were relevant, a fair method of assessment and allowed demonstration of their abilities. Assessors also completed a feedback questionnaire, and provided many positive comments about the process and a very high level of enthusiasm for the use of simulation in future selection processes.

Conclusions

It was felt that the simulation station conducted as part of the 2011 WA selection process was a successful undertaking, although effort-intensive. It revealed extensive information about the candidates, including their communication skills, decision-making skills and ability to perform under pressure. It is thought that simulation may provide insight into behaviours and attributes that may not be elucidated through traditional methods of selection, but that may be important in determining a candidate's suitability for training in anaesthesia. The predictive validity of these observations will be investigated in the appointed candidates.

In summary, the use of simulation for selection is a labour-intensive process but provides interesting information, and may represent a valuable additional tool in the difficult process of trainee selection.

Dr Angela Palumbo, FANZCA
Co-ordinator – Simulation for Selection 2011; Consultant anaesthetist, Sir Charles Gairdner Hospital, WA

References:

1. Gale TC, Roberts MJ, Sice PJ, et al. Predictive validity of a selection centre testing non-technical skills for recruitment to training in anaesthesia. Br J Anaesth 2010;105:603-9
2. Lam WH, Gale TC, Anderson IR, et al. The Anaesthesia Recruitment Validation Group (ARVG) experience. RCOA Bulletin 2009;57:24-6

"It was agreed among all assessors that the simulation scenarios provided very interesting and valuable information about the candidates and their suitability for anaesthesia training."

Medical milestones in the land of Ghengis Khan

Resilience and perseverance build a successful specialty in Mongolia – with help from Australian anaesthetists as Meaghan Shaw reports.

You need resilience to succeed in Mongolia. A sparsely populated, impoverished country with extreme weather and little arable land, it inspires a fierce determination and warrior spirit, characterised by its most famous son and world-conqueror, Ghengis Khan.

Displaying similar resoluteness, Dr David Pescod from Melbourne's Northern Hospital, has been returning to Mongolia's capital, Ulaanbaatar, since 2001, slowly building the trust and capacity of local anaesthetists brought up on decades of health misinformation.

His perseverance has been needed because, for the first five years of his visits, his teachings were scarcely believed.

He first went to Mongolia for the 40th anniversary of the Mongolian Society of Anaesthetists as a somewhat reluctant representative from the World Federation of Societies of Anaesthesiologists (WFSA) due to his previous overseas work.

"It was minus 30 (degrees). It was winter. No one spoke English at all. And I sat for two weeks in lecture theatres listening to lectures in Mongolian, not understanding any of it, and spending the nights drinking vodka and eating mutton fat," he explains.

Despite this, he agreed to return when invited to do some teaching by a leading Mongolian anaesthetist and trainer, Dr Ganbold Lundeg.

For several years, he went to Ulaanbaatar "giving more or less didactic lectures" to anaesthetists who were "happily copying down everything we said" but leaving both sides little wiser about each other.

It wasn't until 2006 when, joined by a Northern Hospital colleague, Dr Amanda Baric, he was giving a small group-learning session on obstetric anaesthesia and discovered how much there was to learn about anaesthesia in Mongolia.

"A question came up about how much suxamethonium you give a lady who's had an awake caesar," Dr Pescod says incredulously, explaining how inappropriate it would be to give a muscle relaxant to an awake patient, and how it doesn't work in the uterus anyhow.

"And that's when we suddenly realised we really need to learn a lot more about what their practices are because there are things you can't predict because they're so weird."

At the same time, they received a confession by Dr Ganbold that he had mistrusted much of what Dr Pescod had been saying until he tried some of the techniques and discovered they worked. People had stopped dying.

"So it turned out for those previous years, they'd been listening to what we'd been saying, but what we'd been teaching them was so opposite to what they'd been taught for 40 years, they didn't believe a lot of it," Dr Pescod says.

He explains that most of the Mongolian knowledge of anaesthesia stemmed from Russian teaching from the 1940s which had become distorted through the years by "Mongolian whispers" until it was full of major omissions, and many myths had become facts.

"They believed that halothane was a powerful analgesic and it's not an analgesic at all," he says. "So all their patients were getting general anaesthetics without any pain relief.

"They were also using antihistamines as a post-op analgesia because if you get enough of them, you stop moaning because you become unconscious."

Another quirk was the practice of giving intra-arterial antibiotics for sepsis, under the mistaken belief it would hasten the recovery of really sick patients.

Having felt increasingly jaded by the Mongolian program, Dr Ganbold's admission reinvigorated Dr Pescod and his colleagues, and sparked the impetus for them to create a training program and write a textbook specific to Mongolia.

Opposite page from left: Ulaanbaatar, Mongolia; Dr Deb Devonshire (right) teaching intubation at an obstetric hospital; Dr David Pescod (right) teaching intubation; Dr Glenda Rudkin (far left) and Dr Amanda Baric (far right) in theatre. Following page: Dr Ian Hogarth airway course.

Dr Pescod says Dr Baric's involvement was pivotal in bringing to the project renewed enthusiasm and vision, and helped tap into the wealth of experience of other Australian anaesthetists.

At that time, anaesthesia in Mongolia was in "free-fall", he says. There were about 30 anaesthetists in Ulaanbaatar, and fewer in the country.

"They were very under-resourced, the death rate was high, and the standing of anaesthetists in the medical community was very low," he says. "Less and less people wanted to do anaesthesia."

He said the older anaesthetists were moving to other administration posts, the Mongolian Society of Anaesthetists appeared to be "a society for the old boys who drank vodka", and, at one stage, the government reduced the anaesthetic training program to six weeks in response to the low numbers of anaesthetists.

But Dr Pescod and Dr Baric were encouraged by a clever bunch of young Mongolian anaesthetists who had been taught at the WFSA training centre in Bangkok and who were motivated to share their knowledge at home.

They sought and gained an agreement from the Mongolian government to extend the training of anaesthetists to 18 months and, in return, they undertook to train the next generation of anaesthetists.

With support from AusAID, ANZCA, the Australian Society of Anaesthetists (ASA) and Interplast, Dr Pescod wrote the textbook *Developing Anaesthesia*, which was translated into Mongolian and made freely available on the internet. Along with Dr Baric and other Northern Hospital colleagues, they wrote the 18 modules for the anaesthesia training program.

The first cohort of 28 new trainees enrolled in 2009 and graduated last year, coinciding with the 50th anniversary celebrations of the Mongolian Society of Anaesthetists, at which Dr Pescod was awarded a medal of honour from the Mongolian government in recognition of his contribution to anaesthesia education. Dr Baric and other members of the team were presented a golden laryngoscope medal.

A further 28 anaesthetists are in training.

"Anaesthesia's now the craft group everybody wants to join," Dr Pescod says. "It's over-subscribed. And the government now has expanded anaesthesia to two years. Other craft groups are now approaching us."

In June, Dr Baric (described as "a powerhouse" by Dr Pescod) will accompany a team of 24 volunteers who will pay their own way, made up of 12 anaesthetists and 12 others including a general surgeon, obstetricians, gynaecologists, midwives and a pain nurse.

Previous trips have included emergency medicine physicians, gynaecologists, obstetricians, neonatologists and a midwife.

AusAID and ASA funding covers the cost of Mongolian anaesthetists, who earn on average $US100 a month, to travel from around the country to attend the one-week international anaesthetic meeting – the only craft that boasts an international gathering.

Dr Roger Goucke, a former dean of the Faculty of Pain Medicine, will also run an Essential Pain Management course, during which Dr Pescod hopes the Mongolians will be convinced of the benefits of morphine over fentanyl.

"We eventually got them to use narcotics intraoperatively and post-op, but they only use fentanyl – they won't use morphine," Dr Pescod says. "We're struggling there. They still believe morphine is a very dangerous drug, whereas the cost of morphine is only a few cents and fentanyl is a few dollars."

The teaching is now more hands-on and involves more problem-based learning in the Soviet-era hospitals, where electricity failure is a regular occurrence.

"One thing we have learnt is you need to learn before you teach," Dr Pescod says.

(continued next page)

Medical milestones in the land of Ghengis Khan
continued

"We have evolved our teaching. We're better teachers now. Rather than going and giving didactic lectures, which is the easiest thing to do, to stand with a Power Point presentation and just present it, we're now running small group learning and problem-based learning, which is harder to do."

Trust has been built, along with a greater understanding of what is needed.

"I gave a lecture one year on awareness," Dr Pescod says. "It was years later Ganbold said to me, 'We don't know why you bothered talking about awareness. All the patients are aware. There's an expectation'."

Dr Baric chips in: "I think patient expectation is a little different now but there would still be quite a lot of awareness. I think they're more afraid of mortality than awareness."

While statistics aren't collected, anecdotally, the death rate due to anaesthesia used to be high at about one a week. Now deaths are rare.

Obstetric practices have also improved thanks to the visits of Australian obstetricians, midwives and anaesthetists. Dr Baric says in 2006, there was a lack of understanding of basic procedures, such as monitoring urine output and the reflexes of pre-eclamptic mothers. Coupled with this, the major obstetric hospital had no blood pressure monitoring devices, was reusing the sole spinal needle over and over again, and its intensive care unit was a room with one oxygen-flow meter and no suction.

"We had to change some of the obstetric practices in anaesthetics and we improved resuscitation and sepsis management," Dr Pescod says. "In association with that, maternal mortality has halved in the last three years, which we're probably partly responsible for, I imagine."

But while things are improving, there is still some way to go.

Dr Pescod says the availability of equipment and drugs is "still atrocious". Two years ago, the cancer hospital had no laryngoscopes. Each year, teams take with them gifts and supplies including monitoring devices, oximeters, stethoscopes, manual blood pressure cups, ultrasound machines, laryngoscope blades, spinal needles, epidural kits and manuals for donated equipment, which is often unused due to lack of instructions.

Much of the Mongolian government's health budget goes to the maintenance of crumbling infrastructure due to an over-abundance of hospitals. This over supply stemmed from the Russian Semashko model of health care, which meant different employment groups, such as police, the military, teachers and railway workers, each had a separate hospital.

Despite this proliferation of hospitals, with a third of Mongolia's population living a nomadic life on the Steppes, many would not get to a city hospital in the event of major trauma. Postpartum complications regularly lead to deaths in the countryside ger camps made up of round, felt-lined tents.

The Mongolian Society of Anaesthetists also faces an uncertain future and can't rely on its impoverished anaesthetists for money. With rental costs in Ulaanbaatar skyrocketing due to a mining boom and an influx of expatriate workers, the society would struggle without Australian funding to pay its annual $US15,000 bill for rent and expenses.

At this stage, Dr Pescod says there is no long-term plan for the society once Australian funding runs out. "The worst-case scenario is we'll have 100-odd anaesthetists trained up and a new training program and new text book, and we'll be able to provide ongoing seminars," he says.

"But the power behind it all is the Mongolian Society of Anaesthetists and we need to keep them funded somehow. We desperately need help from our Australian anaesthetic colleagues to find a solution. $15,000 is little for a business or company to pledge and guarantees 20-plus new anaesthetists, who provide all anaesthetic, intensive care and emergency services to Mongolia."

So what prompts the team to keep returning each year to Ulaanbaatar's drab hospitals and quirky mix of slum ger camps, pot-holed footpaths, shiny new buildings, Irish pubs and Korean barbecue joints?

Dr Baric says it is a sense of accomplishment and seeing palpable improvements each year. "People get a certain satisfaction, especially if they've returned a couple of times and seen a lot of things changed," she says. "We've developed a trust with them. The Mongolians are really keen to learn and keen to improve their specialty."

Dr Pescod agrees the Mongolians are especially enthusiastic students. "I've worked in other Asia Pacific countries, going back again and again, and nothing changes," he says. "In Mongolia, you suggest something and it's taken up and improved every time.

"It's an unusual country where people who leave Mongolia to train overseas come back to Mongolia to work, despite the fact that a Mongolian anaesthetist would be on $US100 a month, it's minus 30 in winter, and they can't afford to own a car or even a one-bedroom flat in a high rise that would be knocked down here."

And from a personal point of view, Dr Pescod has learned more from his perseverance in the land of Ghengis Khan than from any exotic scientific conference.

"From self-interest, there's nothing better than writing basic modules to keep your own skills right up to date. I learn a lot more by doing that than by going to a conference in Paris."

Meaghan Shaw, Media Manager, ANZCA

NZ's anaesthesia workforce – ANZCA study models outlook

A shortfall in the supply of anaesthetists in New Zealand is predicted to increase over the next three years but then decrease until supply outstrips demand by about 2026 at the latest, according to ANZCA's *New Zealand Anaesthesia Workforce Report*.

The New Zealand report – a companion to ANZCA's Australian workforce study done in January 2009 – is being released this month.

Its key finding is that a current shortfall in the supply of anaesthesia services will increase until about 2015, after which it will gradually diminish until equilibrium between supply and demand is reached. The time taken to reach that equilibrium can be reduced significantly if more new specialists can be retained in New Zealand and existing specialists can be encouraged to work for longer than the age at which they indicate they intend to retire.

ANZCA has developed the New Zealand study to contribute to the discussion about the shape of New Zealand's anaesthesia workforce in the future and how demand for anaesthesia services should be met. It will help inform ANZCA's policy deliberations with the government about the future of anaesthesia service delivery in New Zealand, the timely delivery of these services, and the need to maintain quality and safety standards within the profession.

Using data from the late-2009 New Zealand anaesthesia workforce survey and anaesthesia service usage in New Zealand public hospitals, the study seeks to determine the likely shortfall or surplus in the supply of anaesthesia services in New Zealand over the 20-year period 2010 to 2030.

Supply data

Towards the end of 2009, ANZCA, with support from the New Zealand Society of Anaesthetists, surveyed all ANZCA Fellows, other vocationally registered specialist anaesthetists and ANZCA trainees in New Zealand.

As well as demographic details, that survey sought information about qualifications, training, hours and nature of work, location of practice, likelihood of leaving New Zealand and likely age of retirement. It asked respondents to describe the adequacy of the anaesthesia workforce, to identify any geographic or clinical gaps in meeting demand, what strategies would most likely succeed in addressing those gaps and what factors other than the medical workforce adversely affect the provision of anaesthesia services.

The survey drew a 75 per cent response, producing excellent data about the current and projected supply of anaesthesia services.

The combined work of ANZCA Fellows, other vocationally registered anaesthetists, other doctors providing anaesthesia services under supervision and ANZCA trainees was used to determine the total available supply of anaesthesia services in New Zealand.

It showed that, on average, a New Zealand anaesthetist spends 47.6 hours each week delivering a mix of clinical services, with 30.6 hours of that spent on in-theatre anaesthesia delivery. The other 17 hours of clinical work includes pre and post-anaesthesia care, intensive care, pain medicine, after-hours anaesthesia delivery and other medical practice. In addition, on average, another 7.6 hours per week is spent on non-clinical activities such as administration, teaching, research and compulsory continuing medical education. With these being averages based on survey responses, the work of individual anaesthetists can vary considerably from these figures.

While men account for two-thirds of the current overall anaesthesia workforce, women are training in increasing numbers, with 56 per cent of trainees in 2009 being male and 44 per cent being female. The study assumes that future trainee intakes will have a roughly equal gender split and will result in women accounting for 40 per cent of the workforce by 2030. As female anaesthetists spend less time delivering in-theatre anaesthesia services, this affects the supply side of the model, which is predicated largely on in-theatre work. It should be noted, however, that the total time spent by female anaesthetists on all clinical anaesthesia services does not vary significantly from that of men.

Demand data

ANZCA acquired public hospital data of actual in-theatre usage of anaesthesia services from which to calculate the demand for anaesthesia services. Being usage based, these data do not reflect unmet demand, just the actual demand that was being met.

The in-theatre data was extrapolated to calculate the demand for non-theatre and non-clinical work as well as work in private hospitals, based on ratios derived from answers to the survey as to how much of that work constituted the average anaesthetist's overall practice.

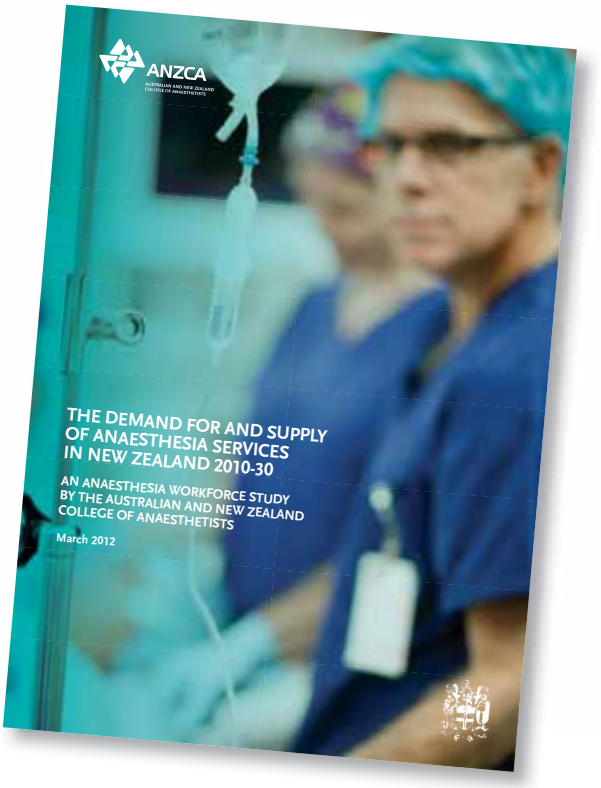
The supply/demand gap

Using in-theatre work as the basis of calculations, the 2009 data revealed a notional shortfall in supply of 24 full-time equivalent anaesthetists (FTEs) – though as the demand data is based on actual usage, clearly that demand was being met somehow and the report comments on this.

The study indicates that this shortfall will increase to about 33 FTEs by about 2014, after which the gap between supply and demand will gradually diminish. The point at which equilibrium is reached varies according to several scenarios that the study examines, but at the latest it would be reached by 2026, after which there would be a small surplus in supply.

The report emphasises that while the variable used to assess the gaps in supply and demand in the workforce model is in-theatre delivery of anaesthesia services, it should be noted that this work is only one component of the range of services that anaesthetists provide. Accordingly, any workforce calculations need to allow for non-theatre clinical work and non-clinical duties, as well as the in-theatre clinical workload.

The report also notes that while the survey indicated that, on average, anaesthetists were spending about 14 per cent of their time on non-clinical duties, ANZCA's recommended guidelines for specialist anaesthetists in teaching hospitals are that "clinical work should not exceed an average of 0.7 of specialists' workload", that is about 30 per cent of time should be reserved for non-clinical duties.



