

September 2011

ANZCA BULLETIN



FPM
FACULTY OF PAIN MEDICINE
ANZCA

**Welfare issues:
Helping doctors
in need**

**PLUS:
ANZCA CURRICULUM REVISION 2013:
WORKPLACE-BASED ASSESSMENTS
ON TRIAL**

10 Spotlight on SA/NT

A special report on anaesthesia in South Australia and the Northern Territory.



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 more than 4500 Fellows across Australia and New Zealand and serves the community by upholding the highest standards of patient safety.

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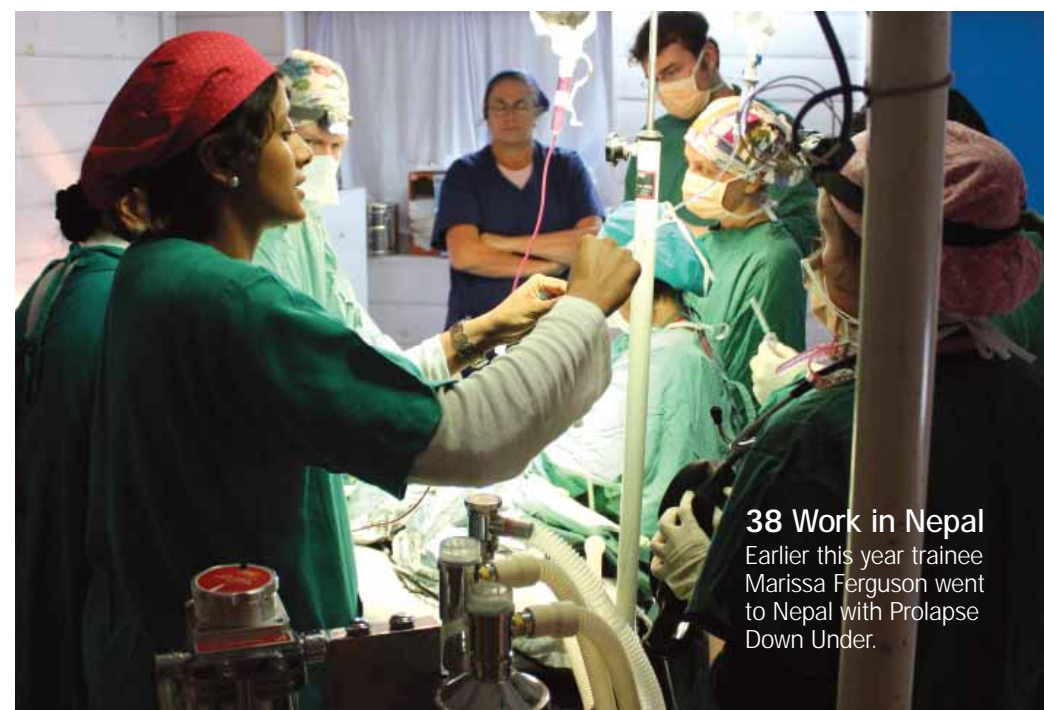
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President's message



Welcome to the September 2011 *ANZCA Bulletin*. In this edition, I would like to highlight “What’s new?” at the College: our new ANZCA CEO, our new ANZCA website and our new ANZCA curriculum.

Our new ANZCA CEO

Early in August, I had great pleasure in announcing the appointment of Ms Linda Sorrell as the new Chief Executive Officer of ANZCA.

For the past four and a half years, Linda has been the Chief Executive of Melbourne Health (an area health service in central Melbourne) during which time she was awarded Telstra Victorian Business Woman of the Year (2007). Prior to this appointment and since 2004, Linda was the Chief Executive of Southern Health, the largest metropolitan health service in Victoria, based around the Monash Medical Centre in Melbourne.

Before moving to Victoria, Linda worked in executive positions in a variety of hospital, network and government settings in New South Wales, covering both clinical and corporate aspects of healthcare.

Linda is passionate about education and has a proven track record in engaging stakeholders to improve quality and safety. Her nursing background has given her a sound understanding of patient care and the work of anaesthetists and pain medicine specialists. She holds a masters of health administration, a graduate certificate in casemix and a bachelor of health services management.

Linda is a highly qualified executive, with nearly 20 years’ experience in high-level management positions in the healthcare sector. She is recognised for her relationship and communications skills, along with innovation and strong business acumen.

Linda commences her new role on September 19 and a detailed profile can be found in this edition of the *ANZCA Bulletin* on page 9.

Our new ANZCA website

The ANZCA website is the main point of interaction with the College for many Fellows and trainees. In September we launched our new ANZCA website, which has been redesigned and reinvigorated to increase its ease-of-use and usefulness for Fellows, trainees and the community at large. This follows a major project undertaken by ANZCA’s Communications and IT units in consultation with ANZCA management, Fellows and trainees.

The content in most areas has been reviewed and updated and I am sure you will find the new website more attractive and easier to navigate through its more logical layout and stylish design.

In keeping with one of our key strategies to “Enhance the level of support provided to our Fellows and trainees in the areas of quality and safety”, we now have a new, improved quality and safety section of the website.

Another of our strategic goals is to “Increase the engagement of the College’s members and the interaction with key external stakeholders” so we have included an improved “Fellows” area listing a number of ways that Fellows can get involved with their College. The new “Patients” section provides our patients with a wealth of sensible and easily understood information about anaesthesia.

You will still find the most widely-read sections of the website easily, including the ANZCA CPD program, on-line journals and professional documents. We welcome any feedback on the new website to communication@anzca.edu.au.

Our revised ANZCA curriculum

Work on the ANZCA Curriculum Revision 2013 project is proceeding apace, with increased involvement of ANZCA's committees and supervisors of training, and relevant tripartite special interest groups (SIGs).

Learning outcomes for each of the ANZCA clinical fundamentals and specialised study units have now been drafted, and these have been widely circulated. The learning outcomes outline the general objective of the unit, as well as the objectives in each of the ANZCA roles during introduction to anaesthesia, basic and advanced training. For example, for the airway fundamental, the draft general objective is that "By the completion of this fundamental the trainee is expected to be competent in advanced airway management and be a resource for teaching airway management skills." The learning objective then expands on what should be achieved in terms of airway skills during each period of training in each ANZCA role (that is, medical expert, communicator, scholar etc).

The next large projects are to complete the volume of practice requirements for each core and specialised study unit, and to develop illustrative teaching cases for use by supervisors and trainees. The Curriculum Redesign Steering Group is being assisted in this work by volunteers from the Curriculum Authoring Groups. Finally, the work of mapping the assessments to the curriculum will begin shortly.

Meanwhile, the project managers have begun the work of sourcing e-portfolio and logbook solutions for supervisors and trainees to record progress through the training program. In addition, the communications process has begun via meetings with regional and national committees and with supervisors of training.

On the assessments front, workplace-based assessments are being tested at several centres. The tools to be used are the mini Clinical Evaluation Exercise (mini-CEX), direct observation of procedural skills (DOPS), case based discussion (CBD) and multi-source feedback (MSF). In this edition of the *Bulletin*, you'll find an article on workplace-based assessments and the work of the Workplace-based Assessments Committee on page 20.

Conclusion

As you can see, there is plenty going on at the College and all over Australia and New Zealand, in terms of progress in training and continuing professional development. Many thanks once again to all those Fellows and trainees who are engaged in these activities.

Professor Kate Leslie
ANZCA President

How are we going with "ENGAGE"?

Embrace new training environments

- Twenty-eight Australian training posts in expanded settings (private, rural) for 2012

Negotiate and influence people

- Initial submission to the Australian Health Practitioner Regulation Agency (AHPRA) regarding the definition of "practice"
- Ongoing involvement in Australia's e-health rollout with the National E-Health Transition Authority (NEHTA)
- A wide-ranging advocacy strategy developed by the New Zealand National Committee

Get involved

- 100 per cent of Fellows have enrolled in ANZCA's Continuing Professional Development program

Advocate quality and safety

- Six new or revised professional documents promulgated to date in 2011

Give your support

- Fifteen applicants for the international scholarship to upskill anaesthetists from neighbouring nations in New Zealand and Australia

Educate yourself and others

- Thirty 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
- Record participation in the recent ANZCA Trials Group annual strategic workshop, regional combined meetings in NSW, Victoria and WA, and at the Rural SIG meeting in the Barossa Valley

Linda Sorrell – ANZCA's new chief executive officer



A keen interest in education is one of the key factors that drew Linda Sorrell to her new role as ANZCA's chief executive officer.

"I have always had an interest in education no matter what organisation I have worked in," said Linda, who joined ANZCA on September 19. "I put a fair amount of effort into developing people."

Linda has nearly 20 years' experience in high-level management positions in the healthcare sector in Victoria and NSW.

She comes with a reputation for "fixing" organisations but is quietly confident there is not a lot that needs fixing at ANZCA. "It has a very good reputation," Linda said. "That's another thing that attracted me to this role."

Linda was most recently chief executive of Melbourne Health, which covers about one-third of metropolitan Melbourne's population and provides services to regional and rural Victorians.

She dramatically improved the financial performance of that organisation and at Southern Health, the largest metropolitan health service in Victoria, where she was also the chief executive.

As acting chief executive officer at the Southern Area Health Service in NSW, similar issues were faced by Linda, who has also worked at the Illawarra Area

Health Service in NSW as deputy chief executive officer.

But Linda is quick to point out that improving the financial situation at each organisation is just part of the picture.

At Melbourne Health, she is proud of the cultural change program she instigated. She targeted the training and development of staff that included management training, customer service training for those on the frontline, values and behaviours workshops, financial literacy training and safety training.

"When you put people in positions at an organisation you can't assume that they know what to do," she said.

At Southern Health she adopted lean methodology to redesigning services and processes which recognises that the root causes of problems need to be addressed in order to find a solution. She brought this method to Melbourne Health where improved sustainability and effectiveness of departments resulted.

Under Linda's leadership, Southern Health was awarded the Outstanding Metropolitan Health Service of the Year by the Premier in 2005 and won the Victorian Australian Human Resources Institute Excellence in People Management Award for Large Not for Profit Organisations in 2005 and 2006.

In 2007, Linda won the Telstra Victorian Business Woman of the Year after being jointly nominated by Southern Health and Melbourne Health.

"It was not just what happened financially," she said. "It was for developing strategies, culture and values in big organisations – broad achievements around planning and clinical services."

Before moving to Victoria, Linda worked in executive positions in a variety of hospital, network and government settings in NSW, covering both clinical and corporate aspects of healthcare.

She believes her former career as a nurse prepared her well for her roles in health management.

"Nurses are good at managing their day – managing patients and managing workloads," she said. "In nursing, like medicine, you can't leave it until tomorrow."

However, wanting to learn more, she completed a bachelor of health services management, did further studies in casemix and a masters of health administration.

Linda said she hoped to get up to speed fairly quickly at ANZCA, getting to know the people in the organisation and developing a good understanding of the training program and the revised curriculum and any challenges facing the College.

Having worked at multi-site organisations – Southern Health alone had 48 – she is aware of the need to embrace areas beyond head office and encourage all to be involved in the future vision of the organisation.

She says emotional intelligence is a key part of her style as a leader. She aims to be decisive but inclusive of people's views and respectful of the organisation and the people in it. "I think I have good communication skills and certainly will do a lot around strategic planning and setting directions," she said.

Outside work, Linda enjoys dancing and fitness. A regular gym-goer, she also walks every morning before work.

Clea Hincks
General Manager Communications,
ANZCA



ANAESTHESIA IN SA/NT

SPECIAL REPORT: HEALTH REFORM AND ANAESTHESIA DEVELOPMENTS IN SOUTH AUSTRALIA AND THE NORTHERN TERRITORY

In this issue of the *ANZCA Bulletin* we continue our series on anaesthesia in state and territory jurisdictions, focusing this time on South Australia and the Northern Territory.



ANAESTHESIA ALONG THE GHAN: FROM GULF ST VINCENT TO THE TIMOR SEA



DR THIEN LECONG, FANZCA CHAIR, SA/NT REGIONAL COMMITTEE

I am Gen X.

I grew up with video games, glasnost, and Gordon Gekko. I exhibit a quiet disdain for corporate authority and my favourite saying is “Yeah, yeah, whatever”. When I was asked to organise some articles highlighting anaesthesia in the South Australian/Northern Territory (SA/NT) region, my typical Gen X reaction was... well... nothing really interesting happens in our region.

How wrong I was.

THE SA/NT REGION

The SA/NT region covers 2.3 million square kilometres and, similar to Western Australia, includes some of the most arid, inhospitable and sparsely populated regions of the country. The spectacular mineral and geographical wealth of the region, such as Lake Eyre, Uluru, and the Kimberley, serve as a counterpoint to the challenges of providing health care to some of the most remote and disadvantaged communities in the nation.

South Australia was established as a colony in 1836 and is the only Australian state to be settled entirely by free settlers. The Northern Territory was added to South Australia in 1863 and was governed until 1911 when administration was relinquished to the Commonwealth Government. The physical link between Adelaide and Darwin was only fully realised in 2004 with completion of the Adelaide-Darwin Railway. Not only did this allow the

iconic “Ghan” train service to complete its journey from south to north but it also links the population centres on the current SA/NT rotational training scheme. You can literally visit all of the SA/NT trainees by taking a single 48-hour train trip starting in Adelaide.

ADELAIDE

Adelaide is a moderately sized city of about 1.2 million people that represents about 70 per cent of the population of SA and sits nestled between the Mount Lofty Ranges in the east and the waters of Gulf St Vincent in the west.

In 2007, as part of a general overhaul of health services, three hospitals were designated by the state government as the healthcare centres for the central, southern, and northern area health networks. These are, respectively, the Royal Adelaide Hospital, Flinders Medical Centre, and the Lyell McEwin Hospital. The Women’s and Children’s Hospital would continue to be the major paediatric and obstetric referral centre for the state, however Modbury Hospital, the Queen Elizabeth Hospital, and Noarlunga Hospital would see significant restructuring of services. Along with these changes, a new Royal Adelaide Hospital would also be built on a new site in the west of the CBD.

These sweeping changes to services have, to a greater or lesser extent, impacted on departments of anaesthesia in all the metropolitan hospitals. Anaesthesia continues to be represented and engaged with government in South Australia at various levels.

In 2008, anaesthetists in South Australia were instrumental in uniting and placing significant industrial pressure on the government during protracted but ultimately successful enterprise agreement negotiations for salaried medical officers. Never has the often misquoted west African adage “speak softly and carry a big stick” been more powerfully demonstrated than during this period of united action.

In terms of individual anaesthesia departments, space does not allow me to mention all the interesting things going on, therefore I will only present a couple of examples.

(continued next page)

ANAESTHESIA IN SA/NT CONTINUED



Flinders Medical Centre (FMC) has, for the last couple of years, pioneered a highly successful collaboration between private and public anaesthetists to provide a neurosurgical training module to trainees. On many levels it has been of benefit to trainees, not only in terms of completing a module that was previously not available at FMC but also in exposing them to a different work environment. Feedback from the private anaesthetists has been positive.

The Lyell McEwin Hospital provides a bi-annual general practitioner (GP) anaesthetist refresher course. This highly successful course is always well subscribed in advance and allows GP anaesthetists from around the region to receive continuing medical education. It also develops links with doctors who are often the first providers of acute care in smaller, isolated regional centres.

The Royal Adelaide Hospital continues to be engaged at multiple levels, from the complex planning involved with building a new hospital to its strong commitment to acute and chronic pain research and teaching. Of note would be the growing interest in regional anaesthesia with the development of a fellowship program and the organisation of an annual regional anaesthesia workshop.

I could go on for another couple of pages but it's now time to get on the train and travel 1500-odd kilometres and 24 hours north to Alice Springs.

ALICE SPRINGS

Alice Springs is a town with a variable population of around 40,000 and sits within the MacDonnell Ranges, straddling the dry Todd River.

Alice Springs Hospital is the most recent hospital added to the SA/NT rotation for trainees and exposes the trainees to the challenges of remote anaesthesia and interacting with indigenous Australians.

Dr Jacob Koshy is the new Director of Anaesthesia and faces the constant challenges of service provision in isolated areas and maintaining a stable workforce. Despite this, the majority of trainees who have rotated through have found the experience valuable to their training.

Another 1500-odd kilometres and 24 hours further north the train ride ends in Darwin.

DARWIN

Darwin is a city of approximately 125,000 people situated on the shores of the Timor Sea. It is closer to the capitals of East Timor, Indonesia, and Papua New Guinea than it is to Canberra.

Dr Brian Spain is the Director of Anaesthesia and struggles with similar challenges to Alice Springs. Being the major referral hospital for the Northern Territory, trainees get to see an incredible spectrum of morbidity compared to the southern states and a high workload. All trainees find the Darwin rotation valuable and enjoyable.

In addition to service delivery and training, Brian and his staff manage to convene the odd continuing medical education (CME) meeting, conduct remote anaesthesia courses, participate in medical aid trips to East Timor and Indonesia, and assist in "Closing the Gap" initiatives in Gove and Katherine Hospitals. On a per capita basis, Darwin punches well above its weight.

SA/NT ACTIVITIES

Two longstanding traditions in SA are the "long" part 1 and part 2 examination preparation courses supported by ANZCA and provided at no cost to trainees.

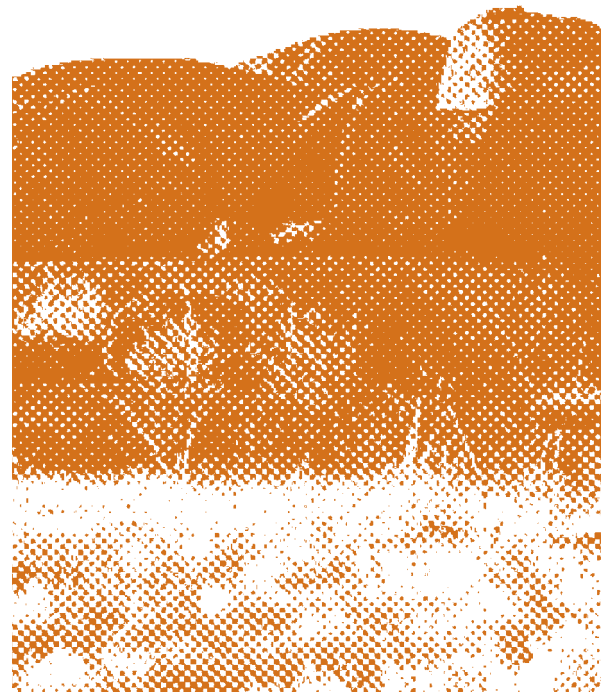
They are unique in that they involve Fellows from all the metropolitan anaesthesia departments facilitating teaching of the part 1 and part 2 syllabi throughout the year. In particular, College records note the inaugural part 1 course in SA in 1971 and this has continued for the last 40 years which is an amazing achievement. We are exploring options for extending involvement of trainees to Alice Springs and Darwin via videoconferencing.

Along with the usual regular CME meetings throughout the year, every three years we convene a major meeting funded by the Burnell Jose Fund. This fund is unique in that its purpose is to allow a visiting speaker to travel around the region and thus benefits the majority of Fellows in the region.

Finally, I have to acknowledge Jodie Cottrell who is our regional co-ordinator and is the heart and soul of ANZCA operations in the region. If not for her work and dedication, many of the achievements in the SA/NT region would not be possible.

I hope that the above has achieved its goal of providing a very brief snapshot of the SA/NT region and a taste of the challenges and achievements of Fellows in the region.

By necessity I have had to be fairly generic in the above discussion, however, as you read through the following articles, keep in mind that they would be typical of contributions from Fellows found in every region, often at their own expense in terms of cost and time and for very little recognition. We are the College, you only need to scratch the surface to understand why.





*From left: Modbury Public Hospital;
Queen Elizabeth Hospital.*

CONTINUING THE TRADITION – THE SA PART 1 LONG COURSE



DR CHRISTINE HUXTABLE, FANZCA PART 1 CONVENOR



DR LIZ CHYE, FANZCA PART 1 CONVENOR

The SA Part 1 Long Course continues a tradition dating back to 1971. It is designed to foster learning in a relaxed environment away from the public teaching hospitals.

The course is run weekly on Wednesday afternoons. Attendance is voluntary and always well supported by our hospital departments. Our registrars can request to be rostered off on Wednesday afternoons to attend and this time is usually not only granted but also often paid. The course is open to all anaesthetic registrars pre-part 1 and intensive care unit (ICU) registrars who are planning to sit the FANZCA part 1 exam.

Over the 44 weeks that make up our calendar year (we take a Christmas break) we cover the majority of the syllabus. Depending on the complexity (and weighting from previous exam inclusion), we cover a pre-defined topic each week. Some sections take multiple weeks to complete; others (those rarely examined or particularly straight forward) are completed in a single session. In the “pre-exam” weeks we incorporate additional sessions looking at exam technique – short-answer questions (SAQ), multiple choice questions (MCQ) and viva.

We do not aim to comprehensively discuss or teach the entire syllabus. Learning is largely self-directed. The registrars who regularly attend are

rostered to direct each afternoon and are expected to know what is interesting, controversial or often asked about their topic. This is what we focus on. An anaesthetic consultant (public, private or academic) is also rostered to each session as a facilitator. Their role is that of expert – to field questions and clarify, if possible, points of contention. This involvement is entirely voluntary which ensures a degree of knowledge and enthusiasm.

This course is not intended to be a simple “part 1 lecture course”. SA has a rotational registrar program. Our registrars move between six metropolitan hospitals, Darwin and Alice Springs (temporarily suspended). The period of attachment varies between one and 12 months. This natural movement means that some find it difficult to form study groups and even friendships along the way.

Our course provides the opportunity for the regular meeting of all trainees during their exam preparation in addition to providing a forum for asking questions, meeting the College staff and consultants on a less formal basis and addressing the occasional problem be it personal or with training.

Enthusiasm for the course waxes and wanes but is now high. Our registrars are participating with a degree of enthusiasm that ensures a high quality product and a great return on their investment.



ANAESTHESIA IN SA/NT CONTINUED

DIVING PARAMEDICS COURSE POPULAR



**DR CHRISTOPHER J ACOTT, FANZCA
COURSE SUPERVISOR**

The Diver Medical Technicians' Course conducted by the Royal Adelaide Hospital's (RAH) Hyperbaric Medicine Unit is 25 years old. The course was originally started by the original head of the unit, Dr (now Professor) Des Gorman, in 1986.

The course's aim is to train professional divers to become "first responders" in the management of a diving or any accident in an isolated environment (for example, a diving platform or oil rig). It is one of the few recognised courses by International Marine Contractors Association (IMCA). The course has proven to be very popular and now has a waiting list of greater than 12 months.

The course is three weeks, 10 divers are trained per course and there are two courses per year. More than 500 divers have been trained as "diving paramedics" or diving medical technicians (DMTs) so far. Although the course was originally developed for the commercial diving industry it has become popular among diving instructors in the recreational diving industry. It has three components:

- occupational first aid (one week);
- a clinical attachment (three weeks beginning in the occupational first aid week); and
- a lecture program (one week).

The clinical component consists of simulation training and direct patient contact in the accident and emergency department, the operating theatres, recovery and day surgery.

Participants are taught airway skills, basic resuscitation techniques, intravenous cannulation, needle aspiration of a pneumothorax and a basic preliminary examination of an injured patient. Every participant has a log book so that each clinical task can be signed off.

The lecture program concentrates on decompression physics and physiology, management of decompression sickness and the injured patient, resuscitation, physiology and anatomy of the cardiovascular, respiratory and neurological systems.

IMCA requires that the DMTs do a refresher course every three years. The RAH runs two to three refresher courses per year depending on the clinical anaesthesia commitment of the course lecturers. The refresher course runs for two weeks and has an occupational first aid and clinical component.

All commercial saturation divers have to be trained as a DMT. A saturation diver is a specialised diver who lives and works under pressure (between 200-300msw) breathing a gas mixture of helium, nitrogen and oxygen.

The time spent under pressure is usually about a month, one week of compression to the required working depth (pressure), two weeks of working and one week of decompression.

During this time the divers are isolated and if one becomes ill/injured the other divers are responsible for the medical care (with guidance from a medical practitioner trained in diving medicine) of the ill/injured diver. This may involve insertion of an intravenous cannula and nasogastric tube, the administration of antibiotics and analgesics as required.

For example, the management of acute appendicitis while pressurised would be intravenous fluids, intravenous antibiotics, analgesics and the placement of a nasogastric tube (for example drip and suck technique).

The course has evolved over the past 25 years, being responsive to feedback and the requirements of the commercial and recreational diving industries.



Above from top: The original Recompression Chamber at the RAH Hyperbaric Medicine Unit; The other Hyperbaric Chamber at the RAH Hyperbaric Medicine Unit, which is used for medical hyperbaric oxygen treatments.



From left: Royal Adelaide Hospital; Grove District Hospital.

TRAINEE WELFARE INITIATIVE KICKS OFF IN SA AND NT



DR MARION ANDREW, FANZCA
REGIONAL TRAINEE WELFARE OFFICER,
SA AND NT

Anaesthetic trainees aged under 30 have been identified as a high-risk group for burnout^{1,2}.

Anaesthetic training inevitably contains periods of stress from concurrent internal and external sources, requires the ability to maintain perspective and a degree of physical and mental resilience. Some stress has been shown to enhance performance but ongoing stress leads to distress, and if prolonged to impairment.

The majority of trainees deal well with stress, perform at a high level, and achieve academic success without incident, while others, despite similar academic credentials, encounter significant problems.

The tragic suicide of one of our South Australian trainees in 2009 brought the issue of trainee welfare sharply into focus. This sad outcome was discussed at a special meeting of the Regional Education Sub-Committee in November 2009 where the committee recognised the vulnerability of trainees, especially those who are separated from family or marginalised from their peers.

A decision was taken to accept the responsibility to promote trainee wellbeing and to plan and implement the SA and NT Trainee Welfare Initiative (SANTTWI).

Under the leadership of the regional welfare officer, departmental welfare representatives have been recruited in the regional training hospitals. The SANTTWI guidelines are now under review by the Regional Education Sub-Committee and the Welfare of Anaesthetists Special Interest Group. Major challenges include clearly defining roles and limitations, establishing effective communication strategies, and confidentiality.

The underlying principle for welfare support has been the recognition that as adults, trainees are primarily responsible for their own welfare. The major goal of SANTTWI is the creation of an easily accessible and visible system for trainees to seek or be offered confidential unbiased support.

SANTTWI has a strictly non-therapeutic role but seeks to help trainees access appropriate resources before impairment or crisis occur. The initiative is in no way designed to replace established mentoring roles.

SANTTWI has been warmly welcomed by the SA and NT Rotational Trainee Committee and feedback from trainees receiving support has been very positive. The trainee welfare initiative is still in its infancy but is learning and growing as it seeks to foster healthy perspectives in our trainees.

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1. Nyssen A.S., Occupational stress and burnout in anaesthesia BJA 2003; (90:333-7)
2. Kluger M.T., Townsend K, Laidlaw Job satisfaction, stress, burnout in Australian specialist anaesthetists. Anaesthesia 2003 58:4;339-345

Further reading

ACECC Review Resource Document 08 (2011) Welfare of Anaesthetists: Mentoring and Peer Support Programs.

Trainee in Difficulty Handbook (Directors of Clinical Training) SA iMET.

Drug and Alcohol Abuse amongst Anaesthetists-guidance on identification and management.



ANAESTHESIA IN SA/NT CONTINUED



REAL-WORLD ANAESTHESIA IN DARWIN



**DR PHIL BLUM, FANZCA
ROYAL DARWIN HOSPITAL**

We are all very comfortable in the western world. You wonder during a quieter moment in theatre whether it is time to upgrade your perfectly functioning iPhone 3S for the new 4. Everyone seems to have a "4" now. We live and work in our insulated little world, generally unaware that we are the privileged minority.

Eighty per cent of the world's population live on less than \$US10 a day. Clean water is difficult to obtain. Starvation is often just one poor harvest away. Ninety-nine per cent of all worldwide obstetric mortality occurs in the developing nations. For every child that dies of pneumonia in the developed nations, 2000 children will die of pneumonia in low and middle-income countries for want of antibiotic and oxygen.

This reality is the "real world".

It is said there are three types of people that choose to work in Darwin: missionaries, mercenaries and misfits. It is often hard to judge the motives of your fellow colleagues but many working in the anaesthetic department at Royal Darwin Hospital do describe a deep sense of social justice.

Almost 50 per cent of our patients are indigenous Australians. Their life expectancy and disease profile are similar to many African countries. Darwin is also on the edge of south-east Asia. Our nearest capital city is Dili, Timor Leste. Many in the department regularly travel to our northern neighbours to lend a hand. Dr Brian Spain was instrumental in starting nurse anaesthetist training in Timor Leste and recently completed a sabbatical in Siem Reap, Cambodia.

Dr Phil Blum has travelled yearly over the last decade to Indonesian and Timor on plastics visits predominately doing cleft repair and burn reconstruction. Dr Suzie Nou just spent more than two years in Suva, Fiji and Siem Reap. Dr Andrew Fenton did Pacific fellowships in Suva. Dr Helge Suhr has recently returned from his second working trip to Uganda. Finally, Dr Andrew Mitchell has spent time working in Samoa.

It is no surprise then that Darwin has now hosted three Real World Anaesthetic Courses (RWAC) convened by Dr Blum. The popular course was initially begun in Tasmania by Dr Haydn Perndt and Dr George Merridew in 1999 and was run for the first time out of Tasmania in Darwin in 2004.

Initially called the Remote Situations, Difficult Circumstances, Developing Country Anaesthesia Course (RSDCDCCA) the name was shortened in 2009 to the more manageable RWAC. The 20th RWAC was just held in Christchurch, New Zealand by Dr Wayne Morriss. Dr Chris Bowden in Frankston, Victoria is the third convener for the RWAC. The aim is to run the course triennially in each centre.

