

June 2011

# ANZCA BULLETIN



**ANZCA**  
AUSTRALIAN AND NEW ZEALAND  
COLLEGE OF ANAESTHETISTS

**FPM**  
FACULTY OF PAIN MEDICINE  
ANZCA

## SHARING PEARLS OF WISDOM IN HONG KONG

PLUS:  
ANZCA CURRICULUM REVISION  
2013 – THE LATEST UPDATE

## 10 Hong Kong CSM

A complete wrap up of the Combined Scientific Meeting 2011 in Hong Kong.



### 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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Cover: The combined scientific meeting in Hong Kong, May 2011.



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# President's message



At the recent College Ceremony during the Combined Scientific Meeting in Hong Kong, we welcomed a record 226 new Fellows to ANZCA and the Faculty of Pain Medicine. As each new Fellow crossed the stage to be presented, it was wonderful to witness how excited they looked about the ceremony and about starting their careers as specialists in anaesthesia and pain medicine. The presentation of each new Fellow was accompanied by cheers from family, friends and colleagues in the audience, indicating their admiration for past achievements and their support for the future.

In my address to the new Fellows at the ceremony, I focused on “What your College can do for you”. While there are many services that Fellows can and do provide to the College, it is good to reflect from time to time on the services that the College offers its Fellows and whether these are meeting their needs where they work and live – and our primary mission of providing safe and high quality care for patients. Some of these benefits are intangible, but without them, we could not take advantage of the opportunities that exist nor manage the risks facing our specialties now and in the future.

## Quality and safety

The College provides a range of services and advocacy that promote safe and high quality care wherever anaesthesia and pain medicine services are provided in our region:

- ANZCA and FPM professional documents.
- Safety alerts.
- Input into clinical indicator projects.
- Triennial mortality reports.
- Hospital inspection and accreditation.
- ANZCA Code of Conduct.
- The ANZTADC incident monitoring project (in collaboration with the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists).

## Continuing professional development (CPD)

The College provides a wide range of CPD resources:

- CPD standard setting.
- ANZCA CPD program.
- CPD program helpdesk.
- Fortnightly CPD emails.
- Library (including books, online journals, assistance with literature searches).
- Publications (including *Acute Pain Management: Scientific Evidence*, *Australasian Anaesthesia* and other guidelines and resource documents).
- Podcasts and webinars.
- Clinical teacher courses.
- Annual scientific meeting.
- Regional ANZCA continuing medical education (CME) meetings.
- Joint CME activities with the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists (regional meetings and special interest groups).

## Communications

Our communications package aims to keep Fellows up to date and to promote our specialties:

- Website.
- *ANZCA Bulletin*.
- Annual report.
- Triennial mortality reports.
- e-newsletters (including annual scientific meeting e-news).
- Other emails with important alerts for members.
- Media releases and interviews.
- Promotion of history and heritage (museum, archives and library).

## Advocacy

Behind the scenes, ANZCA Fellows, trainees and staff work hard to maintain and build the status of our profession and minimise risk, including:

- Policy submissions to governmental and non-governmental bodies.
- Meetings with jurisdictions, hospitals, consumer groups and the media.
- National Pain Summit and National Pain Strategy.

- Workforce studies and reports in New Zealand and Australia.
- Representation on international, national, state and local committees.
- Support to those providing training in traditional and extended environments.
- Handling of queries and complaints by patients and other stakeholders.
- Assisting anaesthetists in difficulty.

### Research

The 2010 Fellowship Survey revealed that Fellows value the research supported by the College, even if they do not participate:

- ANZCA research grant program (>\$800,000 per annum).
- Novice investigator support.
- Gilbert Brown and Formal Project prizes.
- ANZCA Trials Group support for trialists.
- Assistance with survey research for Fellows and trainees.
- Fundraising from the community by our Anaesthesia and Pain Medicine Foundation.

### Training and assessment

With our training program and international medical graduate assessment processes, ANZCA and FPM aim to provide you with colleagues who will advance our specialties, who will help you take great care of your patients, and who will contribute to “fellowship”:

- State-of-the-art redesigned curriculum for launch in the 2013 hospital training year.
- A continually updated IMGS assessment process.
- Support for new Fellows.

### Opportunities to contribute

Significant opportunities for professional and personal development are available to Fellows who participate in College activities and this participation can be very fulfilling. The College provides workshops and mentorship to up-skill Fellows in these roles:

- Council, committee and working group membership.
- Supervisors of training, module supervisors and clinical teachers.
- Curriculum reviewers and authors.
- Examiners and workplace-based assessors.
- Training site inspectors.
- IMGS and area of need assessors.
- Convenors, lecturers and tutors.
- Educational initiatives in anaesthesia and pain medicine in developing nations.