Base case and scenarios

The supply and demand data were used to develop a base case with assumptions that reflect the current supply and demand environments – average number of in-theatre clinical hours, historical growth in Fellows and overseas-qualified specialists, increase in female participation in the profession, retention of trainees, age at retirement, etcetera. Under this base case, a balance between supply and demand would be reached by about 2024.

In addition, the study models four other scenarios to quantify the potential effect of specific initiatives on the supply and demand gap.

Scenario one adds an extra hour a week of pre and post-operative care to the average anaesthetist's workload, thus reducing their availability for in-theatre work but meeting the call for anaesthetists to increasingly take on the wider perioperative role. As any difference between supply and demand in the model is based on in-theatre services, this scenario aggravates the shortfall in supply (to about 56 FTEs by 2014/15), so that it would take longer to reach equilibrium – until 2026.

Scenario two suggests that the supply can be increased if anaesthetists can be encouraged to retire at age 65 (or later) rather than at 62, the average age that the survey indicated they intend to retire. Under this scenario, the break-even point would be reached by 2018. However, the study notes that implementing this scenario could be challenging.

Scenario three suggests increasing supply by improving the new Fellow retention rate, an initiative that would see the supply/demand equilibrium reached by 2022. Approximately 40 to 45 trainees enter their final year of training each year. Of these, about 60 per cent remain to practise in New Zealand, with the rest heading mainly to Australia, driven by the availability of desirable positions and higher salaries. The study suggests introducing specific incentives to help retain more new Fellows in New Zealand.

Scenario four combines scenarios one, two and three – that is, while supply is adversely affected by increasing pre and post-operative care, it is improved by pushing out the retirement age and retaining more new Fellows. Under this scenario, equilibrium would be reached by 2019.

Like all models, the study makes a range of assumptions that seek to mimic the complex pattern of variables that exist within the health services environment in which anaesthesia services are provided.

It takes into account New Zealand's projected population growth to 2030, noting that the large increase in elderly patients will have a marked effect on the delivery of anaesthesia services (as for all health services), which will need to be considered in future health policy. It also comments on the likely effect of the forecast increase in the incidence of diabetes and obesity.

It does not attempt to take into account variables such as changes in government policy or technological developments, both of which can affect supply of and demand for anaesthesia services.

The report will be made available through the ANZCA website (www.anzca.edu.au) once it has been discussed with government.

Susan Ewart,
Communications Manager,
New Zealand, ANZCA

Bullying, discrimination and harassment policy

A policy that aims to ensure Fellows and trainees acting as College representatives are aware of their obligations in relation to bullying, discrimination and harassment has been recently updated.

As the policy, approved at the November 2011 ANZCA Council meeting, says: "ANZCA considers bullying, discrimination and harassment unacceptable behaviour that will not be tolerated under any circumstances.

"Fellows and trainees acting as College representatives are responsible for their behaviour and should ensure an environment free of bullying, discrimination and harassment."

The "Policy on bullying, discrimination and harassment for Fellows and trainees acting on behalf of the College or undertaking College functions" was reviewed in light of new consistent, Australia-wide work health and safety laws that have been drafted by the various state governments and are scheduled to come into effect in 2012.

"Council formalised the policy due to general community expectations and because of the new national work health and safety harmonisation laws," said ANZCA President Professor Kate Leslie.

"The new laws mean volunteers will now be covered by work health and safety legislation, officers will have greater responsibility for workplace safety, and penalties for breaches will be substantially increased."

The new Work Health Safety Act ensures that as well as maintaining safe systems of work, a workplace must be free from bullying, discrimination and harassment.

For Fellows and trainees who interact with each other and others at work, workplace policies apply and the College's policy is in addition to these.

In New Zealand, under the Health and Safety in Employment Act 1992, all employers in New Zealand must take "all practicable steps" to ensure their employees are safe at work. Since 2003, the definition of employees has included volunteers who undertake regular duties for that organisation. "All practicable steps" includes providing employees with a safe workplace, and the information and equipment to enable the employees or volunteers to undertake their duties safely.

An article that describes the new Australian workforce laws and how it may affect Fellows and trainees appeared in the December 2012 edition of the *ANZCA Bulletin*, which can be found at www.anzca.edu.au/communications/anzca-bulletin. The "Policy on bullying, discrimination and harassment for Fellows and trainees acting on behalf of the College or undertaking College functions" can be found at www.anzca.edu.au/resources/corporate-policies.

"ANZCA considers bullying, discrimination and harassment unacceptable behaviour that will not be tolerated under any circumstances."

Clea Hincks
General Manager, Communications, ANZCA

Primary trauma care training helps save Vietnamese lives

The World Health Organization and the global epidemic of trauma

More than 5.8 million people die each year and more than 100 million people are injured from violence and accidents around the world[1]. This causes significant disability and economic loss, especially since 90 per cent of the problem occurs in low and middle-income countries.

Prevention and improvements in trauma care could significantly reduce this burden.

In 1990, road traffic accidents were the ninth leading cause of mortality worldwide. By 2030, it is projected that road traffic accidents will be number five[2].

In May 2007, Ministers of Health from 193 World Health Organization (WHO) member states met in Geneva for the 60th World Health Assembly.

The World Health Assembly is the governing body of WHO and its resolutions are the main policy mechanisms for directing WHO programs. These resolutions provide the WHO with a mandate to undertake activities in a specific area.

The assembly adopted resolution 60.22 on Trauma and Emergency Care Systems[3]. While the resolution was in 10 parts, its key message was to "urge" member states to "do more in the area of trauma prevention and management"[2]. There were a further 10 requests to the Director General of the WHO for assistance to the member states so that they could "do more".

Two years later more than 100 trauma-care leaders from 39 countries from all WHO regions met at a WHO Global Forum on Trauma Care in Rio de Janeiro, to promote such improvements globally. Many key stakeholders attended, including 12 presidents and other officers from international professional societies, as well as 30 highly placed officials from national organisations.

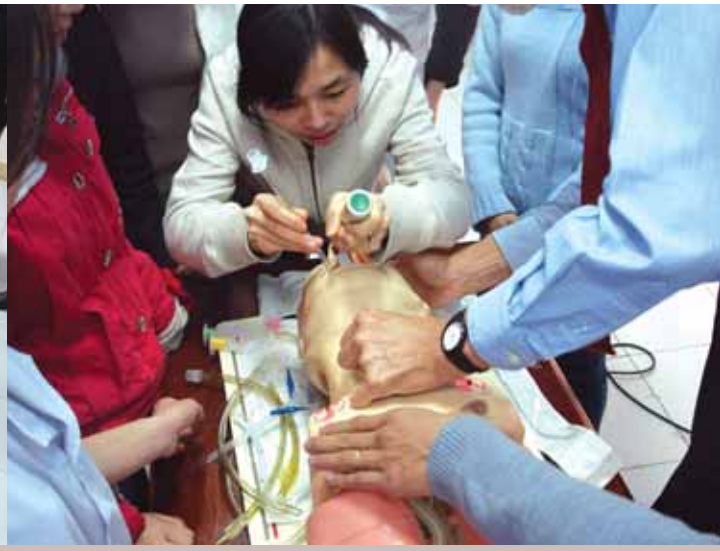
Participants sought to "develop a strategy to promote greater political commitment to affordable and sustainable improvements in trauma care"[1]. The summary statement from the meeting was that "WHO should take the lead in developing a global alliance for care of the injured", and the WHO's Department of Violence and Injury Prevention and Disability was to explore internally within WHO the steps needed to set up such an alliance[1].

In the meantime and for 10 years prior to that, WHA plenary meeting in Geneva in 2007 (and the subsequent WHO Global Forum on Trauma Care in Rio in 2009), the Primary Trauma Care (PTC) organisation has been teaching and training trauma-care responders and providers in low and middle-income countries. (Further information is available at the website www.primarytraumacare.org/) The PTC mission has been to provide healthcare workers with the necessary skills and knowledge to improve trauma management and the outcome from accident and violence. PTC has been vigorously promoting and propagating a strategy of affordable and sustainable improvements in trauma care since the first PTC course was run in Fiji in 1997.

There are significant differences in outcome following injury in countries of different economic levels. One study reports mortality in the seriously injured increasing from 35 per cent in the US, to 55 per cent in middle-income Mexico, to 63 per cent in low-income Ghana[3]. Similarly injured people are nearly twice as likely to die in a low-income setting than in a high-income setting[4].

The effect of improving organisation and planning of trauma care in high-income countries has shown survival gains of eight to 50 per cent through the improved organisation and planning that comes with trauma systems[5].

Many injury deaths in low-income settings could probably be treated well, and economic constraints are only part of the reason for the disparities in trauma outcomes between countries at different economic levels. There is much



that can be done to strengthen trauma and emergency-care services through improved organisation and planning[6]. Several programs in low-income countries have already documented decreased mortality through cost effective sustainable improvements in training, equipment, and organisation and planning[7, 8].

Primary Trauma Care now operates in more than 60 countries and courses have been conducted in Vietnam since 2002, with 20 courses run in Hanoi, Thanh Hoa, Đa nang, Quang Ninh, and Quy Nhon.

Trauma in Vietnam

Vietnam has a population of nearly 90 million with approximately 6.5 million living in the capital, Hanoi.

Injury is one of the leading causes of death in hospital in Vietnam and 80 per cent of this is due to road trauma. The tertiary trauma centre in Hanoi is the Viet Duc hospital, the major trauma referral centre for northern Vietnam. At Viet Duc, traffic accidents account for more than 64 per cent of all injuries treated (from Sydney University Bulletin 2007), of which 74 per cent are as a result of motorcycle accidents. Eighty three percent of patients arriving from outside the Hanoi metropolitan area present to Viet Duc with little or no pre-hospital emergency care, probably significantly contributing to the morbidity and mortality.

The motor vehicle fatality rate in Australia has dropped from 30.4 deaths per 100,000 population (2002) to 7.7 deaths per 100,000, a total of 1,616 deaths in 2007[9]. This reduction has been achieved in spite of a significant increase in motor vehicle use. The 2007 vehicle fatality rate for Vietnam was 16.1 per 100,000, a total of 12,490[9]. The motor vehicle fatality rate in Australia dropped from 8.0 (1970) to 0.8 per 10,000 registered motor vehicles (2007). For Vietnam the comparative figure is a staggering 124 per 10,000 vehicles[10].

Primary trauma care in Vietnam

More than 700 doctors have attended Primary Trauma Care courses since the first course was offered in Ho Chi Minh City in 2002. Subsequent courses have been conducted in Hanoi and a number of provincial hospitals outside the capital.

A considerable amount of work has been done to develop road safety preventative strategies with motorcycle helmets made mandatory in 2007 and the establishment of a national universal access number for the ambulance.

(continued next page)

"Injury is one of the leading causes of death in hospital in Vietnam and 80 per cent of this is due to road trauma."

Above from top left: PTC Course 2011 Hanoi Medical University Hospital; Hanoi transport options; Skills stations; Dr Perndt Instructing at Hanoi University Medical Hospital.

Primary trauma care training helps save Vietnamese lives
continued

The Viet Duc hospital is one of the major teaching hospitals in Vietnam and has hosted the PTC courses since 2003. There is very strong support from the Viet Duc department of surgery (Dr Nguyen Duc Chinh), Hanoi Medical University (Professor Nguyen Huu Tu), and the Vietnamese Society of Anaesthetists (Dr Cong Thang). In addition, the PTC courses have the endorsement of the Deputy Director General, International Cooperation Department in the Ministry of Health. The Sydney University Hoc Mai foundation has supported Vietnamese Primary Trauma Care Fellows for scholarships in Australia since 2007. For further information, visit the website http://sydney.edu.au/medicine/hocmai/

The 2011 PTC course in Hanoi brought the total number to nearly 800 attendees. The Vietnamese faculty included Dr Nguyen Chinh, Professor Nguyen Tu and three junior instructors. The course ran over two days and involved a mixture of lectures, scenario teaching, skill stations and discussion groups. The course is now conducted in Vietnamese, adding to the challenge of the scenarios and small group discussion teaching for the visiting Australian lecturers. The primary and secondary survey concept was very readily appreciated and mannequins in the scenario sessions provided plenty of opportunity for everyone to practice the ABCDE routine.

Has PTC made a difference to the trauma statistics in Vietnam? At this stage it is impossible to definitively answer this question. Has EMST teaching made a difference in Australia or New Zealand? A rigorous, appropriately funded and supported epidemiological pre and post-trauma training intervention study is needed. Vietnam, with the infrastructure, clinical and administrative support given to our PTC program, is an ideal platform to undertake such a study and we are working to attract appropriate funding to support this undertaking.

In the absence of any hard evidence, PTC will continue to be taught and enthusiastically embraced by the new generations of young Vietnamese doctors.

The next courses are being conducted in April/May 2012 in both Hanoi and Ninh Binh province.

Dr Haydn Perndt and
Associate Professor Marcus Skinner
Royal Hobart Hospital, Tasmania

Above from left: Dr Skinner, Dr Perndt and Dr Chinh at Viet Duc Hospital, Hanoi; Professor Tu in the University Medical Hospital Recovery Room, Hanoi.

References:

1. http://www.who.int/violence_injury_prevention/services/traumacare/global_forum_meeting_report.pdf
2. http://www.who.int/violence_injury_prevention/road_safety_status/report/statistical_annexes_en.pdf
3. http://apps.who.int/gb/ebwha/pdf_files/WHA60/A60_R22-en.pdf
4. Mock C N, Jurkovich G J, nii-Amon-Kotei D. et al Trauma mortality patterns in three nations at different economic levels: implications for global trauma system development. J Trauma 1998. 44804–814.
5. Mann N C, Mullins R J, MacKenzie E J. et al A systematic review of published evidence regarding trauma system effectiveness. J Trauma 1999. 47S25–S33.
6. Mock C N WHA resolution on trauma and emergency care services. Inj Prev. August 2007. 13(4): 285-286.
7. Mock C, Arreola-Risa C, Quansah R. Strengthening the care of injured patients in developing countries: a case study of Ghana and Mexico. Inj Control Saf Promot 2003. 1045–51.
8. Husum H, Gilbert M, Wisborg T. et al. Rural prehospital trauma systems improve trauma outcome in low income countries: a prospective study from North Iraq and Cambodia. J Trauma 2003. 541188–1196.
9. http://whqlibdoc.who.int/publications/2009/9789241563840_eng.pdf
10. http://en.wikipedia.org/wiki/List_of_countries_by_traffic-related_death_rate

Preparedness to manage the "can't intubate – can't oxygenate" event

Recent editions of the *ANZCA Bulletin* have presented articles on the topic of the critically obstructed airway in conjunction with infections such as Ludwig's angina and dental abscess highlighting the potentially fatal consequences of airway obstruction caused by these illnesses.[1, 2]

The authors extracted several important lessons from these cases, including the need for anaesthetists to be prepared to secure percutaneous emergency airway access (PEAA) (alternative terms include cricothyroidotomy, tracheotomy or infra-glottic airway) in a 'can't intubate – can't oxygenate' (CICO) event, when supraglottic rescue techniques fail. These recommendations are supported by those of the NAP4 audit on airway complications in the UK.[3]

This article focuses on the components of preparedness to perform PEAA emphasising that while critical care clinicians should be trained and mentally prepared as individuals to manage CICO, the onus also falls on hospital facilities and departments to ensure their system is prepared to deal with the event.

This material represents the consensus views of the working party for "Managing the Critically Obstructed Airway", a training workshop and quality-assurance program for rural specialists, sponsored by the Rural Health Continuing Education (RHCE) Stream 1 program (See Box 1 page 59). This program was developed to promote preparedness within the network of public and private hospitals in the region of Orange, NSW, drawing on sources of information in the published literature and personal experience. A report was included in the September 2011 edition of the *ANZCA Bulletin*[4] and course materials are available online.[5]

Key elements of system preparedness

Awareness – Make "CICO" a brand name within your department

The report of the large NAP4 audit[3] concluded that CICO is often sub-optimally managed, both in terms of disorganised emergency decision-making and practical execution of PEAAs. A CICO situation may be managed in a more organised manner if it is recognised as a discrete event requiring a specific response, in a similar manner to other emergency events such as cardiac arrest. Tagging the event, with recognisable language, specific dedicated equipment and protocols, may have the same effect as branding in advertising – increasing recognition and prompting a desired response. As an example a "CICO pack" and "CICO preparedness checklist"[5] were used in conjunction with the "CICO protocol" in the Orange program.

Decision-making: Enable the decision to perform PEAA to be made without delays

The NAP4 report along with coronial reports, including that of the now well-known case of Elaine Bromiley,[6] suggest the decision to perform an emergency surgical airway is commonly inappropriately delayed and with subsequent poor outcomes. Clear decision-making may be hampered by clinical uncertainty and psychological reluctance caused by negative human factors such as denial, indecision and freezing. The report proposes that training programs "could usefully emphasise behavioural aspects of cricothyroidotomy as equally important as technical training".

Provide decision support prompts

It has been highlighted that a maximum number of attempts at supraglottic techniques should be adhered to.[7] Criteria limiting excessive attempts can be incorporated into a CICO algorithm as a prompt "Is this a CICO event?" – thereby obliging the team to consider PEAA or to clarify an alternative plan (See blue section of Figure 1). This provides a form of approval to proceduralists who may be hesitating unduly but without forcing this action if an appropriate alternative plan is identified.

Develop a supportive culture and appropriate assertiveness within the team

A pertinent observation made in coroners' reports mentioned was the potentially critical role of team members, including nurses and medical colleagues in prompting anaesthetists to commit to a PEAA or in the case of medical colleagues, performing it. Unfortunately this shared decision-making may be marred by a reluctance to speak up or conflict over the appropriateness of the decision or technical approach. We believe this can be improved by involving all members of the team in training, particularly if this provides training in negotiation and assertiveness. Any member of the team should be able to ask the question "Is this a CICO event?" by following the prompt described above.