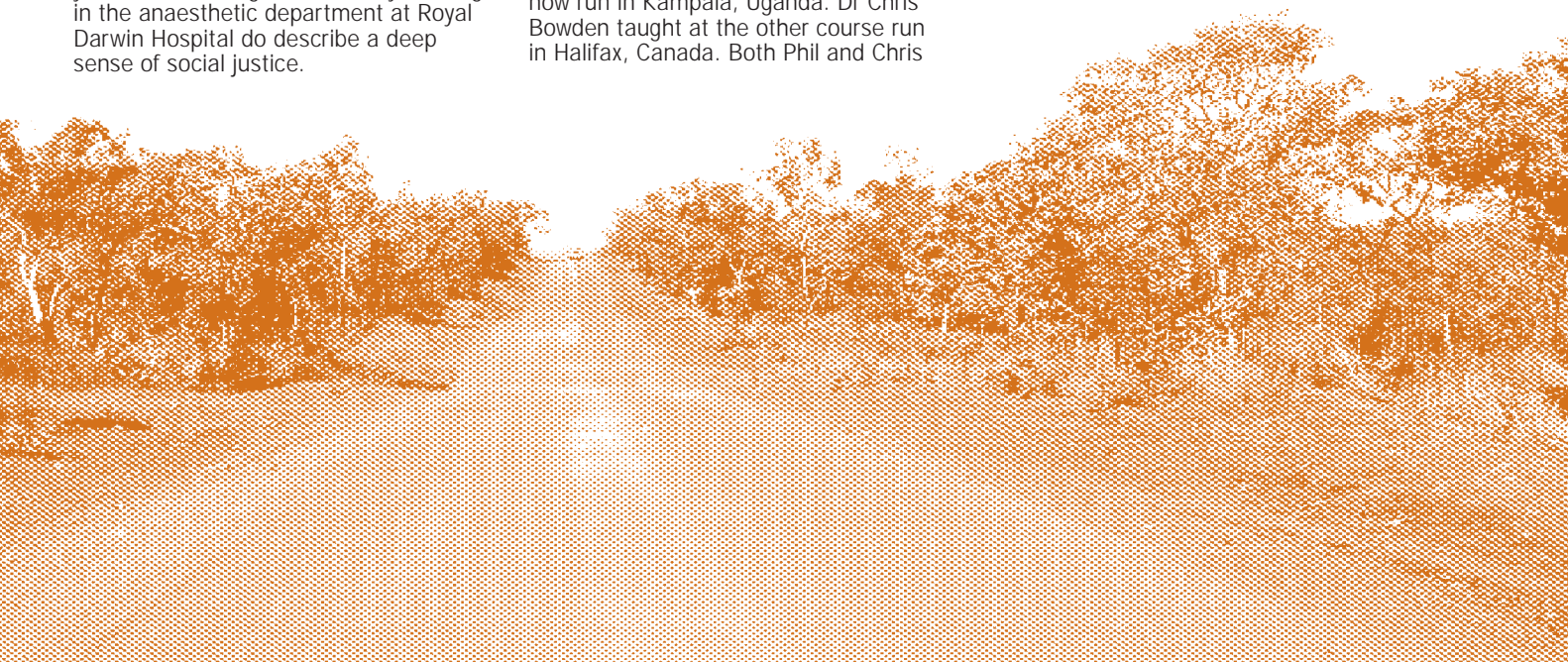
There are only two other similar civilian courses run around the world. Dr Blum recently taught at the Oxford course, now run in Kampala, Uganda. Dr Chris Bowden taught at the other course run in Halifax, Canada. Both Phil and Chris

have realised just how internationally unique the hands-on Australasian RWAC is. There is great international interest to secure positions on our course.

So what is RWAC all about? Many Australasian anaesthetists have provided anaesthetic services and teaching for long- and short-term missions in austere environments. Often thrown into the deep end, it was a matter of learning on the job and hoping not to make too many mistakes.

Haydn and George had an idea of a course that could help prepare Australian-trained anaesthetists to work in the unfamiliar, resource poor, real world. How do you anaesthetise when there is no pipeline or cylinder oxygen? What is drawover and how do you do it? How do I unstick a TEC 3 halothane vaporiser? How do I service an oxygen concentrator? How do I repair that big leak in that ancient Boyle's machine? How do I clean/sterilise that re-useable LMA for the next case? Should I be using LMAs here? What should I do if I catch malaria? Should I teach spinal anaesthesia for caesarean sections when they are all now under GA? Can you resterilise spinal needles? Should I resuscitate that new born with a severe gastroschisis? Why do I feel like I've had enough, three months into a two-year mission and what should I do about it? These are the sort of practical questions that the course attempts to answer.

Teamed with the National Critical Care and Trauma Response Centre based in Darwin, the Royal Darwin Hospital Anaesthetic Department is poised to become an international centre for humanitarian aid and disaster management teaching.





From left: Royal Darwin Hospital; Calvary North Adelaide Hospital.

ANAESTHESIA, RETRIEVAL AND OUTREACH INTENSIVE CARE IN SA



**DR TONY BURKE, FANZCA
SOT-ANAESTHESIA
MEDSTAR EMERGENCY RETRIEVAL**

For the past three years, SA Health has serviced the critical care needs of South Australia, NT, Western Victoria and far west NSW through the centrally coordinated business unit of SA Ambulance – MedSTAR.

Retrieval and outreach intensive care is a contemporary extension of the vision of the Reverend John Flynn to the rural and outback regions. This has been developed over the past 40 years by our pioneering anaesthesia and intensive care colleagues. Fred Gilligan's contribution is commemorated in many ways but will be long remembered by the colloquially named "Gilligan's Island" rooftop helipad at the Royal Adelaide Hospital.

MedSTAR has coalesced the hospital-based adult, paediatric and neonatal services. Medically, we are predominately a specialist staffed organisation with more than a dozen ANZCA Fellows participating in the day-to-day operation along with specialists in emergency medicine and intensive care. MedSTAR emergency teams consist of a doctor along with an emergency critical care registered nurse or rescue paramedic.

We are fortunate to have Fellows drawn from all of the state's major teaching hospitals with contemporary anaesthesia practice in the fields of neonatal, obstetric, cardiothoracic, neurosurgical and of course trauma anaesthesia. With such backgrounds ANZCA Fellows are well placed to use their unique skills to cover the scope of work to which MedSTAR responds which has included:

- Femoral blocks for trauma victims.
- General anaesthesia in the field to a two-year-old with his arm mangled in a meat mincer.
- Spinal anaesthesia to facilitate forceps delivery in distant rural centre.
- Field anaesthesia to relocate multiple fracture dislocations in multiple victims.
- Epidural analgesia inserted and maintained for flight from Kangaroo Island to a tertiary specialist centre.
- Anaesthesia in sitting position for extrication of trauma victims.
- Major burns assessment, resuscitation and access.
- Lung isolation for traumatic bronchopleural fistula.
- Interpretation and assessment of difficult airways with burns/gunshot.
- Bariatric management.
- Advanced ventilation strategies for bronchospasm.
- Volatile induction and bronchoscopy.

To deliver high quality care, MedSTAR maintains a rigorous training environment with a dedicated training hanger and a focus to ensure safe and effective practise in and around all of the transport platforms used, which include SA Ambulance Service sprint cars and ambulances, Agusta Bell 412, BK 117 and EC 135 helicopters as well as Pilatus NG PC12 and Lear Jet 35 fixed wing aircraft.

Annual helicopter underwater escape training is mandatory as is sea survival. Crew resource management courses and the opportunity to participate with the James Cook University Prehospital Trauma course held in Adelaide twice a year provide broad exposure.

As part of the SA/NT rotational training scheme, advanced trainees can be accommodated within the pathway to ANZCA fellowship. Those seeking a placement within their consolidation provisional fellowship year may have a broader exposure to critical care medicine and the inherent assumed skill and knowledge base.

Anaesthesia, retrieval and outreach intensive care have many intersecting and overlapping priorities. To "make a difference" across this vast land and become part of its human story is simultaneously very fulfilling and humbling.



Above from top: Dr Matt Hooper (left), inaugural Director MedSTAR with Rescue Paramedic Shaun O'Sullivan in front of "Rescue 1" at Adelaide Base; Dr Rikke Lindholm inside the compact fixed wing working environment with all equipment secured on the stretcher bridge; Rigorous checking and daily rechecking of all equipment in the hanger.

ANAESTHESIA IN SA/NT CONTINUED



THE ALICE WONDERLAND – AUSTRALIA'S BEST KEPT SECRET



DR JACOB KOSHY, FANZCA
ALICE SPRINGS HOSPITAL

"Alice Springs? Why would anyone want to go there?" the customs officer at Sydney Airport said to us as he finished checking our boxes.

I smiled nervously at my wife. What were we getting ourselves into? We had just landed in Sydney from India and were about to take the next flight to Alice Springs. That was in 2005 and we have not left. That reaction when Alice is mentioned is one I have encountered over and over again mainly from "city slickers" who have no clue about the reality of life here.

Alice Springs is the second biggest town in the Northern Territory with a population of about 30,000. Tourism is a major source of income with more than 300,000 visitors a year. The main attractions are Uluru, the experience of Aboriginal culture and just to see the famed Australian outback.

Alice Springs Hospital has close to 200 beds and caters to approximately 1.6 million square kilometres. It has six operating theatres, a four-bed intensive care unit (ICU) and four-bed high dependency unit (HDU) with full-time intensivists.

All surgical specialties are represented and we have a fairly high number of paediatric cases done through ENT, dental and as emergencies. Overall we do about 7500 procedures a year. We also provide acute and chronic pain services. There is a huge burden of infections and chronic disease in the community. Two hundred patients are on haemodialysis and they present frequently with access-related problems and infections.

The anaesthetic department has always struggled to attract staff but we have been fortunate to have had a reasonably stable department with some truly amazing people over the past five years. A direct result of this has been the ability to have an impact on the performance of the hospital.

From 2005 to 2008 we have seen a reversal in numbers of emergency versus elective cases being performed, from 70 per cent/30 per cent to 35 per cent/65 per cent and incredible figures with regards to waitlist times for elective surgeries, this has been no small feat.

We have the opportunity to be part of the faculty of Flinders University and I have just come back from a Flinders-sponsored trip to learn more about simulation training at the Northern Ontario School of Medicine in Canada. We also have the opportunity to work with the Royal Flying Doctor Service to help with inter-hospital transfers.

As a department we have recently initiated inter-professional learning in our operating theatre. Along with the nurses, surgeons and technicians we choose topics and learn each other's perspectives.

We also intend to do simulated crisis management as part of this initiative to help us better manage them when they occur. The feedback so far is extremely encouraging and it has helped foster such a sense of unity and camaraderie in the unit.

Work here can be challenging but extremely rewarding too. Sixty per cent of our patients are Aboriginal. Learning to communicate effectively with them has been a challenge. I have learnt a bit of the predominant languages here, Arrernte and Pitjintjara.



Awareness of non-verbal methods and use of the interpreter service have made communication much more effective. It has been such a privilege for me to receive the acceptance and trust of these amazing peoples of central Australia.

We are dependent on overseas-trained anaesthetists for our staffing. The only way to attract local candidates to even consider working in rural places like this is if we give them the opportunity to come and work and experience life here. The South Australia and Northern Territory training scheme for anaesthetic trainees is the perfect setting for this to occur. We were fortunate to have been accredited to become part of the rotation. Four candidates came through and had quite positive experiences with life here. Unfortunately we lost one of our FANZCAs and so the rotation had to be temporarily suspended.

The remote location and isolation has its challenges but I tell who ever listens, develop interests outside work. Get your "city fix" once in six to eight months. Explore the amazing countryside. There are world class bush-walking and hiking trails like the 223 kilometre Lara Pinta Trail.

If you are interested in sport, the town has amazing sporting facilities. Waking up each morning to the view of the magnificent Macdonnell Ranges and the singing of the birds and being able to get to work in seven minutes is priceless.

If you are inspired to come and join us, please do. We'll even throw a kangaroo tail on the barbie just for you!

THE OMAR COURSE: BRIDGING THE GAP BETWEEN TRAINING AND EXPERIENCE IN OBSTETRIC ANAESTHESIA



DR SHARIEF SHARAF,
UK TRAINEE
(VISITING ADELAIDE IN 2010)

Flinders Medical Centre is a tertiary referral unit for obstetrics. The out-of-hours anaesthetics service is provided by junior trainees, supported on-site by a senior trainee and a consultant available on call if needed. However, in a busy hospital it is not hard to envisage a situation where the senior trainee is occupied while the junior trainee is asked to manage an emergency obstetric case in the time it takes for the consultant to arrive.

Fortunately, such situations are unusual but as such junior trainees have limited experience in dealing with them. This problem is exacerbated by recommendations to limit hours worked, particularly out-of-hours (AMA, 1999).

Left: Alice Springs Hospital.

Furthermore, courses designed to equip trainees with the skills to manage sick parturients may be restricted to only experienced anaesthetists.

In the attempt to bypass the learning curve faced by inexperienced trainees, in my role as provisional Fellow in obstetric anaesthesia, I sought resources from ANZCA to fund and accommodate a lecture and scenario-based course, named the OMAR course (ultimately funding was received for two one-day courses, including catering!)

The course covered important causes of obstetric death: haemorrhage, PET/eclampsia, and the difficult airway; I wrote the lectures guided by Managing Obstetric Emergencies and Trauma (MOET) course content to ensure relevance and the scenarios covered a curriculum determined by the course faculty of experienced obstetric anaesthetists. These scenarios tested candidates' application of knowledge, their recognition of sick patients and their ability to manage specific clinical scenarios.

Feedback was universally positive, with candidates and the faculty expressing the opinion that the course was useful in that it filled a gap in training not catered for by other courses. However, as an educational resource, the OMAR course was always intended to evolve, and proposals for change before the next course is run have included inviting trainees from other hospitals in South Australia, as well as inviting non-anaesthetic candidates.

In conclusion, trainees have a constitutional right to high quality education, and our patients have a moral right to competent care. I believe the OMAR course fulfils both needs.



Road-testing workplace-based assessments



“Empowering” is the way first year trainee at Western Health, Dr Angela Marsiglio, describes her first-hand experience of the new workplace-based assessments being road-tested at her hospital.

The opportunity to be responsible for a whole case, and to proactively manage it as part of a mini-Clinical Evaluation Exercise (mini-CEX), has been a useful learning tool, according to Dr Marsiglio.

“I think they’re quite empowering because, particularly with the mini-CEX, you get to be the boss of the whole case, while your consultant sits back in the corner,” she says.

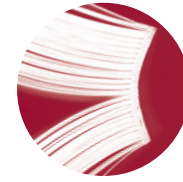
Four types of assessments will be introduced in 2013 as part of the revised ANZCA curriculum and are being piloted at Western Health, the Monash Medical Centre and Royal Melbourne Hospital in Melbourne, and Auckland City Hospital.

The assessments include:

- Mini-Clinical Evaluation Exercise: where a consultant reviews a trainee as they manage an actual clinical case.
- Direct observation of procedural skills: where a consultant reviews the trainee performing a particular skill, such as intubation or regional block.
- Case-based discussion: where a consultant discusses with the trainee an actual case they have managed after the event, and explores their clinical knowledge, reasoning and decision-making skills.
- Multi-source feedback: where a trainee seeks feedback from a variety of people with whom they have contact, such as supervising anaesthetists, surgeons, nurses, theatre technicians and patients.

Feedback from the pilots is being used to shape the final design of the assessments and is a key element in ANZCA’s commitment to delivering a world-class training program for anaesthetists in the 2013 hospital year.





For trainees, the new assessments have meant more structured feedback, from a broader range of sources, and in a timely manner that means issues are dealt with as they arise in a supportive training environment.

For supervisors of training, they receive better information from the Fellows who work with trainees. This means supervisors spend less time gathering information for the in-training assessments at the end of term.

Dr Marsiglio says she has appreciated the regular feedback and ongoing updates, rather than waiting for the end of term assessment.

“I think feedback at the end of term is a little bit too late,” she says. “I think you need to get it the whole way through, because otherwise you get to the end of six months and you’ve got no opportunity to correct the thing that maybe you haven’t been doing too well.”

And while Dr Marsiglio says she already is aware of fostering good relationships with those she works with, the other expected benefit of the new assessments is the broader feedback from others, such as nurses and theatre technicians, which should help ensure trainees are conscious about how they relate to others.

Her supervisor of training at Western Health, Dr Richard Horton, who is also Chair of the Workplace-based Assessment Committee and Victorian Regional Education Officer, says he has found the assessments have made his life as a supervisor of training easier.

Working for Melbourne’s busy western metropolitan health service across four different sites, for a department that provides anaesthetic services for 25,000 to 30,000 procedures a year, while overseeing about 20 ANZCA trainees, means Dr Horton is well-aware of time pressures.

“If it’s going to be difficult anywhere to run a training program, I think this is probably as challenging an environment as there is,” he says.

Dr Horton says the assessments for the most part formalise what consultants already do in terms of reviewing a trainee’s competence and assessing whether they are capable of

being left safely looking after a patient with lower levels of supervision.

“People have been making those assessments all along and making quite significant decisions based on that,” he says.

Now consultants are being asked to review trainees’ work against standardised, defined criteria, which all assessors can use as a benchmark.

“We’re trying to engender a coaching culture to a greater extent in the clinical environment,” Dr Horton says.

He says a benefit for supervisors of training is that feedback is collected continuously, which makes it easier to gather information for global feedback at the end of term for the in-training assessments.

The assessments have also provided better tools and a more structured way to assist trainees with problems.

“I am spending less time managing performance issues, despite our department growing in size, than I was three years ago,” Dr Horton says.

Auckland specialist anaesthetist and education expert, Associate Professor Jennifer Weller, has been leading the pilot implementation at the Auckland City Hospital. She believes the pilot has increased both the quality and quantity of feedback given to trainees through the assessments process.

“This formative component of workplace-based assessments is probably the single biggest advantage of their implementation,” she says.

“Because of this more structured observation, any gaps in learning or performance can be identified early, and remedial steps taken.

“There are fewer surprises for the trainee, as the supervisor has provided the feedback based on a specific case rather than general impressions and non-specific comments.”

Monash Medical Centre anaesthetist, Dr Damian Castanelli, agrees that the extra information gathered through the various assessments helps provide a more accurate picture of the trainee.

“As a supervisor of training, I have a lot more information to use in my in-training assessments and interviews,” he says. “I can point to

specific examples in the mini-CEX or DOPS (direct observation of procedural skills) to illustrate learning points and highlight areas that a trainee might want to focus on in the future.”

Acting General Manager of ANZCA’s Education Development Unit, Mr Olly Jones, says the College is designing training activities and resources to ensure supervisors of training and assessors have the training they need to undertake the assessments.

He says over time, trainees will begin to routinely request their supervisors and assessors complete assessments for them.

“Collectively the assessments will be added to their portfolio and demonstrate their progression through components of the curriculum and their rotations,” he says.

“Every assessment opportunity provides rich opportunities for great feedback and structured guidance.

“When trainees can’t quite grasp a particular skill, the more structured feedback and agreed follow-up work given, the better for everyone.”

Meaghan Shaw
Media Manager, ANZCA

“For trainees, the new assessments have meant more structured feedback, from a broader range of sources, and in a timely manner.”

Opposite page: Western Health Director of Anaesthesia and Pain Medicine, Dr Andrew Jeffreys, supervising Dr Angela Marsiglio for a workplace-based assessment.



Doctors in need

Too often we hear of doctors who have taken their own lives. In this edition of the Bulletin we explore welfare issues in the hope that open discussion will prevent more tragedies within the profession.

The rate of substance abuse among anaesthetists is thought to be similar to the rest of the population but their knowledge of drugs and ease of access makes their situation more dangerous. Meaghan Shaw explores this and other welfare issues.

Dr Ray Hader was a typical, high-achieving anaesthetic trainee.

Like other high-achievers, he did everything full-on, from his medical studies (graduating with honours), to sport (representing Victoria in volleyball). Unfortunately, this was also his approach to drug taking.

He was a likeable trainee working at Western Health in Melbourne when he succumbed to his addiction. His friend, Dr Brandon Carp, says he claims his drug-taking began when he was assaulted at another hospital by a patient who broke his teeth and he took panadeine forte for the pain.

From panadeine forte, he progressed to midazolam, while also using alcohol and other drug cocktails, which steadily got out of control to the point where he was getting deliveries of midazolam at home.

"He didn't have a drug of choice, really," Dr Carp says. "But it seemed that midazolam was what anaesthetised him to death – it was an accident.

"He was a clever guy. I don't know why it seems to happen with anaesthetists. But he knew the dosages, he understood, he was smart. He just got caught."

Unfortunately, the case of Dr Hader is not uncommon, with figures showing that up to a quarter of anaesthetists abusing substances will die from overdose or suicide due to their pharmacological knowledge and ease of access to drugs.

Doctors in general also have been found to have higher rates of depression and anxiety, stress-related illness and alcoholism.

To help anaesthetists and pain medicine specialists in need, the Welfare of Anaesthetists Special Interest Group (SIG) has recently reviewed and updated resource documents that outline the more common professional and personal stresses and give suggested references and strategies to deal with them.

The support is crucial.

Dr Carp says at the time of Dr Hader's addiction, which was for about five years leading to his death in 1998, he was frustrated by a lack of support services and a sense that Dr Hader's colleagues knew he had a problem but didn't act while he looked ok.

"I felt incredibly helpless to do anything, both as a doctor and as a friend, because he was actually working and getting away with it," he says. "He was sort of functional. And I really struggled to find any support mechanisms through the profession that could assist him."

Finally, Dr Carp reported him to the medical board after he used another doctor's script pad.

"The reality was it was best for him because (working in the anaesthetic department) was just like giving candy to a little kid," he says. "And second of all, he could possibly do something to a patient and that would have really destroyed him to know that he had endangered someone else.

"So he understood. He was just waiting for it, really."

Phillip*, a former trainee anaesthetist, also hit a downward spiral of drug abuse, self-loathing and reckless usage.

Starting as a recreational drug user as a junior doctor to "see what all the fuss was about", he infrequently used "anything and everything" including ketafol, opportunistically taking medicines home from work to use them.

But after about five years, he went through a stressful period where he changed jobs, got a mortgage and started a family, and his drug-taking got out of control.

Blaming exam preparation, he became withdrawn, wouldn't answer the phone or knocks on the door, obtained drugs at work, and went home to lock himself in a room to use them with "quite marked feelings of self-loathing".

"Basically I thought I was worthless and couldn't find any way out of it," he says. "I tried stopping on numerous occasions but couldn't. Every last time was going to be the last time, but I found it more and more difficult (to stop) and I was completely out of control.

"The problem was I would never have asked anyone for any help. And the reason for that was, although there was help available, I was completely blinkered into not being prepared to ask for it because I was terrified about losing my livelihood.

"Fortunately, for me, someone at work noticed what I was doing. It was actually a fellow addict and she brought it to the attention of some seniors.

"Unfortunately, this woman who I owe a huge debt of gratitude to died from her own addictive disease by herself, by her own hand, which I think is a tragedy."

For Phillip, it was through the intervention of his hospital, participation in a treatment program and counselling, and regular monitoring by the medical council that he has remained drug-free for the past 12 years. He left anaesthesia but remains in medicine.

"If you do have a colleague who you think has a problem, then you shouldn't sweep that under the carpet, you need to initiate something that's going to intervene in that person's life, otherwise you're going to be going to a funeral," Phillip says.

Incidence of substance abuse

Auckland City Hospital specialist anaesthetist, Dr Robert Fry, in 2005 published research on substance abuse among anaesthetists.

He has long advocated for unnamed unidentified reporting of cases to the College as the incidence of anaesthetists abusing substances is unclear.

However, he says it is likely that anaesthetists have a similar incidence of substance abuse as physicians, with overseas research showing about 10 to 15 per cent of physicians abuse substances – which is no different to the general population.

But where anaesthetists differ, is they are six times more likely to use intravenous drugs which means overdosing, rapid dose escalation and mistakes are more likely as is the need for admission to a treatment facility to get over the addiction.

(continued next page)

"Doctors in general kill themselves more frequently than the general population and anaesthetists are particularly good at it, which is very sad."

Doctors in need continued

“So we tend to do it with stronger, quicker drugs and that’s probably why we tend to end up on the treatment programs so frequently,” he says.

“Because anaesthetists use very strong drugs all the time with absolute control, it is possible that we have an invalid over-confidence that we can do the same for ourselves. And anaesthetists choose these stronger drugs as we have relatively easy access to them.”

His research finds the chances of a substance-abusing anaesthetist dying from overdose or suicide is 25 per cent – higher for registrars at 31 per cent.

And for those who successfully seek treatment, the likelihood of them remaining in anaesthesia long-term is only 20 per cent.

Chair of the welfare SIG, Dr Diana Khursandi, says as well as substance abuse, other factors such as depression, burnout and other stresses can also trigger a suicide.

“Each one is a tragedy for everybody – the people who work with them, the families,” she says.

“Doctors in general kill themselves more frequently than the general population and anaesthetists are particularly good at it, which is very sad.

“One of the things we would hope to do is to try to help these people before they reach that tragic decision. But sadly they’re not always preventable. But depression certainly is treatable, and people who abuse substances can, with the correct intervention and treatment, be successfully rehabilitated.”

Resource documents, which are available on the ANZCA and Anaesthesia Continuing Education Coordinating Committee (ACECC) websites, deal with

two dozen welfare issues ranging from personal health strategies, substance abuse, financial pressures, recognising depression, and sexual misconduct, to mentoring, retirement, latex allergy and medico-legal issues.

They have recently been updated and include new documents on critical incident support, organ donation, communication, consent, mandatory reporting, and the disruptive anaesthetist, while another new document on bullying is being finalised. The documents are pointers to accessing help and are not meant to be prescriptive.

Doctors are notoriously bad at looking after themselves and have a tendency to self-medication and self-prescription, which is dangerous. One of the main refrains from everyone working in the area of doctors’ health is the need for anaesthetists and pain medicine specialists to have their own GP.

It’s one of the first pieces of advice Dr Khursandi gives when addressing anaesthetists on how to look after themselves.

“It’s things like having your own GP, making sure you’ve got support systems if you have a critical incident, making sure you have mentors, making sure that your life-balance includes things other than work, not prescribing for yourself, not having corridor consultations,” she says.

In addition, the support and, in some cases, intervention of colleagues is vital.

“Everyone needs the support of colleagues; if you are getting to a stage where you are extremely distressed, then certainly you should be doing something about it, or other people should be trying to help you,” Dr Khursandi says. “It doesn’t always work though. People don’t always receive the message.”

Mandatory reporting

This is where mandatory reporting can come in. Introduced nationally in Australia last year, and in operation in New Zealand since at least 2003, mandatory reporting requires registered health professionals to report to their registration authorities colleagues whose conduct might put patients at risk of substantial harm. In Western Australia, an amendment means doctors are exempt from reporting when treating other health professionals.

While the new laws in Australia don’t change the onus that was already on medical professionals to report colleagues, the legislation is stricter, and the fear has been that the new legal requirements would stop doctors in need from seeking help.

After 12 months of operation, the impact of the laws on the numbers of doctors seeking help from the Doctors’ Health Advisory Services around the country has been mixed.

Victorian Doctors’ Health Program medical director, Dr Kym Jenkins, says recent feedback from services via the Australasian Doctors’ Health Network shows only in Queensland have callers to the state-based service dropped off. In Victoria they have remained the same, in South Australia the picture is unclear but calls haven’t increased, in New South Wales they initially dropped off but have now picked up, while in ACT the number of callers is too small for analysis. The Northern Territory and Tasmania don’t have a service, and reporting is not required in WA.

Dr Jenkins says the main effect of the laws in Victoria has been an increasing amount of confusion about what needs to be reported, particularly among employers.

“The impact on our service is the level of uncertainty people have about whether they should or shouldn’t report, and various organisations thinking they’re obliged to report when they’re not,” she says.



If in doubt, she checks a hypothetical case with the health committee of the Victorian branch of the Medical Board of Australia.

Queensland's Doctors' Health Advisory Service president, Dr Joan Lawrence, says the Queensland experience has shown mandatory reporting has inhibited doctors from seeking help, despite the service making it clear it does not report patients to the medical board.

"In some cases, where perhaps patients were really at risk if the doctor didn't stop practising, then what we might do is encourage the person who was bringing that doctor to our notice to make contact with the medical board if they saw fit, but we certainly don't report people," she says.

Her advice to anaesthetists is to not hesitate to seek help if they are experiencing problems, including depression, undue anxiety or extreme stress.

"They can be reassured that if they do seek help, they won't be reported," she says. "That's been our concern all along with mandatory reporting – that it will drive people underground, and they'll be so afraid of being mandatorily reported, whether they need it or not, and that it will impact on their practice, that they think they've got to keep it hidden and deal with it themselves, which usually means no treatment, or self-treatment, which is usually even worse."

Investigating substance abuse

Being the subject of suspicion and intervention by colleagues can be a traumatic experience, regardless of whether those suspicions are right or wrong.

One anaesthetist wrongly accused of abusing fentanyl at work, who was the subject of an intervention and urine test, says it nearly ruined his career and destroyed his relationships with some colleagues.

"I found it an incredibly distressing experience which I've never got over," he says.

In his case, he felt the proper procedures were not followed: that the person conducting the intervention was not experienced or trained in doing it and was not from the anaesthetic department; and that neither he nor his wife were provided an adequate level of support or counselling in the aftermath.

"That experience ruined the end of my career for me in terms of the pleasure that I had had from it," he says. "The irony was that I was at a particularly good phase in my professional and personal life at the time."

Cases such as this emphasise the need for hospitals to have in place and follow guidelines, which can be developed with reference to the welfare SIG's resource document and best-practice protocols.

Christchurch Hospital anaesthetist, Dr Vaughan Laurenson, has been involved with welfare issues in his department for about 20 years, during which time he has dealt with about a dozen actual and suspected cases of substance abuse.

He says the incidence of abuse, while uncommon, is common enough that it is likely most anaesthetists will encounter a case during their career.

Protocols emphasise that anyone suspecting someone of diverting drugs should talk to an appropriate senior colleague and not challenge the person themselves.

The process is then to gather evidence and only act once sure there is proof; to set up an intervention, including involving the suspect's family; to notify the health committee of the medical council to suspend the person's registration if they refuse a urine test; to organise a lab to do an urgent urine test; and to organise psychiatric support and follow up care, including an appropriate treatment program.

However, Dr Laurenson says the process is never straight forward and the stakes are high. "There are risks of error, failure, litigation and death," he says.

The problems are compounded by addicts skillful at concealing their addiction, the need to act quickly if a fentanyl addict is spiraling out of control, difficulties in keeping track of drug

dispensing within departments, and the possibility of raising suspicions of others by checking records.

"Once the rumour mill starts up and you start to hear about it from four to five other people ... it's probably time you acted, whether or not you think you're sure, to clear the air, and you can feed back into the system the person's not diverting drugs," he says. "It's a horrible situation."

But the key message, he says, is that it can't be ignored with the hope it will go away.

"It is like any other medical emergency – it must be dealt with in a timely, appropriate manner to the best of your ability."

For Dr Ray Hader, the intervention of his friend proved unsuccessful and he died aged 34 from an accidental overdose, while at home having a meal.

"He always thought he had it under control, he could get the dose right," Dr Brandon Carp says. "I think he just slumped down and he blocked off his airways. And that was it. He was too anaesthetised to wake himself up."

In honour of his friend, and to mark the 10th anniversary of his death in 2008, Dr Carp set up the Ray Hader Trainee Award for Compassion. ANZCA trainees or Fellows within three years of fellowship by examination are eligible to apply for the award, which promotes a compassionate approach to the welfare of anaesthetists, their colleagues, patients and the community.