### The support of fellowship

Fellowship is a link that binds us together no matter where we work and live. The recent combined scientific meeting in Hong Kong underscored the great sense of collegiality that arises from belonging to such a motivated and capable group of professionals and this was shared by those who followed the conference in our e-newsletters. The support of “belonging” makes our mission of great training and great patient care all the more achievable.

### Fellowship: a badge of quality

Fellowship of ANZCA/FPM is an immediately recognised hallmark of a specialist of the highest professional standing. It is a symbol that the holder not only has a license to practice, but also is in good standing with a professional organisation that has the highest aspirations for safe and high quality patient care. Increasingly, we are the medical college that breaks new ground and sets standards for others, locally and overseas. We have every reason to be very proud of our fellowship.

These services could not be provided without the hard work of many Fellows and trainees, and of our wonderful staff in the head office, the regions and New Zealand. I would also like to acknowledge our fruitful collaborations with our sister societies and colleges, hospital departments of anaesthesia and pain medicine, jurisdictions, the media and the community; and also their own fine work on behalf of our specialties.

I invite you to take as much advantage of all this support as possible.

---

Professor Kate Leslie  
ANZCA President

## The value of ANZCA fellowship

### Quality and safety

- Professional documents and standard setting.

### Continuing professional development

- Program, resources and activities.

### Communications

- Website, communications and media program.

### Advocacy

- Building the status of our profession and minimising risk.

### Research

- Evidence to support high quality practice.

### Training and assessment

- High quality colleagues to support our mission.

### Opportunities to contribute

- Support for professional development in College roles.

### The support of fellowship

- Sense of collegiality and belonging.

### Fellowship: a badge of quality

- Immediately recognised hallmark of the highest professional standing.

# Knowledge resources update

The College recently commissioned a review of the archives, library and museum, collectively known as “Knowledge resources”.

Consultants interviewed the honorary curators and archivist, and other Fellows and staff over several months, and as well as museum professionals at other organisations. The report from this review will help the College preserve and share these historically important resources, which are treasured by the Council and Fellows.

An issue that consistently arose during the review was the need for a clearly articulated vision for history and heritage at the College and how history and heritage will be captured, retained and shared among the fellowship. In concert with this, history and heritage need to be communicated in the context of our overall public awareness strategy. These strategies will be developed under the aegis of Council over the coming months.

To oversee the historical collections of the College, a Knowledge Resources Committee has been established that reports to the Council Executive. The committee is working with the report towards cataloguing the collection, relocating the display to Ulimaroa (the historic building at ANZCA headquarters in Melbourne) and preparing for the 20th anniversary of the College next year.

The full report, including strategic plans for the three units, is published on our website at [www.anzca.edu.au](http://www.anzca.edu.au)



# Letter to the editor



The article in the *ANZCA Bulletin* (March 2011) “Perioperative patient preparation – the importance of communication” addressed some highly relevant concerns for anaesthetists. The author comments that he “used to wonder about the interpretation of ‘fitness for anaesthesia’ assessment”. He considers the situation where a physician has assessed a patient as unfit for anaesthesia, yet the anaesthetist “decides that it is in the patient’s best interests to proceed” with anaesthesia.

Anaesthetists not uncommonly advise patients who are high risk for anaesthesia-related complications, and who present for surgery. While we are generally not able to comment in detail on the risks and benefits of surgery, we

(and not generally physicians, unless they have a particular interest in perioperative morbidity and mortality) are best placed to advise on anaesthesia-related risks.

The concept of shared decision-making is not new. The advice that a patient “needs” surgery is being replaced with an approach where surgery is one option. Other options must always include doing nothing, even if that appears to be an irrational choice. In order for patients to realistically define what they “need”, patients deserve good advice, including advice on the risks and benefits of proposed interventions, such as anaesthesia. Only then will patients be able to weigh up the different options, including no surgery, and make decisions in line with their values. Doctors (surgeons, anaesthetists, physicians and family doctors) may not fully comprehend each patient’s value system and their tolerance to risk. While we may have a view as to what is in a patient’s best interests, it is our duty to advise patients of our recommendations, and allow them to make their own decisions.

Only a patient can ultimately decide what is in his or her best interests. I think the concept of anaesthetist as

“gatekeeper”, defining a patient as fit or unfit for anaesthesia belongs to a bygone era. I endorse Dr Roessler’s view that the job of the anaesthetist is to communicate with patients and the community, and to educate them “and provide them with the insight and understanding they need”.