Protocols – use a reliable algorithm that everyone is familiar with

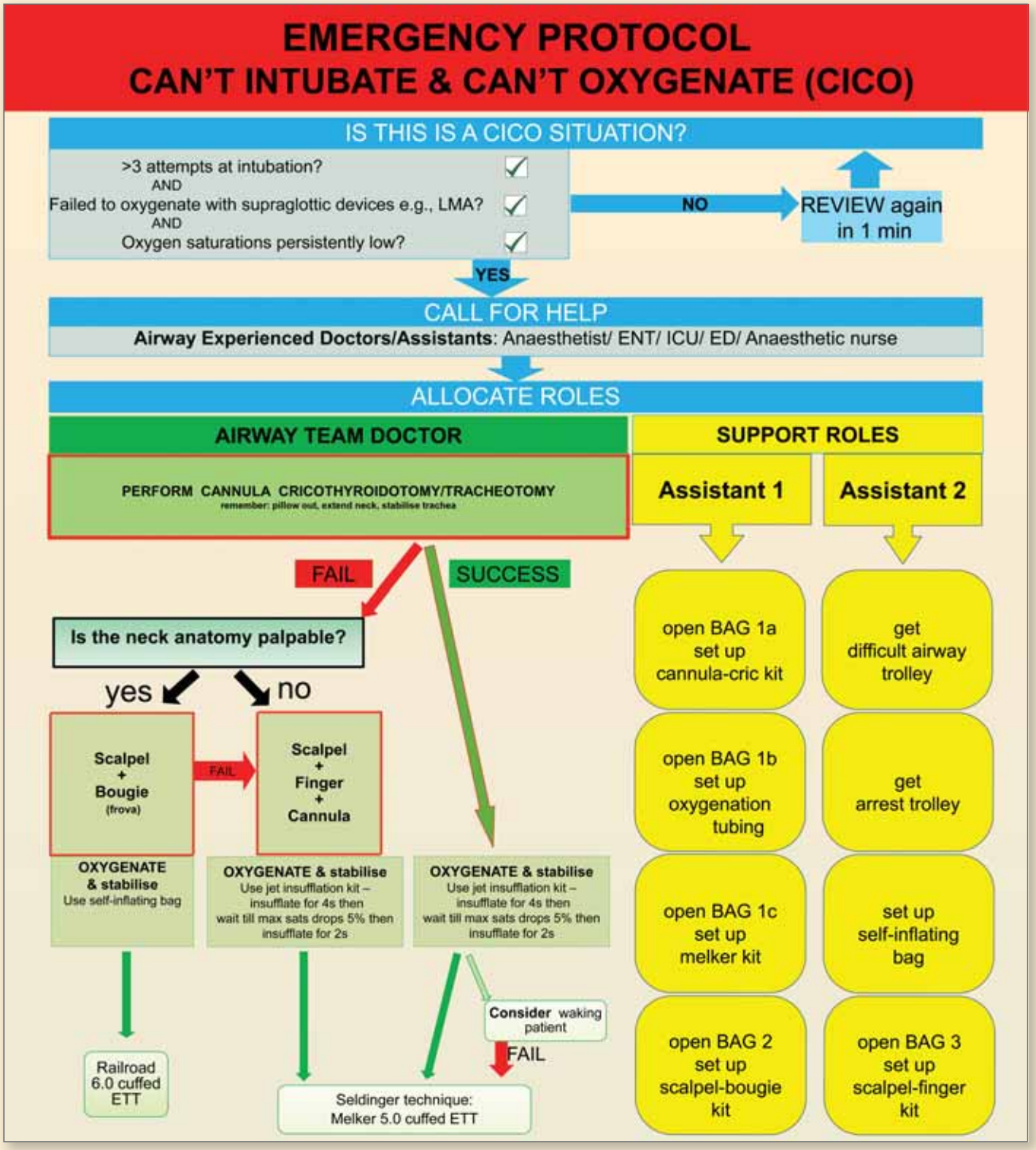
Commit to a procedural algorithm for CICO

Once the decision has been made, PEAA must be achieved quickly. This requires the proceduralist and other supporting team members to act in a coordinated manner; the proceduralist taking logical steps that are anticipated by supporting staff. Numerous algorithms have been described any of which may be effective if it achieves the following: is simple to follow; includes both access and subsequent oxygenation techniques; the proceduralist is confident to perform it; it specifies the exact equipment required which is available and the team adheres to the algorithm.[8] Our group favoured the approach described by Andrew Heard, which has previously been published as a standalone algorithm[4, 8] and has been incorporated into Figure 1 (See green section).

Provide guidance to team-members on their roles during a CICO event

The proceduralist performing a PEAA is reliant upon other staff to provide practical assistance obtaining and handling equipment. We recommend that a guide to team member's roles be incorporated into the algorithm or attached to it. This enables staff to undertake complementary useful tasks with minimal direction. (See yellow section of Figure 1).

Figure 1


EMERGENCY PROTOCOL
CAN'T INTUBATE & CAN'T OXYGENATE (CICO)
IS THIS IS A CICO SITUATION?
>3 attempts at intubation?
AND
Failed to oxygenate with supraglottic devices e.g., LMA?
AND
Oxygen saturations persistently low?
NO
REVIEW again in 1 min
YES
CALL FOR HELP
Airway Experienced Doctors/Assistants: Anaesthetist/ ENT/ ICU/ ED/ Anaesthetic nurse
ALLOCATE ROLES
AIRWAY TEAM DOCTOR
PERFORM CANNULA CRICOTHYROIDOTOMY/TRACHEOTOMY
remember: pillow out, extend neck, stabilise trachea
SUPPORT ROLES
Assistant 1
Assistant 2
FAIL
SUCCESS
Is the neck anatomy palpable?
yes
no
Scalpel + Bougie (frova)
FAIL
Scalpel + Finger + Cannula
OXYGENATE & stabilise
Use self-inflating bag
OXYGENATE & stabilise
Use jet insufflation kit – insufflate for 4s then wait till max sats drops 5% then insufflate for 2s
OXYGENATE & stabilise
Use jet insufflation kit – insufflate for 4s then wait till max sats drops 5% then insufflate for 2s
Consider waking patient
FAIL
Railroad 6.0 cuffed ETT
Seldinger technique: Melker 5.0 cuffed ETT
open BAG 1a set up cannula-cric kit
get difficult airway trolley
open BAG 1b set up oxygenation tubing
get arrest trolley
open BAG 1c set up melker kit
set up self-inflating bag
open BAG 2 set up scalpel-bougie kit
open BAG 3 set up scalpel-finger kit

Preparedness to manage the "can't intubate – can't oxygenate" event
continued

Systems design – ensure equipment, staffing and communication enable the protocol to be completed

- Equipment that is accessible, in good working order and regularly audited or checked should be available to manage patients at different stages of a critically obstructed airway: to monitor a patient for signs of impending airway obstruction (for example, SAO2); to provide supraglottic airway support before the need for PEAA is decided upon (for example, difficult airway trolley); to secure a PEAA (for example, CICO pack) and to confirm correct placement of an endotracheal tube (for example, Capnography, fibre optic bronchoscope).
- The CICO pack should contain only that equipment relevant to the CICO algorithm used in that department. It should be located separately to general difficult airway equipment and be immediately available at all areas where airway management is undertaken.
- Assistance – calling for help is an important part of the CICO algorithm. The system should include a roster or form of agreement about support from other senior medical officers (for example, ear nose and throat surgeons and intensive care physicians) who are available at short notice and a reliable communication system to contact these people.
- Quality assurance (QA): Ensure new staff are oriented to the system; periodically audit preparedness (for example, a "CICO preparedness checklist" audit tool is available at the SCSSC website)[5] and systematically document and audit critical airway events to identify system faults which can be corrected.

Training

Anaesthetists have access to a variety of educational resources relevant to CICO including wet and dry lab workshops and web-based resources. 5,7,9. Training is likely to be most effective when the challenges of real-world situations are reproduced. Ideally workshops should enable step-by-step practice of the specific techniques and equipment the anaesthetist plans to use along with rehearsal of the algorithm within the context of time-critical scenarios. Departmental training can be highly useful to gain agreement on activation criteria, algorithms and equipment; demonstrations and case-based discussion of scenarios easily achieved within the structure of departmental meetings. Better still, critical care disciplines could undertake interdisciplinary training thereby enabling team-based competencies to be rehearsed such as role allocation, leadership, decision-making, assertiveness and ergonomic practice. Attributes of staff amenable to training are shown Table 1.

Table 1: Attributes of staff prepared for CICO events (extract from "CICO preparedness checklist" audit tool[5])

1. The primary proceduralist is:
a. Trained and mentally prepared and available to perform an emergency PEAA.
b. Familiar with CICO activation criteria and algorithm steps.
c. Able to perform in a crisis: to remain calm; stick to the plan; take advice and negotiate with team members; avoid being the overall leader or, if not feasible, assign a deputy or co leader.
2. Other senior medical staff (E.g. ENT, ICU, ED, anaesthesia) are:
a. Able to function effectively in a crisis in a secondary role; in particular to psychologically support the primary proceduralist, cross check and review the situation, offer suggestions, be able to negotiate and escalate concern and be prepared to take over as primary proceduralist, if appropriate.
3. All team members (including senior medical staff):
a. Are familiar with the location and use of equipment.
b. Are familiar with CICO activation criteria and algorithm steps.
c. Prepared to assign the following roles in a CICO event: overall leader, primary proceduralist, proceduralist's assistant, one or more people to set up equipment, timekeeper and scribe.
d. Optimise the team's performance: avoid excess talk, relay communication through the leader, remain calm, be non-threatening to other team members.
e. Understand that it is in the patient's best interests for them to speak up, for example, to seek clarification about a task, make observations, suggest alternatives and if need be escalate a concern.
f. Treat the patient gently and with dignity at all times even during a crisis.

Key points

Anaesthetists, their departments and facilities in which they practise should all be prepared for a CICO event by working toward the following goals.

Anaesthetists' CPD plans:

1. To be fluent with difficult airway algorithms, including supraglottic rescue, which may avert a CICO event.
2. To be familiar with CICO activation criteria and mentally prepared to perform PEAA.
3. To become confident with the specific approaches to PEAA that they intend to perform in their work settings which includes familiarity with every piece of equipment relevant to these and fluency with completing the algorithm in sequence.
4. To revisit this training regularly to retain this knowledge.

Anaesthesia departments' procedures and education programs

1. Create a brand for the event and its management (for example, "CICO" pack and algorithm).
2. Agree on an emergency algorithm including team roles.
3. Ensure equipment is available that is relevant to the algorithm.
4. Provide training aimed at rehearsal of the algorithm and promotion of team decision-making, culture and assertiveness preferably multi-professional and inter-disciplinary.
5. Address systems readiness: orient staff; audit preparedness and undertake QA on CICO events.

Hospitals' procedures and education programs

1. Have an escalation plan enabling assistance from medical professionals trained to perform PEAA.
2. Achieve consistency in respect to management of CICO across the emergency department, ICU and operating theatres.
3. Involve staff from these disciplines in training.

Box 1: Rural specialists may apply before June 2012 to host the "Managing the Critically Obstructed Airway" course before April 2013. Contact SCSSC 99264620 or see website http://www.scssc.edu.au/training/courses/flyers/factsheet-about-the-rhce-simulation-program-course-flyer-scssc.pdf

References:

1. Greenland K. Case report: Death following upper airway obstruction after surgical drainage of Ludwig's angina. ANZCA bulletin March 2011; 54-55.
2. Greenland K. Airway crisis after Extubation ANZCA bulletin June 2011; 60-62.
3. Report of the National Audit Project (NAP4) of the Royal College of Anaesthetists. DAS http://www.das.uk.com/guidelines/downloads.html.
4. Heard AMB. The Can't Intubate Can't Oxygenate Scenario (CICO) Implications of the National Audit Project (NAP4) of the Royal College of Anaesthetists. ANZCA bulletin Sept 2011; 48-50.
5. See RHCE Workshop 4 Fact sheet, Poster and Audit at Sydney Clinical Skills and Simulation Centre (SCSSC) http://www.scssc.edu.au/training/courses/partnered/index.php [Accessed November 2011].
6. Report of anonymous expert witness for the coronial inquest in the death of Elaine Bromiley http://www.chfg.org/resources/07_qrt04/Anonymous_Report_Verdict_and_Corrected_Timeline_Oct_07.pdf [Accessed June 2011].
7. Difficult Airway Society Failed Ventilation Algorithm http://www.das.uk.com/guidelines/cvci.html [Accessed November 2011].
8. Heard AMB, Green RJ, Eakins P. The formulation and introduction of a 'can't intubate, can't ventilate' algorithm into clinical practice. Anaesthesia, 2009, 64, pages 601–608
9. Video demonstrations of Andrew Heard's algorithms can be viewed at http://emcrit.org/podcasts/cricothyrotomy-needle-or-knife/ [Accessed November 2011].

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Working party

- Dr Micah Friend, Royal North Shore Hospital
- Dr Roberta Edmeades, Townsville Base Hospital
- Dr Tsung Chai, Orange Base Hospital
- Dr Andrew Heard, Royal Perth Hospital
- Associate Professor Leonie Watterson, Sydney Clinical Skills and Simulation Centre (SCSSC)
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Disclaimer

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"Elements of poor planning, poor judgement, deviation from recognised algorithms and failures of technical skills were seen throughout the reports submitted to the project (NAP4)."

NAP4 report

The authors of the 4th National Audit Project, Major Complications of Airway Management in the UK (NAP4) have contacted the ANZCA Bulletin about the article "The Can't Intubate Can't Oxygenate Scenario (CICO)" (*ANZCA Bulletin* September 2011, p48-49).

The NAP4 report does not recommend that needle cricothyroidotomy should be abandoned. It recommends that all anaesthetists must be trained in emergency cricothyroidotomy (cannula and surgical) and keep their skills up to date. It recommends that further research on the reasons for needle cricothyroidotomy failures should be undertaken.

Dr Michelle Mulligan
Medical Editor, ANZCA Bulletin

Quality and safety

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 and it is the responsibility of the hospitals to follow up with the manufacturer's representatives, if they have not already been contacted.

Failure of automatic cycling in GE Patient Data Module

When the GE Patient Data Module (GE Healthcare Technologies Canada) is configured in the auto mode for non-invasive blood-pressure measurements it may stop cycling automatically. This will only be detected by recognition that the blood pressure has not changed and observation of the time of the last automated measurement.

The manufacturer has initiated a recall.

CareFusion Alaris PC Unit Infusion Pump rapid battery depletion

A component of the power-supply board of Model 8015 Alaris PC infusion pump may draw a high standby current, potentially resulting in premature battery depletion when not plugged into an A/C power outlet. The low-battery alarm should normally indicate 30 minutes until depletion, but this may not apply and the unit should be plugged into an A/C supply immediately. This is particularly important if vasoactive drugs or drugs with a short half-life are being administered.

The manufacturer has initiated device recall.

Drug cancellation

Two of the four dextropropoxyphene-containing analgesics are cancelled from March 1, 2012, Capadex and Paradex; see advice from the Therapeutic Goods Association: www.tga.gov.au/newsroom/media-2011-dextropropoxyphene-111122.htm

The remaining two dextropropoxyphene-containing analgesics, Di-Gesic and Doloxene currently remain on the Australian Register of Therapeutic Goods.

Please forward any queries to Dr Jason Ferla, Acting Prinicpal Medical Advisor, Therapeutic Goods Administration, jason.ferla@tga.gov.au or by phoning: +61 2 6232 8210.

10th triennial report covering years 2003 to 2005

Executive summary

Cases reviewed

The Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM) reviewed a total of 399 cases that occurred in 2003-05, of which 157 were deaths, 219 were morbidity reports and 23 were critical incidents. It is worth noting that the total number of cases reviewed in the previous triennium was 531, of which 238 were deaths. The difference in number of cases reviewed is due to limited access to coronial cases for deaths occurring during 2003-05. Of the 157 deaths in 2003-05, 40 were classified as anaesthesia-related, indicating once again that the council undertakes review of many deaths in which anaesthesia has played no part. However, this workload is important so that the council is able to maintain confidence that anaesthesia factors are considered in all deaths reviewed. It is possible that due to the reduced access to coronial cases, some anaesthesia-related deaths have not been identified.

Anaesthesia mortality rate

There were 40 anaesthesia-related deaths in Victoria in 2003-05. Using the ICD-10 coding data from the Australian Institute of Health and Welfare, it is estimated that there were 2.35 million anaesthetics administered in Victoria in 2003-05.[1] Therefore the estimated anaesthesia related mortality is one in 58,664. This indicates a very high level of safety for anaesthesia in Victoria.

Causal or contributory factors in anaesthesia mortality and morbidity

Importantly, the most frequent causal or contributory factors associated with anaesthesia mortality were the patient factors of **co-existing medical condition** and **increasing age**. This is consistent with recent literature and is unsurprising given the high proportion of older, sicker patients in the elective and emergency surgical population.[2-6]

However, there were 20 anaesthesia-related deaths in patients aged less than 70 years, and across all the mortality and morbidity cases there was a range of causal or contributory factors including inadequate and/or inappropriate preoperative assessment, as well as problems with anaesthesia drugs, techniques or management, including monitoring. There were also major problems identified with organisational issues and postoperative care, including pain management.

There was one case of malignant hyperthermia in a young patient, who received suxamethonium and died despite very appropriate crisis management. **Anaphylaxis** to suxamethonium was responsible for three deaths and fatal outcomes are more likely if there is any delay in instituting aggressive resuscitation or there is coexisting coronary artery disease. There were also eight morbidity cases confirmed as anaphylaxis to muscle relaxants, of which four each were due to suxamethonium and rocuronium. Cephazolin (five cases) and gelofusine (four cases) were the next most frequently implicated agents in anaphylaxis. Good outcomes were achieved due to early recognition and good crisis management, including the rapid escalation of adrenaline dosage in order to restore adequate arterial blood pressure and cardiac output.

Drug errors (23 reports) persist as the single most frequently reported anaesthesia-related morbidity, despite the widespread promotion of prevention strategies.[7]

Aspiration was responsible for three deaths despite appropriate precautions being deployed in high-risk patients, but several morbidity cases were deemed preventable.

The prevalence of ischaemic heart disease is reflected in the surgical population in that there were eight anaesthesia-related deaths and six morbidity cases attributed to **perioperative myocardial infarction**. Importantly intraoperative hypotension was implicated in four mortality cases and inadequate preoperative assessment in three cases of non-fatal acute myocardial infarction (AMI). Failure to adequately account for pre-existing cardiac disease was also identified in two of the four mortality cases involving intraoperative cardiac arrest.

Of major concern were four deaths directly related to **anaesthesia monitoring**. Three patients died from pulmonary artery rupture associated with the use of a pulmonary artery catheter (PAC) and there was one death from oesophageal perforation due to the use of transoesophageal echocardiography (TOE). There were also eight morbidity cases involving oesophageal injury (four perforations and four tears) secondary to the use of TOE during cardiac surgery. It is recognised that these forms of sophisticated cardiovascular monitoring provide very valuable information to guide perioperative management, but it is imperative to deploy them based on an individual patient risk-versus-benefit analysis.

(continued next page)

An increasingly implicated factor in both anaesthesia-related mortality (43 per cent) and morbidity (17 per cent) is **organisational failure**. This was due to one or more of: inadequate supervision, poor service provision, or failure of interdisciplinary perioperative care planning. Importantly, there were two airway-related deaths in ICU patients, both of which involved organisational problems. There were also three airway-related morbidity cases involving inappropriate anaesthetic planning and management.

Problems with **postoperative care** continue to emerge as a major concern, and these often also involve organisational issues.