Dr Carp says the nature of the award reflects Dr Hader, who was compassionate and passionate about anaesthesia and helping people. "It also helps me deal with my sense of helplessness and loss," he says.

He concedes the award serves a dual purpose.

"At the very least it helps the individual who gets the award to do something that recognises them, and that's good enough," he says. "But if it alerts people to this problem, and makes it more relevant and discussed, then that's probably a good thing as well."

**Not his real name*

"If you do have a colleague who you think has a problem, then you shouldn't sweep that under the carpet."

Coping with the tragedy of anaesthetist suicide

The death of a friend and colleague is sad - but more tragic if it is premature, and particularly distressing if it is as a result of suicide - often a deliberate intravenous drug overdose, says the Chair of the Welfare of Anaesthetists Special Interest Group, Dr Di Khursandi.

Anaesthetists die from intravenous drug overdose much too often. Anaesthetists are almost always successful at suicide because they have the tools, and the experience in using them.

Suicide is the cause of death of up to 10 per cent of anaesthetists.

Sometimes it appears that a drug overdose is deliberate, sometimes accidental. (A substance-abusing anaesthetist should be aware of the effects and doses of drugs that he or she uses at work – so are “accidental” drug overdoses in anaesthetists ever really “accidental”?)

What about those left behind? They need support, sometimes professional support, to deal with the grief – grief is painful, the loss is irreparable.

And to deal with the questions which are asked:

“Why?”

“Why did she do it?”

“Why did he do it?”

“What could I have done to prevent this terrible loss?”

“If I had done things differently, might it not have happened?”

Suicides

Suicides in anaesthetists in recent years have been associated with several factors.

Foremost in the list is depression. Next comes substance abuse.

Then a variety of associated possible “reasons”, or “causes”, including relationship breakdown, personality disorders, other psychiatric illness, being involved in medico-legal proceedings, examination stress or failure, and work stress, particularly being at the sharp end of a critical event with an adverse outcome.

Sometimes two or more adverse situations occur at once, overwhelming a person’s resilience and ability to cope.

Can we reduce or mitigate any of these factors?

Depression - a common and potentially lethal disease

The lifetime incidence of a depressive episode has been quoted as being as high as 60 per cent.

It must be emphasised that in some instances, the first indication of anything amiss is the colleague being found dead. In these cases the death is described as “a complete surprise”.

These tragedies imply that some doctors are so good at hiding their distress, and/or brushing off inquiries from friends and colleagues, that no-one else knows there is anything wrong.

Some depressed doctors may also “conceal their distress from themselves”, consciously or subconsciously – either in the form of denial, or by not recognising that their symptoms are pathological.

Other times the doctor is known to be troubled, but all attempts to offer assistance have been refused. (A friend or colleague can only do so much.)

Occasionally professional help has been ineffective.

“Although depression can be a lethal illness, it is also treatable. People survive it. I did. My mother did not.”

There have been so-called “angry” and/or “selfish” suicides – where a person or group has been targeted – for example, an anaesthetist angry with the profession committing suicide at work, or a separated man killing himself and/or his children to “get back” at his estranged partner.

Some say that obsessive, compulsive, driven types are drawn to anaesthesia. Are these doctors driven to achieve? In these individuals, is professional success achieved at a price? Is the price his or her relationship?

Perhaps some obsessive, compulsive, driven types are more prone to depression. Can the price of being an excellent anaesthetist be depression (or anxiety)?

What can we do?

We can be understanding of, and sympathetic to, the distressed or depressed person.

We may elicit suicidal ideation. We can emphasise repeatedly that suicide is unacceptable.

We can work to be able to recognise the signs of depression in colleagues, while recognising that treatment is NOT our responsibility.

We can strongly and repeatedly urge and recommend that depressed doctors seek professional help. We must be aware of the local professional resources which are available for our colleagues to access.

Although depression can be a lethal illness, it is also treatable. People survive it. I did. My mother did not.

But in all instances, and occasionally despite our best efforts, it is that person’s choice to kill himself or herself. Suicide has been his or her choice, even though that choice may have been made by a troubled mind.

(continued next page)

Doctors in need continued

No-one else, family, friend or colleague, should feel guilty about the death. We should not be angry with ourselves – or the person. We must not beat ourselves up with guilt.

Rather than anger with the person, we might put ourselves in that person's position; we might feel horrified that he or she has reached such a state of inner despair that there is nothing worth living for – and can we imagine what that feels like?

We can work to abolish the stigma of mental illness, a stigma that pervades the community as well as the medical culture.

Mental illnesses are illnesses no different from physical illnesses – after all if we can take insulin for the disease of diabetes, orthyroxine for our hypothyroid state, then why not psycho-active drugs for our brain dysfunction? (There are many other treatment modalities, including diet and exercise, which may ameliorate depression.)

We can work to support our colleagues who are in distress, and continue to approach them, even when our help or suggestions have initially been rejected.

(See Welfare of Anaesthetists Special Interest Group Resource Document (RD) 03.)

Substance abuse

There have always been a small percentage of anaesthetists who feel the need to sample the same drugs they are giving to patients.

Sometimes they want to experience the effects of a drug themselves. Remember the “ether sniffers”, famous in their day, as the first stereotypes of the drug addicted anaesthetist?

Sometimes they are risk-takers, or those with a personality disorder.

Sometimes perhaps they are troubled souls who need the solace of oblivion.

Sometimes they may be affected by psychiatric illness, which may have gone unrecognised and/or untreated.

Sometimes they pursue a career in anaesthesia just to get into the “lolly shop”.

Identification, intervention and treatment of those with substance abuse problems must be done thoroughly and carefully (*see RD 20*).

Personal Stresses

As do all human beings, anaesthetists experience personal stresses, such as relationship breakdown, examinations, professional or personal adverse events.

This is where friends and family, as well as colleagues, play a crucially important role – they need to offer support early, and continue to offer it (*see RDs 5, 11*). Mentors are also important, as are other trusted colleagues (*see RD 08*).

If you have concerns that one of your colleagues is going through a period of professional or personal stress, share your concern with another friend/colleague, and discuss the best avenue to pursue.

Perhaps offer a chat over a cup of coffee to the person who is distressed.

Keep your antennae up!

Litigation

We can all work to avoid litigation, by best practice (although sometimes even the best doctors make mistakes), and by excellent communication skills.

In the rare instance where medico-legal action occurs, we must offer ongoing support to our colleague. The stress can go on for as long as the legal process drags on – sometimes years (*see RD 14*).

Mandatory reporting

If the illness of a colleague is impacting on his or her performance at work, and this decrement is impacting on safe patient care, the issues need to be confirmed before a report is made to the medical council or board. A period of stress leave or sick leave may be recommended, in which some treatable issues may be resolved. Professional advice should be sought (*see RDs 13, 20, 24*).

Welfare of Anaesthetists Special Interest Group

This group has developed the resource documents, which are available on the ANZCA website www.anzca.edu.au and the Anaesthesia Continuing Education Coordinating Committee (ACECC) website www.acecc.org.au.

Those who are concerned about doctors' health issues should read these documents.

Dr Diana Khursandi
Chair Welfare of Anaesthetists
Special Interest Group

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“We can work to support our colleagues who are in distress, and continue to approach them, even when our help or suggestions have initially been rejected.”



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

Pulse of life

It's one of the most basic tools in an anaesthetist's tool box – a simple oxygen monitor, or pulse oximeter, that checks the level of oxygen in a patient's bloodstream and sounds an alarm as soon as it detects the slightest unsafe change.

Attached to the finger or earlobe, the pulse oximeter can detect changes in oxygen levels as small as 1 per cent and give early warning of clinically relevant decreases, which is critical when brain damage or heart failure can occur after as few as three minutes of oxygen starvation.

Prior to the introduction of these devices, the only way anaesthetists could monitor if a patient was not getting enough oxygen was when their skin began turning blue, which was usually too late.

Since they were introduced in the mid-1980s, pulse oximeters have become the universal standard of care in operating rooms in developed countries and literally have saved thousands of lives.

Yet, there are an estimated 77,000 operating rooms in developing countries around the world that don't have these simple monitoring devices. This means about 35 million patients each year being placed at unnecessary risk.

University of Auckland Professor of Anaesthesiology and quality and safety expert, Professor Alan Merry, says this is indicative of a much bigger problem, with hospitals in these countries also typically lacking adequate anaesthetic resources and training to improve the safety of surgery.

"There is data that show the mortality rate of anaesthesia in those areas is sometimes 100 times higher than in Australia and New Zealand, for example," he says.

Which is where a new project called Lifebox comes in. Stemming from the Global Oximetry Project that began in 2004 at the World Congress of Anaesthesiologists in Paris, Lifebox is a new charity that aims to not only provide low-cost pulse oximeters in developing countries, but also to raise the safety standards of surgery there by providing associated resources and training.



From a donation of \$US250, Lifebox is able to deliver a package to a hospital that includes a robust pulse oximeter and educational material, which includes a "how to" CD ROM on using the oximeter, presentations and scenarios for use in training, and a video by Boston University anaesthesiologist, Dr Rafael Ortega, which won a prize last year at the American Society for Anaesthesiology conference. The material is provided in six languages – English, French, Spanish, Chinese, Russian and Arabic.

"This is not a project to just dump equipment somewhere because that's been done in the past with very little

success," Professor Merry says. "This is about changing practice, sustainably."

The project includes promotion of the World Health Organization's Surgical Safety Checklist, which has been shown to save lives and mandates the use of a pulse oximeter – the only item on the checklist costing money.

The Lifebox project has been able to source a low-cost, high-quality pulse oximeter manufactured by Acare in Taiwan, which has replaceable probes costing US\$25 each, making it cheap to maintain.

"It's one I would be completely happy to use," Professor Merry says.

Professor Merry, who is a councillor on ANZCA's Quality and Safety Committee, has been involved in the project from the beginning, as the chair of the Quality and Safety of Practice Committee of the World Federation of Societies of Anaesthesiologists (WFSA). Other founding directors of Lifebox include legendary American surgeon and writer, Dr Atul Gawande, WFSA President, Dr Angela Enright, Association of Anaesthetists of Great Britain and Ireland (AAGBI) President, Dr Iain Wilson, and founder of the WHO Patient Safety Department, Mrs Pauline Philip.

A quality improvement project has already been carried out at four pilot sites in Uganda, Vietnam, India and the Philippines using 84 donated pulse oximeters, and further training took place in Uganda earlier this year, with the AAGBI donating 80 pulse oximeters to the Uganda Society of Anaesthesia.

By the end of this year, about 2500 oximeters will have been delivered to low and lower-middle income countries, with an aim of 10,000 provided by the end of next year. Lifebox estimates that by closing the oximetry gap and increasing the use of the Surgical Safety Checklist, it can cut death rates in developing countries by half.

Professor Merry says Lifebox is encouraging anaesthesia organisations to partner with countries or regions to "oximeterise" these areas and improve their surgical safety standards.

"There is an opportunity here," he says. "There's real momentum already underway. This is a real chance to get involved, make a difference and save lives through safer surgery."

Chair of ANZCA's Overseas Aid Committee, Dr Wayne Morriss, says the Committee will look at options to partner countries in the Asia-Pacific region.

"We take pulse oximetry for granted in Australia and New Zealand, but a working oximeter is not a given in many neighbouring countries," he says. "The Lifebox package provides a great opportunity for us to work with anaesthetists in these countries to dramatically improve anaesthetic safety."

For more information or to make a donation, go to www.lifebox.org.

Meaghan Shaw
Media Manager, ANZCA

Left from top: A baby at the Mbarara Regional Referral Hospital in Uganda wearing a pulse oximeter; A pulse oximeter being used in training at the Mbarara Regional Referral Hospital in Uganda.

Threshold of a dream – anaesthesia in the age of information

Imagine you are running the emergency list in Cairns and are asked to anaesthetise a large lady with an apparently difficult airway for a minor gynaecological procedure.

A spinal would seem an easy solution but she has a ventriculo-peritoneal shunt for benign intracranial hypertension, inserted last year in Townsville. You touch a button on a computer and are able to see that at previous procedures in Cairns and Townsville she had a Grade 1 Laryngeal view and a routine intubation – and that there is a helpful note that despite her body habitus she is easy to ventilate with bag and mask. You proceed uneventfully with a simple propofol/LMA anaesthetic.

A young woman in Innisfail declares on the table in the induction room that she is “allergic to lots of drugs”. The senior medical officer (SMO) anaesthetist touches a button and is able to examine her four recent anaesthetics in Cairns, following which he reassures the patient that she has recently had all the drugs he is going to use with no problem and proceeds with the anaesthetic.

On another occasion an anaesthetist in Cairns is faced with an adolescent male needing urgent dental surgery but the patient has a history of tracheal trauma and stenosis managed in a Brisbane hospital. The same button lets the anaesthetist examine the previous case record and be reassured that she could proceed with a routine anaesthetic.

Imagine you are a general practitioner anaesthetist in a rural hospital anaesthetising a frail 80-year-old lady who has already lost one leg to vascular disease and are wondering how best to manage her likely post-operative pain. You touch the same button and can see that after a similar procedure in Cairns her post-operative pain score rocketed up as soon as her sedation wore off and she required multiple doses of fentanyl for pain



control. You confidently administer more fentanyl during the procedure and prescribe a post-operative fentanyl pain protocol.

There is no longer the need just to *imagine*; each of these scenarios actually took place in Queensland this year. So how was this possible?

The answer is that it depended on a number of initiatives – the deployment of systems for creating electronic anaesthesia records, for storing the records in a central location, and for matching the identity of a person in one hospital with the identification of the same person in all other public hospitals in Queensland. The latter is provided by a central function, “Client Directory”, which uses multiple points of concordance to automatically link the UR number of a person in any hospital with their UR number in all other Queensland hospitals, irrespective even of changes of name. Where there was insufficient detail for confident matching, the patient has been contacted directly to check if each presentation was indeed theirs.

Each time a new booking or record is opened, the program, WinChart, sends the local UR number to the client Directory and receives back the rest of the patient’s details, thus ensuring that new records are attributed to the correct identity.

On closing the record of an anaesthetic, an image of the record showing the patient vitals together with the documented medications, techniques and notes is saved as a portable document format (.pdf) – a tiny file that can be whizzed around easily by computers. This pdf is stored together with the raw details of the case, but a copy is also sent to a central server, called the WinChart Enterprise Portal (WEP), and this is the name on the button which gives access to the whole spread of information.

The WEP is accessible from any Queensland Health computer. An authorised user can log in using their unique identity and password (and strict integrity is maintained using Active Directory, which enforces regular password changes and quality) and can enter the UR and hospital location of their patient.

WEP receives from Client Directory the list of all UR and hospital references for this patient and assembles all the pdf images into a single timeline for this patient. Clicking on an icon on the timeline brings that pdf image to the screen within seconds. Where the user has already opened a record for a particular patient in theatre, a WEP button on the notes screen automatically retrieves the timeline of all electronic records for that patient, no matter where they were created and whether they were recorded, for example, under a woman's married or maiden names.

Future developments in this area will make images of the patient's anaesthetic pre-assessment record visible in the same timeline, as well as information about any documented alerts, such as adverse drug reactions or anaesthetic difficulties, and of their acute pain management.

It will soon be the single most comprehensive source of information about a patient's past perioperative experience, instantly available anywhere within the state's computer network and allowing a myriad of uses of the accumulated data.

My personal "dream" is for the system to guide the progress of each patient from the time of their presentation to a surgeon right through to ensuring that they have returned to normal function – attending along the way to the details of anticoagulant management, antibiotic prophylaxis, investigation results, etc – and checking that they are back on their appropriate medications at the end of the process. But that will have to wait for another day and perhaps another article.

Associate Professor John Archdeacon
Director of Anaesthesia, Intensive Care
& PeriOperative Medicine,
Cairns Base Hospital

Left: Associate Professor John Archdeacon using the WinChart Enterprise Portal (WEP).

Windscreen repairs – shedding light on improving healthcare

At face value, it might seem that the world of corporate business, and delivery of high quality anaesthesia and surgery, have little in common. In reality, some of the principles and practices in businesses and industries far removed from healthcare have significant potential to help improve healthcare.

The windscreen repair business provides a simple example. Organising the repair of a chipped or damaged windscreen was once a labour- and time-expensive business. One dropped in to the local repairer, had the windscreen inspected, made an appointment for repair, dropped off the car early on the scheduled day, and picked it up after work (or the next day if you forgot to ask them to leave it on the street when they closed!). When my windscreen was chipped some months ago, I was pleasantly surprised at the phone or internet methods used by O'Brien Glass to assess and organise a repair. It is interesting to go online and look at the way they gather and process information (www.obrienglass.com.au/2110.o.html).

Of course medical care is much more complex, but we can consider the fundamentals of what they are doing. It is clear their use of remote access, structured electronic questionnaires, and computer decision support, can pre-evaluate clients' problems and requirements. They obtain information, process the data, plan provisional solutions, and communicate with the customer.

These fundamentals have considerable overlap with preoperative screening: take a patient history and (at some time) perform a physical examination, plan investigations, make provisional differential diagnoses, and form provisional management plans. It is therefore interesting to think more broadly about how we approach delivering medical care.

A need to evolve and innovate in order to improve

Business and industry, whether for-profit or not-for-profit, need to deliver a value proposition (where value addresses both cost and quality) to their organisations and customers. This may be a matter of company profits, or survival of a service, but an increasingly rapidly changing society requires continual evolution and innovation to do so.

Take on-line retailing. We might once have considered the improved cost (cheaper or more convenient) was outweighed by the risks of poor quality (buying something unsuitable). The current generation of consumers has proven us wrong, even for items we might have thought needed personal service or hands-on scrutiny. Businesses which have been slow to respond to consumer needs (think bookstores and clothing stores) have struggled.

An ageing population, with its increasing burden of chronic disease, produces a seemingly insatiable demand for healthcare services. This is now coupled with finite resources, societal expectations and demands (time, immediacy, convenience) and technological advancements. This combination requires a continual review of practice to ensure we deliver genuine value without compromising quality and continual exploration of innovation.

Strategic innovation and change

In his book, *Game Changing Strategies* (Jossey-Bass 2008), Costas Markides tells us that business can innovate through new products (e-books instead of paperbacks), or through new strategies ("new ways of doing business"), such as IKEA instead of conventional department stores.

Medicine is replete with product innovation. We read daily of new medical devices and medicines and we are fortunate in this country to have their quality addressed through strong regulatory systems, such as the Therapeutic Goods Administration. The overall value proposition (adding in cost, or cost-benefit), is dealt with in other ways, including expert opinion and market forces. Some of the current challenges and debate in this area can be seen in the latest issue of *Newsweek*, August 22 and 29.



We think less often of strategic innovation in medicine, but examples of "new ways of doing business" include the Dartmouth Back Pain Clinic (using remote early triage, including electronic assessment tools, to direct patients to the best care pathways), and the Royal District Nursing Society SA's medication service (videophone-based remote patient care models).

Markides also tells business about two important aspects of strategic innovation – why we often don't change, and how to start. Consider some of the following in relation to our own medical practice or systems.

Why don't we change?

Large established companies which seem to be doing OK; traditional or closed thinking; too busy; fear of destabilising core business or silo; costs of investment; who benefits or is incentivised to change.

How do we go about change?

The use of pilots; fast cycles of change; flexibility; and proper experiments with measurement and evaluation; the use of satellite organisations to change yet minimise disturbing the core organisation (for example, Jetstar and Qantas).

Stepping back and critically scrutinising existing processes is a key component of industry. IDEO, a US-based design company, provides an example of how this can be done. It takes a broad ranging view on existing products or organisations, unpacks the fundamentals, and looks to repack them to provide better value. As stated on its website, "observation, prototyping, building, and storytelling ... can be applied by a wide range of people to a breadth of organizational challenges." (www.ideo.com).



“IDEO, a US-based design company... takes a broad-ranging view on existing products or organisations, unpacks the fundamentals, and looks to repack them to provide better value.”

A simple example is their approach to the humble supermarket trolley (www.ideo.com/work/shopping-cart-concept). Taking nothing for granted, a team sat back, and looked at all elements of existing trolleys and what they are intended to do. Over four days they redesigned and reconstructed the trolley, considering the engineering (what do we really want from castor wheels?), functional design (a child seat without a table for toys encourages other forms of entertainment, such as plucking things from the shelves), and indirect design benefits (a trolley with no wire bottom might reduce theft and diversion to other uses).

We in healthcare should also be open to scrutinising what we do and how we do it, and consider new approaches. Maintenance of the high standards of medicine in this country mandates we take on board Markides’ suggestions of pilot processes and careful measurement and evaluation of outcome.

Assessment and preparation for surgery – an increasing challenge that may benefit from innovation

The preoperative visit, or “seeing premeds”, has always been an important part of an anaesthetist’s job. It now looms as one of our biggest challenges. Our ageing population, with its prevalence of chronic illness (obesity, diabetes, cardiac and vascular disease...) increases the requirements for assessment and treatment prior to surgery.

This encompasses anything from new or adjusted medicines (for example, betablockers, aspirin), preoperative behavioural change (for example,

exercise programs, ceasing smoking), to comprehensive well-documented communication with patients (for example, informed consent). To ignore this challenge risks the excellent safety record of anaesthesia in Australia and New Zealand. The latest Australian triennial mortality report for anaesthesia, published in 2009, already shows a high incidence of inadequate assessment and management in patients with poor anaesthesia-related outcomes.

Just as in business, changes around us challenge the service and care we provide. For example, we had a long tradition of face-to-face assessment by anaesthetists in hospital wards the night before surgery. The trend to bring patients into hospital on the morning of surgery is convenient for patients and may provide apparent savings for institutions but is not necessarily a good fit with preoperative assessment for complex and elderly patients.

So how do we respond to these challenges? We are already training more anaesthetists, the Medical Benefits Schedule now better acknowledges preoperative assessment, and advanced preoperative visits with an anaesthetist, in rooms or outpatients, are more common.

Are there other things we might do apart from expanding existing processes? Pre-screening and streaming of patients, through paper questionnaires, nurse-based clinics, general practitioners and perioperative physicians, may be of assistance, and have been successfully introduced in a number of surgical settings. Do they represent true value and has this been well measured?

The quality element is measurable in many ways. Sensitivity and specificity analysis is one means of assessing any screening tool. Scientific data are available in some settings for approaches such as nurse-based clinics and preoperative questionnaires, but is absent in others.

Measurement of the cost element must be wide-ranging to be valid, and include training of staff, turnover rates, late cancellations, morbidity, and funding models (which may or may not represent true financial cost). Further, a change in one component of a process or system is quite likely to produce downstream (or upstream) effects.

These may enhance or reverse the benefits of change in any single element. For example, video-conferenced assessment of patients is an attractive (and now MBS funded) innovation, and may be valuable in terms of time and travel costs for both patient and anaesthetist. It may allow deferral of examining patients to the day of surgery, but the known high incidence of unanticipated cardiac murmurs in the elderly risks an increase in day-of-surgery cancellations unless management (and costs) of unexpected findings on the day of surgery is factored into the new model.

(continued next page)

Above: Videophone-based remote medication management (Royal District Nursing Society, SA).

Windscreen repairs – shedding light on improving healthcare continued

An IDEO-like approach to preoperative assessment

As mentioned previously, unpacking the principles of preoperative assessment suggests it shares many features with other service industries. Collection of information, assessment/calculation of need, and planning of delivery, are critical.

Further, from our day-to-day interaction with other services industries (consider banking via automatic teller machines or self-serve baggage check in at airports) we are aware of substantial changes in service delivery. Note also that these changes have been carefully explored and managed. Frequent travellers will have noticed that self-serve baggage check in with Qantas was tested in one or two airports before roll out and supported by deployment of personnel to assist customers learn the system. Investment to facilitate change is essential.

So can we take an IDEO approach and re-look at preoperative process? I believe we can. What it takes is groups from various backgrounds, prepared to consider the problems, prepared to explore innovative solutions and focused on improved quality.

In South Australia and Western Australia we have been looking at remotely delivered (phone or internet) pre-screening through smart questionnaires (300 question set, delivery in 14 minutes without clinicians) and decision support. This is a similar but more complex approach to that of O'Brien Glass.

At this stage, it appears to have sufficient quality (sensitivity and specificity, in particular) to act as a pre-screening tool, to allow accurate triage and streaming to day of surgery admission. This would theoretically reduce outpatient clinic requirements by 40-50 per cent, and allow funds to be used to enhance quality or capacity in other areas.

A questionnaire alone, however, does not make a new process, model of care, or "new way of doing business".

There are multiple aspects and steps involved. Nursing assessment is also important, and much information is common to medical assessment – why not obtain synergies through combined



questionnaires? Videoconferencing might provide an opportunity for clinician follow up, but still leaves physical examination largely unaddressed – how does one anticipate and manage an unexpected cardiac murmur detected on the day of surgery?

How can we provide patients with high quality information remotely – O'Brien Glass starts this online by providing the client with online statements such as "it is likely we can repair your windscreen". Repeated documentation (sometimes with unreconciled inconsistencies) and transcription, both consume large amounts of clinicians' time – might this be reduced with careful planning or IT tools?

Consistently collected and sufficiently reliable information, effectively summarised and/or pre-analysed with decision support, is a feature of online windscreen assessment – this already supports specialist medical care in some settings.

Clinicians, of course, need to have confidence in content and processes. Ideally, they have been involved in their development. Accurate documentation (paper or electronic) and checklists will be increasingly important as required information increases in volume and complexity.

We are familiar with their benefits through innovations such as the Surgical Safety Checklist. This doesn't replace clinical expertise, but augments it, as it does in industry. We marvelled at Captain Sullenberger's skill and

expertise in an emergency water landing of a jet aircraft in New York's Hudson River in 2009 (see www.youtube.com/watch?v=Ji542901nMs&feature=related). However, we may be less aware that, in parallel, his co-pilot was working through the written emergency checklists to make sure nothing was overlooked.

In summary, regardless of how comfortable we are with our current preoperative system and processes, we have to acknowledge this may not be the best fit with our changing environment.

We owe it to our healthcare system and patients to at least consider change. There is no unifying pathway or model of care. Each context is somewhat different, but the principles of efficiently collecting and processing information, and the benefits of partnering systems with medical expertise, are common to all.

The teachings of staff and colleagues at London Business School's Senior Executive Program and Harvard Business School's program on leading high-performance healthcare organisations, are gratefully acknowledged.

Professor Guy Ludbrook, FANZCA
University of Adelaide and
Royal Adelaide Hospital,
South Australia

Above: London Business School.

Prolapse Down Under in Nepal

In March 2011, Dr Marissa Ferguson travelled to Nepal to assist Dr Ajintha Pathmanathan (FANZCA) with anaesthesia delivery for a gynaecology camp coordinated by the medical aid organisation Prolapse Down Under (PDU).

Nepal is a land-locked country of about 23 million people located in Southern Asia. Access to medical care varies greatly by region and is particularly limited in rural centres. These areas are burdened by poverty, limited education and understanding, underdeveloped resources and difficulties with transport. The majority of the approximately 1300 doctors in Nepal are centred in Kathmandu and other large cities^{1, 2}.

Prolapse Down Under (PDU) is the brainchild of Dr Ray Hodgson, an obstetrician and gynaecologist from Port Macquarie in NSW, Australia. The location for the maiden mission, a rural town called Phaplu, was chosen based on the high prevalence of uterine prolapse. This is thought to be due to a number of factors, including lack of skilled childbirth attendants, with often traumatic deliveries^{3, 6}; short recovery time post-partum before return to heavy manual labour^{3, 6}; high parity (due to limited access to contraceptives and cultural pressure to continue to bear children until a son is born⁷), and possibly nutritional deficiencies. Furthermore, once a prolapse has developed, few women can afford the medical and transport fees required to access prolapse repair surgery⁸.

Phaplu itself is a small rural village located in the mountainous district of Solukhumbu in eastern Nepal. We arrived in Phaplu after an exhilarating flight through the breathtaking mountains south of the Himalayas. Soon after arrival, we set to work.

Patients began to arrive at the hospital the following day and we soon found that we had several hundred patients presenting with urogynaecological and other health complaints. Through efficient screening by local medical officers and a recently retired gynaecologist from Kathmandu (who describes herself as “retired, but



“Our team encountered many challenges in the operating conditions, including intermittent and unpredictable electricity outages.”

not tired” – a moniker that was very accurate considering that she screened up to 100 patients in a single day) the number of patients suitable for surgery was considerably reduced.

Surgical treatment was prioritised for those with functionally debilitating prolapses. Those amenable to conservative treatment underwent the insertion of a ring pessary, as well as education regarding the management of these devices. A significant proportion of screened patients were unfit for surgery, primarily due to previously undiagnosed co-morbidities.

By necessity, preoperative assessments were very thorough; often this was the first time that women had seen a healthcare worker, and we identified a number of untreated medical conditions. In particular, we found a high incidence of chronic cough, likely a form of chronic obstructive airways disease due to a dependence on solid fuels combined with a lack of adequate ventilation systems for indoor stoves.³ However, the possibility of tuberculosis also necessitated the delay of a number of cases for results of further investigation.

We were fortunate to have a team of American doctors from San Diego (with the Healing Hands for Humanity organisation) visiting to teach the local staff (nurses and doctors) basic obstetric ultrasonography. We managed to hijack the machines occasionally along with our trained colleagues and on rudimentary cardiac examination found signs of significant cardiopulmonary disease, clearly a cause for concern.

For example, we identified two women with valvular heart disease (aortic stenosis and mitral regurgitation). Neither woman had the finances to afford surgical care in Kathmandu and unfortunately neither patient remained in the hospital for medical management – their cardiac symptoms impacted less upon their quality of life than the symptoms from their prolapses.

We were relatively fortunate in the number of investigations available to us in this remote area of Nepal. These investigations included full blood examination, creatinine and urea, group and hold, ECG, sputum and urine microscopy, and chest X-ray. Another common chronic health condition which became evident on screening investigations was a high prevalence of preoperative anaemia (mean Hb 10.1g/dL). This was probably due to chronic helminthic infection combined with malnourishment, and was contrary to my expectation of polycythemia, given our altitude at 2413 metres.

We performed all elective procedures under spinal anaesthesia. Our team encountered many challenges in the operating conditions, including intermittent and unpredictable electricity outages (head torches doubling for theatre lights), lack of suction and effective diathermy, and equipment shortages as the camp progressed. In addition, the ambient temperature in the operating room was chilly at the best of times; one of our nurses had the foresight to bring “space-blankets” for patients to maintain body



temperature intra-operatively, and we improvised a fluid warmer in the form of an old unused infant incubator.