There were two deaths attributed to hypoxia in which there were deficiencies in the provision of appropriate postoperative care in the general ward. The delivery of safe **postoperative pain management** also presents challenges.

There were eight **major neurological complications** involving actual or potential **spinal cord injury** from either epidural haematoma or abscess secondary to **central neural blockade**. In most cases, the outcome was contributed to by organisational failure involving one or more of: (i) inadequate neurological observation of the patient; (ii) poor co-ordination of anticoagulant and/or anti-platelet therapy; and (iii) failure to urgently perform appropriate diagnostic imaging (MRI or CT myelography) to either diagnose or exclude spinal-cord compression.

Finally, of equal concern was the number of reports (almost certainly reflecting a more widespread problem) of **postoperative respiratory depression**, sometimes to the point of respiratory arrest or unresponsiveness, associated with postoperative opioid analgesia, in particular, patient-controlled analgesia (PCA) with morphine. This was often associated with organisational failure involving inadequacies in the provision of postoperative orders and/or documentation of patient observations, including sedation level, respiratory status and oxygenation monitoring.

Value of sustainable morbidity reporting

This report reconfirms the important contribution to anaesthesia safety by the collection, analysis and dissemination of information obtained from morbidity reports. There were a total of 219 morbidity reports, of which 179 (82 per cent) were anaesthesia-related, compared with 157 mortality reports of which 40 (25 per cent) were anaesthesia-related. There is of course some reporting bias in that anaesthetists are more likely to report a morbidity case deemed to be anaesthesia-related. However, and particularly in light of the extremely low anaesthesia mortality rate, the recognition that there is substantially more knowledge to be gained from detailed review of morbidity is widely appreciated by the Victorian anaesthesia community.

The complete report is available by visiting the Department of Health Victoria's website http://docs.health.vic.gov.au/docs/doc/Tenth-Report-of-The-Victorian-Consultative-Council-on-Anaesthetic-Mortality-and-Morbidity

References:

1. Australian Institute of Health and Welfare. Australian hospital statistics 2004–2005. Cat. No HSE 41. Canberra: AIHW; 2006 < www.aihw.gov.au/publication-detail/?id=6442467847>.
2. McNicol L, Story D, Leslie K, Myles P, Fink M, Shelton A, Clavisi O, Poustie S. Postoperative complications and mortality in older patients having non-cardiac surgery at three Melbourne teaching hospitals. Medical Journal of Australia May 2007: 186;(9):7.
3. Itani KM. Fifteen years of the National Surgical Quality Improvement Program in review. Am J Surg 2009;198 (5 Suppl):S9-S18.
4. K Wilkinson, I C Martin, M J Gough, J A D Stewart, S B Lucas, H Freeth, B Bull, M Mason. An age old problem. A review of the care received by elderly patients undergoing surgery. London: National Confidential Enquiry into Patient Outcome and Death; 2010.
5. Australian and New Zealand Audit of Surgical Mortality. National Report. Adelaide: Royal Australasian College of Surgeons; 2009.
6. Story DA, Leslie K, Myles PS, Fink M, Poustie SJ, Forbes A, et al. Complications and mortality in older surgical patients in Australia and New Zealand (the REASON study): a multicentre, prospective, observational study. Anaesthesia 2010, 65:1022-1030
7. Australian and New Zealand College of Anaesthetists. Guidelines for the Safe Administration of Injectable Drugs in Anaesthesia. Melbourne: 2009; ANZCA <www.anzca.edu/resources/professional-documents/ps51.html>.

Associate/Professor Larry McNicol
Chairman, VCCAMM

Dr Patricia Mackay
Emeritus consultant, VCCAMM

ANZTADC update

Emergency drug errors: A worldwide problem

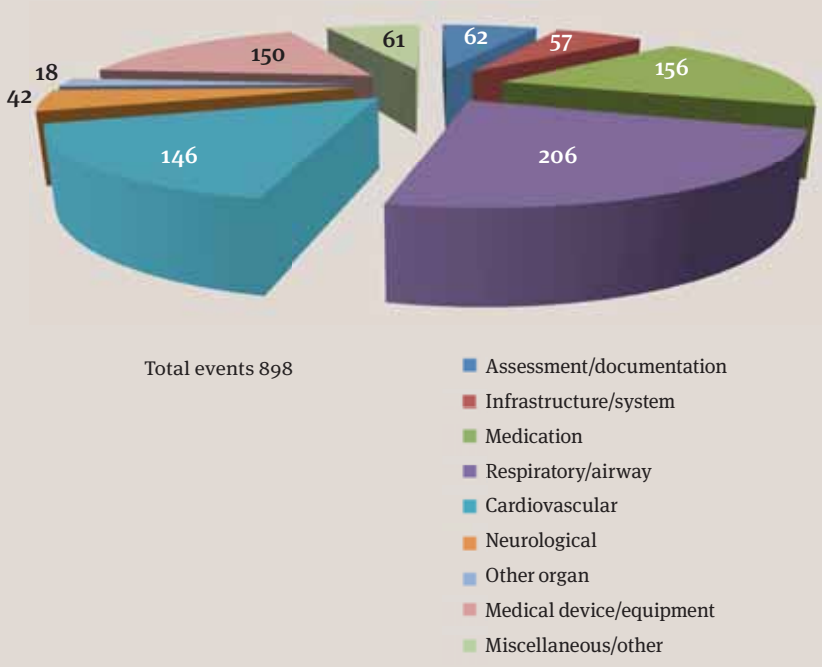
ANZTADC was invited to present at the International Registries Session at the American Society of Anesthesiologists Annual Meeting in October 2011. This meeting facilitated discussion relating to quality improvement through data collection at an international level and was run by the Anesthesiology Quality Institute (AQI) which is the US's equivalent of ANZTADC. As a result of this discussion it was agreed to share summarised data and to share summarised solutions to anaesthetic problems at an international level.

There was a report to the AQI of a serious drug error involving phenylephrine, which was published in the ASA (US) newsletter in January 2012[1].This report prompted ANZTADC to review incidents where emergency drugs were involved to analyse the circumstances relating to emergency drug errors in New Zealand and Australia. For the purpose of this article emergency drugs are defined as medications pre-prepared to manage potential life threatening events that may occur suddenly during anaesthesia. Some of the drugs commonly drawn up include suxamethonium, atropine and vasopressors.

There were 156 Medication errors up to February 11, 2012, which was 17.37 per cent of the total reports. These were further subcategorised in 44 errors (28 per cent of medication errors) that involved a syringe swap, the wrong drug being given or wrong drug almost being given. Eleven of these 44 cases (25 per cent) involved vasopressors. Some involved accidental administration and in other cases another drug was given instead of the intended vasopressor. The outcomes were assessed by the person entering the incident according to five pre-set categories. Three incidents were self assessed as "potential hazards", five as "near misses" and three as "harm to patient". None of the incidents so far, have been assessed as "serious harm" or "fatal". Nevertheless the potential for serious harm or fatal outcomes is always present with this type of error. Further evidence of errors with contingency drugs may also be seen in the 10th VCCAMM report[2].

Emergency drugs can be a two edged sword. On the one hand they might be required quickly and pre-drawing the drug saves time. It also confirms that the drug is indeed in the anaesthetic trolley. On the other hand, many of these drugs are thrown away, as described in the article "Assessing waste: An audit of pre-drawn emergency anaesthetic drugs" by Nathan Goodrick in the *ANZCA Bulletin*[3]. In addition, there have been reports to ANZTADC and AQI that emergency drugs are given in error into a variety of ports including vascular and epidural. Although we may say that this should never occur, we would assert that every doctor has given, or will in the future, give the wrong drug by mistake. Although most of these errors do not result in actual harm they all in fact have the potential to do serious harm depending on the type of drug, the route and the dose that is actually given.

Figure: Main category coding, February 2012



Why does this happen? This is complex and a full analysis will be published in future articles. These are some of the issues we have identified so far.

1. Surrogate identification – similar sized syringes, ampoules or labelling.
2. Distraction – For instance an event occurs that requires the drug to be given urgently, or there is another distraction occurring in the theatre. This could include teaching junior staff, observing/assessing junior staff or being observed/assessed by senior staff or poor communication between junior staff and their supervisor it could involve a discussion of an unrelated matter, medical or otherwise. During this period we effectively are on 'autopilot' regarding the drug administration.
3. The fact that the emergency drugs and the anaesthetic drugs are in close proximity in the anaesthetic trolley workplace.
4. The drug trolley may have been restocked incorrectly or compartments in the trolley have a poor layout.

It is almost certain that further issues which will be identified when we have collected more incidents in the database.

What can we do about this problem? There are of course both human and system factors. As noted in the AQI article "humans, after all, are brilliant intuitive problem solvers but are easily distracted and are noted for their unreliability in a repetitive process (in the industrial engineering sense)"[1]. This statement sums up the problem entirely. Whilst an article such as this one will remind anaesthetists for a short period while it is fresh in their memory, it will not stop this type of incident from recurring. What is required is a safer system. At the system level these are some of the interventions that have the potential to reduce this type of error.

1. Use syringes prefilled either at point of manufacture or by the hospital pharmacy. Pre-filled syringes have been highlighted as a potential safety improvement in anaesthesia and have been recommended in ANZCA college guideline *PS51 Guidelines for the Safe Administration of Injectable Drugs in Anaesthesia* 2009[4].
2. Use epidural catheters with a unique port
3. Keep emergency drugs and anaesthetic drugs in separate containers in the work area.
4. Check twice plus timeout.
   a. When preparing the syringe perform a two person check, draw up drug and attach label.
   b. Before connecting syringe, check label, check port, and then mentally check that this is the drug we intend to give.
5. Ensure label is visible when looking at the gradations on the syringe as this will be in the field of view when injecting the drug.
6. Use colour coded labels to highlight the class of drug. In Australia, New Zealand and USA these colours are yellow for induction agents, red for relaxant, blue for narcotics and purple for vasopressors. While colour would not prevent an error within classes generally a class error would be more serious than an alternative within a class.
7. Scanning has the potential to significantly reduce medication errors. Where available scan the barcodes on the ampoule when drawing up. Then scan the labels of the syringe before injecting. The scanning device should preferably confirm audibly as well as visually[5].
8. Ensure that contingency emergency drugs are appropriately managed at the end of each case.

This article is designed to highlight the benefit of pre-filled syringes in improving the safety in the context of contingency emergency drugs, however a comprehensive summary of the new paradigms surrounding medication errors can be found in the article APSF Hosts Medication Safety Conference (APSF Newsletter 2010)[6].

Two of the ANZTADC registered sites have described the use of pre-filled syringes to overcome the problem of drug wastage and medication error involving these drugs. The Royal Brisbane and Women's Hospital (RBWH) in Queensland, Australia are trialling pre-filled ephedrine and metaraminol syringes and Canterbury Hospital in Christchurch, New Zealand are trialling pre-filled phenylephrine syringes. The image above is a photograph of the RBWH Ephedrine syringe showing the pharmacy label in the medications Australian format, together with the purple label identifying a vasopressor, as used in the operating theatre. This information will be expanded into a full article when more data is available. In the meantime please email support@anztadc.net if you are using pre-filled syringes or if you have an additional suggestion for preventing these errors.

Dr Nathan Goodrick, Dr Genevieve Goulding, Dr Bryce Curran, and **Adjunct Professor Martin Culwick.**
ANZTADC Analysis Subcommittee and co-opted Authors.

Acknowledgements: **Dr Hamish Gray, Ms Heather Reynolds** and **Dr Patricia Mackay.**

References:

1. Case 2012-1 – When Blood Pressure Equals "Patent Pending" R.Dutton AQI. American Society of Anesthesiologists Newsletter. Volume 76 Number 1 p32-33. Jan 2012.
2. http://www.health.vic.gov.au/vccamm/vccamm-reports.htm
3. Goodrick N. Assessing waste: An audit of pre-dawn emergency anaesthetic drugs' ANZCA Bulletin: December 2011
4. ANZCA College Guideline PS51 2009.
5. Clinical assessment of a new anaesthetic drug administration system: a prospective, controlled, longitudinal incident monitoring study. Anaesthesia. Volume 65, Issue 5, May 2010, Pages: 490–499, C. S. Webster, L. Larsson, C. M. Frampton, J. Weller, A. McKenzie, D. Cumin and A. F. Merry
6. http://www.apsf.org/newsletters/html/2010/spring/01_conference.htm

ANZCA Trials Group

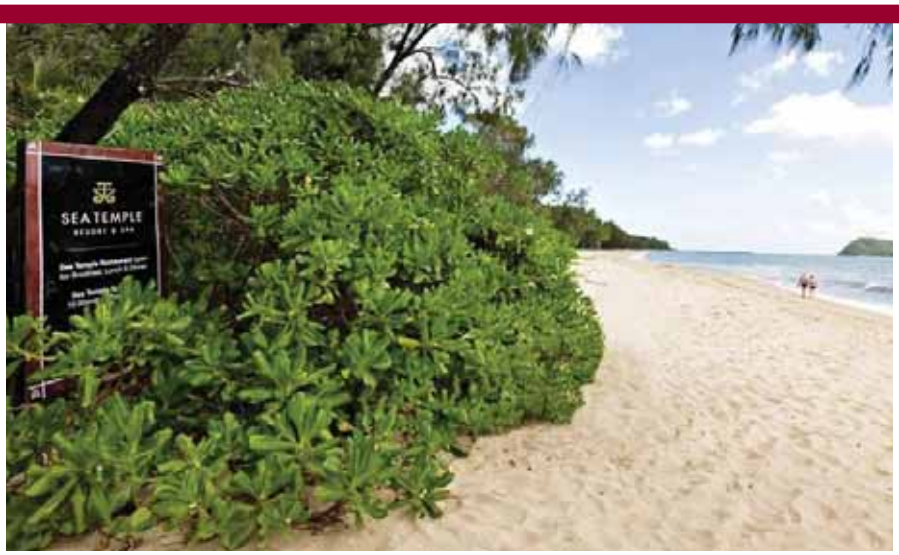
ANZCA Annual Scientific Meeting Perth 2012

The ANZCA Trials Group has two sessions planned for the 2012 Annual Scientific Meeting, which will be held in Perth from May 12 to 16.

On Saturday May 12, Associate Professor Tim Short will chair a session including presentations from the chair of the Australian and New Zealand Intensive Care Society-Clinical Trials Group (ANZICS-CTG), Associate Professor Steve Webb (pictured), and research updates from three recipients of ANZCA Pilot Grant awards. Associate Professor David Story will chair the second session on Tuesday May 15. It features presentations on research design and methodology.

The annual ANZCA Trials Group lunch will be held on Sunday May 13 from noon to 1pm. Professor Paul Myles will give a short update of the Nitrous Oxide Anaesthesia and Cardiac Morbidity after Major Surgery-2 (ENIGMA II) and Aspirin and Tranexamic Acid for Coronary Artery Surgery (ATACAS) trials while most of the meeting is devoted to a Perioperative Ischemic Evaluation-2 Trial: POISE-2 Trial investigators' meeting. This is open to existing investigators and their research coordinators, as well as researchers who are interested in future participation. The national coordinator for Australia and New Zealand, Professor Kate Leslie, will chair the meeting. POISE-2 can part-subsidise research co-ordinators to attend the two-day weekend registration of the ASM.

For further information, contact **spoustie@anzca.edu.au**



ANZCA Trials Group Research Workshop Palm Cove 2012

Following the success of this workshop in August 2011, the event will be held again in Palm Cove on August 10-12. This meeting was a huge success last year and drew very positive feedback on the location, venue and content. Registrations are available online: www.anzca.edu.au/fellows/Research/anzca-trials-group-events.html.

The aim of these meetings is to present, mentor and encourage new ideas for multicentre research in anaesthesia, perioperative and pain medicine. The ANZCA Trials Group encourages researchers to submit ideas for future multi-centre research.

Guest speakers this year include the chair of the ANZICS-CTG, Associate Professor Steve Webb and biostatistician Dr Katherine Lee from the Murdoch Childrens Research Institute, Melbourne (pictured).

We encourage anaesthesia co-ordinators and allied health to attend. Breakout sessions will be included for this group.

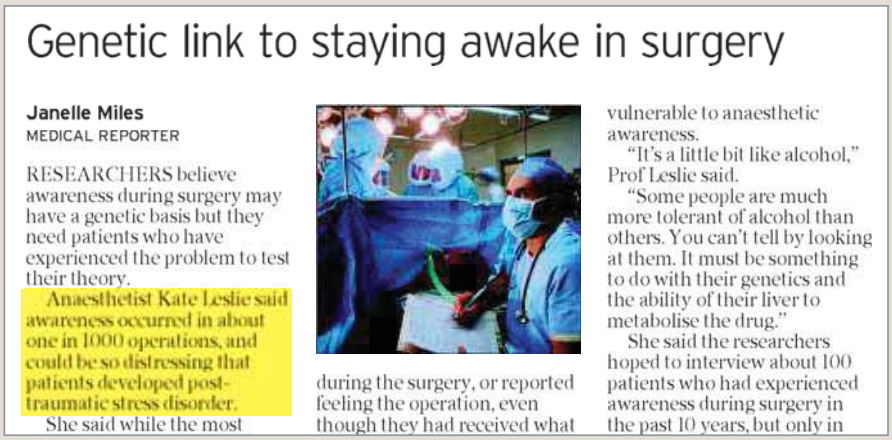
For further information, contact **spoustie@anzca.edu.au**

Stephanie Poustie
ANZCA Trials Group and Monash University Research Coordinator

Survey research policy

ANZCA Council has endorsed The ANZCA Trials Group survey research policy. This policy applies to all Fellows, trainees, special interest groups and regional committees who wish to have a facilitated by the College. The policy is available on the ANZCA web pages under Corporate Policies or the Trials Group section.

ANZCA in the news



Genetic link to staying awake in surgery

Janelle Miles
MEDICAL REPORTER

RESEARCHERS believe awareness during surgery may have a genetic basis but they need patients who have experienced the problem to test their theory.

Anaesthetist Kate Leslie said awareness occurred in about one in 1000 operations, and could be so distressing that patients developed post-traumatic stress disorder.

She said while the most

during the surgery, or reported feeling the operation, even though they had received what

vulnerable to anaesthetic awareness.

"It's a little bit like alcohol," Prof Leslie said.

"Some people are much more tolerant of alcohol than others. You can't tell by looking at them. It must be something to do with their genetics and the ability of their liver to metabolise the drug."

She said the researchers hoped to interview about 100 patients who had experienced awareness during surgery in the past 10 years, but only in

The issue of awareness during anaesthesia is a perennial favourite of the media.

A media release calling for people who have been aware during anaesthesia to come forward so researchers can investigate if there is a genetic link to this uncommon experience generated significant media coverage and responses from the public.