One memorable challenge that we faced was the management of a 57-year-old woman who required a laparotomy at midnight for sepsis and acute haemoglobin drop on the third post-operative day. Anaesthetic issues included the management of significant anaemia with no formal blood bank service; maintaining stable haemodynamic status in the context of significant bleeding and sepsis; and delivery of general anaesthesia in a resource-constrained environment. We were able to cross-match blood and administer two units of whole blood preoperatively from volunteers in the camp, thankfully without complication. Initially an epidural was inserted for a vaginal evaluation under anaesthesia; however, when it became clear that a laparotomy was required, a gas induction was performed using halothane and intubation proceeded uneventfully.

We encountered a number of issues in the delivery of post-operative care. The ward nurses were not trained in recovery and post-operative management. In particular, they were unable to provide regular monitoring of vital signs, to manage urinary catheters or to act on untoward findings. In addition, oxygen cylinders were not available, and instead we relied upon oxygen concentrators. These provided adequate oxygenation for the less stable patients... until the daily power outage arrived!

The second of our more challenging patients experienced a myocardial infarct immediately post operatively. For this patient and for our woman recovering from her laparotomy for retroperitoneal haemorrhage, we converted the recovery room into a makeshift high-dependency unit (HDU), where we continued supplemental oxygen and monitored both patients for a further 48 hours. During this time, both patients slowly improved and were then transferred to a makeshift HDU section on the general ward, where they continued to make an excellent recovery.

This trip was rewarding both medically and culturally. In dealing with the various challenging situations, I learnt a number of valuable lessons. These included the importance of teamwork, not only amongst our group, but also in forming a team collaborating with the local staff. Effective communication was also essential, particularly due to the language barrier; our interpreters were invaluable in this respect.

I came to truly appreciate the importance of a thorough history and examination and I have no doubt that my clinical skills have improved as a result. Finally, I would encourage any doctor considering joining such a medical aid trip to do so. Despite being relatively junior, I was able to learn and contribute as a valuable team member.

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 with assistance from Dr Ajintha
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Above from top left: A lifetime of carrying heavy loads, particularly soon after childbirth, contributes to the high prevalence of uterine prolapse amongst Nepalese women; The PDU team performing a laparotomy at midnight; Celebrating the conclusion of a successful camp.

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 their ground medical support while putting out a call on the intercom: “Is there a doctor on board?”

Fortunately there were six anaesthetists returning from the CSM, and the patient responded to treatment that was available in the emergency medical kit. Soon after, on another flight a young man had a grand mal convulsion, another group of anaesthetists responded to the call “Is there a doctor on board?” Meanwhile, in the cockpit things were not much better with take-off aborted due to windshear and the “fire engine one” alarm occurring four times.

These scenarios took place at the Flight Training Center at Cathay Pacific in Hong Kong as an offsite workshop of the CSM. We ran in-flight medical emergency simulations for 24 participants to familiarise them with the emergency medical equipment available on board, to appreciate the unfamiliar and confined environment and to understand the airline protocols in medical emergencies.

We used a mockup of the Boeing 777 cabin, a Sim-man 3G high fidelity mannequin, actors and a team of flight attendant trainers to set up the scenario for in-flight medical emergencies. Cockpit simulation was done with a flat screen simulator with flight instructors from Cathay Pacific.



It is likely that doctors who travel regularly will receive a call for help during their careers. In-flight medical emergencies are relatively common occurring at approximately one per 10,000 -40,000 passengers, with one death per 3-5 million passengers and medically related diversion of aircraft in 7-13 per cent of cases¹. There will be a medical person on board in 83 per cent of flights². The most common diagnose are vasovagal syncope (22.4 per cent), cardiac (19.5 per cent) and neurological (11.8%)³.

Resuscitating a patient in the confined space of an economy seat may be difficult. The seats will not lie flat and there will be other passengers crowded around who may need the flight attendant. In this scenario the mannequin was moved from the economy seat to the galley area. We had been briefed on the contents of the emergency medical kit by Cathay Pacific’s aviation chief medical officer but it was still difficult in the emergency to find the correct drugs and equipment.

An oxygen cylinder was used and the automated external defibrillator (AED) was available but not used. The contents of emergency medical kits may vary between airlines but is being standardised in the aviation industry. Table 1 gives an example.

Table 1. Example of aviation emergency medical kit

Kit Specification – European Joint Aviation Authorities

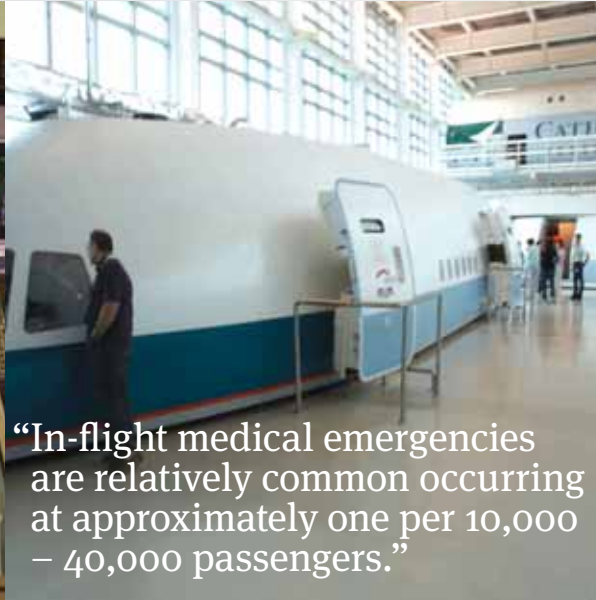
(JAA) Regulation: JAR-OPS 1.755 – Emergency Medical Kit

Contents:

- Sphygmomanometer
- Syringes and needles
- Oropharyngeal airways (two sizes)
- Tourniquet
- Disposable gloves
- Needle disposal box
- Urinary catheter
- A list of contents in at least two languages (English and one other)

Drugs: Adrenocortical steroid, antiemetic, antihistamine, antispasmodic, atropine, bronchial dilator (inhalation and injectable forms), coronary vasodilator, digoxin, diuretic, adrenaline (epinephrine) 1:1000, major analgesic, medication for hypoglycaemia, sedative/ anticonvulsant, uterine contractant.

Note that there is no requirement for an IV kit, although some carriers including Qantas will have IV fluid. There is no intubation equipment although a laryngeal mask may be included.



“In-flight medical emergencies are relatively common occurring at approximately one per 10,000 – 40,000 passengers.”

One of the main issues raised in the debriefing is who had authority in the emergency. According to the Cathay Pacific protocols, the cabin crew retains control and will run the emergency within their abilities. Cabin crew personnel are trained in first aid, cardiopulmonary resuscitation and the use of the AED. They will be guided by the medical advice of their ground medical support.

Cathay Pacific use Medlink, which is a 24-hour service based at the Trauma Centre of Banner Hospital, Phoenix in Arizona, US. The doctors on board are to follow the instruction of the ground medical support and to communicate patient information to them. The decision for diversion ultimately rests with the captain of the aircraft in liaison with the flight control. This surprised a number of the anaesthetists on board who assumed they had autonomy in decision-making for patients under their care. However, the cabin crew withheld the medical responders from administering medications until it was approved by Medlink.

Communication with Medlink is by satellite phone, which may be interrupted. We noted during both scenarios that the participant who communicated with Medlink was not the leader of the medical response team. A decision for flight diversion was made in both scenarios.

During debriefing, the leader of the medical response team disagreed with the decision for diversion but was not involved in the decision. One of the observers was involved in another ground support medical service and noted that there may be communication issues during an emergency.

The cockpit simulations showed how the aviation industry uses checklists before and after takeoff and landing, and the use of standard operating procedures together with memory items in an emergency. We discussed how we can adapt these principles to anaesthesia.

We received many encouraging comments on the way back in the coach. I heard a number of times that this was the highlight of the CSM for some participants. This workshop was the result of collaboration with Cathay Pacific and they generously provided their simulation facilities, aviation medical specialists, flight instructors and flight attendant trainers. They also learned a great deal from the encounter.

Dr Tim Brake, FANZCA
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Dr Tim Brake was the “Is there a doctor on board?” workshop co-ordinator at the 2011 Hong Kong Combined Scientific Meeting.

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Above from left: Dr Phillipa Hore and Dr Michelle Mulligan in the cockpit; the flight simulator controls; the Flight Training Center at Cathay Pacific, Hong Kong; anaesthetists taking part in the in-flight medical emergency simulation workshop.

The National Inpatient Medication and Adult Deterioration Detection System Charts: Notes of caution

The National Inpatient Medication Chart (NIMC) and the Adult Deterioration Detection System (ADDS) chart have both been developed under the umbrella of the Australian Commission on Safety and Quality in Health Care (ACSQHC) with the aim of improving patient safety.

However, we believe that caution is needed when prescribing and titrating *prn* opioids for the management of acute pain and therefore in the use of these charts.

National Inpatient Medication Chart and “maximum 24-hour doses”

The “National Inpatient Medication Chart Local Management Guidelines”¹ outline how this chart² should be used and what alterations are and are not allowed to be made by local jurisdictional working groups.

The NIMC currently requires a “maximum 24-hour dose” to be entered for all medications prescribed on a *prn* basis. While this is very appropriate for drugs such as paracetamol and nonsteroidal anti-inflammatory drugs, where a maximum limit is commonly recommended and where there is a reasonable idea of what that maximum dose should be, this is not the case for opioids.

There is no good way to predict the dose of an opioid that a patient might need for management of their acute pain. While initial doses are better based on patient age rather than weight (in opioid-naïve patients at least), there is an eight- to 10-fold variation in requirements in each age group.³

To artificially specify a “maximum dose” would at best require an inaccurate guess. It might, in a few patients, be an appropriate guess, it could mean that other patients do not get an adequate amount (and nursing staff, if busy, would be more likely to stop at this dose rather than ask for a change in prescription), or in some patients that maximum dose may be excessive.

Furthermore, it is well established that patients in acute inpatient settings may be subject to often rapid changes in health such as development of sepsis, renal impairment and fluid shifts. These factors may also alter opioid dose requirements. In addition, other drugs may be added that increase the risk of sedation with opioids.

This makes the requirement to use a 24-hour maximum dose unsafe. What was safe today may not be safe tomorrow or even in a few hours time!

We believe that it is important to encourage all staff to titrate the amount of opioid given to each patient, which requires regular assessment of both pain and sedation – increasing sedation being used as a more reliable indicator of early opioid-induced ventilatory impairment (OIVI) than a decrease in respiratory rate.⁴

The sedation scoring system used by many of us and promoted by the Victorian Quality Council⁵ records sedation on a four-point scale of 0 to 3 – see Table 1. While a score of 1S is used in many institutions (to indicate a patient who will stir in response to a mild stimulus but without waking them completely), it is not used by others, as a sedation score of 2 could remain undetected and thus an opportunity for appropriate early intervention (for example, a reduction in size of the next dose of opioid administered) is lost. Use of a sedation score of ‘S’ (patient is sleeping) is not recommended as it often means that no attempt is made to wake the patient and thus even severe OIVI may be missed.⁴

Therefore, if this sedation scoring system is used, a preferable “maximum 24-hour dose” would be “if sedation score < 2” – or “SS < 2”.

On page 14 of the “National Inpatient Medication Chart Local Management Guidelines”¹ it notes that the maximum 24-hour dose is one item that should not be altered without ACSQHC approval. In part, as an explanation, it says that “Indication and maximum daily dose (that is, maximum dose in 24 hours) must be provided to ensure safe and appropriate administration and to minimise the risk of overdose”.

However, the risk of opioid overdose will not be reduced by simply guessing at a maximum allowed 24-hour dose.

Patient safety can only be improved if opioids are titrated according to the patient’s pain reports and level of sedation. Some hospital drug committees have, without ACSQHC permission, approved a change to allow the maximum 24-hour dose for opioids to be written as “SS < 2” rather than a specific dose, which will also encourage monitoring of sedation scores. Others have approved the use of “N/A” – not applicable (appropriate) for *prn* opioid prescriptions.

Adult Deterioration Detection System charts and a patient’s level of sedation

In order to titrate opioids safely, therefore, the nurses should monitor and record a patient’s sedation score on a regular basis and increasing sedation should be taken to mean a deterioration in the patient’s condition related to opioid administration (until proven otherwise). If a sedation score of 2 or higher is noted, appropriate and urgent intervention is indicated.

However, there is no ability to record sedation scores on the ADDS chart.⁶ A patient’s level of consciousness is reported using the AVPU scale (A = alert, V = responds to voice, P = responds to pain and U = unconscious).

A report called “The Development of the Adult Deterioration Detection System (ADDS) Chart”⁷ notes that “each AVPU category corresponds to a restricted range of Glasgow Coma Scale”. On page 11 of this report, the rationale behind this choice is said to be that “the AVPU scale seemed to be a simpler, less subjective, more behavioural measure of consciousness than other measures (such as “Sedation Scores”, which involve assigning descriptors such as “mild”, “moderate”, etc)”. However, the AVPU does not describe the amount of “stirring” of the patient needed or permitted in order to assess level of consciousness, whether by voice or an undefined “amount” of pain, nor does it indicate the actual response of the patient. Therefore the AVPU is not sensitive enough to detect early stages of OIVI.

It is therefore suggested that sedation scores should also be used. While the words “mild”, “moderate” etc are often involved in the descriptions of each level of sedation, they are accompanied by reasonably objective rather than



subjective definitions of what they mean. A patient who wakes easily but has difficulty staying awake (sedation score = 2; considered to indicate early OIVI) is usually easy to determine. Reasonably similar definitions are to be found on the sedation side of the Richmond Agitation and Sedation Scale, commonly used in intensive care units to measure a patient's level of agitation or sedation.⁸

It may be possible to get individual institutions to change their ADDS charts accordingly, again on the basis of enhanced patient safety. In our opinion, sedation scores should be seen as a "sixth vital sign", pain being the fifth. Increasing sedation, like increasing pain, should be considered important indicators of patient deterioration.

The principles outlined above are supported by the Quality and Safety Committee of the Australian and New Zealand College of Anaesthetists.

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Table 1: Sedation Scores⁵

0	awake, alert
1	mild sedation, easy to rouse
1s*	asleep, easy to rouse
2	moderate sedation, easy to rouse, unable to remain awake
3	difficult to rouse

* may not be used in some centres where a score of 1 is used whether or not the patient is asleep as a sedation score of 2 could be missed

The experiences of a medical volunteer at the Winter Olympics



Behind the amazing feats of Torah Bright and Lydia Lassila winning gold in snowboarding and aerials for Australia at the Winter Olympics in Vancouver in 2010, there was an essential team of doctors, nurses and allied health staff providing first-class medical care. Trainee anaesthetist Michelle Gerstman was lucky enough to gain some exposure to this as a volunteer at Whistler during the Winter Olympics and Paralympics.

There are two general groups of people requiring medical care at the Olympics. Firstly, there are the athletes who are pushing themselves to their limits and who are unfortunately at high risk of injuring themselves.

Secondly, there are the spectators and workforce who may have pre-existing medical conditions or who may sustain injuries while attending events. Overall, there is a huge influx

of people who are unable to be cared for by the existing medical services. This care was provided by a dedicated medical team, backed up by existing resources. Medical care was provided at each sporting venue as well as at two polyclinics located in the athlete villages in Vancouver and in Whistler.

The polyclinic had the capacity to assess, investigate and treat athletes and was largely staffed by voluntary medical, nursing and allied health staff. Services included a general practice-type clinic with sports medicine physicians as well as dental, ophthalmic, nutrition, physiotherapy and some specialist services. Laboratory, pharmacy and medical imaging, including an MRI machine, were available, generally avoiding the need for athletes to travel the two hours to Vancouver. For some athletes, this level of care was far greater than is available to them in their home countries.

In addition to sub-acute services, the polyclinic was equipped for emergency cases with medical, trauma and resuscitation bays, as well as a portable operating theatre. An anaesthetist and a surgeon were on call 24 hours a day with a response time of less than five minutes during competition. This

service was designed for life or limb surgery where a patient was too unstable to be transported to Vancouver. Two anaesthetists shared the anaesthetic role.

One of the issues in this environment is that the staff are not familiar with the team or the environment. We all know how important this is in a medical emergency. The medical and nursing staff had attended several simulation training sessions in order to gain experience working together.

When treating athletes, medical staff had to be aware of anti-doping laws and exercise caution with intravenous fluids, opioids or benzodiazepines. Obviously when an athlete's health was at risk their well-being was the priority.

At each venue there was a medical team set up to provide care for both the spectators and competitors. Spectators presented with a variety of medical problems, from musculoskeletal injuries after falls to cardiogenic shock post myocardial infarction. Injured spectators who could not be managed onsite were transferred to an existing medical service.

I was based at the alpine skiing venue, as well as the cross country skiing site. Downhill skiing is notorious for accidents, not surprisingly with competitors reaching speeds of over 100km/h while racing down steep, icy pitches.



“The polyclinic was equipped for emergency cases with medical, trauma and resuscitation bays, as well as a portable operating theatre.”

Throughout the games there were many stories of inspiring and courageous performances. Anja Paerson, a Swedish Alpine ski racer, flew 60 metres off a downhill jump losing balance and crashing. The next day she returned to the same ski run and won a bronze medal in the super combined event. Petra Majdic of Slovenia, a favourite for the 1.2 kilometre cross country sprint, fell two metres into a ravine during the warm-up sustaining fractured ribs and a pneumothorax. Determined to compete, she managed to qualify through the heats and eventually won a bronze medal, despite collapsing at the end of each sprint. There were endless stories of Paralympians overcoming adversity such as cancer and trauma.

A highlight of the job was the proximity to the field of play and the athletes. I was commonly located at the finish line of the event where I experienced first-hand the raw emotion of athletes competing for their country and the joy of winning a medal or a personal best performance. I also saw close up the steepness of the ski runs and visited the biathlon shooting range.

As part of my volunteer job, I spent some time in the Olympic family lounge. This involved taking care of dignitaries and celebrities from all over the world.

The kings and queens of Sweden and Norway regularly attended the cross-country events, and I even wished the King of Norway “happy birthday” after a little Norwegian coaching. I met members of the Australian team who gave me an amazing souvenir – an Australian Olympic jacket.

The buzz in Whistler village was incredible with athletes wandering around in their team outfits and supporters in traditional dress from their country. Various locations had been converted into “houses” dedicated to different countries. They would prepare traditional food and drinks from their country, such as cheese fondue in the Swiss house and hot mulled wine in the Austrian house. When an athlete won a medal, they celebrated in their country’s house and I met several athletes after their victory. The medals were beautiful – individually handcrafted, unique for each athlete and surprisingly heavy.

The team of volunteers included Canadians as well as several internationals. I made lifelong friends and still keep in touch with many fellow volunteers. The volunteers were dressed in blue uniforms and known as the “blue coats” officially, or the “smurfs” affectionately. There is an incredible bond between volunteers from the games.

Overall the experience at the games was unforgettable. It was a unique opportunity, experiencing the atmosphere created by the best in the world competing in so many different events, and watching sports I would never have seen otherwise. It was certainly impressive to see the organisation behind providing a medical service to such a broad range of people in varied locations. And of course there was some amazing skiing.

Dr Michelle Gerstman
Trainee anaesthetist, Victoria

Above clockwise from left: Vancouver hosted the 2010 Winter Olympics; Michelle Gerstman with two olympic gold medals; Edwina Fordyce, Michelle Gerstman and Alex Dashwood; the portable operating theatre.

Adverse outcomes in acute pain management

There is good evidence that, despite the evolution of acute pain services and better training in acute pain management, there continues to be adverse outcomes, in particular related to the use of opioids which are still the main agents employed in acute inpatient pain management.

In the excellent review by Associate Professor Pamela Macintyre, Dr John Loadsman and Associate Professor David Scott in a recent publication in *Anaesthesia and Intensive Care*¹ the term opioid-induced ventilatory impairment (OIVI) is suggested as the correct term to cover central respiratory depression, sedation and respiratory obstruction which alone or in combination may decrease alveolar ventilation and lead to increased arterial carbon dioxide levels. They indicate that increasing sedation is the most reliable clinical sign of early OIVI, which should be closely monitored on a regular basis, and that opioid doses may need to be reduced, regardless of the level of pain control. Severe OIVI can co-exist with a “normal” respiratory rate.

Another article by Associate Professor Macintyre, Dr Jennifer Trinca, Dr James Sartain, Professor Stephan Schug and Associate Professor Scott, in this issue of the *Bulletin* (page 42), gives further details about the need to monitor a patient’s level of sedation on a regular basis, a suggested sedation scoring system, and the potential problem, therefore, associated with the national Adult Deterioration Detection System (ADDS) chart now in place in many hospitals.

The following brief case reports from the archives of the Victorian Consultative Council on Anaesthetic Mortality and Morbidity highlight many of these issues, including the need for education of all staff involved, appropriate monitoring for all patients given opioids, and guidelines to be followed should excessive sedation occur.

Case 1

A 30-year-old cyclist sustained bilateral calcaneal injuries which were treated by open operation under general anaesthesia. He had sustained no head or other injuries, there was no history of substance abuse and he did not have any hepatic or renal impairment. Recognising that calcaneal injuries can be particularly painful he was given PCA morphine with a 1mg bolus and five minute lockout but no background infusion and he was returned to a medical ward.

On the first postoperative day, due to inadequate pain relief and a high demand rate, the bolus dose was increased to 2mg and non-steroidal anti-inflammatory drugs were also administered. In the early morning of day two, he was found unconscious with a Glasgow Coma Score of 3, a respiratory rate of 10/min and evidence of respiratory obstruction. At this stage he had not been seen for four hours. There was no response to naloxone, CT scan was normal and the diagnosis was made of hypoxic brain injury. He was eventually discharged from ICU and following rehabilitation made some recovery but with markedly impaired cognitive function.

Review of his medication revealed that he had required 88mg morphine since the previous morning, including 52mg in the 10 hours overnight prior to his collapse. While this is a high amount of morphine it may be a reasonable requirement in a young patient – as long as they are not sedated. In addition he had received tramadol 100mg nine hours and five hours pre-collapse as well as ibuprofen.

The issues in this case were the level of supervision and level of training of nursing staff in pain management in a medical ward, the additional drug therapy, the appropriateness and/or accuracy of the overnight observations and the four hour observation gap during the night. In addition, it may be wise not to increase the PCA bolus dose solely on the basis of total PCA demand

rate. It is important to distinguish the number of doses actually delivered from the total number of demands made. The number of “unsuccessful demands” (i.e. made within the lockout period) correlates well with degree of patient anxiety and pain catastrophising scores.

Case 2

A 50-year-old patient with no major medical problems but with a BMI of 35 underwent an uneventful removal under general anaesthesia of a mandibular plate inserted following an earlier facial reconstruction.

She suffered severe pain and was given PCA morphine with a 1mg bolus and five minute lockout. In the first 20 hours she received 101mg of morphine with unsatisfactory pain relief. PCA morphine was then increased to 2mg bolus doses and she was also administered tramadol 100mg and paracetamol. Four hours later further tramadol 100mg was administered and at observations 1½ hours later she was noted to be “sleeping” and was not disturbed for a meal. At the next observation 1½ hours later she was found to be apnoeic and asystolic. In the six hours prior to the arrest she had received 30mg morphine as well as the 200mg tramadol.

She was resuscitated but developed multi-organ failure and there was no neurological recovery.

Autopsy confirmed features of multi-organ failure but the conclusion and subsequent coronial investigation identified hypoxic brain damage as a result of pain management as the cause of death.

The issues in this case were the poor pain relief and increasing doses of morphine, a failure to wake the patient to check on her level of sedation – a sedation score of ‘S’ is not recommended², limited supervision in a non-surgical ward and the possibility of respiratory obstruction in an obese patient.

Case 3

This was a brief report of a patient undergoing an inter-hospital transfer with inexperienced medical supervision. He was on a background morphine infusion and during transport was administered several bolus doses of 1mg morphine with a resulting respiratory arrest and the need for emergency intubation and ventilation in the ambulance.

This case highlights the possible risk of background infusions with frequent “top-ups” by inexperienced personnel in adverse surroundings.

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In the last three publications of the *Bulletin* we have had the benefit of detailed case reports of adverse outcomes following difficult airway management along with recommendations for better management.

Acute pain management is seen as another area where a similar exercise is important and it is hoped that Fellows will be able to provide additional reports that can be edited carefully and included in future *Bulletin* productions.

Patricia Mackay
Communication/Liaison Portfolio
Quality and Safety Committee

The ECRI Institute

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

It is recognised that 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 of the *Bulletin* can only highlight some of the alerts that may be relevant and it is the responsibility of hospitals to follow up with the manufacturers' representatives if they have not already been contacted.

The following alerts may be relevant to Australia and New Zealand:

1. Care Fusion 3100B High Frequency Oscillatory Ventilator Diaphragms

These ventilators are mainly employed in intensive care units in patients who cannot tolerate the lung volume changes associated with conventional mechanical ventilators.

The rubber diaphragm of the ventilator may fail before the manufacturer's recommended replacement after 4000 hours of use, resulting in inability to ventilate.

The proper function of the oscillatory ventilator depends on rapid movements of the piston and integrity of the diaphragm. The current manufacturer's recommendations include replacement of the driver assembly after 4000 hours of operation and care in use of cleaning agents on the diaphragm. However some reports have indicated that deterioration may occur with lesser usage and a check with visual and tactile inspection is recommended before each circuit connection.

When not in use the diaphragm should be protected from damage and UV light with a plate supplied with the oscillator and should be stored in a temperature and humidity controlled environment.

2. Phillips IntelliVue Monitor

Data may appear on the wrong XDS remote display under certain circumstances when a Phillips IntelliVue physiologic monitor is disconnected from an IntelliVue XDS remote display and reconnected to a different XDS remote bedside display unit in the same or a different room.

As a result the original data may be associated with the wrong patient as manual reassignment on the central display unit is required to show information on the new display unit.

Phillips recommends that XDS systems operating with software version H00xx or earlier be upgraded to H15xx which supports automatic transfer of patient information from the monitor to the XDS display. H15xx is available as a download free of charge from the Phillips website.

3. SmithsModel 2120 CADD-Solis Infusion Pumps

Under delivery or non delivery may occur if the medical cassette reservoir or administration set is not firmly latched to the above infusion pump.

A Smiths representative should be contacted to demonstrate the action required to ensure proper delivery.

4. Animas Model 2022 Insulin infusion pumps

Manufacturer Animas Corp A Johnson and Johnson

An incorrect InF capacitor component may have been employed in the manufacture of the “replace battery” irrespective of the condition of the battery.

Animas issued an urgent pump recall letter on July 29.

The review of ECRI alerts has been continuing and over the past few months there have only been a few alerts which directly affect Australia and New Zealand.

If you have an alert or warning which you would like to publicise to your peers please email qs@anzca.edu.au for possible publication in the *ANZCA Bulletin* and/or *E-newsletter*.

Patricia Mackay
Communications/Liaison Portfolio
Quality and Safety Committee

The Can't Intubate Can't Oxygenate Scenario (CICO)

Implications of the National Audit Project (NAP₄) of the Royal College of Anaesthetists

CICO is a rare and terrifying event, which if incorrectly managed can be catastrophic. It is difficult to know the incidence of such an event. NAP₄ shows one in 50,000 but this may be a four-fold underestimate. In the emergency department this figure may be as high as one in 100^{1,2,3}. We have proposed a simple algorithm⁴ (see diagram) which is now being taught in multiple centres around Australia and we hope that this algorithm will be considered by those unfamiliar with it. Clear guidelines for the management of difficult airways exist from institutions such as the Difficult Airway Society (DAS) and the American Society of Anesthesiologists (ASA), but this clarity ceases once the CICO scenario arises. At the point of CICO simple well rehearsed steps should be followed in an effort to counteract the negative human factors that may be exhibited at this point.

At Royal Perth Hospital in Western Australia we have been running simulated CICO in a live animal model for more than seven years. We have observed more than 500 participants successfully work through our algorithm under stressful circumstances. The nuances of the techniques are beyond the scope of this article, but in essence we suggest in the first instance picking a cannula technique (allowing safe simple fast oxygenation) and limiting the maximum number of attempts allowing a rapid progression to a scalpel technique. Most anaesthetists will be familiar with a cannula in their

hands in a crisis situation as opposed to a scalpel. The algorithm and the techniques can be successfully taught in a half day session.

NAP₄ was a one-year prospective audit looking at serious airway complications in all 309 National Health Service hospitals in the UK. There were 58 "emergency surgical airways" performed, of which 25 were performed by anaesthetists and the vast majority of the others were by head and neck surgeons. There was a high failure rate of cannula cricothyroidotomy (15 out of 26 attempted), though the authors recognise that the successes could have been under reported as the project specifically studied events with poor outcomes. Only 11 of the 29 cases where tracheostomy was the first line were true CICO scenarios⁵, for example 11 cases took over an hour to secure an airway¹.

In the second section of the NAP₄ results published in the *British Journal of Anaesthesia* it was suggested "needle cricothyroidotomy has a high failure rate and therefore should be abandoned, particularly as surgical approaches were generally successful"³. The authors do however offer some caution over this conclusion. An alternative interpretation is our belief that there is no evidence for this recommendation and that the NAP₄ results are in fact concordant with the algorithm, equipment and techniques that we have been teaching. In the event of a CICO situation, following logical steps, using standardised appropriate equipment and with adequate training, the success rate of a cannula technique would be higher. In our stressful animal model simulation we have a 90 per cent success rate (using both cannula and scalpel techniques) with our algorithm after a short manikin training session. Further evidence is still required to translate this to clinical practice, but

researching the CICO scenario will always prove difficult to achieve due to the obvious limitations of human research into this event. We strongly believe all anaesthetists should be trained in the management of CICO and a scalpel technique "surgical airway" should be taught alongside a cannula technique to prepare for every eventuality.

A conclusion that cannula techniques should be abandoned based on audit data is possibly unwarranted. Hypothetically, if you were to audit giving non airway-trained doctors laryngoscopes for the first time, in the middle of an *in extremis* situation you would end up with a "high failure rate" (this would be compounded further by giving these doctors poor quality equipment). The equally unwarranted and didactic conclusion would be to suggest abandoning all laryngoscopy.

We agree with many of the NAP₄ suggestions for the low success rate of cannula techniques, beyond that of just under reporting: lack of training (or of ongoing training), failure of technical skills, poorly designed equipment, device failure, attempting to ventilate as opposed to oxygenate, and a whole range of human factors which may have been reduced with a clear algorithm and personal preparedness¹. These failings have specifically been addressed in our training for CICO which is reflected not only in the successes in the live animal model, but also from feedback of real life situations from our previous training attendees. To allow and encourage airway specialists to revisit their planned approach to the CICO situation, we have placed instructional videos for public access on You Tube (Channel: Drambheardairway).