ANZCA President Professor Kate Leslie, Royal Children's Hospital anaesthetist Associate Professor Andrew Davidson and Waikato Hospital anaesthetist Professor Jamie Sleigh were all interviewed about a possible genetic link to anaesthetic awareness.

The release was just one of eight issued by the Communications Unit recently, leading to a potential audience of nearly one million Australians and New Zealanders learning more about anaesthesia and pain medicine.

Other releases highlighted:

- The West Australian scientific conference featuring the invention by Perth anaesthetist Dr Chris Mitchell of a reflective needle, which improves visibility for ultrasound-guided regional anaesthesia.
- The Tasmanian scientific conference looking at the withdrawal of painkillers by the Therapeutic Goods Administration, improvements to knee replacement surgery, and the use of hydrogen peroxide in surgery.
- A decision by the Australian Government to fund a national electronic system to track the prescribing and dispensing of opioids, which was recommended by the Faculty of Pain Medicine in conjunction with the Royal Australasian College of Physicians.
- A paper by Faculty of Pain Medicine Fellows Associate Professor Milton Cohen and Dr John Quintner and their colleagues about the possible inadvertent extinguishment of empathy by doctors and other health professionals for chronic pain patients.
- The New Zealand National Committee's welcome of the inaugural report from New Zealand's Perioperative Mortality Review Committee.

Inaugural ANZCA media award

New Zealand health journalist Lorelei Mason, of TVNZ, won the inaugural $A5000 ANZCA Media Award for the best news story or feature about anaesthesia or pain medicine that appeared in the Australian or New Zealand media in 2011. Ms Mason beat 14 other entries with her story, "Awake Craniotomy", which aired as the lead item on New Zealand's top rating daily current affairs show, *Close Up*, on February 21.

The story showed a patient at the Wellington Hospital undergoing an awake craniotomy, a type of brain surgery where the patient is conscious during the middle part of the procedure and asked to perform neurological tasks so the surgeon can test regions of the brain before they are incised or removed.

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

"This was a stand-out piece of journalism that showed how important anaesthesia is to this complex surgical procedure. It was an amazing story that highlighted what can be achieved in this day and age through anaesthetic drugs and pain management. The piece was well-written, and clearly and simply explained the procedure and the patient's experience to the audience. The level of trust and access Lorelei Mason gained to showcase this operation was extraordinary."

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

Meaghan Shaw
Media Manager, ANZCA

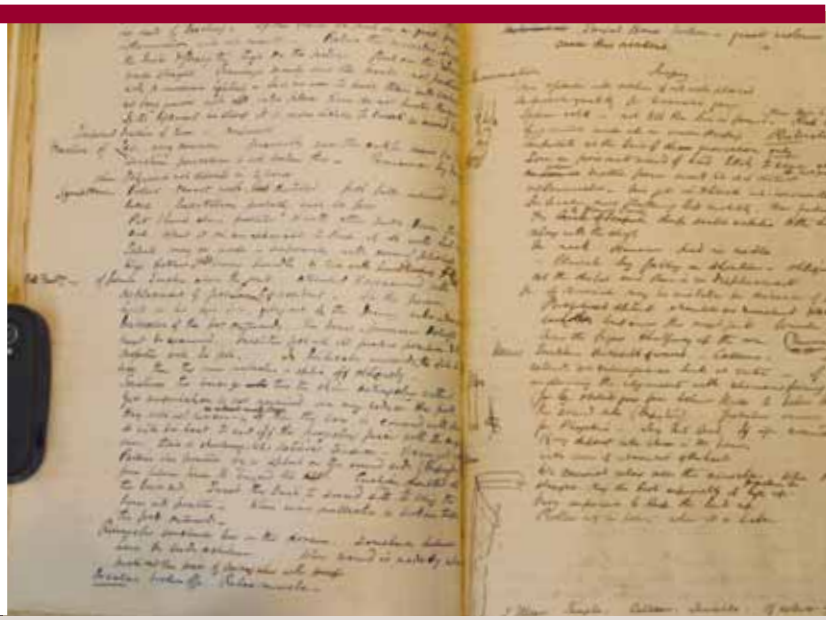
Media releases distributed by ANZCA (since December):

"WA anaesthetic needle invention goes global" *(February 24)*
"Chronic pain patients warned on drug withdrawal" *(February 17)*
"Fewer deaths and overdoses to result from opioid tracking" *(February 15)*
"Perioperative mortality review report welcomed" *(February 15)*
"Lorelei Mason wins inaugural $5000 ANZCA media award" *(January 31)*
"Genetics could be the key to anaesthetic awareness" *(January 23)*
"Health professionals urged to have greater empathy for patients" *(January 18)*
"Research funding ensures high-quality and safe anaesthesia" *(December 20, 2011)*

Since December, ANZCA has generated:

8 print stories
13 online stories
23 radio mentions

Anaesthetic history: The Clover diaries



An extraordinary find marks the beginning of an adventure through time for Dr Christine Ball.

In 2007, a project team investigating the paper objects held in ANZCA's Geoffrey Kaye Museum of Anaesthetic History, opened up a picture frame to investigate a page of neat, faded handwriting. What we discovered was an entire book encased in the frame – a casebook written by Joseph Clover between 1846 and 1853.

Joseph Clover was one of the first full-time anaesthetists in Britain and we had no idea how we came to have such an important and valuable item in the collection. It transpired that Robert Macintosh had gifted the book to Geoffrey Kaye and, in trying to determine how this had occurred, I began to search for other Clover papers around the world.

The search has taken me several times to the UK. I have visited Joseph Clover's hometown of Aylsham in Norfolk, spent hours trawling through the family archives at the Norfolk Record Office, clambered around graveyards and spent weeks at the Wellcome Institute in London. The University of British Columbia in Vancouver has sent other papers in digital form and I have published several papers as a result. I have become great friends with Joseph Clover's great grandson and hope this work will eventually result in a biography.

Early last year I was granted a fellowship at the Wood Library Museum in Park Ridge, Illinois, to continue my study of the papers of Joseph Clover.

The museum, run by the American Society of Anesthesiologists, awards a number of fellowships each year open to anaesthetists and trainees.

The Geoffrey Kaye Museum maintains a close working relationship with both the honorary and employed staff at the Wood Library Museum, and we share many of same issues when it comes to managing and cataloguing collections.

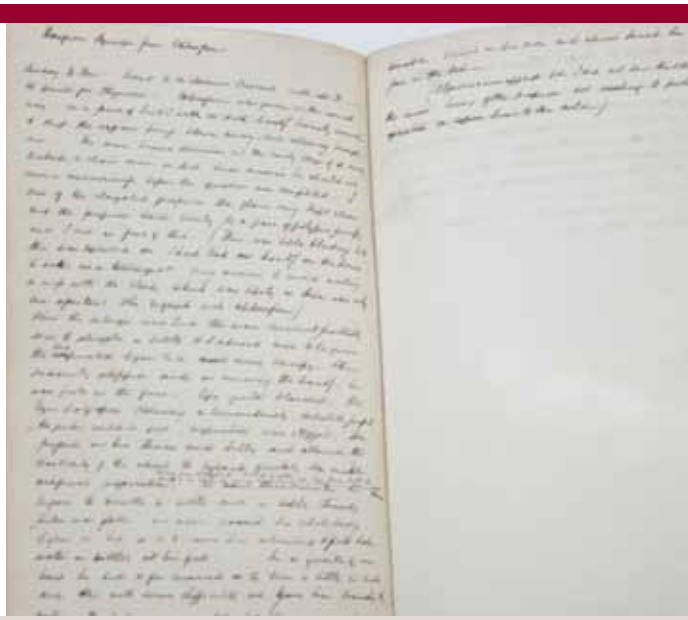
In October last year, I spent two weeks at the Wood Library Museum, a time that happily coincided with the American Society of Anesthesiologists meeting in Chicago, allowing me to combine both activities.

The museum owns three of Clover's diaries, dated from 1850 to 1852, and the fellowship was awarded to allow me to study these diaries on site, with the aim of providing transcriptions later. The museum staff made me extremely welcome, a room was set aside for my work and the Clover material was waiting on my arrival.

It subsequently transpired that they own another Clover diary from 1867 and a set of lecture notes from 1846.

I photographed every page of the documents to allow more detailed study at my leisure. The photographs will also provide a digital backup of the documents. Photography is often the best way to obtain such a backup as it minimises the exposure to light (without flash) and does not require the spine to be flattened as is necessary for a photocopy.

I have photographed the casebook at the Geoffrey Kaye Museum in the same manner, and the digital images are stored and backed up on our database. Professional flat bed scanners provide better images, but the high cost means they are usually found in large organisations such as the Wellcome Institute.



Of course, this visit to the Wood Library Museum provided many other opportunities. I toured the collection and compared their storage, security and cataloguing systems with our own. There were objects that I wanted to photograph for a future presentation and the staff assisted in locating them and making them available. Interesting trade literature, archival documents and cataloguing material was scanned for me within minutes.

I left Australia with one project to complete and have returned with several more.

Most importantly I made new friends and established new contacts with one of the few centres in the world that has a collection comparable to our own. Such contacts are invaluable and will help the progress of both institutions.

I would like to thank the Board of Trustees of the Wood Library Museum for awarding me the fellowship and Karen Bieterman and her staff for making me welcome. I also recommend this fellowship program to other anaesthetists with an interest in history, no matter how small. The program is particularly beneficial to trainees, providing them with mentorship and a wealth of material and ideas.

For further information on how to apply for a fellowship by making a submission to the WLM Board of Trustees please download a guide here: **www.woodlibrarymuseum.org/fellowship/fellowship_guide.php**

Dr Christine Ball
Honorary Assistant Curator and Honorary Archivist, Geoffrey Kaye Museum of Anaesthetic History

Above top left: Dr Christine Ball, Honorary Assistant Curator and Honorary Archivist, Geoffrey Kaye Museum of Anaesthetic History; Case notes in Wood Library Museum; Clover diaries in Wood Library Museum; ANZCA Clover Book from frame.

Below: ANZCA Clover Book after conservation.

High altitude training: a career pinnacle

Dr Ben Darveniza tackled the Nepalese Diploma in Mountain Medicine last year, describing it as one of the more interesting medical experiences of his career.

The Nepalese Diploma in Mountain Medicine (Nep DiMM) is a fantastic opportunity to gain credentials in wilderness, expedition and altitude medicine while experiencing some of the world's most amazing culture and scenery. The diploma, which will run this year for four weeks in November 2012, is divided equally between theory and practical, and is based initially in Kathmandu before traveling to the stunning Everest region.

The qualification and contacts open doors to work as an expedition doctor or participate in research in high altitude medicine. No previous expedition or altitude experience is necessary as all practical requirements are taught during the three weeks spent in the amazing Everest region, however a knowledge of basic climbing skills is useful prior to commencing the course.

Developed by the International Mountaineering and Climbing Federation (UIAA, using its French initials), the DiMM has been running since 2003 and has since spread to seven countries including Switzerland, Italy, the UK and Japan. The Nepalese DiMM is the only course in English run over a single month.

The core syllabus, as prescribed by the UIAA, spends equal time on theory and practical, and allows countries to adapt the course to their unique issues. The Nepalese course places an emphasis on altitude medicine, encouraging Nepalese and western doctors to gain experience in this developing field while fostering further research into high altitude medicine.

I was fortunate to participate in the pilot 2011 course after learning of it while in Nepal on a mountaineering expedition. The dates worked perfectly so, after a late application was accepted, and still sporting a (frankly quite scary) month-long climbing beard, I introduced myself to my fellow candidates.

With participants from South Africa, Poland, England and Nepal, the diversity of backgrounds and medical experience of the candidates is one of the strengths of the experience. Becoming friends with the Nepali doctors and gaining insight into their culture and the difficulties of working in a resource poor medical system was particularly interesting.

The first week of the course is spent in Kathmandu, attending daily lectures, with opportunity in the evenings to explore the nearby temples, sights, sounds and camping shops. The theory component involves altitude physiology and illness, expedition health, remote area trauma care, emergency dental care, group psychology, wilderness and travel medicine and is taught by range of Nepalese and western experts.

We were fortunate to receive lectures from field leaders and notables such as Professor Basnyat (medical director of the Himalayan Rescue Association, president of the UIAA medical commission and co-author of the chapter of Harrison's "Altitude Illness") and Dr Jim Milledge (pioneer in altitude physiology and member of the "silver hut expedition").

Flying to Lukla, the trek to the mountain training location follows the first few days of the Everest base camp trek to Namche Bazaar before diverting to a less touristed but equally spectacular valley. The stunning scenery and clear views of Ama Dablam and Everest make the trek in another of the highlights of the course.

The majority of our time in the mountains was spent in Thame, a sleepy Nepali village wedged between sheer mountains at an altitude of 3800 metres. The lectures continued, but we also undertook practical sessions led by a

mixture of Nepali and western climbing guides at the nearby bolted rock crag, covering skills such as rope work, rock climbing, rescue scenarios and navigation.

The last five days of the course involved a mini-expedition to a nearby glacier, where we received instruction on glacier travel, crevasse rescue, ice climbing and emergency shelter construction. A heavy emphasis was placed on wilderness medicine scenarios and how to cope with medical emergencies with limited resources in difficult situations.

Given the importance of Nepal in the history of mountaineering it is apt that a DiMM course is now run in the Himalaya. This also allows participants to relate the theory to their actual experiences of the effects of altitude. Altitude physiology is of particular interest to anaesthetists.

Participating in the DiMM 2011 was one of the more interesting medical experiences in my career. The chance to meet, learn with and learn from some truly fascinating people and exposure to another field of medicine re-inspired me to use medicine as a tool to pursue an interesting life. The contacts formed have opened doors to pursue less trodden paths in high altitude research or expedition medicine.

For anyone with an interest in practicing medicine while exploring the world and working in developing countries, for those who love the mountains and wish to spend time among them, or for those with an interest in high altitude physiology and research, I couldn't recommend the Nepalese DiMM more highly. Applications are now open for the 2012 course, which will run from November 9 until December 8. The cost is $US4500 including all accommodation, food and internal flights. Further information can be obtained from the following websites:

http://mmsn.org.np/dimm/

http://medex.org.uk/diploma/about_diploma.php

www.theuiaa.org/upload_area/files/1/DIMMreg_20101-3.pdf

Otherwise feel free to email myself for further information bendarvo@yahoo.com.au.

Dr Ben Darveniza,
Provisional Fellow, Gold Coast Hospital, Queensland

"The chance to meet, learn with and learn from some truly fascinating people and exposure to another field of medicine re-inspired me to use medicine as a tool to pursue an interesting life."

Above from top left: High altitude training: Nepalese Diploma in Mountain Medicine participants explore the scenery; A view of the camp on a mini-expedition to the glacier; Course participants pose with a mountain backdrop; Rock climbing instruction: Course participant Migma Sherpa (right) with a sherpa climbing guide.

New Zealand news

Improving quality and safety in New Zealand

The two New Zealanders on the ANZCA Council are playing a leading role in improving quality and safety in New Zealand's hospitals.

Professor Alan Merry is chair of New Zealand's Health Quality & Safety Commission (HQSC) while Dr Leona Wilson, immediate past president of ANZCA, has just taken over as chair of the Perioperative Mortality Review Committee (POMRC). In February, both the commission and the committee released major reports that can help reduce harm to patients.

The Health Quality & Safety Commission, which was established on December 1, 2010, assists health sector providers to improve service safety and quality.

POMRC was established in April 2010 and reports to the commission. Its origins date back to earlier committees that examined maternal deaths and anaesthetic mortality. Doctors lost confidence in the latter of those committees when the police obtained a report via its process as they prepared to charge an anaesthetist with manslaughter in 1989.

The case resulted in an ANZCA-led campaign to change the standard for manslaughter when a person is owed a special duty of care by another person, such as a doctor, from simple to gross negligence. Understandably, it also resulted in a degree of caution around mortality review and reporting at that time, and a re-examination of the legislative protections for such review groups. However, it was also acknowledged that such reporting is necessary to improve safety levels within individual practice and the wider healthcare system.

New legislation, developed to offer greater protection around information collected, and the successful operation of other mortality review committees, restored confidence in the system. Various bodies, including ANZCA, pressed hard for a new national perioperative mortality review committee, leading to the establishment of the POMRC.

The committee's role is to review and report on perioperative deaths in New Zealand, with the aim of reducing their number. This includes all deaths occurring within 30 days of an invasive procedure or anaesthetic, as well as those occurring prior to hospital discharge, irrespective of the time from the index procedure. Operative procedures are defined in the broadest sense and include investigations such as gastroscopies, colonoscopies, and angiographic procedures. Similarly, anaesthesia includes any general anaesthetic, neuraxial block (for example, epidural or spinal), regional block, local anaesthetic and/or sedation.

Professor Merry describes POMRC's first report as internationally innovative in its whole-of-system approach and says it will help reduce harm to patients by providing a better understanding of deaths that occur in the days and weeks following surgery and anaesthesia.

For its inaugural report, POMRC looked at national data collections to better understand the information collected and to make recommendations on how to enhance existing systems so that a report for the entire healthcare system can be generated.

The report analysed data from the National Minimum Dataset and National Mortality Collection for the years 2005 to 2009, looking at four main categories: hip and knee arthroplasty, colorectal resection, cataract surgery and anaesthesia. These categories were selected to take advantage of existing national data and because they would provide an index of work carried out in most New Zealand hospitals.

Findings indicated that overall mortality rates for these areas were comparable with similar international reports.

Between 4000 and 5000 patients die following any form of surgical procedure and anaesthesia each year in New Zealand. Outgoing POMRC chair Professor Iain Martin says that in many cases the operation played no part in the patient's death. However, in a small number of cases, there were lessons to be learned that could help improve the quality of healthcare delivery in New Zealand.

POMRC's new chair, Dr Leona Wilson, says the report provides valuable insights into perioperative mortality and will help POMRC build on advances already made in this area.

The report's main conclusion is a recommendation that building upon existing data collections will enable the establishment of a whole-of-healthcare system mortality review process and that the work of the committee for the coming years will drive these developments. POMRC would like to see mandatory submission of data by all healthcare facilities; private as well as public.

(continued next page)

The HQSC Board will consider the report's recommendations and make a decision about next steps by the end of June.

The Chair of ANZCA's New Zealand National Committee, Dr Geoff Long, issued a media statement describing POMRC's work as valuable because it highlighted areas where additional care needed to be taken to improve quality and safety. He says the report has helped to identify risk factors that anaesthetists could take into account when talking to patients and deciding on their appropriate care. "This will contribute directly to better outcomes for our patients," Dr Long says.

The HQSC has also released its 2010/2011 report of serious and sentinel events in New Zealand's district health boards (DHBs). A serious or sentinel event results in, or has the potential to result in, serious lasting disability or death not related to the natural course of the patient's illness or underlying condition.