Difficult airway and CICO events are often unanticipated. No anaesthetist

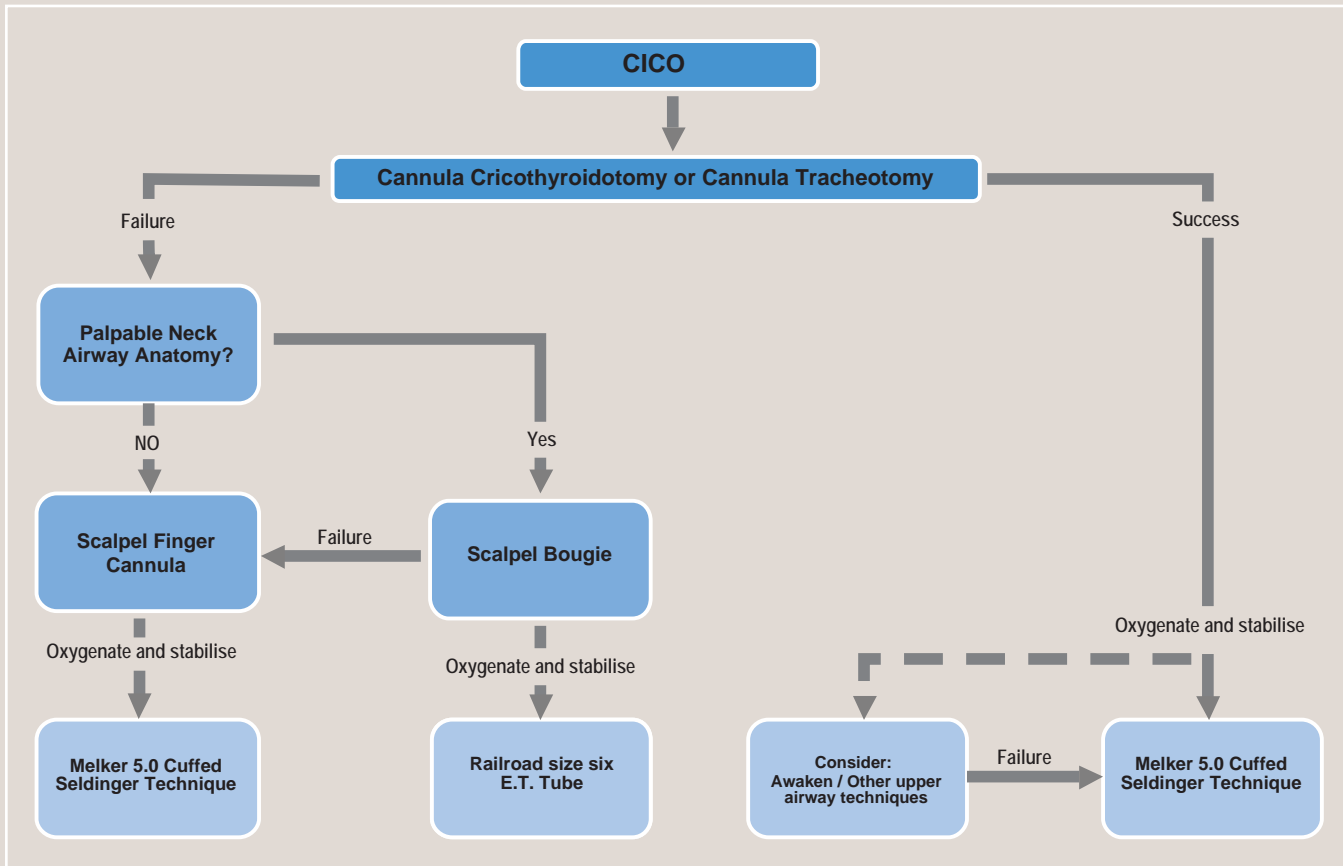


Figure: CICO algorithm adapted from Heard, Green and Eakins 2009⁴

would like to be faced with managing this situation and it is unrealistic to think there will always be a surgeon available who is capable of “bailing you out”. It is reasonable to conclude that anaesthetists should be physically and mentally empowered with an adequate plan and adequate equipment to deal with this situation and the NAP₄ data adds further evidence to support this conclusion.

Dr Andrew Heard
Staff Specialist Anaesthetist
Royal Perth Hospital

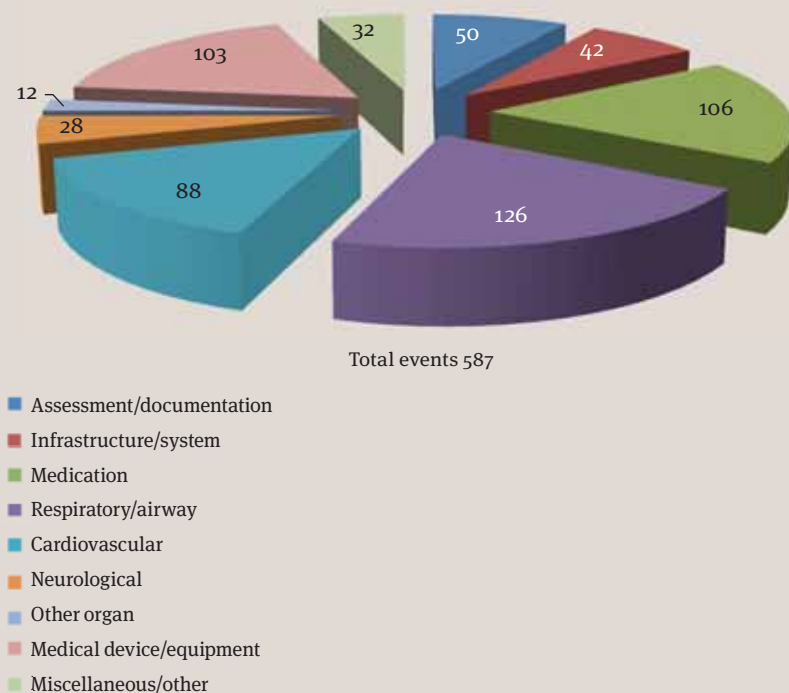
Dr Edward Debenham
Airway Fellow
Royal Perth Hospital

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2. Cook TM, Woodall N, Frerk C. Major Complications of Airway Management in the UK. Part 1 Anaesthesia. *Br J Anaesth* 2011; 106: 617-31
3. Cook TM, Woodall N, Harper J, Benger J. Major Complications of Airway Management in the UK. Part 2: intensive care and emergency departments. *Br J Anaesth* 2011; 106: 632-42
4. Heard AM, Green RJ, Eakins P. The formulation and introduction of a ‘can’t intubate, can’t ventilate’ algorithm into clinical practice. *Anaesth* 2009; 64: 601-8
5. Norris AM, Hardman JG, Asai T. Editorial: A firm foundation for progress in airway management. *Br J Anaesth* 2011; 106: 613-16

ANZTADC's webAIRS (web-based Anaesthetic Incident Reporting System)

Figure: Main category coding, September 2009 – July 2011



Incident analysis

The Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) is a joint endeavour funded by the Australian Society of Anaesthetists, ANZCA and New Zealand Society of Anaesthetists. Software to enable a web-based anaesthetic incident reporting system (webAIRS) has been produced and this chart shows the main categories for the 587 incidents collected between September 1, 2009 and July 21, 2011.

The largest main categories were respiratory/airway (21.47 per cent), medication (18.06 per cent), medical devices and equipment (17.55 per cent) and cardiovascular (14.99 per cent). Each of these categories has been further subdivided. In this issue the ANZTADC analysis subcommittee has drilled down on medication incidents which accounted for 106 of the 587 incidents (18.06 per cent).

Once again a particular area of concern has been the misreading of ampoule labels; but in particular in this latest data group, insulin errors. At the ANZCA combined scientific meeting 2011 in Hong Kong a presentation was made that included problems with misinterpretation of the labels on insulin ampoules. This misinterpretation has in turn lead to incorrect dilutions for insulin infusions.

It should be noted that insulin doses are expressed as units per millilitre (ml) not units per ampoule. The most common ampoule available is insulin 100 units/ml in 10mls ampoules, that is 1000 units in 10mls. However other commonly used anaesthetic drug labels are expressed as the dose per ampoule.

For instance fentanyl is 100 mcg in 2mls (or 500 mcg in 10mls) which is 50mcg/ml. Insulin is therefore the exception to the normal rule and in the reported errors it was assumed that the insulin ampoule contained 100 units whereas it actually contained 1000 units (10ml amps) or 300 units (3ml amps).

In each of the errors that occurred the insulin was drawn up in a standard syringe instead of an insulin syringe. It is therefore recommended that an insulin syringe always be used for measuring the insulin dose to be added as this is calibrated in units rather than mls.

Also, if possible, ask your pharmacist to add a warning label to insulin ampoules to be used in the operating theatre which states the total number of units per ampoule (usually 1000 units in 10mls or 300 units in 3mls).

Alerts reported

Recent alerts reported have included problems with both infusion pumps and infusions sets. The problem reported with infusion pumps is that some pumps have suddenly failed to respond and also failed to deliver the infusion which in turn requires re-booting and re-programming the pump.

This has occurred in the situation where solutions containing inotropes are being used and has led to severe hypotension whilst the problem was being corrected.

The second problem involves infusions sets and the problem reported here is that separation of the infusion set can occur between silicone components and plastic components.

This appears to occur in sets with no anti-reflux valve and has occurred when back pressure has existed in the infusion line causing a silicone joint to pop apart.

In this article the brands involved cannot be named, but please report any similar problems to ANZCA and include the brand involved, a detailed description of the problem, what appears to have caused the problem, any temporary solutions applied to overcome the problem and your contact details.

This will enable ANZTADC to build a profile of problem devices and report the problem to the Therapeutic Goods Administration (TGA Australia) and Medsafe (NZ). Please report the problem using the webAIRS website (www.anztadc.net) or if not registered with webAIRS please email Giselle Collins at anztadc@anzca.edu.au.

There are 30 hospitals reporting to ANZTADC using the webAIRS software and we wish to thank all of the registered sites for taking part in the ANZTADC project and for the useful feedback provided. If you would like to register your hospital please do so via the link on the ANZCA website or via the following URL www.anztadc.net/RegisterAccount.aspx?org=658365. The secure ANZTADC program is provided at no cost to fellows of ANZCA, members of the ASA, and members of NZSA. If you need help with ethics or other approvals at your hospital ANZTADC will assist with the relevant applications.

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NZ anaesthetic technicians can now register as health professionals

After an 11-year process, anaesthetic technicians in New Zealand can register under the Health Practitioners Competence Assurance Act 2003 (HPCA Act). Until now, they were the only operating theatre personnel with direct patient involvement who were not registered under that legislation.

The forerunners of the NZ Anaesthetic Technicians' Society (NZATS) indicated in 2000 their wish to be covered by this legislation but were set various criteria to meet before that would be considered. Having fulfilled the criteria, the NZATS formally applied for registration under the HPCA Act in 2005, supported by both ANZCA and the NZ Society of Anaesthetists (NZSA).

Then Chair of ANZCA's New Zealand National Committee (NZNC), Dr Vaughan Laurenson, said that anaesthetic technicians were "already indispensable members of the operating room team" and that registration would acknowledge this in a tangible way and put them on an equal footing with medical and nursing staff. The resulting increased professionalism would also lead to better standards of patient care and safety.

Anaesthetic technicians' registration will be administered by the Medical Sciences Council of New Zealand (MSCNZ), formerly the Medical Laboratory Sciences Board (MLSB), which has changed its name to reflect its wider scope. An Anaesthetic Technician Advisory Committee has been assisting the MSCNZ with preparatory work for the new regime, which takes full effect on April 1, 2012 but with registration possible from mid-September this year.

NZNC representative on the NZATS, Dr Malcolm Stuart, and the NZSA representative, Dr Andrew Warmington, made huge contributions over the years to the process and are on the advisory committee.

In anticipation of the Order-in-Council that confirmed the legal framework, the then MLSB sent out a consultation document in mid-June on the proposed registration and recertification framework for anaesthetic technicians.

That document defined the profession of anaesthetic technology, scopes of practice, qualifications, competencies required for the profession of anaesthetic technology, registration and certification processes, application fees, enrolment in a recertification program,



and accreditation of the education providers and training hospitals. The proposals have been amended following consideration of submissions.

The scope of practice for anaesthetic technicians emphasises that the technician is a member of an anaesthetic care team. It does not allow them to prescribe and/or administer agents used for general anaesthesia and/or sedation independently, a key point in the NZNC submission.

Under the new regime, health practitioners who undertake anaesthetic technology duties for a minimum of 384 hours in one year will be expected to be registered in the scope of practice of an anaesthetic technician. While trainee technicians will not need to be registered, they will be required to work under the supervision of a registered anaesthetic technician.

There are grandfather clauses for those already working in the field of anaesthetic technology. Anaesthetic technicians registered with the NZATS at May 31, 2011 will be granted registration under the new regime, provided they apply by March 31, 2012. New Zealand registered and enrolled nurses who have specialised in anaesthetic technology for at least the past five years can also apply for registration.

Otherwise applicants will need a tertiary qualification in anaesthetic technology from a New Zealand university, relevant clinical experience and successful completion of an anaesthetic technician examination, or have passed a substantially equivalent course of training, exams and experience in New Zealand or overseas.

From April 1, 2012, only those registered will be able to hold themselves out to be anaesthetic technicians or practising anaesthetic technology.

The MSCNZ says that an expanded practice role will be developed. It says that this will support governmental policy to improve productivity within New Zealand healthcare facilities, and within an affordable framework.

The MSCNZ is also responsible for accrediting the providers of anaesthetic technology education and the training hospitals. Hospitals that had NZATS approval as a training hospital as at May 31, 2011 will be automatically granted MSCNZ accreditation. Others will need to apply. Accreditation for education providers and training hospitals will be on a five-yearly basis.

Initially, it is expected that NZATS will manage the examination framework on the MSCNZ's behalf.

The MSCNZ membership is being increased by two places to 12, with one place for an anaesthetic technician and the other, initially, for a medical anaesthetist who would be appointed for a two-year term. This short-term appointment is seen as a way of helping to promote acceptance and support for the registration of anaesthetic technicians within New Zealand's anaesthesia community.

For further details and information, see www.mlsboard.org.nz.

Susan Ewart
Communications Manager, New Zealand

*Above from top left: Dr Andrew Warmington;
Dr Malcolm Stuart.*

Continuing Professional Development

CPD tips – stroke treatment

Dr Vincent Sperando is a consultant anaesthetist at St George and Liverpool Hospitals in Sydney, where he has an interest in anaesthesia for trauma, orthopaedic and neurosurgery. He also has an interest in medical education. He regularly instructs at the Sydney Clinical Skills and Simulation Centre located at Royal North Shore Hospital and is a current volunteer assisting with the authoring of the new ANZCA curriculum. He is a published author of works of fiction.

With the assistance of Dr Suyen Ho, registrar at St George Hospital, he continues his series of articles directing Fellows to convenient places to collect continuing professional development (CPD) credits.

This is the third article of a sub-series aimed at directing Fellows to best practice guidelines in medicine, in particular, areas of medicine where there have been significant changes and advances in their management. This sub-series was chosen because the recent curriculum survey identified that most Fellows felt the existing ANZCA curriculum under-represents medicine during the training period.

The National Health and Medical Research Council (NHMRC) recently posted on the internet an array of clinical practice guidelines aimed at the Australian medical practitioner. There are many existing practice guidelines listed on the site that are relevant to the anaesthetist. The featured guidelines in this article were selected off the NHMRC site and can be accessed free of charge at www.nhmrc.gov.au/guidelines/health_guidelines.html. I would encourage all Fellows to visit the site as there may be many articles of interest.

The National Stroke Foundation has recently updated national guidelines for the management of stroke published as *The National Stroke Foundation, Clinical guidelines for stroke management 2010*. The article is sizeable at 172 pages but it is only the first 45 pages on the acute management of stroke that is likely to interest most anaesthetists as this is where we may be asked to assist. Journal articles of approximately 45 pages would normally qualify for a minimum of two hours of continuing professional development credits in category 1, level 1.

The above guidelines have been chosen because there have been many recent changes in the management of stroke within Australia. It has also been chosen because the acute management is likely to involve the assistance of anaesthetists more commonly.

The impact of the Australian ageing population has increased the incidence of stroke at an estimated 60,000 new or recurrent strokes per year, according to the guidelines. The majority occur in those aged over 75 and carry a significant burden on the individual and society. The goal of the National Stroke Foundation is to raise community awareness of early stroke symptom detection, streamlining efficient stroke services for effective early intervention and subsequently aligning multiple health disciplines in the process of rehabilitation.

This synopsis will focus on these current evidence-based recommendations in the continuum of acute stroke care and innovations in medical treatment of stroke.

Early assessment and diagnosis

Early recognition, diagnosis and treatment of suspected stroke is vital in the intervention of stroke management, particularly in the “hyper-acute” presentation (symptom onset within the first 24 hours). The document discusses several diagnostic screening tools and their validity in accurately fast-tracking stroke referral. Of significance, transient ischaemic attack (TIA) sufferers continue to be a risk for secondary stroke especially those with underlying prognostic risk factors, that is:

- Age greater than 60 years.
- Diabetes mellitus.
- Longer symptom duration (greater than 10 minutes).
- motor or speech symptoms of TIA.
- hypertension blood pressure (greater than 140/90 mmHg).

Other factors that increase risk include atrial fibrillation, tight carotid stenoses and two or more TIAs within the last week. Of importance, atrial fibrillation accounts for up to 25 per cent of acute thrombotic stroke event, according to the guidelines. In order to emphasise the risk of stroke progression, a revised definition of TIA has been proposed, shortening the time frame for “disturbances in focal or global cerebral function within 24 hours to less than one hour without evidence of infarction (cellular death secondary to lack of blood supply)”. The pathway in the early investigation of an essential stroke workup includes brain imaging, electrocardiogram, routine and specific blood tests which are detailed in the NHMRC document.

Of note, it is important to understand that brain imaging is an integral modality in the diagnosis of ischaemic stroke and stroke mimics. In addition, this is particularly true in the hyperacute setting to exclude intracerebral haemorrhage (ICH) in view of the potential treatment with thrombolysis. Magnetic resonance imaging (MRI) has high sensitivity (99 per cent) and specificity (92 per cent) and is considered the imaging modality of choice compared with computed tomography (CT) brain for ischaemic stroke.

PATIENT SELECTION CRITERIA RT-PA

INDICATIONS

1. Onset of ischaemic stroke within the preceding three hours.
2. Measurable and clinically significant deficit on NIH Stroke Scale examination.
3. Patient's computed tomography (CT) scan does not show haemorrhage or non-vascular cause of stroke.
4. Patient's age is > 18 years.

ABSOLUTE CONTRAINDICATIONS: DO NOT ADMINISTER RT-PA IF ANY OF THESE STATEMENTS ARE TRUE.

1. Uncertainty about time of stroke onset (e.g. patients awaking from sleep).
2. Coma or severe obtundation with fixed eye deviation and complete hemiplegia.
3. Only minor stroke deficit which is rapidly improving.
4. Seizure observed or known to have occurred at onset of stroke.
5. Hypertension: systolic blood pressure \geq 185 mmHg or diastolic blood pressure > 110 mmHg on repeated measures prior to study.
6. Clinical presentation suggestive of subarachnoid haemorrhage even if the CT scan is normal.
7. Presumed septic embolus.
8. Patient has received heparin within the last 48 hours and has elevated PTT or has known hereditary or acquired haemorrhagic diathesis (e.g. PT or APTT greater than normal).
9. INR > 1.5.
10. Platelet count < 100,000/uL.
11. Serum glucose < 2.8 mmol/l or > 22.0 mmol/l.

However, due to the longer imaging time and limited availability of MRI scanners compared to CT in hospitals, its limitation will continue to promote CT as the imaging modality of most use in the foreseeable future. However, in the instance of a stroke presenting after 8-10 days, MRI is superior to CT in differentiation between an ischaemic and haemorrhagic event.

Acute medical management: Hyper-acute intervention

Thrombolysis is an important aspect of acute stroke management. Systematic reviews demonstrate a net benefit for patients treated within three hours of stroke (but may be used up to 4.5 hours after stroke onset) with intravenous recombinant tissue plasminogen activator (rt-PA is the only thrombolytic agent approved for use in Australia).

The guidelines say it has been shown to reduce the odds of death or dependency. Thrombolysis is a time-dependent intervention requiring rapid and efficient processes both in pre-hospital and hyper-acute hospital settings, that is, primarily in the

emergency department. Stringent and specific inclusion and exclusion criteria must be met before administration of rt-PA. The indications and absolute contraindications are outlined below, with more detailed criteria outlined in the NHMRC document.

Drug therapy in the management of an acute stroke includes antithrombotic therapy. It is recommended in the hyper acute setting by the authors to be given within 48 hours of stroke onset once intracranial haemorrhage ICH is excluded.

Aspirin monotherapy is the drug of choice with the first dose of at least 150mg to 300mg, with subsequent doses reduced to 100mg daily. If patients have received thrombolysis, aspirin should be delayed for at least 24 hours and only after follow-up brain imaging excludes haemorrhage. Comparison with anti-coagulation therapy (that is, unfractionated heparin, low molecular weight heparin etc.) is also discussed. There appears to be no evidence of added benefit over aspirin in the treatment of acute ischaemic stroke.

Acute medical management: Secondary prevention

Acute and long-term blood pressure control remains the cornerstone for secondary prevention of recurrent stroke. The end point therapeutic goals for lowering blood pressure within the first 48 hours of acute ischaemic stroke onset remain a challenge with negative outcomes (in death or dependency) for both high and low as well as large drops in blood pressure.

In general, it is desirable to cautiously reduce blood pressure by no more than 10-20 per cent from baseline. The patient should be monitored for neurological deterioration in the first 48 hours, ideally within a dedicated stroke unit, according to the guidelines. In particular, ischaemic stroke patients suitable for antithrombotic therapy should have blood pressure aimed at less than 180mmHg systolic blood pressure and less than 110mmHg diastolic blood pressure. In acute primary intracerebral haemorrhage, there is currently inconclusive data to recommend a precise blood pressure lowering threshold but maintenance of elevated blood pressure to less than 180mmHg systolic with a mean arterial blood pressure of 130mmHg is acceptable. Acute blood pressure lowering therapy in the acute phase is currently the subject of the Australian INTERACT-2 trial and results from it and other trials will be available in the next few years.

Other considerations outlined in the guidelines in management of patients with a major acute ischaemic stroke include:

- Oxygen supplementation only to patients who are hypoxic (that is, oxygen saturation less than 95 per cent).
- Maintenance of euglycaemia by blood glucose monitoring and appropriate glycaemic therapy in all patients.
- Antipyretic therapy should be used routinely where fever occurs as pyrexia (commonly a symptom of an infection) is associated with poorer outcomes (death and disability) after a stroke.

(continued next page)

Continuing Professional Development

continued

- General principles of seizure management with an anticonvulsant medication should be used in patients with post stroke seizures however the preferred medication, dosage and duration of treatment are currently unclear.

Acute surgical management

Surgical intervention for ischaemic stroke is possible in well selected patients. Large life-threatening space occupying brain oedema or middle cerebral artery (MCA) infarcts leading to “malignant infarct” have a poor prognosis. Hence hemicraniectomy is considered in carefully selected patients aged 18-60 years, where surgery can occur within 48 hours of symptom onset and significant neurological deficit due to MCA involvement.

In summary, these guidelines should assist the anaesthetist in recognising the challenges in managing patients with an acute stroke and hopefully have highlighted the complexity in management and potential involvement during the hyper acute period. I would encourage all Fellows interested in medicine to read this quarter’s highlighted article.

2011 CPD audit successfully completed

In May 2011, 2 per cent of ANZCA and FPM Fellows were randomly selected for a continuing professional development (CPD) audit of the 2008–10 triennium. The purpose of the audit was to verify that Fellows have met the triennial requirement of the CPD program. Not all active Fellows were included in the selection criteria, as the CPD team excluded all Fellows who reside in Christchurch (due to the recent earthquake), and Fellows who were selected for a CPD audit within the past six years. (Please note that the policy of excluding audited Fellows from audit selection for the subsequent two triennia has been rescinded, as of the completion of the 2008-10 triennium.)

Supporting documentation is not required for all listed CPD activities, in recognition that maintaining comprehensive documentation is burdensome and of limited benefit.

However, Fellows are asked to provide evidence of all recorded category 3 activities, publications, workshops, courses and conferences.

The response rate to the audit of 99 per cent has been very pleasing. A minority of Fellows have been granted exemptions on the basis of personal circumstances. A number of Fellows have been granted time extensions, but all are expected to successfully demonstrate compliance with the program’s requirements. The CPD department have been available to assist Fellows where requested.

In conclusion the overall response and result of the 2011 CPD audit has been a positive one.

CPD remains a requirement of regulatory authorities in Australia and New Zealand for specialist registration. An audit remains an essential component of any CPD program. ANZCA will continue to strive to provide a CPD program of a suitable standard that is as user-friendly as possible.

Dr Rodney Mitchell
Chair, CPD Committee

Improving the online CPD portfolio

December 2010 marked the end of the first triennium for the ANZCA CPD program. After receiving feedback from Fellows and staff alike the College is implementing a redevelopment of the online portfolio system, that will create a more user-friendly and intuitive portfolio.

Further details of the upcoming changes will be released via the *CPD E-Newsletter* and *ANZCA E-Newsletter* in the coming months.

New Fellows Conference 2012



“Progress occurs when courageous, skillful leaders seize the opportunity to change things for the better.” Harry S. Truman

Leadership in medicine has never been more important than in today's world. Whilst being a new Fellow may mean the end of tutorials, examinations and study groups, it also means the beginning of a journey as a fully-fledged member of a profession which is continuously evolving.

Change is inevitable, and the anaesthetic and pain medicine communities will always need leaders who can recognise the need for change, as well as initiate, shepherd and influence that change. Leadership defines what the future should look like, aligns people with that vision, and inspires them to make it happen despite obstacles¹. It is not simply charisma, or some mystical characteristic handed out to a select few; rather (like anaesthesia) it involves knowledge and skills, and the synthesis of these into an art. The aim of the New Fellows Conference for 2012 is to foster that art.

The New Fellows Conference (NFC) takes place in concurrence with the ANZCA annual scientific meeting (ASM). Participants are sponsored by ANZCA and selected via the various College regional and national committees. Selection is open to all ANZCA and FPM Fellows within eight years of attaining

fellowship. Participation in the NFC is an opportunity to meet and network with like-minded Fellows and to engage in activities with an emphasis on building skills for career and personal growth.

In 2012, it will be held at the magnificently restored, heritage-listed Caves House in Yallingup, located about 260 kilometres from Perth (yes, Western Australia is big), in the south west wine region of Western Australia. Delegates will be accommodated at the adjacent Seashells Resort. The white sands and dramatic coastline of Yallingup beach, a world-renowned surfing spot, are only a short stroll away.

We are planning an exciting and interactive conference program based on the theme of “Team Leadership”, providing participants with opportunities to explore their leadership style and further develop team leadership skills.

The current program development includes the following sessions:

- Team games and challenges – facilitated by the Merribrook corporate events group. Clear your head after the coach trip south in this outdoor physical session (we do have a contingency plan for bad weather). It promises to be fun and a great way to get to know other delegates, as well as putting your leadership skills to good use in solving the many and varied challenges. We plan to follow this with a thought-provoking debrief over a few drinks.

- “As One” leadership training – facilitated by Ms Anveeta Shrivastava, Director and consultant at Deloitte. Based on a major global initiative, this workshop is designed for you to determine your leadership style, and show you how you can apply various leadership and follower archetypes to your own organisation. It will show you new ways to lead and get your team working together.
- Leadership in a crisis – facilitated by Dr Mary Pinder, intensivist. This session will discuss leadership skills and leading a multidisciplinary debriefing when things go wrong.

The evenings will provide ample opportunity for delegates to socialise and sample some of the region's famous food and wines. We look forward to a stimulating and exciting conference, in the beautiful surrounds of the southwest coast and wine region.

Dr Angeline Lee
Dr Irina Kurowski
NFC 2012 Co-Convenors

Reference

1. John Kotter, Professor, Harvard Business School



Media releases distributed by ANZCA (since July)

“Study predicts ward patients at risk of critical event,” (August 12, 2011)

“Respected medical chief to head College of Anaesthetists,” (August 3, 2011)

“Anaesthetists discuss management of mass disasters,” (July 29, 2011)

“New patient program cuts hospital stays by three days,” (July 22, 2011)

“Alternatives to gastric band surgery for the obese,” (July 8, 2011)

“Access to blood products in remote towns to be discussed,” (July 7, 2011)

“ANZCA Bulletin out now: Japanese earthquake and tsunami; Grand Prix medical guru; ultrasound epidurals,” (July 4, 2011)

“Breastfeeding mums warned about painkiller use,” (July 1, 2011)

Since July, ANZCA has generated...

32 print stories

37 online stories

58 radio mentions

10 television stories

A broad range of anaesthetic and pain-related topics have been covered by the media since July, helping to attract public interest in the work of anaesthetists and pain medicine specialists.

All up, 137 media stories have been generated by the ANZCA Communications Unit, with several anaesthetic conferences jointly organised by ANZCA raising issues that have been picked up extensively in the media.

The NSW conference, “The Opioid and the Anaesthetist” in early July led to nearly 75 media mentions, with a warning issued to breastfeeding mothers on codeine use by Royal North Shore anaesthetist Dr Gavin Pattullo widely covered, and Dr Alex Wodak, the director of the Alcohol and Drug Service at Sydney’s St Vincent’s Hospital, talking on ways to limit problems from prescription opioids.

Another widely covered conference was the Rural Special Interest Group meeting in the Barossa Valley in July, which discussed the availability of

blood products in remote Australian towns and the possibility of establishing emergency blood donor panels. The story received enormous follow-up, with nine ABC radio programs featuring the story, and more than 20 mentions on radio news bulletins, in newspapers and online websites.

Other conferences to receive media coverage included the Melbourne combined continuing medical education meeting (which discussed a trial of the Enhanced Recovery After Surgery program at Geelong Hospital that cut hospital stays by three days, and the link between vitamin D deficiency and diabetes); the WA combined scientific meeting (which heard from Perth anaesthetist Dr Mary Hegarty and her experience of assisting with the disaster response to the 2005 London bombings); and the ANZCA Trials Group workshop (which learnt how computer analysis of routine blood tests can help predict the risk of a critical incident of a hospital patient up to 12 hours before it occurs).

In addition, the *Medical Journal of Australia* careers section ran a feature

on anaesthesia as a career in July, which included interviews with ANZCA President Professor Kate Leslie, SA anaesthetist Professor Guy Ludbrook and Victorian anaesthetist Professor Paul Myles.

On the back of a feature in the last *ANZCA Bulletin*, Channel 9 produced a news feature that ran around Australia in July on ultrasound-guided epidurals, featuring Hobart anaesthetist, Dr Nico Terblanche.

In New Zealand, Chair of the New Zealand National Committee, Dr Geoff Long, contributed comment to a joint media release issued in late July by several medical colleges supporting a new maternity standards framework. The release was mentioned briefly in an article in *The Dominion Post*.

And comment from Dr Long was also included in an article on the recent anaesthesia workforce review in the *Sunday Star Times* in August.

Meaghan Shaw
Media Manager, ANZCA

The Anaesthesia and Pain Medicine Foundation



Dedicated to raising funds for medical research and education

Research in anaesthesia, intensive care, pain medicine and perioperative medicine is crucial with far-reaching significance and benefit in fostering safety and quality patient care. The foundation is dedicated to raising funds for medical research and education in these extremely important areas.

Fellows and registered trainees of ANZCA are eligible to apply for grants each year to support their research goals in these areas: project grants, simulation/education grants, novice investigator grants and academic enhancement grants. All these grants are advertised elsewhere in the *Bulletin* and will be available on the ANZCA website by December 1, 2011.

Increase in funding for simulation/education grants

The Anaesthesia and Pain Medicine Foundation has increased funding for simulation/education grants to \$60,000. The funding can be for one or more projects.

Simulation/education grants were established in 2001 to explicitly encourage research in these areas and also because of the challenges in comparing clinical and laboratory research with research education. The available funding for these grants was then capped at \$35,000.

A review of grants by the Research Committee resulted in changes in the simulation/education grant process. The committee felt the current process did not always achieve its objectives of promoting research in these areas as when a number of strong applications were received, funding restrictions sometimes resulted in an inability to fund more than one application. It was also felt that it was inappropriate for these grants to be funded at a lower level than the project grants.

Therefore the following changes have been approved and ratified at the August meeting of council:

- The funding amount available for simulation/education grants has increased up to \$60,000 per annum to be in line with project grants.
- The Research Committee is permitted to allocate the total amount of \$60,000 between one or more simulation/education grants at their discretion.
- If there are more highly ranked simulation/education grants than can be funded within the \$60,000 available, then they will automatically be put in the pool to be competitive with the project grants and funding allocated, if appropriate.
- The simulation/education grants are also considered eligible for the Harry Daly Research Award which is awarded each year to the highest ranked grant assessed by the ANZCA research grant processes.

To make a donation, bequest or to become a patron or for any other inquiries please contact:

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ANZCA Trials Group – third annual workshop



The ANZCA Trials Group conducted its first Strategic Research Workshop in 2009 at ANZCA House and again for the second workshop in 2010. This year, the third annual workshop was held in the exotic environs of Palm Cove, Queensland from August 12-14.

The number of attendees has doubled each year. While many of the 60 attendees this year were College Fellows participating, or keen to participate, in multicentre research, many of the trial co-ordinators from around Australia, New Zealand and Hong Kong were able to attend. A new group of attendees were statisticians from university departments associated with anaesthesia and pain medicine studies.

The aim of these workshops is to further the primary role of the ANZCA Trials Group to improve the evidence base of anaesthesia and pain medicine by developing and conducting high quality, multicentre randomised controlled trials. Updates were given of existing multicentre trials, with emphasis on finding new centres to

participate in these trials. The ANZCA Trials Group Executive Committee takes the opportunity at the research workshops and at the ANZCA annual scientific meetings to meet in person to discuss strategy and policy. The importance of identifying Fellows keen on a long-term research role was agreed by all. Associate Professor Tim Short has taken over as Chair of the ANZCA Trials Group from Associate Professor David Story.

The most important part of the annual workshop is to appraise and mentor ideas for multicentre research. This year there were four new proposals presented for discussion. Dr Warren Pavey from Perth presented on Prothombinex VF versus fresh frozen plasma in bleeding in cardiac surgery. Dr Cameron Osborne from Geelong presented the "Geelong Rosuvastatin & Incidence of Myocardial Infarction Pilot Study (GRIMIP Study)" which received an ANZCA Trials Group pilot grant. Dr Julian Dimech from Auckland presented

a proposal on "Remote ischaemic preconditioning for vascular surgery" and an audit by a laparotomy network in the United Kingdom. Vigorous discussion centred around the practical aspects of developing these trials including pilot work as well as strategies for large data bases (registries).

As part of the evolution of the workshops, this year there were three invited speakers. Professor Rinaldo Bellomo from the Australian and New Zealand Intensive Care Society-Clinical Trials Group (ANZICS-CTG) gave two presentations: "Reflections on large pragmatic RCTs: ICU or operating theatre? Time for both?" and "Can we identify and help at-risk ward patients?" Both talks highlighted the random nature of many events in clinical care and decision making. Professor Bellomo also reinforced the benefits of multicentre studies conducted collaboratively by the ANZCA Trials Group and ANZICS CTG.

Professor Andrew Forbes, from the Department of Epidemiology and Preventive Medicine at Monash University, gave two talks. They were: “Where did those patients go? What to do about missing data” and “Propensity score methods: hope or hype?” Professor Forbes is known to many from his statistical collaboration in many ANZCA Trials Group studies and has also taught biostatistics to many in the audience. Discussions about projects were enhanced with comments and questions from Professor Forbes and the other statisticians.

The ANZCA Trials Group was delighted to host Professor Richard Hall, Anesthesiology, Medicine and Pharmacology, at Dalhousie University in Nova Scotia, Canada. Professor Hall talked at the workshop on “Perioperative Anesthesia Clinical Trials (PACT) - A Canadian Clinical Anesthesia Trials Initiative; Opportunities and Challenges”. Professor Hall was also a guest of the ANZCA Trials Group Executive Committee meeting and was able to provide insights and practical suggestions. All were very keen on ongoing multicentre collaboration between Canada and ANZCA.

Professor Paul Myles gave updates on two ANZCA Trials Group studies that are under way. The first is the “Nitrous Oxide Anaesthesia and Cardiac Morbidity after Major Surgery-2 (ENIGMA II)” study that examines efficacy of removing nitrous oxide from the anaesthetic gas mixture in patients with coronary artery disease undergoing major surgery. ENIGMA II is proceeding very well with over 4000 patients randomised at over 30 centres worldwide (www.enigma2.org.au).

Associate Professor Philip Peyton also provided a rationale for a chronic pain study associated with a planned long-term follow up study for ENIGMA II. This work builds upon early findings from ENIGMA I by Professor Matthew Chan in Hong Kong on the possible

effects of nitrous oxide on chronic pain after surgery. The other trial is the “Aspirin and Tranexamic Acid for Coronary Artery Surgery (ATACAS)” which asks “Should low-dose aspirin be continued up until the day of CABG surgery?” and “Should tranexamic acid be used for all at-risk CABG surgery?” ATACAS has randomised 1450 patients at 14 centres in four countries (www.ATACAS.org.au).

Ms Sophie Wallace presented the ANZCA Trials Group “Business case for the employment of a research nurse”. The business case is a useful tool for anaesthesia departments that are developing a research profile. The program included for the first time a concurrent “breakout session” for nurses and research staff.

Professor Kate Leslie provided an induction session for investigators and research staff for the “Peri-operative Ischemic Evaluation-2 (POISE-2) Trial”. This is an international trial run from Canada that aims to determine the effect of aspirin and/or clonidine on post-operative mortality and myocardial infarction (www.anzca.edu.au). Professor Leslie gave a short presentation on the rationale for the trial and then the operational aspects of the trial. Discussion time was lively enabling participants to share many of the challenging aspects of running a study in a clinical anaesthesia setting including ethics committees and surgeons.

As with the 2010 workshop, progress of past proposals was reviewed. Associate Professor Tim Short presented pilot data from “Balanced Study of anaesthesia with BIS 50 or BIS 35 in higher risk patients”. This promising study was supported by a pilot grant from the ANZCA Trials Group. Dr Elizabeth Hessian presented the “Subcostal Ultrasound guided tap Infusions for Pain Relief of Abdominal Incisions (SUSTAIN for PAIN Study)”. Dr Hessian first presented her ideas at the

2009 workshop and is now conducting a multicentre randomised trial that was awarded a 2010 ANZCA Research Grant.

Professor Paul Myles presented pilot work on the “REstrictive versus LIBeral Fluid Therapy in Major Abdominal Surgery” (the RELIEF study) with a survey of anaesthesia and intensive care researchers across Australia, New Zealand, Hong Kong and internationally about fluid therapy in abdominal surgery. Pilot work for the RELIEF study is ongoing in collaboration with the Australian and New Zealand Intensive Care Society-Clinical Trials Group, and is also a recipient of a 2011 ANZCA Pilot Grant Award. Associate Professor Tomas Corcoran presented further pilot work for a large multicentre study on the effects of dexamethasone on post operative infection.

Participants enjoyed the social events that included welcome drinks and food upon arrival and the conference dinner in the Lime and Pepper Restaurant on Saturday evening. We were fortunate to have warm and balmy weather and all agreed that Palm Cove was a perfect venue for a mid-winter get away to discuss all things research. Many who flew in and out were envious of those with the forethought of adding a few recreational days.

Associate Professor David Story,
Retiring Chair, ANZCA Trials Group

Stephanie Poustie,
Co-ordinator, ANZCA Trials Group

Opposite page clockwise from top left: Peppers Palm Cove Queensland; attendees at the workshop; Ms Sophia Sidiropoulos and Ms Sarah Baulch; Dr Elizabeth Hessian, Dr David Bramley and Professor Richard Hall.



NZ Anaesthesia ASM – early bird rate closes soon

A man who epitomises the “rags to riches” fairytale will provide the opening address at the NZ Anaesthesia Annual Scientific Meeting, for which early bird registration closes on September 30.

The conference is being held in Auckland’s Grand Convention Centre from midday Wednesday November 2 until 12.30 on Saturday November 5.

After a welcome from the leaders of the co-hosts (ANZCA’s New Zealand National Committee and the NZ Society of Anaesthetists), Sir Ray Avery, New Zealander of the Year in 2010, will give the opening address.

After a childhood spent in English orphanages and foster homes, Sir Ray developed an interest in science and has gone on to forge a hugely successful career in the pharmaceutical industry but is perhaps best known for his philanthropy.

In 2003, Sir Ray established Medicine Mondiale as an independent development agency and charity. It creates low-cost sustainable solutions to combat global poverty and health issues for the most vulnerable and neglected societies.

After meeting Fred Hollows, Ray Avery designed manufacturing processes for intraocular lenses (IOLs) and supervised the construction of IOL laboratories in Eritrea and Nepal for The Fred Hollows Foundation. These laboratories now provide a significant proportion of the world market for IOLs and use technology invented and gifted by Sir Ray.

Some of Sir Ray’s inventions include the Acuset IV Flow controller helping with the safe administration of potent IV drugs, the Liferaft Incubator which uses innovative technology to reduce mortality of premature babies associated with bacterial infections, and a nutritional product from waste by-products of meat and kiwifruit industries to assist children suffering from diarrheal diseases.

Other keynote sessions in the ASM program will look at new horizons in care delivery, including the place of alternative providers; new developments in high dependency unit/intensive care unit medicine; new methods of drug delivery; and safety issues including safety in anaesthesia practice, medico-legal safety and keeping the patient safe beyond the operating theatre. Pain, trauma and hot topics in medicine such as obesity and diabetes are also on the agenda and there is a wide range of workshops.

Well-known television personality and psychologist Nigel Latta will no doubt present a less reverent view in his session on the Saturday morning.

There is time, too, for scientific presentations both at the trainee and the specialist level. ANZCA will hold its annual general business meeting for New Zealand Fellows on the Thursday evening, followed by the NZ Society of Anaesthetists’ annual general meeting.

A fully subscribed trade exhibition will provide plenty to look at during the tea and lunch breaks and there is a strong social program.

The opening night welcome function will be held at the brand new Viaduct Events Centre on the Auckland waterfront (a change from the previously advertised Maritime Museum). Thursday will see a “Mash 4077” theme function and there will be a conference dinner on the Friday night.

In addition, all trainees (including those not attending the ASM) are invited to the traditional ANZCA “Meet the President” cocktail hour, this year being held on the Thursday evening. This event gives trainees an excellent opportunity to meet ANZCA’s President, Professor Kate Leslie, as well as catch up with colleagues from around the country.

For further information on the ASM and to register, see www.nzaasm2011.co.nz.

Annual General Business Meeting

The annual general business meeting for New Zealand Fellows will be held at 5pm on Thursday November 3 as part of the New Zealand Anaesthesia Annual Scientific Meeting. The venue is New Zealand rooms 1 and 2, Level 5, SkyCity Convention Centre, 88 Federal Street, Auckland. New Zealand Fellows wanting to suggest items for the agenda or put motions to the meeting, should contact Anna Pears at the New Zealand National Office, phone +64 4 499 1213 or email anzca@anzca.org.nz by September 30.

New Zealand National Committee

New chair



Dr Geoff Long, an anaesthetic consultant at Waikato Hospital and head of its Professional Division, Anaesthesia, Emergency Department and Intensive Care Unit, is the new chair of the New Zealand National Committee. He took over in July, succeeding Dr Vanessa Beavis, who had served three years in the role.

Now a generalist anaesthetist, Dr Long was previously involved in cardiac anaesthesia, setting up the cardiac surgical unit at Waikato Hospital in 1989 and introducing and teaching transoesophageal echocardiography at Waikato 10 years later.

As well as work and postgraduate study in the UK and New Zealand, Dr Long has worked in Sweden and has served as an anaesthetist with the International Committee of Red Cross in Pakistan and Afghanistan. In 2000, he volunteered to serve as a civilian anaesthetist to the New Zealand army field hospital in East Timor for two months and he remains a civilian volunteer.

Dr Long has been a member of ANZCA's New Zealand National Committee since 2006, serving as assistant formal project officer 2006-2009 and as national education officer 2009-2011. Previously, he has also served as a Waikato representative for the New Zealand Society of Anaesthetists (NZSA) and was the NZSA national secretary 1983-84.

Outside work, Dr Long enjoys kayaking, scuba diving and cycling, and takes a keen interest in the restoration, riding and racing of classic and vintage motorcycles.

Other officers

While no external elections for NZNC membership were required this year, internal elections have resulted in the following office bearers for the 2011-12 year:

Chair, Dr Geoff Long (Waikato)

Deputy Chair, Dr Nigel Robertson (Auckland City)

Honorary Secretary/Treasurer, Dr Gary Hopgood (Waikato)

National Education Officer, Dr Indu Kapoor (Wellington)

Formal Project Officer, Dr Jennifer Woods (Christchurch)

National Quality & Safety Officer, Dr Joe Sherriff (Southland)

The other elected committee members are: Dr Vanessa Beavis (immediate past chair), Dr Kerry Gunn (Fellowship Affairs Officer), Dr Vaughan Laurenson (Chair, NZ Panel for Vocational Registration), Dr Gerard McHugh and Dr Malcolm Stuart. Dr Amber Chisholm has stepped down from the NZNC due to family commitments and Dr Sally Ure (Wellington) has been co-opted to take her place for the 2011-12 year.

July meeting

Workforce issues dominated the agenda for the July meeting with the NZNC adopting a strategy for advocating its position on workforce issues, deciding to develop a formal position paper on the anaesthesia workforce review and to make a submission on Health Workforce New Zealand's proposed trainee funding criteria. ANZCA Vice-President Dr Lindy Roberts was able to attend the whole meeting and report on Council activities.

Joint meeting with NZSA



At their annual joint meeting, held in July, the NZNC and the executive of the NZ Society of Anaesthetists (NZSA) noted that they were largely in agreement on the future direction of the anaesthesia workforce, on the proposed registration process and scope of practice for anaesthetic technicians, and about their response to Health Workforce New Zealand's (HWNZ) proposed trainee funding criteria. The two groups signed a memorandum of understanding for running a part 3 course for advanced trainees and they will work towards upgrading the website for the NZ Anaesthesia Education Committee. The meeting concluded with NZSA President, Dr Rob Carpenter, making a presentation to Dr Vanessa Beavis to mark the end of her three-year term as NZNC Chair.

Advocacy



As well as at the cocktail party, held on the eve of the NZNC's July meeting (see page 75), NZNC representatives had two key meetings on the Monday immediately following its July meeting, both of which came within its advocacy strategy. At the first, Dr Geoff Long, Dr Vanessa Beavis and NZ office General Manager, Heather Ann Moodie, had a lengthy and useful discussion with HWNZ Principal Policy Analyst, Ruth Wiltshire. In particular, they discussed the anaesthesia workforce review and the proposed new funding criteria for trainees. They also met the new Director-General of Health, Dr Kevin Woods (pictured above), informing him about ANZCA and the role it plays in training anaesthetists as well as setting and maintaining standards of practice. They advised him of the NZNC position on various issues.

Medical trainee funding criteria

HWNZ has released proposed prioritisation criteria for its investment plan, with commentary that refers to "expanded roles and scopes of practice to make better use of existing workforces". HWNZ says its interest is in funding the training component and not the service component of medical trainees, the latter being the responsibility of the employer. At its July meeting, the NZNC expressed concern that the training/service ratios that HWNZ proposed adopting were unrealistic and the committee is taking this up with HWNZ.

Trainee events

ANZCA trainee cocktail function

All New Zealand trainees are invited to a "Meet the President" trainee cocktail function being held in conjunction with the New Zealand Anaesthesia Annual Scientific Meeting (ASM) in Auckland. The ASM runs from Wednesday November 2 to Saturday November 5, with the cocktail function being held on the Thursday November 3 from 6.15pm to 7.15pm. This event provides an excellent chance to meet ANZCA President Professor Kate Leslie and an opportunity to catch up with trainees from around the country. It is open to all trainees, regardless of whether they are attending the ASM or not. For those who come, a casual dinner out afterwards (at own expense) is being arranged. A personal e-invitation is being sent to all trainees with further information.

Annual Registrar Meeting



This year's registrar meeting will be held at Auckland City Hospital on Friday December 2. The morning session will cover practical employment topics such as: "Why should I hire you"; "Private demystified"; financial management; How to start in research; and the Christchurch earthquake.

The afternoon is dedicated to scientific presentations, providing an opportunity for trainees to present their formal projects. All ANZCA trainees are encouraged to submit abstracts to be considered for inclusion in this session. Three prizes are available.

See the annual registrar meeting link on the ANZCA NZNC website (www.anzca.org.nz) for further information.

NZ Anaesthesia Part 3 Course



Timed to coincide with the annual registrar meeting, the ANZCA NZ Trainee Committee has organised a New Zealand Anaesthesia Part 3 Course, to be held on Saturday December 3 at Middlemore Hospital, Auckland. It has been deliberately timed to follow on from the annual registrar meeting so that as many people as possible from outside Auckland can attend both easily. The course is a joint venture between the ANZCA NZNC and the NZSA, having been initiated by ANZCA's NZ Trainee Committee (NZTC). The overarching topic is "Bridging the Gap: becoming a consultant and beyond".

Numbers are limited to 24 to facilitate an interactive course for ANZCA senior trainees. The course will give trainees an opportunity to obtain insight into the working lives of senior medical officers and to discuss some of the issues that may arise when they transition from trainee to consultant, including how to write that "consultant CV", what not to say in the interview, where FANZCA can take you and what life is really like as a consultant. Visit the Part 3 Course page on the ANZCA NZNC website (www.anzca.org.nz) for further information.

The NZTC is very grateful for the support that Middlemore Hospital is providing to get this inaugural Part 3 course under way. Two of its consultant anaesthetists, Dr Julian Dimech and Dr Annick Depuydt, have been offering part 3 sessions to that hospital's trainees for some time, covering topics not taught in formal anaesthesia training. They are lending their experience to co-convene the national part 3 course and Middlemore's Clinical Director of Anaesthesia, Dr Helen Frith, has been very supportive. The course will be held at Ko Awatea, Middlemore's new, purpose-built educational facility.

Ministry of Health CMO



ANZCA Fellow, Dr Don Mackie, has been appointed chief medical officer for the Ministry of Health, effective August 1. He will also head the ministry's Clinical Leadership, Protection and Regulation Business Unit. With a clinical background in anaesthesia and the management of emergency medicine, Dr Mackie joins the ministry having been chief medical officer at Counties Manukau District Health Board since October 2005 and chair of the national chief medical adviser's group since October 2007. Before that he had extensive clinical experience in New Zealand and the United Kingdom. He has also held clinical teaching and academic posts in the United States.

Pharmacist prescribing

The chief executive of the Pharmacy Council of NZ, Bronwyn Clark, has said that proposed legislative changes that will allow some pharmacists to prescribe some medicines will not apply to anaesthetic medicines. That restriction is in line with NZNC submissions and the committee is delighted that its views have been accepted.

Ms Clark made this clear when commenting in an *Otago Daily Times* newspaper article on a new qualification being offered for pharmacists who want to prescribe medicines under legislation expected to go through Parliament this year. It will be the first such qualification in Australia and New Zealand and the first to be offered jointly through both the Otago and Auckland universities. Prescribing pharmacists, who could include hospital pharmacists, will require the postgraduate course certificate.

Council of Medical Colleges (CMC)

NZNC Chair Dr Geoff Long represented ANZCA at the August Council of Medical Colleges meeting, along with New Zealand office staff members General Manager, Heather Ann Moodie and new Policy Officer, Brigid Borlase. Items discussed included:

- What requirements colleges had for fellows and trainees re-entering the workforce and whether New Zealand needed a "return to medical work" program.
- The Medical Council of New Zealand (MCNZ) requirement for general registrants to have regular practice reviews (RPR), what involvement colleges would have in that assessment and the possibility RPRs could become mandatory for vocationally registered doctors as well.
- Colleges' involvement in MCNZ vocational practice assessments for international medical graduates.
- Prevocational education in the PGY 1 and 2 years and colleges' preferences for core competencies to be covered.
- Clinical leadership – what education resources the colleges have for trainees and fellows, and whether these can be pooled.
- The Australian Medical Council/MCNZ joint accreditation process and the extra requirements that the MCNZ has said colleges will need to fulfil.
- Trainees' involvement in colleges and the opportunities to provide feedback on training processes.
- The Health Quality & Safety Commission – current projects such as the serious and sentinel events report and how colleges can use this for CPD purposes; infection control; medicines safety; and quality indicators.
- Health Workforce New Zealand (HWNZ) training hubs and how these relate to the colleges' rotations.
- New Zealand's support of specialty academia posts and whether it is sufficient.
- Simulation as an educational tool – HWNZ's plans and the definition of simulation; and its effect on apprenticeship-style training.

- A statement from chief medical officers on professional standards of behaviour and whether it is needed or whether it duplicates what is already stated by colleges, the MCNZ, the NZ Medical Association and others.
- A report on enhancing the CMC's operation, which proposes various options, each with budget implications for the council's constituent colleges.

The NZNC and ANZCA's New Zealand office staff will respond to a number of these issues.

Healthcare funding forum

Medical Director of the UK's National Health Service (NHS), Professor Sir Bruce Keogh, led a recent Royal Australian and New Zealand College of Radiologists' Forum on Funding, Models of Healthcare and Quality. After backgrounding the NHS, he discussed people's changing expectations of healthcare and how regulators could respond to that. Noting that all western countries were struggling with healthcare funding, he also pointed out that huge variances in treatment costs between countries did not necessarily align with measurable gains in life expectancy. He called for innovation in the provision of healthcare, just as there was in other service industries and said that spending more was not necessarily the way to improve outcomes. Rather there was a need to focus on quality, productivity, innovation and prevention. Referring to medical colleges, he called on them to use their resources to provide strong clinical leadership and influence change. It was also important, he said, that the healthcare workforce agreed with any changes. Quality targets, such as improving waiting times in emergency departments, had proved successful, he said.

(continued next page)

As well as Sir Bruce, a panel discussion included HWNZ Executive Chair Professor Des Gorman and the National Director of the Ministry of Health's National Health Board Unit, Mr Chai Chuah.

Suggested changes from now until 2015 include: reducing demand through better quality; a shift to more community and self-care; greater integration of services; redefining who does what, how and when, and where care is delivered; changes to the funding and business models used in healthcare provision; more timely provision of care; telehealth developments; and integrated health records.

New surgery centre may exclude trainees



The New Zealand Government has approved a \$37 million elective surgery centre at North Shore Hospital, with Health Minister Tony Ryall calling it a new concept that will reduce waiting times for non-emergency surgery. He said the increase in efficiency was based on new workforce arrangements, the streamlining of pre- and post-surgical visits, and providing patients with an appointment for surgery at the time of their consultation.

The new centre, due for completion in 2012, will have 40 beds, four operating theatres and be staffed by a team of 80 clinicians. It will treat only non-emergency cases, avoiding the delays that can occur for elective surgery when theatres are shared with acute cases. The centre is expected to perform a wide variety of operations, up to 6000 a year, through all specialities.

However, a newspaper report said that medical staff for the new centre would be limited to specialists, with no role for trainee specialists or junior doctors. ANZCA's New Zealand National Committee has written to the Minister to clarify this because of its potential implications for anaesthesia training.

Anaesthesia treatment injury data

Treatment injury data from New Zealand's Accident Compensation Corporation (ACC) has released a treatment injury profile for anaesthesia for the year ending 31 March 2011. Of the 7667 decided treatment injury claims in that period, 222 (3 per cent) arose as a result of treatment events within anaesthetic care. However, only 56 per cent (124) of those 222 claims were accepted.

The most common injury occurring in anaesthesia was tooth/denture plate damage, which accounted for 58 of the 124 claims (nearly 47 per cent). This damage related most commonly to endotracheal intubation. The 58 represented a big decrease over the year before when this category accounted for 79 accepted injury claims from anaesthesia events. The next two highest were anaphylactic reaction (13 claims), usually in relation to anaesthetic induction agents, and nerve damage (11), most commonly relating to epidural and regional anaesthesia.

ACC also reported on adverse event notifications. For anaesthesia, there were five sentinel event notifications and three serious event notifications.

A sentinel event is defined as an event during care or treatment that has resulted in an unanticipated death or major permanent loss of function not related to the natural cause of the client's illness or underlying condition, pregnancy or childbirth. A serious event is an event, or related events, that have the potential to result in death or major permanent loss of function not related to the natural course of the client's illness or underlying condition, pregnancy or childbirth.

The anaesthesia-related specific events that ACC reported were:

- Adverse drug reactions to neostigmine and propofol resulting in a cardiac arrest and an anaphylactic reaction, respectively.
- Endotracheal intubation resulting in hypoxic brain injury, perforated oesophagus and tooth damage.
- Failure to aspirate gastric contents preoperatively in a patient with bowel obstruction, which led to aspiration of gastric contents, ARDS and death.
- Ventilator disconnection resulting in hypoxic brain injury.
- Epidural anaesthesia resulting in brain damage or injury.



New Zealand cocktail function

The New Zealand National Committee was delighted to welcome key stakeholders to a cocktail function it hosted on the eve of its July meeting. The function marked the changeover of NZNC chair from Dr Vanessa Beavis, who had held the position for three years, to Dr Geoff Long and provided the opportunity to introduce ANZCA's Vice-President, Dr Lindy Roberts, who had flown from Perth to attend. Guests at the function included New Zealand's Minister of Health, the Hon Tony Ryall, and its new Director-General of Health, Dr Kevin Woods. The Chair and Deputy Chair of the Health Select Committee, Dr Paul Hutchison and Grant Robertson respectively, also attended, as did representatives from the Medical Council, Pharmac, other medical colleges, the NZ Society of Anaesthetists, other medical bodies and the Ministry of Health.

Above clockwise from top left: Outgoing NZNC Chair Dr Vanessa Beavis, the Minister of Health Hon Tony Ryall, incoming NZNC Chair Dr Geoff Long; FPM representative on NZNC Dr Kieran Davis, NZNC member Dr Kerry Gunn, NZSA President Dr Rob Carpenter, Royal Australasian College of Surgeons Deputy Chair Nigel Willis, ANZCA Councillor Dr Leona Wilson; FPM Dean Dr David Jones, Pharmac Medical Director Dr Peter Moodie; ANZCA Vice President Dr Lindy Roberts and Director-General of Health Dr Kevin Woods.

Australian news

South Australia and Northern Territory



Cardiac Dysfunction

On July 27 2011, the South Australia and Northern Territory Continuing Medical Education Committee held "Cardiac Dysfunction" presented by guest speakers Dr Jayme Bennetts and Dr Tom Painter. There were over 50 attendees who came to the meeting.

Above clockwise from top left: Dr Min Qi Lee, Dr Tony Barnard and Dr Scott Ma; Dr Prashan Kuruppo with Theo Tsaconas from MSD; Guest Presenter Dr Tom Painter with Dr Carolyn Wood; Dr Anthony Laver and Dr Sidney Jacobs; Trainees who attended the Primary Sciences course.

Primary Sciences course

The Primary Sciences course, facilitated by Dr Mark Finnis, provides a course content which is applicable to the primary exams of both ANZCA and the College of Intensive Care Medicine of Australia and New Zealand (CICM). The course is predominantly an interactive "tutorial format" although the program remains flexible with space within the program for trainees to select topics for later in the course. The course also includes some small group trial viva sessions. Sixteen trainees from both Colleges attended this year's course which was held at the SANT Regional Office from August 8-12.

Western Australia



Western Australian Winter Scientific Meeting 2011

The Western Australian Winter Scientific Meeting was held on Saturday July 30 at the University Club of the University of WA. It represented the second of a two-part series of meetings with the theme "Dealing with Disaster". Convened by Dr Anton Van Niekerk this meeting focused on disaster management, and was a follow on from the Autumn Scientific Meeting held in March, which focused on the causes and prevention of anaesthesia disasters.

The meeting was opened with a traditional "Welcome to Country" from Mr Noel Nannup, a member of the Nyoongar people, the Aboriginal people of the Perth area.

The Dr Ian McGlew Lecturer was Dr Di Khursandi, from Queensland, who gave a very interesting lecture on "What to do when bad things happen". This was followed by an enlightening presentation from Dr Mary Hegarty, entitled "Management of a Major incident: Lessons from the London Bombings".

The morning free paper session consisted of four very interesting and well presented papers. The Nerida Dilworth Prize, for the best presentation of scientific material by a trainee, was awarded to Dr Silke Brinkmann, and was presented by Dr Nerida Dilworth.

In the afternoon, presentations, small group sessions and workshops covered such topics as "Updates in Cardiology", "Keeping the Anaesthetist alive", "Talking to Relatives", "The obsolete Anaesthetist", "Muscular Mayhem", "Choose your Airway Weapon", "Debriefing after Disaster" and "Teaching on the Run". Presenters included Dr Rahesh Kanna, Dr Silke Brinkmann, Dr John Rampono, Dr John Gibbs, Dr Luke Torre, Dr Nigel Hamilton, Dr Mary Pinder, Dr Michela Salvadore and Dr Claire McTernan.