Of the 377 events reported, 86 patients died, although not necessarily as a result of the adverse event that occurred. More than half (195) of the events reported were falls. A total of 25 medication errors were reported, along with 108 clinical management incidents which included:

- Delays in responding to a patient's changing or deteriorating condition.
- Poor communication between health professionals.
- Delayed diagnoses due to failings in referral processes and the reporting of results.

Professor Merry says the report is "not about apportioning blame – it's about improving the quality and safety of our health and disability services".

The HQSC works closely with the sector to prevent and reduce harm from falls, he says. It is also working on initiatives to reduce medication errors and healthcare associated infections, promote use of the World Health Organization's safe surgery checklist, and to improve the quality of data and reporting of adverse events.

Professor Merry urges health professionals to familiarise themselves with the report's findings and to look at how they can make the services they provide safer for patients.

Copies of both the POMRC and HQSC reports, and associated materials, are available at www.hqsc.govt.nz.

Susan Ewart,
Communications Manager, NZ, ANZCA

Australian news

Australian Capital Territory

Annual ACT ANZCA/Australian Society of Anaesthetists combined continuing medical education meeting

The 2012 Canberra "The Art of Anaesthesia" meeting was held over the weekend of March 3-4 and was chaired and organised by Professor Thomas Bruessel. This year's theme "Outcome: What really makes a difference?" seemed to generate plenty of lively debate during the breaks and feedback was overwhelmingly favourable. Unfortunately our weather did not really hold and we were lucky not to be completely washed out. Many thanks are due to our distinguished speakers and delegates who patiently negotiated flooded roads and detours in order to make their presentations. We certainly hope you managed to enjoy some of Canberra's indoor exhibitions during your downtime. It was also our honour to have the Vice-President of ANZCA, Dr Lindy Roberts, and the Education Officer of the Australian Society of Anaesthetists (ASA), Dr Vida Viliunas, open our meeting and welcome our delegates. The feedback received from this event has been tremendous, with many delegates making comment on the relevance and interest of the program presented.

Above clockwise from top left: Professor Thomas Bruessel, Professor Dr Hartmut Buerkle, Professor Stephan Schug; Delegates enjoying morning tea; Dr John Ellingham discussing The Internet; Dr Carmel McInerney, ACT Regional Committee Chair and Dr Lindy Roberts, Vice President ANZCA; Delegates enjoying lunch; Associate Professor Ross Kennedy discussing Outcome and Volatile Agents; Delegates listening to a presentation.

South Australia and Northern Territory

The Part 0 Trainee Induction Course

The Part 0 Trainee Induction Course was held on January 28 for the new SA/NT trainees joining the rotation scheme. It was facilitated by the 2011 and 2012 Trainee Committee Chairs Dr Rowan Ousley and Dr Vicki Cohen. Topics covered were how the rotational scheme works; roles of ANZCA, Australian Society of Anaesthetists (ASA) and the Group of Australian Society of Anaesthetists Clinical Trainees (GASACT); supervisors of training and their role; and trainee welfare issues.

Above from top: Part 0 trainees from left:
Back row: Greg Houghton, Kris Usher, Ravi Sandhu, Carrie Worthley, Robyn Maina, Chelsea Hicks, Jessica Staker.
Front row: Miad Habibi, Torin Clack, Narguess Jahangiri.

Trainee Committee Chairs Vicki Cohen (2012) and Rowan Ousley (2011).

Flinders University award

At the end of last year Dr Meredith Craigie (pictured above) was presented with a Flinders University School of Medicine Dean's Award in recognition of the significant contribution she has made over many years to teaching here and in Indonesia.

The criteria for the award are: outstanding service to the school over an extended period beyond the normal expectations of the position to which the person has been appointed or elected; and significant contribution to enhancing the reputation and standing of the school.

Dean's Awards are judged rigorously and only a few are made in any year.

Dr Craigie's award was one of only four in 2011. I hope you will join me in congratulating Dr Craigie.

Professor Harry Owen
Professor of Anaesthesia and Pain Medicine
Flinders University

New South Wales

Supervisor of training workshop

Thirty-four eager supervisors of training (SOTs) immersed themselves in the revised curriculum at a full-day workshop at the ANZCA NSW premises on Friday March 2. Dr Peter Gibson and ANZCA General Manager, Education Development, Oliver Jones started with an up-to-date review of the revised curriculum structure. They were able to clarify many questions and provided some common-sense insights into the reasoning behind the curriculum development and the practical implications on day-to-day SOT work.

Most of the day focused on workplace-based assessments (WBAs) – or workplace-based training tools as we decided we would rather call them! All four NSW WBA champions participated in the day. Dr Emily Wilcox provided an introduction to the tools and a close-up view of direct observation of procedural skills (DOPS). Dr Phil Byth and his helpers demonstrated a case-based discussion and Dr Brendan Orr led the group through the Mini-Clinical Evaluation Exercise (mini-CEX). Evaluations of the day revealed learning on many levels for most participants. Key messages that many in the group took away include these assessments having a primarily formative purpose, that as many of the department need to be assessors as possible, assessments have to be prospectively agreed with trainees, and the rating scale is not a pass/fail one, but a more valuable and intuitive description of how much supervision is required. The group left with some understanding of the next stages in development and propagation of the revised curriculum, the material that will be available for them to use in the future, and a new motivation to go back to their home departments and start teaching and recruiting assessors.

Our thanks go to ANZCA NSW staff who ensured that the day ran very smoothly and that the catering was excellent. The group enjoyed the chance to network, indulge in open and meaningful discussions, and to welcome several new SOTs to the fold. Our next meeting in November will focus on the role of the SOT overall in the revised curriculum.

Dr Natalie Smith, FANZCA
NSW REO

Queensland

Queensland regional report

The start to 2012 has been far less dramatic than last year. While we have noticed high tides lapping the edge of the riverbank at West End, this has not been the cause for concern that existed last year when the ANZCA Queensland regional office was evacuated.

The first two months of 2012 has been packed with activity.

- The ANZCA Queensland Regional Committee, Faculty of Pain Medicine Queensland Regional Committee and College of Intensive Care Medicine Queensland Regional Committee as well as the ANZCA Training Committee, and the ANZCA/ASA Continuing Medical Education Committee have all convened their first meetings.
- The ANZCA/ASA CME Committee has been particularly active, with plans for the annual conference well in hand. This year's conference will focus on OPAL – "Obstetrics, Paediatrics and Law: Gems anaesthetists need to know".
- There have been two evening lectures (February 6 and 9).
- The GASACT course was held in the West End office on January 28 followed by a well-attended and much-enjoyed social evening at the Shafston Hotel.
- Two webinars supported by funding from Queensland Health were held for trainees preparing for exams.
- The primary lecture series commenced on Saturday February 11.
- 220 registrars have commenced new hospital rotations.
- 70 candidates have sat at least one part of the primary exam.
- All Queensland regional committees have been canvassed for input to the ANZCA 2013-2017 strategic plan.

The two-year terms of the ANZCA and FPM regional committees will expire in June and new committees will be elected for 2012-14. Calls for nomination for these committees closed February 29 and March 2 respectively. The committees have proud records of achievement. Fellows are encouraged to step up and add their contribution to furthering the profession.

Above from top right: Dr Chris Breen, Chair ANZCA/ASA Continuing Medical Education Committee, Professor André van Zundert and Associate Professor Michael Steyn, Deputy Chair QRC; Dr Helen Karl, Associate Professor Anaesthesiology and Pain Medicine and Kathleen Cooke, CME convenor Faculty of Pain Medicine QRC at the Faculty evening lecture on February 9; André van Zundert, Professor of Anesthesiology, Catharina Hospital – Brabant Medical School, Eindhoven, Netherlands, presenting to Queensland Fellows at the evening lecture on February 6.

Opposite page: Tsharna Stewart (TressCox Lawyers), Dr Paul Nicholas (Queensland Trainee Committee Chair), Dr Sean McManus (Queensland Regional Committee Chair), Cassandra Heilbronn (TressCox Lawyers), Amity Evans (ANZCA QRC Course Co-ordinator), Simon Farmer (Walshs Accountants), Dr Brett Segal (former QTC Chair), and Dr Colin Brodie (QTC Social Convenor).

Trainee event

The annual Queensland Trainee Committee social event was held in Brisbane on January 28, 2012, following the GASACT Part 0 course. This year's event was a cocktail party celebrated at the iconic Shafston Hotel in East Brisbane with the Chair of the Queensland Regional Committee, Dr Sean McManus, attending in support of the new and existing trainees.

The attendance on the night demonstrated how important it is for the trainees and consultants to have a social event with their colleagues from both sides of the river, and we look forward to further such opportunities later in the year.

The Queensland Trainee Committee would like to thank our generous sponsors, Walshs Accountants, TressCox Lawyers and Dr Oncall.

Dr Colin Brodie
Queensland Trainee Committee
Social Convenor

Victoria

Part 0 course

Forty-five trainees attended the Part 0 Course on March 2 at ANZCA House. The all-day course was supported by LMA PacMed, who provided airways equipment, and Abbott Australia.

The new trainees were given an insight into the resources available at the College and presentations were made by Victorian Fellows on various aspects of the training program focusing on welfare, planning and an approach to exams. A lively panel session with rotational supervisors and supervisors of training was part of the course and the new Victorian Trainee Committee Chair, Dr Mark Heynes, joined the session. The hands-on airway workshop was of special interest. We especially thank the presenters and workshop facilitators for giving so generously of their time and effort.

Dr Richard Horton
Convenor

Above: Dr Jane Anderson (facilitator) with trainees.

Western Australia






Western Australian Summer Scientific Meeting 2012

The Western Australian Summer Scientific Meeting was held on Saturday February 25 at the University Club on the grounds of the University of WA. The theme of the meeting was "What's new in anaesthesia?" with topics that ranged from the role of innovation in healthcare, to new drugs and techniques in anaesthesia, to changes that are occurring that will affect anaesthetic practice in Perth.

The plenary speaker was Dr Tracey Tay from John Hunter Hospital in Newcastle, who gave an interesting lecture titled "Innovation in healthcare – the good, the bad and the ugly". This was followed by an enlightening presentation from Dr Chris Mitchell on the "Development of the Mitchell Needle". Guest speaker Professor Stephan Schug then discussed "Updates in pain therapy".

The morning free paper session consisted of four well presented papers by three anaesthesia trainees and one Fellow. The Nerida Dilworth Prize, for the best presentation of scientific material by a trainee, was awarded to Dr Peter Unwin, and was presented by WA Australian Society of Anaesthetists Chair, Dr Andrew Miller. In the afternoon, a second free paper session by final year medical students was held due to the high number of papers submitted and this was also well received.

During the morning session there were also "Advanced Life Support: Simulation" workshops which were organised by Dr Angelique Halliday and her team. In the afternoon, small group workshop sessions were held for delegates on "Videolaryngoscopes" and "Regional anaesthesia: Ultrasound-guided paravertebrals, TAP blocks and rectus shealth blocks". Thank you to presenters Dr Nigel Hamilton and his team, Dr Nicholas Prophet, Dr Tim Chapman, Dr Chait Tak, Dr Harmeet Aneja and Dr Dick Ongley. Running concurrently we also had an evidence-based interactive presentation in the auditorium with three thoughtful discussions. Presenters were Dr Bill Weightman, Dr Ed O'Loughlin, Professor Thomas Ledowski and Dr Andrew Miller.

The afternoon finished with a session on "What is happening in anaesthesia in Perth". This included an update on the new Fiona Stanley Hospital by Dr Gavin Coppinger. Dr Angeline Lee then discussed the workplace-based assessment. A panel consisting of Dr Steve Watts, Dr Joe Pracilio, Dr Sai Fong, Dr Richard Clarke and Dr Rob Storer discussed the issue of trainee in private practice.

The DRC (Bunny) Wilson Memorial Lecturer was Dr David Hillman, who gave an entertaining talk on his career in anaesthesia.

The meeting was very well subscribed, with 123 consultant anaesthetists, 12 trainees and six GP anaesthetists attending. Many stayed to finish the day with a sundowner overlooking the picturesque Swan River.

The WA CME Committee would like to thank all the presenters, sponsors and attendees for making the Summer Scientific Meeting 2012 a success and especially meeting convenor Dr Angela Palumbo for her excellent efforts with CME in Western Australia.

ANZCA/ASA Gilbert Troup Prize in Anaesthetics

The ANZCA/ASA Gilbert Troup Prize in Anaesthetics for 2011 at the University of Western Australia was awarded to Dr Evan Heinecke (pictured above). The College and the Society established the prize in 2001 to foster undergraduate and postgraduate teaching of anaesthesia at the University of Western Australia.

Tasmania

Combined annual scientific meeting

The 2012 Joint ANZCA/ASA Scientific Meeting was held at The Tramsheds, Launceston from February 17-19. Thirty-four Fellows and six trainees attended the conference titled “Great expectations? Out with the old and in with the new”. Invited speaker Dr Gavin Pattullo delivered two talks, “Dead opiate society” and “Femoral nerve block; as simple as it seems?” An update was given on workplace-based assessments by Dr Deb Wilson, along with a cardiology update by Dr Geoff Evans and an intensive care unit update from Dr John Lewis. Aequis’s guest presenter Mr Kajanga Kulatunga, a portfolio specialist at MLC Investment Management, spoke on “What the rise of the ‘East’ really means for your investments?” and “Are term deposits the ‘safest’ investments?” Dr Stephen Swallow gave an overseas update. The meeting attracted 15 trade exhibitors, two of which were major sponsors. The annual general meetings of the Tasmanian sections of both ANZCA and Australian Society of Anaesthetists were held during the conference.

Opposite page clockwise from top left: Delegates enjoying the afternoon session; Regional Anaesthesia workshop presenter Dr Harmeet Aneja with delegates; Dr Tracey Tay; Guest speaker Professor Stephan Schug; Nerida Dilworth Prize winner Dr Peter Unwin with WA ASA Chair Dr Andrew Miller; Guest speaker Dr Chris Mitchell.

Dean's message

Good news. On Sunday February 12, the Australian Government announced $5 million in funding for a national online electronic controlled drug monitoring system, following a successful pilot in Tasmania.

For all types of pain where opioid prescribing is appropriate, both prescribers and dispensing pharmacies will have the ability to review and monitor similar or other controlled drug prescribing for a particular patient.

While a major aim is to identify doctor shopping and similar inappropriate behaviour, the benefits will not only be related to reducing prescription drug abuse and diversion. The fact that there is such a problem adds a layer of inhibition to the widespread opio-phobia barrier, which prevents some doctors prescribing opioids even where they would be appropriate.

Using opioid risk assessment tools (ORT) and this long-awaited monitoring tool should give prescribing doctors increased confidence in their decision making because they can see what has already been dispensed to a particular patient. This will improve the process of prescribing of pain relief.

However, the government can only do so much. By funding this they facilitate what we as professionals can do; it is up to us to make it work and achieve the benefits. Undoubtedly there will be a learning curve once it is introduced.

The government's support also teaches us that it is necessary to keep chipping away to get our message across on important matters. It has been no small time since Faculty members recommended such a monitoring system. From around 2007-08 the momentum picked up, culminating in this as a major recommendation of the Prescription Opioid Policy released in 2009 by the Royal Australian College of Physicians (RACP), into which the Faculty of Pain Medicine, ANZCA and the Chapter of Addiction Medicine, RACP were major contributors.

Subsequent to that report, both our director of professional affairs and immediate past dean have, among others, submitted on behalf of the Faculty to several bodies considering opioids at different levels, reiterating the messages of the policy document.

I first heard of a prescription-monitoring program (PMP) in West Virginia from a visiting speaker at a conference. The program began around 1995 (although it did close down for a period). The growth of the internet and availability of better information technology equipment in healthcare environments has reached a level of maturity that allows this project to work.

In New Zealand, serialised triplicate prescription pads for controlled drugs, with a copy sent to Medicines Control, have failed to halt bad opioid prescribing, except for post hoc investigations, because data appears not to have been entered into a computer database close to real-time, as required. However, we have had a system of rapid internet application for special approvals for high-cost medicines in place for more than five years. This reflects the administrative priority for a cost-control electronic system above a system of clinical value, such as the Australian Government has announced. New Zealand is now challenged to follow suit!

It begs the question as to why there is a soaring death rate from abuse of (usually someone else's) prescription opioids, but also accidental overdoses by those for whom they were being prescribed. This is a problem among non-abusing recipients. Careful prescribing is by no means less important just because there is such a monitoring system. Prescribers must have a high level knowledge about opioid analgesics – something to which our members can contribute at undergraduate levels – because without that little is taught on this subject.

Now in its 12th year, the Faculty is entering an exciting period of looking into the future. We are setting a vision for where we will be in 10 years and developing a five-year strategy in parallel with ANZCA. The starting point will be a facilitated workshop on the vision, from which more detailed strategies will be developed. The chief executive officer and Policy Unit contributed a comprehensive consultation plan for both internal and external stakeholders. Consultation at regional committee level included Faculty input. If you have a burning idea and have not contributed through the formal processes, please contact a board member, the Faculty of Pain Medicine's General Manager Helen Morris, or myself. It is not too late to have your say.

Re-accreditation also is under way, with the mammoth task of preparing a submission that answers questions about the standards set by the Australian Medical Council. ANZCA and the Faculty are undergoing this process simultaneously, and the Medical Council of New Zealand will follow the same process (unified?).

Many aspects of our blueprinting process directly inform this, so it is fortunate timing. Of course, because Medical Council of New Zealand has not yet completed its first accreditation of the Faculty, they will not consider our re-accreditation in this round. But it does make sense for the two bodies to collaborate and for one to accept the result of the other.

Before long our annual major meeting – the annual scientific meeting in Perth – will be here. This is a time for re-energising and renewal – hearing of new ways to do things, new topics, new faces and places.

I usually try to find topic(s) on the program that I know next to nothing about; not to deny going to topics of existing high interest though, since there are always different perspectives and emphases. I hope each of you who attend will pick up some tip, trick or hint that you can put to good use for your patients back home.

Until then – something the theatre receptionist in my hospital has put up to keep us on track and to help each day go well – "It is nice to be important, but much more important to be nice".

Dr David Jones
Dean, Faculty of Pain Medicine

News

Election of FPM Dean-elect
Dr Brendan Moore, has been elected Dean-elect of FPM and will assume his new role following the AGM on May 13.

Faculty of Pain Medicine Board election
Dr Ray Garrick FRACP (NSW), Dr Michael Vagg FAFRM (RACP) (Vic) and Dr Andrew Zacest FRACS (SA), have been elected unopposed to the Faculty board.

The ballot for the three remaining vacancies will close at 5pm **April 4, 2012**.

Training Unit Accreditation update
Following a successful review, the Royal North Shore Hospital has been re-accredited for pain medicine training. After its initial review, Townsville Hospital has become an accredited training unit, bringing the number of accredited pain units to 27. Dr Max Sarma and Dr Chris Orlikowski have also been ratified as co-supervisors of training at the Royal Hobart Hospital.

Admission to Fellowship of the Faculty of Pain Medicine
By examination:

Dr Chui Chin Chong, FANZCA (Western Australia)

Dr Symon Ross McCallum, FANZCA (Queensland)

Dr Timothy James Brake, FANZCA (Hong Kong)

Dr Luke John Murtage, FANZCA (New South Wales)

Dr Richard Paul Sullivan, FANZCA (Victoria)

Dr Richard Martin Talbot, FANZCA (Victoria)

Dr Nathan Charles Taylor FANZCA (New South Wales)

Dr Kevin Young, RACP (Victoria)

2012 Pre Exam Short Course
The 2012 Pre Exam Short Course will be held from September 14-16 2012, at ANZCA Brisbane Regional Office, West End Corporate Park, River Tower, 20 Pidgeon Close, West End Qld 4101

2012 Examination Dates
November 23-25, 2012 (Friday to Sunday)

The Auckland Regional Pain Service, Auckland NZ

Closing date for registration: **October 5, 2012**

FPM Board meeting report

February 2012

Faculty board
The Faculty board met on February 26. Dr Brendan Moore, FANZCA (Qld), was elected to the position of Dean-elect. Dr Lindy Roberts was congratulated on election to President–elect of ANZCA.

Terms of reference (TOR) were approved for the board and its committees and will be published on the FPM website. TORs for roles will follow for approval at the May board meeting.

The Faculty board will next meet in Perth on May 10 and the new board will meet on May 13.

FPM strategic planning 2013-2017
The FPM has initiated a process for the development of an updated strategic plan in alignment with ANZCA's strategic planning process. The FPM Board held a strategic planning workshop at ANZCA House on February 27 and a second workshop will be held in conjunction with the May 10 board meeting.

Commencing the process at this time will enable the board to capture the experience of the long-serving board members due to retire in May 2012, as well as the views of newly elected members. This also provides an opportunity to align FPM's strategic planning with ANZCA's planning process, and to join with ANZCA in considering the development and adoption of a shared vision and possibly a set of organisational values for the College and Faculty.

A project plan and a consultation and communications plan have been developed and the consultation process has commenced with the CEO meeting FPM regional chairs in conjunction with visits to ANZCA regions during February and March. External stakeholders are being invited to comment and their feedback will be considered at the May workshop.

Board election
Dr Ray Garrick FRACP (NSW), Dr Michael Vagg FAFRM (RACP) (Vic) and Dr Andrew Zacest FRACS (SA), have been elected unopposed to the Faculty board in accordance with FPM regulations 1.1.3 and 1.1.4. There being five nominees for the three remaining vacancies, a formal ballot will now proceed. In accordance with FPM regulations, at least one of the three vacancies must be filled by a Faculty Fellow with FANZCA. The remaining two vacancies may be filled by any Faculty Fellow. Ballot papers have been circulated to Fellows. The ballot closes at 5pm on Wednesday April 4, 2012.

GP online learning project
A number of Fellows are now involved in developing content for the GP online learning initiative. This phase is expected to be completed by June when early stages of the product will be available for review. The program will be able to be utilised on iPads and iPhones.

Relationships
RANZCOG

Dr Rupert Sherwood, President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), met with the board in February to explore areas for collaboration and opportunities to include pain medicine in the RANZCOG curriculum, training and practice. A Faculty professional document on persistent pelvic pain is in development.

ANZCA

Dr Kieran Davis will represent the Faculty on the ANZCA code of conduct and pledge working group and will consult with FPM Fellows with specialty backgrounds other than ANZCA to ensure broad relevance.

As part of the ANZCA strategic plan consultation, the ANZCA CEO met with the FPM Board to seek their input. The board provided feedback and appreciated the opportunity to comment.

FPM Board meeting report continued

The ANZCA and FPM continuing professional development standard has now been published on the website.

The Faculty has been invited to assist ANZCA in disseminating information on how the new curriculum will affect the training of anaesthetists in pain medicine. Pain medicine will now be a core fundamental in the curriculum and there will be flexibility to allow the provisional fellowship year to be entirely in pain medicine as well as defined learning outcomes, resources and research in pain medicine as part of anaesthesia training.

The board supported ANZCA's proposed changes to regulation 30 regarding the reconsideration and review process.

The FPM endorsed ANZCA's policy on bullying, discrimination and harassment for Fellows and trainees acting on behalf of the College or undertaking College functions.

Fellowship

Two new Fellows were admitted in December and six in February, taking the total number of admissions to 318.

Education

Curriculum blueprinting project

The curriculum blueprinting process is proceeding according to schedule. A face-to-face meeting of the core working group was held in Melbourne on February 28 and another will be convened during the annual scientific meeting (ASM). A framework has been developed and from this resources will be developed to complement the clinical exposure.

2012 Examination

The venue for the 2012 examination has been confirmed as the Auckland Hospital, Friday November 23 to Sunday November 25. The 2011 examination report is now available on the website.

Training unit accreditation

Townsville Hospital has been accredited for training in pain medicine and Royal North Shore Hospital has been re-accredited.

Continuing education

2012 FPM Spring Meeting

Dr Jerome Schofferman, US, has agreed to be the keynote speaker at the Faculty's 2012 Spring Meeting in Coolum in September.

Professional

Chronic pain outcomes initiative

A consensus dataset has now been agreed for the chronic pain outcomes initiative. A precise business case is in development with the intention to present to state governments. A working group met in Wollongong in March to progress this further.

Painaustralia

Painaustralia has agreed to support National Pain Week in July 2012. Faculty Fellows have been asked to contribute to a GP education forum in Parliament House Canberra.

Painaustralia has been successful in influencing the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) with regard to the disability support pension table.

Pharmaceutical Benefits Advisory Committee (PBAC)

The National Medicines Policy Committee (NMPC) has provided a series of recommendations to government on the issue of opioid use for non-cancer pain. Currently the NMPC is awaiting direction from the government on how to proceed, and a response to the submission is on hold pending further direction from government. No timeline is available as to when a government response might be coming.

Dextropropoxyphene

When the Therapeutic Goods Administration announced in November 2011 the cancellation of dextropropoxyphene-containing analgesics from March 1, 2012, they also indicated they would be referring doctors' queries to pain or addiction specialists. The FPM director of professional affairs has undertaken on behalf of the FPM and the Chapter of Addiction Medicine (RACP) to produce a transition guideline, currently in development.

Submissions

A submission to the Australian Medical Council for ongoing accreditation is in the final stages of development for submission by the end of March 2012.

The Faculty has recently contributed to the following submissions:

- Australian Health Practitioner Regulation Agency (AHPRA) public consultation paper on the definition of practice.
- National Prescribing Service (NPS) prescribing competencies framework project: core competencies to prescribe medicines safely and effectively.
- Independent Hospital Pricing Authority – activity-based funding for Australian public hospitals.

GP superclinics and Medicare locals

The board discussed the role of pain medicine in GP superclinics and Medicare locals in the delivery of pain services and how to engage and work with them. It was reported that the Newcastle experience has been positive with a number of collaborative projects running.

Doctors health program funding

The Faculty board supported a proposal to make a submission to the Medical Board of Australia in support of the funding of external doctors' health programs. Fellows will be notified, through our e-newsletter *Synapse*, of the opportunity to make individual submissions.

Finance

The Faculty ended the year with a positive position against budget.

2012 board meetings

May 10 (Thursday) board meeting and strategic planning workshop (Perth)

May 13 (Sunday) annual general meeting and new board (Perth)

August 13 (Monday) board meeting (Melbourne)

October 29 (Monday) board meeting (Melbourne)

Library update

New titles

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

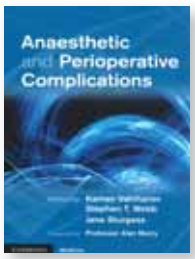
The Anaesthetist's companion / Rathie, Lachlan. 2011. Kindly donated by the author.

British academic anaesthetists : 1950-2000: Volume 1 / Harrison, Michael J. 2011. Held in the New Zealand office. Kindly donated by the author.

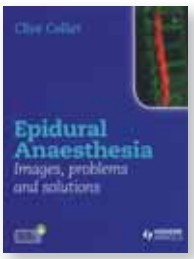
History of British intensive care, c.1950 - c.2000 / Reynolds, L A [ed]; Tansey, E M [ed] 2011.

Monitoring in anesthesia and perioperative care / Reich, David L. [ed], et al., 2011.

The Patient's choice: quality at the end of life / Australia. Dept. of Health and Ageing.; Rural Health Education Foundation. 2011. (Book; DVD)

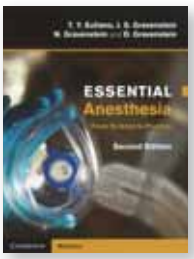


Anaesthetic and perioperative complications / Valchanov, Kamen [ed]; Webb, Stephen T. [ed]; Sturgess, Jane [ed]. 2011.

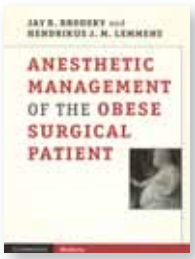


Epidural anaesthesia: images, problems and solutions / Collier, Clive B. 2012. Kindly donated by the author.

Anesthesia oral board review: knocking out the boards / Lovich-Sapola, Jessica A [ed]. 2010.



Essential anesthesia: from science to practice / Euliano, T Y, et al. -- 2nd ed, 2011.



Anesthetic management of the obese surgical patient / Brodsky, Jay B.; Lemmens, Hendrikus, J. M. 2012.

Examination intensive care medicine / Foot, Carole, et al -- 2nd ed, 2012.

New resources for 2012

The ANZCA Library has added a new cutting-edge collection of online books and journals that are available to ANZCA Fellows and trainees.

The *MDConsult and Anesthesiology Collection* includes:

- *Miller's Anesthesia* now online.
- 17 anaesthesia-related online books, and many more titles on topics such as emergency medicine and surgery.
- *Anesthesiology Clinics* and *Critical Care Clinics* now available online, along with more than 30 other *Clinics of North America* titles.
- Anesthesiology and pain management patient handouts.
- More than 50,000 high-quality medical images.

Emergency Medicine Australasia is the official journal of the Australasian College for Emergency Medicine (ACEM) and the Australasian Society for Emergency Medicine (ASEM), and publishes original articles dealing with all aspects of clinical practice, research, education and experiences in emergency medicine.

Systematic Reviews is a new journal that encompasses all aspects of the design, conduct and reporting of systematic reviews.

Access journals and online textbooks is via the library quick-link on the ANZCA homepage (College ID log-in required).

Database enhancements

The new year has brought a number of exciting improvements to the *OvidSP Medline*, *OvidSP Embase* and the *Pubmed* databases.

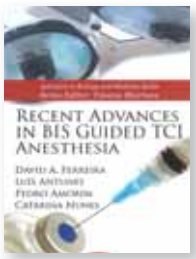
The *PubMed*® Advanced search page has been modified to provide users with a less cluttered, more intuitive way to build searches.

OvidSP now makes it easier to change between the two databases, Medline and Embase, as well as navigate within the Journal A-Z list. Other enhancements include:

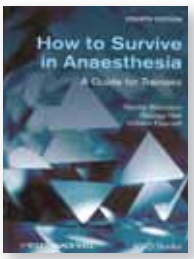
- Ability to export citations to an MS Excel document.
- Access to click buttons at the bottom of the search results screen.
- New advanced search entry tips for Keyword, Author, Title and Journal.

Historical notes on Anaesthesia and Intensive Care / Ball, Christine M.; Westhorpe, Rodney N. 2012.

The MGH textbook of anesthetic equipment / Sandberg, Warren MD. [ed]; Urman, Richard D. [ed]; Ehrenfeld, Jesse M. [ed]. 2011.



Recent advances in BIS guided TCI anesthesia / Ferreira, David A., et al. 2010.

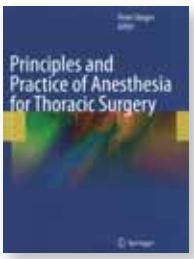


How to survive in anaesthesia: A guide for trainees / Robinson, P Neville; Hall, George; Fawcett, William. -- 4th ed, 2012.

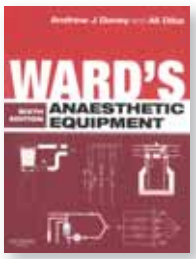
The physics, clinical measurement and equipment of anaesthetic practice: for the FRCA / Magee, Patrick; Tooley, Mark. -- 2nd ed, 2011.

SAQs for the final FRCA / Shorthouse, James; Barker, Graham; Waldmann, Carl. 2011.

Management of the difficult and failed airway / Hung, Orlando R [ed]; Murphy, Michael F [ed]. -- 2nd ed, 2012.



Principles and practice of anesthesia for thoracic surgery / Slinger, Peter D [ed]. 2011.



Ward's anaesthetic equipment / Davey, Andrew J [ed]; Diba, Ali [ed]. -- 6th ed, 2012.

Improve your searching with revised subject headings

The *National Library of Medicine PubMed* database uses medical subject headings (MeSH) to classify articles by the most appropriate keyword. 2012 brings new terms to reflect the changing health field, some of which may be of interest to ANZCA and FPM Fellows and trainees, such as:

- Acute pain.
- Chronic pain.
- Musculoskeletal pain.
- Nociceptive pain.
- Patient safety.

Both *PubMed* and *OvidSP Medline* databases use MeSH.

Contact the library to optimise your literature search strategy or access the library homepage.

Anaesthesia and pain medicine highlights

Special Issue: 'State of the Art' in Airway Management
Anaesthesia. 2011, 66 Supplement s2

Colloids versus crystalloids for fluid resuscitation in critically ill patients. Perel P, Roberts I. Cochrane Database Systematic Reviews. 2011, Art. No: CD000567.

Epidural versus non-epidural or no analgesia in labour. Anim-Somuah M, Smyth RM, Jones L. Cochrane Database Systematic Reviews. 2011, Art. No:CD000331.

Neuromodulators for pain management in rheumatoid arthritis. Richards BL, Whittle SL, Buchbinder R. Cochrane Database Systematic Reviews. 2012, Art. No: CD008921.

Single dose intravenous propacetamol or intravenous paracetamol for postoperative pain. Tzortzopoulou A, et al. Cochrane Database Systematic Reviews. 2011, Art. No: CD007126.

Nitrous oxide for colonoscopy. Aboumarzouk OM, et al. Cochrane Database Systematic Reviews. 2011, Art. No:CD008506.

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

ANZCA Council meeting report

February 2012

Report following the council meeting of the Australian and New Zealand College of Anaesthetists held on February 25, 2012

Death of Fellow and trainees

Council noted with regret the death of the following Fellows and trainee:

- Dr Bruce Warren Gunner (NSW) FANZCA 1992, FFARACS 1956
- Dr Philip J Barnes (SA) FANZCA 1992, FFARACS 1982
- Dr Dianne Margaret Cole (Qld) BTY1 trainee
- Dr Michael Keith Logan (NSW) FANZCA 1992, FFARACS 1971

College honours and awards

- Dr Jeremy Ormond Cooper has been made a member of the New Zealand Order of Merit (MNZM) in the 2012 New Year Honours List.
- Dr Neil Thomas Matthews and Dr Rod Westhorpe have been awarded the Medal of the Order of Australia (OAM).
- Dr John Patrick Keneally and Dr Harry Frank Oxer have been awarded the Medal of the Order of Australia (AM).
- Professor Teik Oh has been awarded the Dudley Buxton Medal of the Royal College of Anaesthetists.

Education and Training Committee and trainees

ANZCA Curriculum Revision 2013: The ANZCA Council approved the master document containing the learning outcomes and their links to the assessments for the revised curriculum. This document will be posted on the website soon. Regulation 37 "Training in anaesthesia leading to FANZCA, and accreditation of facilities to deliver this curriculum" was also approved in part – a further version of this regulation will be considered at the April council meeting, along with *The ANZCA Handbook for Training and Accreditation*, following which both documents will be circulated for consultation.

Internal Affairs

Election of the President-elect: ANZCA Vice-President Dr Lindy Roberts (WA) was elected president-elect and will take office at the annual general meeting in May 2012.

ANZCA Strategic Plan 2013-2017: The council received an update on the strategic planning process. Consultation is being undertaken with Fellows and trainees, as well as external stakeholders, in preparation for a strategic planning workshop to be held prior to the April council meeting. Concurrently, the Faculty of Pain Medicine is undertaking a parallel and complementary strategic planning process.

ANZCA History and Heritage Strategy: The council approved a strategy and budget for achieving the strategic objectives of the History and Heritage Action Plan. Expressions of interest regarding strategic options for accommodation are being sought. ANZCA management will work within the budget allocated and prioritise actions accordingly.

Regulation 23 – "Recognition as a Specialist in Anaesthesia for International Medical Graduate Specialists (IMGS) and Admission to Fellowship by Assessment for IMGS": A copy of the amended regulation will be made available on the ANZCA website soon. Changes include: renaming the "WBA" the "IMGS WBA" and renaming the "structured performance assessment" the "IMGS examination".

Membership of the Indigenous Health Committee: The council approved the appointment of Dr C Mich Poppinghaus to the ANZCA Indigenous Health Committee.

ANZCA Trainee Committee membership: Dr Michael Lumsden-Steel (Tas) and Dr Paul Nicholas (Qld) have been appointed co-chairs of the ANZCA Trainee Committee. The other members are: Dr Ashokka Balakrishnan (Singapore), Dr Sheila Barnett (NZ), Dr Jennifer Myers (ACT), Dr Mark Heynes (Vic), Dr May Leung or Ms Silky Wong (Hong Kong), Dr Vanessa Percival (WA), Dr Ye Yun Phang (Malaysia), Dr Vicki Cohen (SA and NT), Dr Michael Wirth (NSW), Dr Genevieve Goulding, Chair, Education and Training Committee, Mr Oliver Jones, General Manager, Education Development Unit. Co-opted members are: GASACT representative TBA, Dr Kathryn Hagen (New Zealand Society of Anaesthetists), Dr Anand Parmeswaren (Welfare of Anaesthetists Special Interest Group representative) and Dr Andrew Thomas (Training Accreditation Committee representative). The outgoing Trainee Committee co-chairs, Yvette Bostock (WA) and Simon Martel (NSW) and members were acknowledged.

Financial reporting to ANZCA committees: The council agreed that financial reporting would be included on all committee agendas as a standing item. Committee terms of reference to be amended to include the financial roles of committees: development of an annual activity plan, familiarity with the approved budget, oversight of the financial management of budgeted activities, and support for management in decision making to ensure the best possible financial outcome. This will include that the roles of committee do not include the day-to-day financial management of the College, which is the role of ANZCA management.