The meeting was very well subscribed, with 153 delegates attending. Many stayed to finish the day with a sundowner overlooking the picturesque Swan River.

The feedback received has been very positive. The WA Continuing Medical Education Committee would like to thank the convener, Dr Anton Van Niekerk, presenters, sponsors and attendees for making the Winter Scientific Meeting 2011 a success.

Above clockwise from top left: Delegates in the morning session; Meeting convener, Dr Anton Van Niekerk, invited speaker Dr Di Khursandi, ANZCA WA Chair Dr Jenny Stedmon and morning session speaker Dr Mary Hegarty; Dr Silke Brinkmann, winner of the Nerida Dilworth Prize with Dr Nerida Dilworth; Delegates Dr Sarah Wyatt and Dr Michele Moore with ALS Instructor Dr Murray Giles at one of the afternoon workshops.

New South Wales



NSW joint continuing education meeting

"The Opioid and the Anaesthetist" meeting was held at the Sydney Hilton on Saturday July 2, 2011. The meeting attracted more than 340 delegates from across Australia and New Zealand. The conference spanned the broad range of developments and issues relating to opioids – from optimising drug selection to managing side effects.

The key note lectures covered topics including "Iatrogenic opioid prescribing and its contribution to illicit use", "Sustained release opioids and acute pain management", "The opioid abusing anaesthetist", "Modern prevention of opioid side effects", "What is the best opioid for my patient?", and "When opioids fail", as well as covering what is new.

Group learning sessions addressed "Obstetrics and opioids", and "Managing the opioid dependant patient". The workshop with Dr Tony Padley covered revised Australian Resuscitation Council guidelines. The conference generated 75 media mentions nationally.

We congratulate the NSW Anaesthetic Continuing Education Committee and NSW ANZCA staff on the success of this event. They are already planning for next year.

Above clockwise from top left: Dr David Elliott's group learning session on "Obstetrics and Opioids"; the exhibition area; Dr Richard Halliwell's plenary session on "What is the best opioid for my patient?"; Dr Tony Padley's hands on workshop "Revised ARC guidelines"; Dr Malcolm Hogg's plenary session on "Sustained Release Opioids and Acute Pain Management".



NSW FPM CME dinner

On Thursday August 25, 2011, NSW FPM Fellows and trainees, and Fellows and nursing staff from the Chapters of Addiction and Palliative Care Medicine from Sydney and the surrounding area, gathered for the NSW Regional Committee's Continuing Medical Education Dinner Meeting. Our evening at Mathew's Peacock Gardens Restaurant Crows Nest was kindly sponsored in equal part by Janssen and Mundipharma Pty Ltd.

The many disciplines fundamental to the practice of pain medicine were well represented, and there was an encouraging number of current and potential trainees in attendance. Dinner was a convivial banquet style, with ample opportunity for socialising and networking among the delegates.

The CME topic was on refractory pain, looked at from three different perspectives: pain medicine, palliative care and addiction medicine. Three individual presentations were conducted by Drs Stephen Gibson, Abigail Walton and Mark Hardy, followed by a panel discussion. Delegates discussed the challenge of refractory pain management at various levels.

Overall, the meeting was a great success, achieving our aims of providing an opportunity for education as well as fostering a sense of community and peer support among pain medicine practitioners in Sydney and the surrounding areas.

Above clockwise from top left: Dr Martine Holford, Dr Mark Hardy and Dr Glen Sheh; Dr Nathan Taylor and Dr David Gronow; The banquet dinner; Dr K Khor, Sr Mary Wadiwell and Dr Winnie Hong.

Queensland

Queensland Regional Report

There has been a plethora of activity in Queensland over the past few months.

It started with a successful webinar pilot on how to pass the primary exam. This is a project that has been funded by a special grant from Queensland Health to assist trainees who have difficulty attending education sessions in person. Plans are now in place to deliver podcasts with follow up webinars to assist trainees prepare for the 2012 primary exam.

The end of June heralded the opening of applications for 2012 training placements with subsequent interviews for assessing suitability for training conducted in early August.

Activity continued with an evening continuing medical education (CME) lecture, the 35th Combined ANZCA/ Australian Society of Anaesthetists Annual CME conference, the continuing Saturday morning primary lectures, the two week Primary Exam Preparation Course, the Queensland Regional Committee annual general meeting, the Final Exam Preparation Course, the Sunshine Coast practice viva weekend and has concluded with the final written and clinical exams.

Included here are short reports on some of these activities. The Queensland Regional Committee acknowledges the invaluable support of the many contributors to these successful activities and thanks them for their continued efforts.



35th Annual Qld ANZCA/ASA Continuing Medical Education Conference

Our annual conference in Queensland continues to grow and this year's meeting was attended by more than 100 delegates.

The title of the day "My big fat safe practice" was a lure I'm sure.

The format for the third year was a combination of formal lectures, problem-based learning discussion (PBLD) programs and a workshop.

The dual themes of bariatric surgery and safe practice seemed a popular choice.

We had a variety of speakers from anaesthesia, surgery and intensive care and this gave a variety of viewpoints.

The bariatric session was particularly effective with the surgery available presented by Dr Michael Donovan from the Sunshine Coast, and the challenges of anaesthesia in general and the airway in particular presented by Dr Marcus Soo and Dr Nick Hutton.



Primary Exam Preparation Course

The Queensland Primary Exam Preparation Course was held from July 11 to 22 at the ANZCA Qld offices in West End. It was attended by an enthusiastic group of about 30 participants who were in various stages of preparation towards the primary exam. We were lucky to have a range of excellent speakers from both public and private anaesthesia practice and ICU who covered the major syllabus topics.

Participants provided much positive feedback about the course. Particularly mentioned were the usefulness of completing practice short-answer questions and multiple-choice questions under exam conditions, the excellent catering provided by sponsors and the quality of the presentations by the various lecturers. I would like to thank all the staff at ANZCA Qld for their assistance in making the course run smoothly, as well as all the presenters for their time and effort in preparing and delivering the lectures. I also acknowledge Dr George Pang's invaluable assistance in helping to mark the practice exams.

Dr Rebecca Ruberry,
Convener

The safety session covered diverse topics including the use of iron infusion to prevent perioperative blood transfusion by Dr Bernd Froessler from Adelaide, who decides appropriate therapy in high risk surgical patients by ICU director from QEII Hospital Dr Malcolm Wright, and the new surgical safety checklist by Dr Peter Moran.

These themes made the basis for the workshops and round table discussions of the afternoon.

A big thank you to all those behind the scenes and to the speakers for giving up a Saturday.

Dr Helen Davies
QLD CME Conference Convener

Opposite page clockwise from top left: Dr Bernd Froessler, Dr Peter Moran, Dr Malcolm Wright; A lecture at the conference; A problem-based learning discussion; An airway workshop.

Queensland (continued)



ANZCA Qld Annual General Meeting

The ANZCA Queensland Annual General Meeting was held on Wednesday July 27, 2011 in the Brisbane office. Dr Sean McManus, the Chair of the Queensland Regional Committee, reported on the strategic goals of the committee and the progress of a number of projects including web conferencing and the Queensland Anaesthetic Rotational Training Scheme (QARTS).

Professor Tess Cramond presented the "Tess Cramond Award" to Dr Nathan Goodrick for his presentation "Audit of pre-drawn emergency anaesthetic drugs" at the 2011 Annual Registrars Meeting.

Following the Annual General Meeting, the guest speaker was Dr Brett Robinson, former Australian Rugby Union player for the ACT Brumbies and Wallabies. Dr Robinson is currently Project Leader – Australian Pharmaceutical Healthcare Service (APHS) Integrated Clinical Oncology Network (ICON). His presentation on "Achieving excellence or believing anything is possible" was well received by the attendees.

Above from top: Guest speaker Dr Brett Robinson; Dr Nathan Goodrick and Professor Tess Cramond.

Tasmania



2012 Combined ANZCA/ASA Annual Scientific Meeting

The joint meeting of ANZCA and the Australian Society of Anaesthetists will be held at the Tramsheds in Launceston February 17-19, 2012. Speakers will include Dr John Lewis from Western Australia and Dr Gavin Pattullo from New South Wales.

A registrar's workshop is being planned for mid-October which will be open to all levels of trainees. The theme of the workshop will be professional development with an emphasis on Modules 2 and 12.

Australian Capital Territory

Workshop rescheduled

The advertised cardiovascular workshop to have been held on August 20 has been rescheduled to November 12 due to many reasons including the IT upgrade to the ACT office. The workshop will be on the management of acute cardiovascular conditions relevant to anaesthesia. Particular topics which will be covered include the management of intra and post-operative dysrhythmia, cardiac pacing, implantable cardioverter-defibrillators, and the management of intra and post-operative ischaemia. The meeting will be held at The Canberra Hospital and will feature both lectures and practical hands-on simulation sessions. The content is aimed at both Fellows and trainees, with limited places available. Further information, including how to register, will be soon available on the ACT section of the ANZCA website.

Victoria



Victorian Regional Committee

A record number of delegates attended the 32nd Annual ANZCA/ASA Combined Continuing Medical Education Meeting at the Sofitel Melbourne on Collins on Saturday July 23.

The theme was "Hot Topics in a Cool City – Melbourne Winter Anaesthetic Meeting".

The first session looked at obstetrics, including a presentation by Royal Women's Hospital anaesthetist, Associate Professor Alicia Dennis, who argued that transthoracic echocardiography should be available in all critical care and emergency settings where pregnant women are managed. Another presentation by Mercy Hospital for Women anaesthetist, Associate Professor Scott Simmons, looked at evidence relating to the benefits of combined spinal and epidural anaesthesia for childbirth.

The second session was devoted to fluids management and included a paper by Barwon Health staff anaesthetist, Dr Simon Gower, who presented the findings of the Enhanced Recovery After Surgery program being trialled at the Geelong Hospital, which has cut from 12 to nine days the average length of stay for patients who have undergone elective major abdominal surgery.

After lunch, a session on medications looked at Thiopentone, Gabapentin and Pregabalin, and skin antisepsis.

The final session highlighted the risks and prevalence of vitamin D deficiency, including a link with diabetes, and the growing importance of anaesthesia for Electroconvulsive Therapy.

Above clockwise from top left: Paper presenters Dr Philip Peyton and Dr Forbes McGain, Dr Peter Seal, and paper presenters Dr Scott Simmons and Associate Professor Alicia Dennis; ASA Victoria Chair Dr Mark Suss, Victorian Regional Committee Chair Dr Andrew Buettner, ASA Co-Convenor Dr Peter Seal, CME Officer and Convenor Victorian Regional Committee Dr Mark Hurley; Victorian Regional Committee Chair Dr Andrew Buettner and Dr Robert Dawson who was presented with a certificate of recognition to mark his fifth year as a supervisor of training; ASA Victoria Chair Dr Mark Suss presenting Dr Bruce Jones with a lapel badge and certificate in recognition of his 50-year membership of the ASA.

Other events

Rural Special Interest Group meeting



The Rural Special Interest Group (SIG) held its fourth annual meeting in the Barossa Valley from July 7 to 9 with the theme "Challenging Rural Anaesthetists". The meeting was well supported with more than 80 delegates and a much larger number of trade displays than in previous years, and once again GP anaesthetists accounted for over a third of the delegates.

The meeting covered a variety of clinical challenges including difficult airway management, anaphylaxis, local anaesthetic toxicity and muscular dystrophies. A separate session focussed on massive haemorrhage and the difficulty of accessing blood products in rural areas with a lively discussion about the value of "Emergency Donor Panels". The rural SIG was very pleased to welcome Kate Leslie in her role as ANZCA President to the meeting where she spoke to us about the new curriculum and opportunities for training in rural areas in a session that also included discussions about the Joint Consultative Committee on Anaesthesia program for procedural GP training. The final session covered aspects of safety from the environment we work in to looking after our own mental and physical health.

The meeting also hosted two workshops: the first on difficult airway management co-ordinated by Chris Acott, and the second was an introduction to the "Teaching on the Run" program hosted by Scott Fortey.

The weather in SA was best described as encouraging attendance at plenary sessions although this did not detract from delegates enjoying the gastronomic experiences on offer in the Barossa. The social events were well attended with the highlight being the dinner held at the Chateau Tanunda winery.

The meeting ran very smoothly and I would like to thank Hannah Burnell who, in her role as SIG Co-ordinator, assisted in planning and hosting the meeting, as well as all the speakers, whose high quality presentations ensured the meeting was a great success.

The final business of the meeting was the rural SIG annual general meeting where plans for next year's meeting were discussed. The theme will be "The Return of the Accidental Intensivist" and will be held at the Peppers Resort, Torquay, Victoria from July 6 to 8, 2011.

Above clockwise from top left: Dr Craig Mitchell and Dr John Male; airway workshop participants; Dr Eileen Halliday in an airways workshop; Dr Rod Mitchell, Professor Kate Leslie, Dr Frank Moloney, Mrs and Dr Patrick Farrell; Dr Deb Gardiner and Dr David Rowe.

CICO scenario training



On Saturday June 11, 2011 anaesthetists from Orange Base Hospital and the Sydney Clinical Skills and Simulation Centre hosted a multi-professional, multi-disciplinary course as part of a broader program aimed to improve preparation for the “cannot intubate, cannot ventilate (oxygenate)” (CICO) scenario. With emphasis on a team and systems-based approach, the course addressed a range of topics including defining the challenges of the CICO scenario, recognising a CICO scenario, preparedness to act, human factors, equipment and system design, along with hands-on practice of the trans-tracheal procedure. The highlight was the presence of Dr Andrew Heard, whose years of experience in developing an approach to the CICO scenario was distilled and taught in a lecture and practiced at a team-based workshop using an adaptation of his wet-lab approach (which was highly educational, entertaining and messy!). The course was attended by 25 staff from Orange Health Service including

both medical (mainly anaesthetists, but also surgeons, emergency physicians and intensive care specialists) and nursing staff (from various working backgrounds). Overall, the response to the program has been very positive and momentum for the next stage of implementation of the CICO scenario approach is gathering pace. The course was funded by the Rural Health Continuing Education (Stream 1) scheme. Further information about the course can be obtained from www.scssc.edu.au/index.php (search for CICO).

Dr Tsung Chai, Dr Helen Zois, Clinical Associate Professor Leonie Watterson

Above clockwise from top left: Dr Roberta Emeades, Dr Andrew Heard, Clinical Associate Professor Leonie Watterson, Dr Tsung Chai, Dr Helen Zois; Practice trans tracheal airway on a simulated trachea; Dr Tsung Chai with course participants; Workshop.

ANZCA farewells Dr Mike Richards

A dinner was held in June to farewell ANZCA's departing chief executive officer, Dr Mike Richards. The dinner was held before June Council and attended by councillors and staff.

At the dinner ANZCA President, Professor Kate Leslie, paid tribute to Dr Richards who left the College to return to his management consulting practice at Princes Hill Consulting Group. Dr Richards had been at the College for five and a half years. His replacement is Ms Linda Sorrell who started at the College on September 19.

Clockwise from top left: Honorary College Solicitor Michael Gorton from Russell Kennedy with Dr Mike Richards; Professor Kate Leslie, David Broadbent, Carolyn Handley, Dr Leona Wilson, Rosemary Broadbent; Dr Vanessa Beavis, Dr Lindy Roberts, Professor Alan Merry; guests at the farewell dinner.



Dean's message



A long debated question – what does a specialist pain medicine person do? The Faculty has been undertaking a “blueprinting” exercise to help answer that and other important questions to ensure that it has the right curriculum to produce the right “product”.

By now you should be aware of the new Medical Board of Australia/ Australian Health Practitioner Regulation Agency protected title (in Australia) for those who have FFPANZCA (Fellow of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists) – namely “specialist pain medicine physician”. How many of you are using it? It is a bit of a mouthful, till you have spoken it a dozen times, then it becomes easier.

It does identify a medical specialist who can fully assess a patient with a pain predicament in a biopsychosocial framework, and can advise across the whole spectrum of available management options, including pharmacological, psychological/ cognitive behavioural, physical, lifestyle change and rehabilitative strategies. It does not characterise persons who simply assess for and perform invasive procedures to the pain sufferer.

It would not do a service to the public to turn out mostly persons to do procedures to the exclusion of meeting the much higher need for “comprehensive pain physicians” (see below). The specialist pain medicine physician doesn't have to do all of the above activities, but at least needs to know the spectrum of what is available, when it is appropriate to apply any of them and be able to guide the patient to engage the right professionals to do them, often but not exclusively from within members of a multidisciplinary team.

This leads to the Faculty's recent engagement one day a week of a professional educationalist, Ann Maree Bullard. In the very short time she has been with us she has already distilled some important key roles which she has, for the time being, termed a “comprehensive pain physician”.

From a bottom-up perspective these cover the clinician attributes, with overarching competencies similar to the CanMEDS (Canadian Medical Education Directives for Specialists) framework^{1,2} – the medical expert as a communicator, collaborator, advocate, scholar, professional and manager.

Higher level skills as leaders and change agents in both patient management and for teams and services round out the attributes. This framework is not unique to FPM Fellows, as ANZCA and other specialist colleges also promote such a framework. As Mrs Bullard takes the “blueprinting” exercise forward you may well be approached for your input.

Three major initiatives are currently maturing: the GP online education project (supported by a substantial grant from the Bupa Health Foundation); the pain management outcomes project; and the need for a registry of implanted technologies (comparable with orthopaedic joint replacement registries).

These latter two are about gathering facts for future evaluation aimed at answering difficult questions about utility/efficacy, risk-benefit and cost-benefit balance. Only the pooling of data across many service locations will get enough information about real-life use to be of value.

Here, it is important to draw a distinction between results from tightly controlled protocol-driven research results, often in the hands of the enthusiast-expert for that particular field who may not have to do anything else except the item under study. This is in contrast to the same procedure being applied across many locations in the hands of the routine clinical team dealing with a heterogeneous population of persons with pain predicaments, plus varied social and environmental circumstances. As all of these need more than the busy clinician to maintain momentum, the Faculty board is considering securing a project officer for a defined period to do just that. Watch this space.

Succession planning both at governance and clinical service level is highly relevant to our specialty. The current cohort of leaders in both areas was mostly among the foundation Fellows, and of course these are no longer in supply with inevitable attrition soon to bite into our numbers.

Training younger clinicians and new leaders is vital. We currently have 32 trainees in structured training, clearly too few. We have approximately one year's numerical output of trainees who, after completing all clinical and examination requirements, delay completion and submission of their case report, and consequently admission to fellowship.

A single cause cannot be identified, but small changes to rules are being considered to eliminate this attrition. If you happen to be one of those (and of

course if you are reading this I would assume you are at least still interested!) then we would like to hear from you – either way. Maybe there is something for us to learn if you could let us know why?

Vocational recognition in Australia – and we are confident that it is not far away in New Zealand – is a sign that your expertise as a pain specialist does count, and you can make changes that can help many people get on with living their lives.

I must raise again what is clearly a “hot topic” in our part of the world. The US has had significant turmoil from outbreaks of poor quality opioid prescribing, deaths and even physicians jailed for various breaches.

On its recent agenda the board noted engagement with several agencies pursuing opioid related matters. The Faculty has made a submission to the Pharmaceutical Benefits Advisory Committee stakeholder meeting on opioids with more dialogue expected, the National Prescribing Service is taking interest under the quality use of medicines initiative, and the National Pharmaceutical Drug Misuse Strategy (NPDMS) has also had input. In all of our dealings with these agencies our position has been for responsible monitored goal oriented prescribing with appropriate controls. These are embodied in our professional document PM1³ and the associated two-page checklist available on our website.

I would urge you all to be familiar with them, even if you do not actively practise in this area. We can be expected to be scrutinised far more in the future if international trends mean anything. We can be more proactive in our aims to reduce adverse outcomes, and our specialty can be expected to educate more others than our own about this – expert educators and communicators!

Prescribing opioids is very appropriate and frequent in acute pain cases. Caution is necessary in relation to the National Inpatient Medication and Adult Deterioration Detection System Charts, which is explained elsewhere in this edition of the *Bulletin*⁵.

All anaesthetists and pain Fellows should familiarise themselves with this matter – as some of the precautions we would want with this form of opioid prescribing are not being incorporated by the national body responsible for promoting these charts.

A paper in the most recent issue of *Anaesthesia and Intensive Care*⁶ describes the condition of Opioid Induced Ventilatory Impairment (OIVI) and explains the importance of understanding the need for sedation monitoring alongside opioid prescriptions.

Keep safe!

Dr David Jones
Dean
Faculty of Pain Medicine

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New professional document

The Faculty of Pain Medicine has recently published a professional document addressing the difficult and controversial issue of spinal cord stimulation (SCS) in the management of patients with chronic pain.

“Difficult” because neuromodulation not only requires much clinical acumen and technical expertise but also is invasive, very expensive and labour-intensive.

“Controversial” because evidence of efficacy is difficult to generate, as controlled studies are very difficult to perform. The Faculty document is based on a review article authored by eight Fellows: Leigh Atkinson, Raj Sundaraj, Charles Brooker, James O’Callaghan, Peter Teddy, John Salmon, Tim Semple and Max Majedi [*Review: Recommendations for patient selection in spinal cord stimulation*. *J Clinical Neuroscience* 2011; 18: 1295 - 1302].

The literature identifies three broad categories of indications for SCS, by likelihood of response. Conditions likely to respond include “failed back surgical syndrome”, refractory angina pectoris, complex regional pain syndrome, and neuropathic pain secondary to peripheral nerve damage. Conditions that rarely respond include pain associated with spinal cord damage, central pain of non-spinal cord origin, spinal cord injury with clinically complete loss of posterior column function, and perineal or anorectal pain.

In the grey area of possible response are pain associated with peripheral vascular disease, brachial plexopathy, axial pain following surgery and intercostal neuralgia such as post-thoracotomy. Apart from the skill of the implanting team, selection of subjects is the key to success. The professional document and the review summarise indications and contraindications for SCS, provide guidance on selection and timing for referral, and discuss the benefits and complications associated with the procedure.

To view the Faculty Professional Document PM9 (2011) *Neuromodulation (Spinal Cord Stimulation) in the Management of Patients with Chronic Pain* online visit www.fpm.anzca.edu.au.

News

Fellowship training and examination dates for 2011

Pre-examination short course

September 23-25, 2011

ANZCA Queensland Regional Office
West End Corporate Park, River Tower,
20 Pidgeon Close, West End, Qld 4101
Registrations have closed.

Examination

November 25-27, 2011

The Royal Brisbane and Women's
Hospital, Queensland

Closing date for registrations:
October 7, 2011.

Admission to fellowship

By examination:

Dr Frank Thomas
Dr Nicholas Christelis

By election:

Dr Milana Votrubec

Qld
Vic

NSW

Faculty of Pain Medicine Board

The 2011 – 2012 Faculty of Pain Medicine Board was appointed during the CSM in Hong Kong in May.



Back: Dr Guy Bashford, Dr Christopher Hayes, Dr Frank New, Professor Stephan Schug, Dr Raymond Garrick, Dr Lindy Roberts, Professor Edward Shipton, Ms Helen Morris (General Manager)
Front: Dr Carolyn Arnold, Dr Brendan Moore (Vice-Dean), Dr David Jones (Dean), Dr Penelope Briscoe, Associate Professor Leigh Atkinson.

Painaustralia – New non-government organisation formed to implement National Pain Strategy



The National Pain Summit, held at Parliament House, Canberra in March 2010, endorsed a comprehensive National Pain Strategy for Australia, to improve the quality of life for people with pain and their families, and to minimise the burden of pain on individuals and the community.

The first objective of that strategy, to establish a national body involving all stakeholder groups to identify partnerships, framework and resources required to build capacity and deliver proposed outcomes, has now been achieved with the formation earlier this year of Painaustralia.

Painaustralia is very grateful for the integral support, professional and financial, that it has received from ANZCA especially in this early phase. The purposes for which Painaustralia has been established reflect the core business of anaesthetists and pain physicians, and the leadership shown by the College is highly valued.

The chair of the Board of Directors of Painaustralia is Mr James Strong. The co-opted directors are Mr Geoffrey Applebee, Mr Kieren Perkins, Mr Robert Regan, and Justice James Wood and Professor Michael Cousins (Chair, National Pain Strategy). Directors appointed by the major contributing members are Associate Professor Milton Cohen (ANZCA/ FPM) and Professor Stephen Gibson (Australian Pain Society). Ms Diana Aspinall, nominated by the Consumers Health Forum, and Ms Elizabeth Carrigan, nominated by the Australian Pain Management Association, have been appointed consumer directors. The CEO of Painaustralia is Ms Lesley Brydon.

Directors appointed by the major contributing members are Associate

Professor Milton Cohen (ANZCA/ FPM) and Professor Stephen Gibson (Australian Pain Society). Ms Diana Aspinall, nominated by the Consumers Health Forum, and Ms Elizabeth Carrigan, nominated by the Australian Pain Management Association, have been appointed consumer directors. The CEO of Painaustralia is Ms Lesley Brydon.

The focus of Painaustralia's strategic plan is articulated in goal one of the National Pain Strategy, namely recognition and optimal treatment of people in pain as a national health priority, with its three main objectives:

- To establish a national body involving all stakeholder groups to identify partnerships, frameworks and resources required to build capacity and deliver proposed outcomes.
- To destigmatise the predicament of people with pain, especially chronic non-cancer pain.
- To achieve federal and state government recognition of chronic pain as a chronic disease in its own right.

The other goals of the National Pain Strategy that will inform Painaustralia's activity include:

- Knowledgeable, empowered and supported consumers.
- Skilled professionals and best-practice evidence-based care.
- Access to interdisciplinary care at all levels.
- Quality improvement and evaluation.
- Research to identify and address gaps in knowledge and practice.

Already Painaustralia has been involved in advocacy, in collaboration with other

bodies, to address the proposed removal of infusion pumps from the prostheses list and the recent deferral of listing of several drugs on the Pharmaceutical Benefits Scheme despite their approval by the Pharmaceutical Benefits Advisory Committee.

More recently, Painaustralia has identified that many people with chronic pain may well be discriminated against by the proposed revision of eligibility for access to income support through the Disability Support Pension and is lobbying to bring equity and fairness to this aspect of public policy.

The need to improve the primary healthcare interface for people experiencing pain is emphasised throughout the National Pain Strategy.

The establishment of Medicare Locals, instituted on July 1, provides an excellent opportunity to raise awareness of the needs of patients living with pain, and to ensure that improved pain services are on the planning agenda. Painaustralia has been involved in the first National Medicare Locals Stakeholder Round Table and will inform each Medicare Local of the National Pain Strategy and advocate for pain services to be considered in the needs assessment and planning for each community.

Painaustralia has been approached by many consumer and professional groups for information regarding educational and clinical resources. Given the importance of goal two of the National Pain Strategy – knowledgeable, empowered and supported consumers – Painaustralia is undertaking a review of consumer pain education and self-management resources. This involves an audit of currently available material and instituting a process for evaluation with a view to endorsement. A parallel process is in train with respect to resources for professionals.

These developments, so early in the history of a new health-based non-government organisation, underline its relevance and the need for the predicament of people in pain – whether acute, cancer-related or persistent non-cancer pain – to be addressed as a national health priority.

For more information about Painaustralia, visit www.painaustralia.org.au.

Associate Professor Milton Cohen,
Director of Professional Affairs, FPM

FPM board meeting report

August 2011

Faculty board

The Faculty board welcomed Professor Stephan Schug to his first board meeting as the co-opted WA representative and Professor Kate Leslie, ANZCA President, who attended for the day.

Dr Lindy Roberts was congratulated on being re-elected ANZCA Vice-President and Honorary Treasurer. Dr Alan Merry was congratulated on his appointment as Head of the School of Medicine in Auckland.

Relationships Portfolio

ANZCA

The board was updated on the ANZCA curriculum redesign, due for implementation in 2013. Pain will be one of seven clinical fundamentals within the curriculum – pain-related learning outcomes have been developed. The new curriculum structure will allow formal FPM training to be undertaken in the provisional fellowship year, entry to which will require completion of the ANZCA fellowship exam. An electronic log book is under development for ANZCA trainees which will allow those planning to undertake FPM training to be able to demonstrate pain-related experience. Next steps are to define volume of practice including mandatory time in pain medicine as part of ANZCA training.

FPM/RACGP on-line modular GP education in pain management

Development of this initiative is progressing well with the first meetings of the Steering Committee, Curriculum Development Committee (CDC) and Technology/Adaptation Committee (TAC) occurring on August 12 in Melbourne. The CDC comprises three FPM representatives and six GP representatives, two of whom are also Faculty Fellows. The focus of this group is to seek opinion and agree upon the top 10 topics for consideration. This will finally be narrowed down to six topics for development in GP on-line program format.

The aim is to prepare primary care practitioners to better deal with the burden of pain and it was agreed that engagement with the Royal Australian College of General Practitioners (RACGP) at a higher level should be pursued to ensure the success of this initiative. Dr Morton Rawlin, Chair of the Victoria Faculty and Chair of the National Faculty of Specific Interests, has agreed to represent the RACGP President, Dr Claire Jackson, at the October board meeting.

Opportunities will be explored in the future to develop and modify this initiative to reach other groups.

RACS

The pain management section of the Royal Australasian College of Surgeons has been officially recognised by RACS Council, and terms of reference for that section have been established. Nominations are now being sought for those interested in pain and an executive is to be convened shortly. Liaison between the FPM and the section will also be established at an administrative level and reports will be exchanged regularly. It was agreed to invite Dr Andrew Zacest to the October and February board meetings.

Liaison with pain societies

The next Australian Pain Society (APS), New Zealand Pain Society (NZPS), FPM executive teleconference is scheduled for August 30, 2011. Issues for discussion include the forthcoming 2011-2012 Global Year Against Headache and the planned National Pain Outcomes Initiative.

Corporate Affairs

Appointment of ANZCA CEO

The board noted the appointment of Ms Linda Sorrell as ANZCA CEO, commencing September 19, 2011, and was appreciative of the opportunity for the dean to participate in the selection panel. The board looked forward to welcoming Ms Sorrell at the October board meeting.

Occupational Health and Safety

The board noted that new OH&S laws would be effective from January 1, 2012 and were advised of the implications of expanded definitions for employers and employees (now workers) to include a broader range of people, including volunteers. The College is planning a

communications campaign on this issue to raise awareness of responsibilities under the new laws.

Strategy workshop

A strategy workshop will be held in conjunction with the February board meeting and will be facilitated by Mr Jonathan Schauder of the Change Agent Network.