Quality and Safety

Professional documents To2 - Guidelines on Checking Anaesthesia Delivery Systems and **PS37- Guidelines for Health Practitioners Administering Local Anaesthesia:** Following consultation, these documents and their background papers were approved with copies to be made available on the ANZCA website soon.

Ossie Guide to Clinical Handover Improvement: The council has endorsed this publication with a link to be on the College website under "endorsed guidelines". It is supported by the Implementation Toolkit for Clinical Handover Improvement.

National Blood Authority publication Patient Blood Management Guidelines: Module 1 – Critical Bleeding/Massive Transfusion: The council has endorsed this publication with a link to be on the College website under "endorsed guidelines".

Research

ANZCA Survey Research Policy: The College often receives requests from Fellows, trainees or industry for contact details of its members for a survey, or requests to distribute a survey to the entire fellowship. In response to these requests and the recent changes to privacy legislation, the ANZCA Trials Group has developed a policy that outlines the requirements for scientific and well-constructed surveys that meet ethical and privacy standards. Please contact Stephanie Poustie for more information.

Professor Kate Leslie
President

Dr Lindy Roberts
Vice-President

Obituary

Dr Iain MacDonald 1947 – 2011

Iain MacDonald was born in Carlisle, UK, and immigrated to New Zealand when aged three years. His father was "surgeon commander" at the Devonport Naval Base in Auckland and the family lived in Browns Bay on Auckland's North Shore. Tennis, yachting and music featured in his formative years, all subsequently playing an important role in his life.

Iain attended Kings College in Auckland and followed the family influence by studying medicine at the University of Otago in Dunedin.

University life was highlighted by his involvement in music, especially guitar. He became a superb lead guitarist, playing in many of the influential bands in the Dunedin/university 1970s' rock scene. He married Alison (nee Calvert) in 1971 and they had five children.

Iain graduated MB ChB in 1973 and spent his house surgeon years in Wanganui before returning to Dunedin in 1977 to commence registrar training in anaesthesia. He was part of a vibrant and stimulating department in those days, led and influenced by Dr Barry Baker. He sat and passed his FFARACS in 1981, translating to a FANZCA in 1992 when the College began.

Iain and Alison and their four children (one died in infancy) then set off on the great OE (overseas experience), which took them first to Adelaide (1981) and then onto Oxford (UK) in 1982, where he was senior registrar in the Nuffield Department of Anaesthetics.

He became a very competent paediatric anaesthetist and developed an interest in regional anaesthetic techniques, especially for major orthopaedic procedures, that stayed with him throughout his career.

After European travels and a short experience in Saudi Arabia, Iain returned to New Zealand with his family, to take up an appointment as a specialist anaesthetist in Napier, Hawke's Bay, in 1983. He was just the fourth specialist in Hawke's Bay and one of only two based at Napier Hospital.

As the appointment was only part time, he joined the visiting staff of the private hospitals, Princess Alexandra in Napier and Royston Hospital in Hastings.

Iain worked in the public hospital system until 1996, contributing hugely to the modernising and development of the department, the delivery of operative anaesthesia, the establishment of a very successful obstetric service and the teaching of registrars. He was part of the intensive care team, an involvement that was, especially in the early years, onerous and stressful.

Iain was pragmatic, methodical and safe in his anaesthesia practice. He was technically highly skilled and patient outcomes were superb. He was an excellent practical teacher.

Iain found the pressures imposed on public practice overbearing and "retired" from the public system in 1996, continuing in private at Royston Hospital until his retirement from all anaesthesia at the end of 2008.

He became a foundation shareholder in Royston Hospital and was a valued member of the hospital medical advisory committee. He provided a leadership role for anaesthesia throughout the development and expansion of the hospital and especially its new theatre complex.

Iain was a private man, highly intelligent and widely read (astronomy, nautical history). He could be a stimulating and at times controversial conversationalist. He enjoyed a glass or two and a smoke.

He loved to sail and had a Whiting 29 based in Auckland for a number of years and more recently a Salar 40 motor sailor (Shannon) that was his pride and joy.

Iain's retirement dreams were cruelly denied him as, soon after he retired, his beloved wife Alison developed a brain tumour and died in May 2011. Iain nursed her through her fight and was inspirational in his dedication to her. During this difficult time he experienced symptoms of his own, which were ignored until Alison was laid to rest. His lung cancer was aggressive and advanced by the time of diagnosis and palliative treatment gave only temporary relief. Iain died peacefully on November 16, 2011 surrounded by his family and friends.

He will be missed – not only for his expert practice of anaesthesia and contribution to medicine in Hawke's Bay, but also for his friendship.

We extend our deepest sympathy to his children and their families.

Dr Trevor Mitchell, FANZA,
Hawke's Bay, New Zealand

Obituary

Professor Lucien Morris 1914 – 2011

One of ANZCA's longest standing honorary Fellows has died, two weeks before his 97th birthday.

Professor Lucien Morris was elected to honorary fellowship of the Faculty of Anaesthetists, RACS, in May 1989 and transferred to ANZCA honorary fellowship in March 1992 with the foundation of the College.

He was elected in honour of his interest in Australasian anaesthesia dating back to 1958 when he was one of the early Australian Society of Anaesthetists (ASA) Overseas Visitors (the first of many later American Overseas Visitors), and for his scientific contributions to anaesthesia, particularly his invention of the Copper Kettle anaesthetic vaporiser[1,2].

Lucien Morris was born on November 30, 1914, in Mattoon, Illinois, USA, and grew up in Cleveland, Ohio, where his father was head of biochemistry at the Western Reserve University until dying from tuberculosis when Lucien was 11. This event left the family in straightened circumstances, particularly during the Depression years, requiring Lucien to help out the family by selling his large stamp collection, working as a portrait photographer, and later earning money as a canoe guide in Canada and as a fencing coach, where his specialty was sabre.

He graduated from Oberlin College, Ohio, with a chemistry major in 1936, and an MD from Western Reserve University in 1943, during which he coached the Case Institute of Technology fencing team with some successful competitions with the "Big Ten Universities".

While teaching a graduate biochemistry class to earn money as a medical student, Lucien met Jean Pinder, whom he married in 1942. He often claimed this was his most successful enterprise. Jean accompanied him on his international visits and was well remembered in Australia and New Zealand from their numerous visits.

During his internship, the second half of which was in Madison, Wisconsin, he decided to specialise in anaesthesia after witnessing some poor anaesthesia options and techniques. He was advised to see Ralph Waters, then Chief of Anesthesia in Madison, and the first full-time academic anaesthetist in the world, who after an hour's interview offered Morris a training position.

This had to be postponed because of a call to military service during World War II, where he spent two-and-a-half years in the US Army Medical Corps, including a year in England as Head of Anesthesia and Operating Section for the 103rd General Hospital at Ludgershall, England.

Towards the end of the war he attended an anaesthetics review course at Oxford University organised by the Nuffield Professor there – Robert Macintosh. This was the start of life-long connections with many British anaesthetists.

After the war, Morris returned to Madison to work with Waters who was at that time re-evaluating chloroform as an anaesthetic agent as part of the centenary of its introduction. Morris complained about the inadequate vaporiser being used and Waters encouraged him to build a better one.

This led to the development of the Copper Kettle vaporiser[3,4] marketed by the Foregger Company for the next 25 years. Morris, along with others who worked with Waters in Madison, always spoke glowingly of his time there, and later constructed the Aqualumni Tree diagram[5] of the diaspora who emanated from Madison across the United States and further afield.

In 1949 Morris left Madison for the University of Iowa and from there to a full professorship in the University of Washington in 1954 in Seattle. He established the Anesthesia Research Laboratories and Heart Center in Providence Hospital, Seattle, after the University of Washington refused to honour their employing agreement with him for an independent department.

His next move was to the University of Toronto (1968-70) again to establish an anaesthesia research laboratory, and finally as founding Chair of the Department of Anesthesiology at the Medical College of Ohio in Toledo from 1970 until retirement in 1985.

Morris was also elected to fellowship of the Faculty of Anaesthetists, Royal College of Surgeons, in 1978, and awarded an Honorary DSc from the Medical College of Ohio, Toledo, in 1994.

Lucien Morris had wide interests within the broad field of anaesthesia, one of which was a dedication to low-flow anaesthesia[6-8].

There were many reasons for this interest in low-flow anaesthesia which all coalesced, particularly in the days before the ease of modern monitoring: his beloved mentor Ralph Waters was a devotee; the chemistry and physics of saturated anaesthetic vaporisation into the closed anaesthetic circuit; the easy demonstration of anaesthetic uptake from this circuit; and the ability to monitor closely the physiology of the patient using the concentrations in the circle system all appealed to his scientific mind.

Also the economy of gases and anaesthetic vapours, both financial and environmental, was attractive after his early frugal life experience.

It is perhaps ironic that the success of the Copper Kettle vaporiser indirectly led to the disenchantment of many anaesthetists with low-flow anaesthesia, because the vaporiser was able to produce very high toxic concentrations of anaesthetic within the closed circuit, unless the anaesthetist really understood the principles involved. Morris was also fortunate to work with Stuart Cullen on the use of xenon as a general anaesthetic, and was involved in the early studies on humans with xenon[9].

Lucien Morris was not only a famous anaesthetist, he was a first-rate scientist. Fastidious in the detail of research with an excellent grasp of chemistry and physics and also of biochemistry, physiology and pharmacology, he had a clear sharp logical mind, which was active to the end. His last publication was in 2011 on history[10].

Lucien was an intensely loyal friend who carried an excellent appreciation of the place of history within the specialty. He never forgot his mentors, and was a willing mentor of many others within the United States and around the world. ANZCA was proud to count him as one of our esteemed honorary Fellows.

Lucien Morris is survived by Jean, two sons and two daughters. Another son predeceased him.

Professor Barry Baker, FANZCA
Executive Director of Professional Affairs, ANZCA

References:

1. Morris LE
Anesthesiology 2006; 104(4): 881-4
Copper Kettle revisited.
2. Sands RP Jr, Bacon DR
Journal of Clinical Anesthesia 1996; 8: 528-32
The Copper Kettle: a historical perspective.
3. Morris LE.
Anesthesiology. 1952; 13(6): 587-93
A new vaporizer for liquid anesthetic agents.
4. Morris LE 1959 (June 16) (Original Filed October 30 1953)
US Patent No 2,890,696
Anesthesia Apparatus.
5. Morris LE
American Society of Anesthesiologists Newsletter 2001; 65(9): 21-24
Ralph M Waters' Legacy: the establishment of Academic Anesthesia centers by 'Aqualumni'.
6. Morris LE.
Anaesthesia & Intensive Care. 1994; 22(4): 387-90
The use of the Copper Kettle vaporizer in closed system carbon dioxide absorption anaesthesia.
7. Morris LE.
Anaesthesia & Intensive Care. 1994; 22(4): 383-6
Closed carbon dioxide filtration revisited.
8. Morris LE.
Anaesthesia & Intensive Care. 1994; 22(4): 345-58
Inspired humidity in anaesthesia breathing circuits: comparison and examination of effect of Revell circulator.
9. Morris LE, Knott Jr, Pittinger CB
Anesthesiology. 1955; 16(3): 312-9
Electro-encephalographic and blood gas observations in human surgical patients during xenon anesthesia.
10. Rao VS, Schroeder ME, Sim PP, Morris DC, Morris LE
Bulletin of Anesthesia History 2011; 29(3): 40-3
The University of Oklahoma: the first independent Academic Anesthesia Department.

Obituary

Dr Bruce Warren Gunner 1927 – 2011

Warren was born on November 9, 1927 in Mosman. His senior schooling was at North Sydney Boys High and following the leaving certificate he won an exhibition to Sydney University graduating in medicine in 1951.

Following residency and registrar training at Royal Newcastle Hospital (in company with his lifelong friend Brian Pollard) Warren and his new bride Helen travelled as ships surgeon to the Nuffield Department of Anaesthetics in Oxford where they spent two years, following in the footsteps of Brian Dwyer. Warren met Helen when she was a theatre sister in Newcastle and it was there they began their life-long journey of love and companionship. To make ends meet in Oxford, Helen worked in the adjacent eye hospital in the theatres.

In 1959 Warren was appointed Director of Anaesthesia at the Adelaide Children's Hospital but after one year, wanting to return to Sydney, took the position of Deputy Director of Anaesthetics at St Vincent's working with the recently appointed director Brian Dwyer. Together they were to form a dynamic and leading department which due to their stewardship is now one of the leading departments in the country.

At this point in time recovery units were absolutely basic, cardiac surgery was in its infancy and intensive care units were unheard of. Warren played a pivotal role in all of these. Painstaking work in the animal laboratory and then the excitement of the first open heart surgery performed at St Vincent's in 1960. Warren and Brian Dwyer ran the perfusion and John O'Leary was the anaesthetist.

Slowly the anaesthetic and surgical community came to the conclusion that if patients with critical medical conditions or following major surgery were to survive, then a special physical facility need be established. After overcoming many obstacles the first intensive care unit was born in 1968 with Warren as Director of Resuscitation and Intensive Care. In the years preceding its formal recognition, the fledging unit was run by both Brian and Warren.

Warren then spent the next three years developing the unit and teaching the new discipline to the nursing and medical staff. It must be remembered it was a case of flying blind as there was sparse literature and few colleagues to consult with. In 1971 Warren resigned to take up the position of Medical Director with Pfizer where he stayed for a number of years. He did however maintain his attachment to the hospital and in later years returned to his original art of giving anaesthetics.

Bob Wright took over the directorship of the unit in1971 and is still in that position. Warren still maintained interest in the new unit and visited Bob and discussed the many clinical issues. On reflection Bob found these discussions invaluable.

In spite of his illustrious professional career Warren's main love was for his wife Helen and his beautiful girls Christina and Anne. My wife Mary Rose and I have had a close association with the family for many years, with Mary Rose working with Warren in the Cameron Wing in the early sixties. Both living in Roseville, Warren would often drive her to work and Mary Rose would on occasions baby sit Christina and Anne.

Both girls were high achievers, medical graduates and practitioners of the highest regard. It was a cruel and unexpected blow to the family with the sudden death of Christina a few years ago. The girls were the apple of Warren's eye and the affection was always returned with passion. He of course doted on the grandchildren (Matthew, Grace, Rebecca and Lucy) and his family was the epicenter of his life.

Both Helen and Warren had a great love of travel even when Warren's health was rapidly failing. Having travelled extensively in the past, of recent years they became very fond of sea travel because of the convenience of not having to pack and unpack. Warren in a wheel chair was no problem to Helen and with determination they would go. When Helen would join the various shore excursions, Warren would stay on board and entertain the remaining passengers. Mary Rose and I would say that they would never make the trip, and not only did they make it but were already making arrangements for the next one. It was only a few months ago that I asked Warren what was on the agenda going forward and he suggested Berlin was the next possibility.

In times of sorrow it's good medicine to have a good laugh and Helen and I did so recently. We related our experiences in San Francisco and other destinations and found them a great consolation. Of recent months the care Helen gave to Warren was just marvelous. Nothing was a bother and as he weakened she never gave up. Looking back I am sure she will be so grateful she was able to have this time with him in the sure and certain knowledge that she did everything that was humanly possible to make him comfortable.

One of the greatest privileges of my life was in 2009 when Warren rang to ask me if I would be his sponsor for his entry into the Catholic Church. I think he was always a catholic and in spite of often pulling Helen's leg over religion was always totally supportive and understanding. A small intimate ceremony was held in St Therese of the Child Jesus, Beauty Point and we then retired to the automobile club for lunch. Warren also loved St Vincent's and its people. He always tried to attend the alumni and it was only in the last couple of years that ill health overcame him.

To Helen, Christina, Anne, the grandchildren, sons in law you can be justly proud of your husband, father and grandfather. He loved you all intensely and he will always be in our prayers.

Dr Anthony Williams,
FANZCA

Obituary

Dr Dianne Margaret Cole 1968 – 2011

Originally serving as a police officer for the Queensland Police Service, Dr Dianne Cole completed a Bachelor of Biomedical Sciences from Griffith University in 2004, and a Bachelor of Medicine/Bachelor of Surgery from the University of Queensland in 2008. Colleagues who went through medical school with Dianne called her "Dynamic Di", paying homage to her ability to multitask, her amazing preparedness for tutorials and enthusiasm for her medical studies.

Dr Cole began training in anaesthesia in February 2011, commencing as an anaesthetic registrar at the Mater Adult Hospital, Brisbane. Although only being a doctor for two years before this, right from day one Dianne impressed us all with her personal qualities – qualities that we all strive for as doctors.

In her approach to her work and study, she was thorough, organised and confident. She had the ability to think laterally and to bring together different concepts. This, combined with her focus and determination, meant she was well on track to passing the primary examination.

To her patients she was personal, humane and empathetic.

She was well regarded by all her colleagues, and knew everyone by name. When the situation required, she could be forthright and direct. While she had a fairly serious persona at work, Dianne would occasionally surprise everyone in the theatre with a dry, sardonic comment in her "policewoman" voice – only to break out in one of her wide, teeth-flashing smiles when she realised that she'd fooled us all!

Dianne had been on sick leave for the second half of 2011. During that time, Dianne's absence from work was noticed, and I was frequently asked after her. There was widespread excitement and relief that Dianne's health had improved and that her return to work was imminent. Despite all the pain she experienced over the past six months, Dianne was determined to return to work and to overcome the formidable administrative barriers that lay ahead.

Sadly, Dianne took her own life on December 22. Only after her death, did her colleagues learn of her long-term struggles with mental illness. Our hearts go out to her husband, Brian, and three children.

Our sadness at her passing is matched by our sadness of her unrealised dreams, just as they were starting to take flight. Dianne's untimely death is a reminder to us all to cherish and celebrate what we have today, to strive for our dreams, and to support and nurture our colleagues.

Dr Mark Young, FANZCA
Regional Education Officer, Queensland.

Dr Cole's family requests that any gifts be made to beyondblue in memory of Dr Dianne Cole. Fellows may donate online at www.beyondblue.org.au.

Doctors welfare

If you are concerned about yourself or a colleague, contact the Doctors' Health Advisory Service Hotline nearest to you.

Australia:
New South Wales/Northern Territory +61 2 9437 6552
Australian Capital Territory +61 407 265 414
Queensland +61 7 3833 4352
Victoria +61 3 9495 6011
Western Australia +61 8 9321 3098
Tasmania 1300 853 338
South Australia +61 8 8273 4111

New Zealand: 0800 471 2654

Information about the Welfare of Anaesthetists Special Interest Group can be found at: www.anzca.edu.au/fellows/special-interest-groups