Regional Committees

Queensland

The board was updated on the progress of the Persistent Pain Health Services strategy by Queensland Health. The progress is being developed by the Queensland Statewide Persistent Pain Steering Committee, chaired by Professor Julia Fleming.

The following Qld committees have also been established:

- Exit and Entry Committee (chaired by Mr Glen Bradley).
- General Practitioners' Advisory Group (chaired by Dr Tania Morris).
- Patient Education Committee (chaired by Mr Michael Dean).

The Metro South Service is now well advanced in developing a three tiered service to the general practitioner community and public hospital. Accommodation has been found in Logan City, about 15 kilometres from the Princess Alexandra Hospital, to provide community services. The board noted the following appointments:

Dr Frank Thomas
Director Metro South Service.

Dr Tania Morris
Acting Director Sunshine Coast Nambour Unit.

Dr Tony Espinet and Dr Leigh Dotchin
Acting Directors Gold Coast.

New South Wales

It was noted that the new NSW Minister for Health and Medical Research, Jillian Skinner, has set up a taskforce to report on an appropriate model of care for chronic pain in NSW by September 30. The taskforce has asked the NSW Agency for Clinical Innovation Pain Network for recommendations by September 1. Included in the submission will be a request for funding toward the National Pain Outcome Initiative.

Victoria

A meeting of Victorian Fellows during the combined scientific meeting in Hong Kong had agreed in principle to form a regional committee and plans are now underway to form the committee and convene a continuing medical education evening on December 14, 2011.

It was reported that \$2.4 million of additional funding has been made available through Subacute Ambulatory Care Services (SACS) to chronic pain units around the state to address waiting lists. Previously funding for chronic pain units had come from a variety of sources, however most chronic pain units in Victorian public hospitals are now under this unified funding program.

National Pain Strategy

Painaustralia is rapidly evolving under the pressure of demands from many groups seeking information, and is working hard in its advocacy role.

Medicare locals are now being formed, the first 15 commenced in July with others to follow in January and July 2012, to a total of 62. Painaustralia is working to ensure that pain is represented by both clinicians and consumers where possible in these reforms.

A consumer reference group has been formed to ensure that Painaustralia consults with and involves consumer groups in the development of policies, priorities and actions. Painaustralia commenced circulation of a newsletter in June 2011.

Fellowship Affairs Portfolio Fellowship

Since the May board meeting, the following have been admitted to fellowship by examination:

Dr Frank Thomas, FANZCA (Qld).

Dr Nicholas Christelis, FANZCA (Vic).

This takes the total number of admissions to 308.

Continuing Education and Quality Assurance

Scientific meetings

2011 Spring Meeting

Early bird registration for the Faculty's spring meeting at the Park Hyatt Hotel, Canberra, on October 28-30 closes on September 1, 2011. The meeting theme is "An exploration of the Pain/Musculoskeletal Polemics – Policies, Procedures and Pragmatics".

2012 ASM – Perth

The Faculty's scientific program is well advanced for the Refresher Course Day and annual scientific meeting (ASM) programs, led by Dr Dan Bennett (FPM ASM Visitor) and Dr Henrik Kehlet (FPM Perth Visitor).

2012 Spring Meeting

The Hyatt Regency Coolom has been secured as the venue for the 2012 spring meeting in Coolom, Queensland. Dates have been confirmed September 28-30. Dr Brendan Moore and Associate Professor Leigh Atkinson will convene the meeting with the assistance of Dr Tania Morris. Liaison with the RACGP is occurring with the aim of having a joint meeting with a planned launch of the joint RACGP/FPM online educational program.

2013 ASM Melbourne

Professor Edzard Ernst (UK) was confirmed as the FPM ASM Visitor and Professor Fabrizio Benedetti (Turin) as the FPM Melbourne Visitor for 2013.

Professional

National Pain Outcome Initiative

The next step is a face-to-face meeting in Canberra to gain clinician consensus from FPM, APS and NZPS representatives on a minimum data set. The plan is to keep pace with the Queensland and New South Wales agendas for domains of measurement and outcome tools, then approach the respective state and federal governments for funding.

New Zealand application for specialty recognition

The stage two application was submitted to the Medical Council of New Zealand (MCNZ) on June 29, 2011. There are three further steps to occur before vocational scope recognition is confirmed by MCNZ.

- By August 30 panel members will be appointed by the MCNZ Education Committee based on nominations from branches related to our scope of practice. The panel will assess the application documentation and prepare a report for presentation to the Education Committee.
- The Education Committee will meet in November and will make a recommendation to council and we will be advised of the outcome
- If council approves the application they will publish by notice in the New Zealand Gazette the new scope of practice and its qualification(s).

Medicare Telehealth Advisory Group

Telehealth was introduced on July 1, 2011, enabling patients located in general practices, eligible residential aged care facilities and Aboriginal Medical Services and other facilities to "see" specialists without the time and expense involved in travelling to major cities. This presents a good opportunity for the practice of pain medicine. It is only in support of video-consultations, not telephone alone. The Faculty will have representation at the fourth advisory group meeting, scheduled for August 25.

It was noted that WA has had six years' experience with the integration of this technology for remote patients and it has worked well.

Acute Pain Management: Scientific Evidence 4th Edition

Professor Stephan Schug has accepted the role of chair of the working party for the development of the 4th edition, due for publication in 2015.

National Pharmaceutical Drug Misuse Strategy

The Faculty's submission on this strategy had been compiled out of consultation and other individuals had been encouraged to respond. An outcome is imminent. The Faculty will also have representation at the Expert Reference Group meeting on September 5 in Melbourne.

FPM board meeting report continued

Pharmaceutical Benefits Advisory Committee (PBAC) Opioid Stakeholders Meeting

A Faculty submission regarding Pharmaceutical Benefits Scheme-subsidised opioids was sent in early May. The outcome of the July PBAC meeting at which this issue was to be discussed is pending.

Pain device implant register

Initial enquiries have been made with the Data Management and Analysis Centre (DMAC) at the University of Adelaide about the possible establishment of a pain device implant register with a focus on implants and their performance. DMAC is the team responsible for running the Australian Orthopaedic Association National Joint Replacement Registry. The board supported further development of this project.

Certification of proceduralists

A paper outlining the driving consideration for the Faculty to have an opinion on this matter will be brought to the next board meeting. There has been a suggestion in the past that the Faculty run its own examination. One option for consideration is accreditation for procedural training as a sub-section of the Training Unit Accreditation Committee.

Recommendations for patient selection in spinal cord stimulation

Faculty Fellows Associate Professor Leigh Atkinson, Associate Professor Raj Sundaraj, Dr Charles Brooker, Dr James O'Callaghan, Professor Peter Teddy, Dr John Salmon, Dr Timothy Semple and Dr Max Majedi were congratulated on the article in the *Journal of Clinical Neuroscience*. A link to the article is to be included in *Synapse*.

Australian Commission on Safety and Quality in Health Care

The National Inpatient Medication Chart (NIMC) and the Adult Deterioration Detection System (ADDS) Chart have both been developed under the umbrella of the Australian Commission on Safety and Quality in Health Care (ACSQHC) with the aim of improving patient safety. A group of Faculty Fellows has written to the ACSQHC expressing concerns about an aspect of the NIMC

that forces setting upper limit doses in post-operative pain management, and that sedation has not been appropriately addressed as the sixth vital sign. The authors are concerned that people should be informed that caution is needed when prescribing *prn* opioids for the management of acute pain and therefore in the use of these charts. A detailed article is included in this issue of the *Bulletin*.

Pharmac Analgesic Subcommittee

The board noted that New Zealand National Committee nominations, Dr Kieran Davis and Dr Christopher Jephcott, have been appointed by the board of the Pharmaceutical Management Agency of New Zealand (PHARMAC) to the Analgesic Subcommittee of the Pharmacology and Therapeutics Advisory Committee (PTAC) for a three year term, ending July 31, 2014.

Trainee Affairs Portfolio

Education

Blueprinting

The Faculty's part time (one day a week) professional educationalist, Mrs Ann Maree Bullard, presented to the board on her progress in moving forward this initiative, distilling some important key roles of the specialist pain medicine physician similar to the CanMEDS framework. A working group meeting is planned in conjunction with the October board meeting.

Undergraduate Prize

A number of medical schools have accepted the invitation to participate and the prize is now being implemented. The Faculty has not been prescriptive in how they select the prize winners. It is anticipated that the number of medical schools participating will continue to grow.

Podcasting

A number of FPM podcasts are in development. The following podcasts are now available on the Faculty website at www.fpm.anzca.edu.au

Professor Spencer Liu
Does postoperative analgesia improve postoperative outcomes?

Dr Meredith Craigie
FPM examination and case report

Examination

The board and Examination Committee supported a request from the FPM Queensland Regional Committee that the venue for the pre-examination short course be rotated between the states on not less than a three yearly basis. Queensland Fellows were thanked for undertaking to run the course for the 2011-2013 period.

The Faculty's 2011 pre-examination short course will be held at the Queensland Regional Office from September 23-25. The examination will be held at the Royal Brisbane and Women's Hospital (November 25-27). The closing dates for registrations are September 9 and October 7 respectively.

Eighteen examiners have been reappointed for a further three year period.

Training Unit Accreditation

Following successful reviews, the Royal Perth Hospital (WA) and Singapore General Hospital were re-accredited for pain medicine training. A Certificate of Accreditation was accepted for distribution to accredited units.

A sub-committee of the Training Unit Accreditation Committee is progressing a proposal to significantly revise Faculty Professional Document PM2, *Guidelines for Units Offering Training in Multidisciplinary Pain Medicine* to include recognition of Tier 2 hospitals.

Resources Portfolio

Project Officer

The board supported the appointment of a part time Project Officer in 2012 to coordinate the GP online education initiative, the National Pain Outcomes Initiative and the implant register initiative.

Finance

ANZCA's Acting Executive General Manger Corporate Resources, Mr Geoff Tory, and General Manager Finance, Ms Galina Fidler, met with the board to discuss the 2012 budget processes and year to date management reports. The Faculty continues to have a favourable budget variance to the end of July 2011.

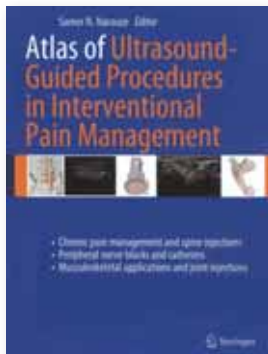
Library update

New titles

Books can be requested via the ANZCA Library catalogue on the ANZCA website: www.anzca.edu.au

ANZCA Fellows and trainees are entitled to borrow a maximum of five books at one time from the College Library. Loans are for three weeks and can be renewed on request. Fellows and trainees can also reserve items that are currently out on loan.

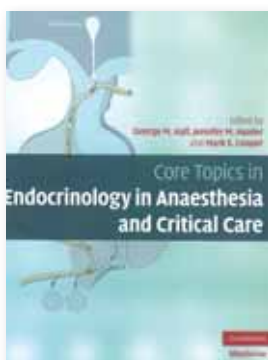
Items will be sent to other library users however Melbourne-based Fellows and trainees are encouraged to visit the ANZCA Library to collect requested books. When requesting an item from the catalogue, please always remember to include your name, ID number and current postal address to ensure prompt delivery.



Atlas of ultrasound-guided procedures in interventional pain management
Narouze, Samer N. [ed]. New York: Springer, 2011.



Difficult airway management
Papat, Mansukh [ed]. 1st ed. Oxford: Oxford University Press, 2009.



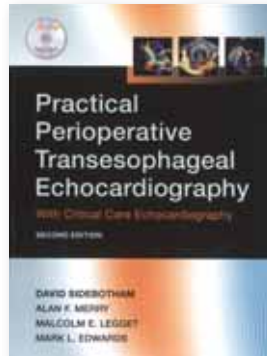
Core topics in endocrinology in anaesthesia and critical care
Hall, George M. [ed]; Hunter, Jennifer M. [ed]; Cooper, Mark S. [ed]. Cambridge: Cambridge University Press, 2010.



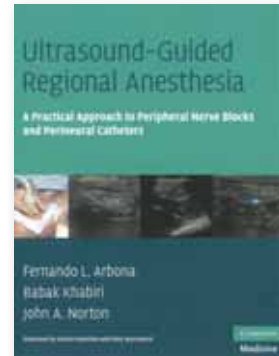
Dr Podcast scripts for the primary FRCA
Leslie, Rebecca A. [ed]; Johnson, Emily K. [ed]; Goodwin, Alexander P.L. [ed]; Thomas, Gary [ed]. Cambridge: Cambridge University Press, 2011.



Obstetric anesthesia
Palmer, Craig M; D'Angelo, Robert;
Paech, Michael J. Oxford: Oxford
University Press, 2011.



**Practical perioperative
transesophageal echocardiography:
with critical care echocardiography**
Sidebotham, David [ed]; Merry, Alan
[ed]; Leggett, Malcolm [ed]. 2nd ed.
Philadelphia, PA: Elsevier Saunders, 2011.



**Ultrasound-guided regional
anesthesia: a practical approach
to peripheral nerve blocks and
perineural catheters**
Arbona, Fernando L.; Khabiri, Babak;
Norton, John A. Cambridge: Cambridge
University Press, 2011



Oxford handbook of pain management
Brook, Peter [ed]; Connell, Jane [ed];
Pickering, Tony [ed]. Oxford: Oxford
University Press, 2011.



Rang and Dale's pharmacology
Rang, H.P.; Dale, M.M.; Ritter, J.M.;
Flower, R.J.; Henderson, G.; Ritter,
J.M.; Dale, M.M.; Moore, P.K. 7th ed.
Edinburgh: Elsevier Churchill
Livingstone, 2012.

Annual refresher course lectures
(61st. : 2010 Oct. 16-20 : San Diego,
California) American Society of
Anesthesiologists Annual Meeting/
American Society of Anesthesiologists.
Park Ridge, Ill.: American Society
of Anesthesiologists, 2010.

Contact the library
Librarian: Laura Foley
Phone: +61 3 8517 5305
Fax: +61 3 8517 5381
Email: library@anzca.edu.au

Medical education resources

Did you know that the ANZCA Library provides a number of medical education resources to support clinical teachers and education development staff?

Journals include:

- *Clinical Teacher*
- *Medical Education*
- *Medical Teacher*

Books include:

- *Assessment in medical education and training: a practical guide* / Jackson, Neil [ed]; Jamieson, Alex [ed]; Khan, Anwar [ed]. – Oxford: Radcliffe Publishing, 2007.
- *Medical education: developing a curriculum for practice* / Fish, Della; Coles, Colin. – 1st ed – Maidenhead: Open University Press, 2005.
- *The pocket guide to teaching for medical instructors* / Bullock, Ian [ed]; Davis, Mike [ed]; Lockey, Andrew [ed]; Mackway-Jones, Kevin [ed]. / Advanced Life Support Group; Resuscitation Council (UK). – 2nd ed – Malden, MA: Blackwell Publishing, 2008.

Databases include:

- ERIC – Education Resources Information Center
- HEAL – Health Education Assets Library

Visit the ANZCA Library online today:
www.anzca.edu.au
(College ID log-in required.)

Latest research in anaesthesia and pain medicine

Log in to the ANZCA Library website to access these journals, articles and guidelines.

Single, double or multiple-injection techniques for axillary brachial plexus block for hand, wrist or forearm surgery in adults.

Chin KJ, Handoll HHG. *Cochrane Database of Systematic Reviews* July 6; (7): CD003842. 2011

Vasopressors for hypotensive shock.
Havel C, Arrich J, Losert H, Gamper G, Müllner M, Herkner H.
Cochrane Database of Systematic Reviews May 11; (5): CD003709. 2011

Nitrous Oxide for Colonoscopy.
Aboumarzouk OM, Agarwal T, Syed Nong Chek SAH, Milewski PJ, Nelson RL. *Cochrane Database of Systematic Reviews* August 10; (8): CD008506. 2011

A Literature Review of Randomized Clinical Trials of Intravenous Acetaminophen (Paracetamol) for Acute Postoperative Pain
Macario A, Royal MA. *Pain Practice* 11(3): 290-6, 2011

Awareness in children: a secondary analysis of five cohort studies
Davidson AJ, Smith KR, Blussé van Oud-Alblas HJ, et al. *Anaesthesia* 66(6): 446-54, 2011

Effect of patient sex on general anaesthesia and recovery.
Buchanan FF, Myles PS, Cicuttini F. *British Journal of Anaesthesia* 106(6): 832-839, 2011

The association between obesity and difficult prehospital tracheal intubation.
Holmberg TJ, Bowman SM, Warner KJ, et al. *Anesthesia and Analgesia* 112(5): 1132-1138, 2011

The management of accidental dural puncture and postdural puncture headache: a North American survey.
Baysinger CL, Pope JE, Lockhart EM, Mercaldo ND. *Journal of Clinical Anesthesia* 23(5): 349-60, 2011

Ketamine as an analgesic in the pre-hospital setting: a systematic review.
Jennings PA, Cameron P, Bernard S. *Acta Anaesthesiologica Scandinavica* 55(6): 638-43, 2011

Reversible brain death after cardiopulmonary arrest and induced hypothermia
Webb AC, Samuels OB. *Critical Care Medicine* 39(6): 1538-42, 2011

Anesthesia and neurotoxicity to the developing brain: the clinical relevance
Davidson, AJ. *Paediatric Anaesthesia* 21(7): 716-21, 2011

Health and safety alerts – ECRI Institute notices

The ANZCA Library subscribes to ECRI publications on operating room risk management and health device alerts and information. Check this space regularly for updates on the latest information produced by ECRI.

Health Devices, Vol. 40, No. 7, July 2011

Health Devices, Vol. 40, No. 8, August 2011
- Sound Decisions – a guide to selecting ultrasound equipment

Operating Room Device Alerts

- Breathing Circuits, Anesthesia

Operating Room Risk Management

- Electronic Health Records

- Medical Device Hazards and Recall Management

- Patient Positioning

Library use for New Zealand-based borrowers

New Zealand-based trainees, Fellows and others doing the ANZCA Continuing Professional Development Program can again borrow books from the ANZCA Library in Melbourne, at least for a trial period. The library has operated a policy for about nine years of not lending books out of Australia but the New Zealand National Committee has been working with the library to address this.

A key issue has been the courier costs involved. One possible solution is to stock more books in the New Zealand library. However, it is difficult to assess demand for any particular text because the lending policy has discouraged potential borrowers from requesting loans.

Accordingly, loans will be available for a trial period so that demand can be assessed. Those in New Zealand wanting to borrow books should email library@anzca.edu.au.

ANZCA Council meeting report

August 2011

Report following the council meeting of the Australian and New Zealand College of Anaesthetists held on August 20, 2011

Death of Fellow and Trainees

Council noted with regret the death of the following Fellows:

- Dr David Cranleigh Thomson Bush (NZ), FANZCA 1992, FFARACS 1963.
- Dr William John Watt (NZ), FANZCA 1992, FFARACS 1961.

College Honours

Appointment: Professor Alan Merry has been appointed the Head of the School of Medicine, University of Auckland.

ANZCA Council Citation: Following nomination by the Queensland Committee, Associate Professor Victor Ian Callanan was awarded the ANZCA Council Citation.

Robert Orton Medal: Dr Duncan Islay Campbell has been awarded the 2011 Orton Medal for his contributions to anaesthesia, in particular his invention of the Campbell ventilator. He will be invited to receive the medal at the ASM to be held in Perth in 2012.

Education and Training

Curriculum redesign 2013: Work continues on completing the new curriculum for implementation in the 2013 hospital employment year, with the involvement of dozens of Fellows, trainees and staff. In June, the College published transition arrangements with regard to the primary examination and advanced training year 3. Current work by the project managers involves assessing expressions of interest for the IT platform to support the curriculum. Work will commence shortly in preparation for the Australian Medical Council review of the College's training program and CPD program in 2012.

Fellowship Affairs

Council welcomed Dr Carmel McInerney, Chair ACT Regional Committee, who provided an update regarding developments and concerns in her region.

Fellow participation in ANZCA continuing medical education (CME) events:

ANZCA's stand-alone CME events rely on a significant pro bono contribution by the organising committee and speakers, and most Fellows undertake these activities willingly without reimbursement

or payment. The ANZCA Fellowship Survey and subsequent discussions at the Fellowship Affairs Committee resulted in a re-evaluation of this policy. At its August meeting, council reaffirmed its policy that no Fellow will be reimbursed or paid for contributions to our stand-alone events. The College will explore further non-financial means by which to acknowledge and thank Fellows.

Internal Affairs

Appointment of the new ANZCA CEO:

Ms Linda Sorrell has been appointed the new CEO of ANZCA. Linda is a highly qualified executive, with nearly 20 years' experience in high-level management positions in the healthcare sector. She is currently the CEO of Melbourne Health, a large health network in the centre of Melbourne. Linda commences her new role on September 19, 2011.

ANZCA Constitution: A final draft of the revised constitution has been approved by council. Key changes include the inclusion of Faculty of Pain Medicine (FPM) Fellows who do not hold FANZCA as members of the College, explicit inclusion of the Dean of FPM as a director, and clarifying the status of Honorary Fellows.

History and heritage strategy: A working group led by Dr Justin Burke, Councillor, tabled the first draft of the strategy at the August council meeting. The aim of the strategy is "to preserve and promote the history and heritage of anaesthesia and pain medicine in Australia and New Zealand in a way that is accessible, engaging and relevant to current and future Fellows". The draft strategy has been circulated within the College for comment.

Occupational health and safety laws:

Senior management and the president were briefed on the introduction of new occupational health and safety laws in Australia that 1) explicitly extend the responsibility of businesses to their volunteer workforces and 2) explicitly require volunteers to contribute to a safe and healthy workplace. ANZCA will undertake a communications campaign to ensure that Fellows, trainees and staff understand the implications of these changes.

ANZCA regulations

Regulation 2.15 – Finance, Audit and Risk Management Committee: An amendment to regulation 2.15 has been made to limit the term of the non-Fellow members to six years, unless otherwise approved by council.

Regulation 7 – Annual Subscriptions:

A revision of regulation 7 has been undertaken to streamline concessions offered to Fellows, including for older anaesthetists, those on extended leave and those undertaking voluntary or humanitarian work, as well as special consideration in circumstances of financial hardship. The changes to the regulation will take effect from the commencement of the 2012 budget year.

Continuing Professional Development (CPD) Committee

CPD: Work continues on enhancements to the IT platform supporting the ANZCA CPD program and ANZCA's standard on CPD for anaesthetists. Advice has been sought from the Medical Board of Australia, Australian Medical Council and the Committee of Presidents of Medical Colleges on this matter.

Professional Documents

PS9 - Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures: A Document Development Group (DDG) will undertake an "end of pilot" review of PS9. Feedback will be sought from regional/national committees, the FPM Board, ANZCA Trainee Committee, Quality and Safety Committee and relevant special interest groups for consideration by the DDG. All endorsing bodies will be formally invited to provide feedback on the document after the DDG's formation.

Revisions of the following professional documents (and their background papers as applicable) have been approved and are available on the ANZCA website:

PS3 Guidelines for the management of major regional analgesia (joint ANZCA/FPM document)

AO1 Policy for the development and review of professional documents

Other Business

College merchandise is available for purchase from the ANZCA website www.anzca.edu.au with any profits going to support the College's medical research managed by the ANZCA Foundation.

Professor Kate Leslie
President

Dr Lindy Roberts
Vice President

Dr Reinhart (Reiny) Rippert 1930 – 2011



My friend and mentor Reinhart (Reiny) Rippert died on May 12, 2011 after a long illness. A detailed obituary written by Chris Ball and Mark Buckland appeared in the supplement edition of *Anaesthesia and Intensive Care*. This is a short personal account about this wonderful man.

I first met Reiny at the Austin Hospital Heidelberg during 1964. Reiny, with a number of other Alfred hospital anaesthetists (Bernie Dunn, Philip Armstrong and George Robinson) gave anaesthetics for the thoracic list. The surgeons were the master thoracic surgeons of Melbourne, including James Officer Brown, Ken Morris, George Stirling, James Clareborough and Jack Hayward.

I was privileged to be a registrar to Reiny for these lists which started with a thoracotomy followed by diagnostic bronchoscopies performed in pitch darkness. In October that year, Reiny asked me of my intentions for the next year. I said that I intended to spend a second year at the Austin. Reiny, using a few expletives, pointed out that the Austin was only recognised for one year of training and that he would recommend me for a vacancy at the Alfred which, thanks to Reiny, I obtained.

There had been a mass resignation from the specialist anaesthetic staff in 1964. In 1965 the staff consisted of Robert Orton as director, Max Griffith as deputy director and Reiny as first assistant. Max and Reiny shared on-call duties from Monday to Thursday and shared weekends on call.

Reiny was an extraordinary teacher by example. He had an ability to rescue and resuscitate patients who should not have survived. Reiny was particularly worried about the ability of one of my colleagues, and if rung would say “turn up the oxygen to 100 per cent, do nothing else and I will be there in five minutes”.

Reiny had some wonderful terms of phrase. He was particularly keen on bicarbonate for acidotic patients and used the term “43 beans”. This was a play on the number of beans in a cup of Nescafe. Soon after I arrived at the Alfred, Reiny asked me if I was a member of Medical Defence. We were to give anaesthesia for ECT. The anaesthetic consisted of 2 millilitres of 10 per cent thiopentone mixed just before the procedure with 1 millilitre of suxathonium.

Reiny’s other major strength was anaesthesia for the developing open heart program. These patients mainly had severe rheumatic heart disease and at times up to three valves were repaired or replaced. The Alfred did two such cases a week and Reiny shared these lists with Dick Connock. Heparinisation could only be described as crude with large doses of heparin given to ensure that the blood did not clot in the heart-lung machine. Reversal was equally crude using protamine. As a consequence many patients would return bleeding to the operating theatre that night. Reiny’s standard equipment included a pair of coroner’s deposition forms to keep away the evil spirits.

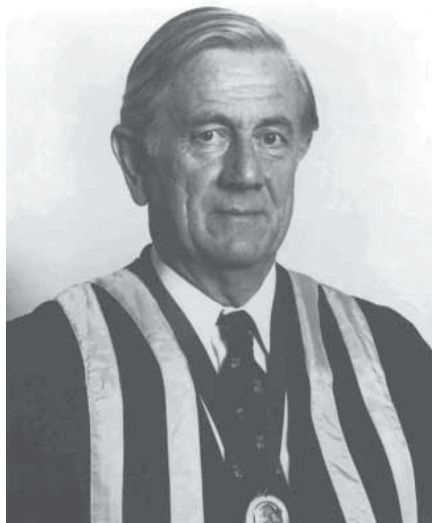
Reiny had a wonderful gift of supporting trainees in trouble. He gave much support to one of my colleagues who lost a patient in the operating theatre and gave equal support to all trainees.

I have lost a great friend and mentor, and sadly I was at the combined scientific meeting in Hong Kong and was unable to attend his funeral.

Dr Ian Rechtman, FANZCA,
Melbourne

Photo previously published in Anaesthesia and Intensive Care 2011 39:30-32 (Suppl 1).

Dr William John (Jack) Watt OBE 1918 – 2011



Dr Jack Watt was born in Ashburton, New Zealand, on October 26, 1918, the eldest of the three children of Lesley and Gladys Watt. His education was at Ashburton Primary School, followed by St Andrews College, Christchurch, and Timaru Boys' High School, before he proceeded to the University of Otago in Dunedin where he graduated with a medical degree (MB ChB) in 1944. His house surgeon time was broken by service with the New Zealand Army Medical Corps in Egypt, Italy and Japan in the later stages of World War II.

On his return to Auckland in 1948, Dr Watt was one of the first anaesthetic registrars in that city, before going to the United Kingdom where he gained further experience and took his two-part Diploma of Anaesthetics (DA) and later became a Fellow of the Faculty of Anaesthetists of the Royal College of Surgeons. During this time, he married Rosamund Rae. They returned to Auckland in 1952, Dr Watt to be a full-time specialist anaesthetist at Green Lane Hospital. He spent much time with the cardiothoracic team and administered the anaesthetic for the first cardio-pulmonary bypass operation in New Zealand in 1958.

On Dr Eric Anson's retirement, Dr Watt became Auckland's second Director of Anaesthetic Services in 1958, a post he held until retirement in 1983. There have been no further directors in Auckland. As one of our southern colleagues remarked, "It took a committee to replace Jack Watt". During this long period many changes took place with advances in anaesthesia techniques and equipment. The strength of the department, which initially served four major hospitals and some minor ones, grew. Training of increasing numbers of young doctors was instituted and promoted, so the Auckland hospitals became a major teaching centre for anaesthesia under Dr Watt's leadership and active involvement. He was also much involved in the promotion and teaching of cardiopulmonary resuscitation, both for St John Ambulance personnel and other groups. The training of Pacific Island anaesthetists was also largely promoted and effected by Dr Watt over many years.

Besides his duties as director of anaesthesia, Dr Watt served New Zealand's anaesthetic fraternity well. In the Faculty of Anaesthetists, Royal Australasian College of Surgeons, he became a Fellow in 1961 and was elected to the board of the faculty in 1968. He served as assessor from 1973-74, was vice dean from 1974-75 and was dean of the Faculty of Anaesthetists from 1976-78 – the first New Zealander to achieve this high office, equivalent now to president of the Australian and New Zealand College of Anaesthetists. For his services, Dr Watt was awarded the Faculty of Anaesthetists' Medal in 1982.

In the New Zealand Society of Anaesthetists (NZSA), Dr Watt was an early member and became secretary-treasurer in 1953, was vice president for two years and was president for 1960 and 1961. Frequently, he was a conference organiser and a willing speaker. Dr Watt was made a life member of the NZSA in 1979 and was involved in setting up the Anson Memorial Foundation, being one of its early trustees.

In later years, Dr Watt undertook a survey of anaesthetic services round the Pacific area for the World Health Organization and reviewed training at the Anaesthesia Centre in Manila. For his services to anaesthesia and the St John Ambulance, Dr Watt was made an Officer of the Order of the British Empire (OBE) in 1981. His long involvement with the Order of St John saw him become a Knight of Grace with that organisation.

Dr Watt was a skilled and practical anaesthetist, a leader, a talented teacher, a first class administrator, a diplomat, a tactful negotiator, a congenial colleague and a good friend to many of us. He had great patience and I only ever saw him cross once! Dr Watt was one of New Zealand's most eminent anaesthetists and while on the Board of the Faculty of Anaesthetists gave New Zealand a strong presence in what was predominantly an Australian-oriented body. His diplomacy and resolution have given New Zealand a lasting legacy in international anaesthesia. Dr Watt died on August 2, 2011 and will be greatly missed, but he leaves us with great memories.

We extend our deepest sympathy to his widow Rosamund, their four daughters and their families.

Dr Basil Hutchinson, FANZCA,
Auckland