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**Joanna Sutherland, FANZCA**  
Department of Anaesthesia  
Coffs Harbour Health Campus,  
New South Wales

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## Queen’s birthday honour

Dr Anthony Kirkwood from Orange, New South Wales, was a recipient of the Order of Australia Medal (OAM) for his services to medicine as an anaesthetist. It was announced as part of the Queen’s birthday honours list on June 13, 2011.

# HONG KONG CSM WRAP UP 2011

## Scientific program

The CSM featured more than 150 presentations, 66 workshops, 47 problem-based learning discussions (PBLDs) and quality assurance sessions and 94 posters.

The meeting boasted an impressive line-up of invited speakers – Dr Steve Yentis (ANZCA CSM Visitor) from London, Associate Professor David Scott (Australasian Visitor) from Melbourne, Professor M. Catherine Bushnell (FPM CSM Visitor) from Montreal, Professor You Wan (Hong Kong Visitor, Pain Medicine) from Beijing, Professor Vincent Chan (Hong Kong Visitor) from Ontario, Professor Spencer Liu (Society of Anaesthetists of Hong Kong Visitor) from New York, Professor Mervyn Singer (HKCA Visitor) from London and Professor Homer Yang (HKCA Visitor) from Ottawa.

One of the highlights of the scientific program was a real-time ultrasound-guided regional anaesthesia demonstration. Associate Professor Manoj Karmakar demonstrated a sciatic nerve block, a lumbar plexus block and spinal anaesthesia for a patient undergoing a total knee replacement at the Prince of Wales Hospital in Hong Kong with the live footage beamed into the convention centre.

The prestigious Gilbert Brown Prize for research by Fellows within eight years of admission to their original fellowship, was awarded to Dr Paul Sadleir from Sir Charles Gairdner Hospital in WA for “Sugammadex unlikely to attenuate rocuronium-induced anaphylaxis – evidence from an in-vivo model”.

Formal project prizes were awarded to Dr Sharnie Wu from Lithgow in NSW for “Anterior sub-Tenon anaesthesia for cataract surgery” and Dr Yee Wah Tse from Hong Kong for “Sudden blackout of the Dräger Zeus anaesthetic machine”.

The CSM 2011 trainee poster prize was awarded to Dr Natalie Kruit from NSW for “25 year retrospective analysis of trends in management of liver trauma” and Associate Professor Ross Kennedy from Christchurch, New Zealand won the CSM 2011 open poster prize for “Use of intrathecal morphine does not influence ‘MAC-awake’ of sevoflurane”.

To maximise the dissemination of presentations delivered at the meeting, ANZCA’s Education Project Officer Susan Batur worked on behalf of FPM to record several podcasts that can be accessed via the FPM website.

A successful workplace-based assessment (WBA) workshop was also coordinated by Dr Jodi Graham on behalf of the ANZCA Workplace-based Assessment Committee to introduce delegates to some of the challenges faced in introducing WBA tools to the ANZCA training program.

## Pain medicine

The well-attended FPM Refresher Course Day – 158 registrants – was a highly successful precursor to the CSM marred slightly by the temporary illness of keynote speaker Professor Bushnell.

The theme of the Refresher Course Day was “Pain management: Getting closer to the dragon pearl”. Twelve speakers gave presentations on sessions titled “Neurobiology”, “Challenges in opioid therapy”, “Outcomes in pain management” and “Eastern influences”.

The rest of the FPM program held over the first two days of the CSM covered psychology, cancer pain, professionalism, musculoskeletal pain and acute peri-operative pain.

FPM wrapped up its CSM program with its annual general meeting at which the winner of the Dean’s Prize was announced as Dr Rohan Russell for “A comparison of post-operative opioid requirements and effectiveness in methadone-maintained and buprenorphine-maintained patients”. The Free Paper Session winner was Dr Allyson Browne for “Screening for acute factors that predict pain post trauma: A pilot study”.



Clockwise from top left: Hong Kong CSM 2011 Convenor Dr Chi-Wai Cheung opening the conference; FPM Scientific Convenor Dr Phoon-Ping Chen, CSM Scientific Convenor Professor Warwick Ngan Kee, Hong Kong College of Anaesthesiologists President Professor Michael Irwin, ANZCA President Professor Kate Leslie, FPM Dean Dr David Jones and Dr Chi-Wai Cheung at the conference opening; delegates at the conference; ANZCA/HKCA College Ceremony Orator Dr John Chan; Professor Kate Leslie and Professor Michael Irwin at the Gala Dinner; Professor Warwick Ngan Kee; delegates in the Convention Hall.





# HONG KONG CSM WRAP UP 2011

## Events

The formal ceremonies and events of the meeting generally had a Chinese theme that can only be described as spectacular.

The CSM began with the lion dance ceremony, where officials painted the eyes on the faces of three lions, and welcoming speeches by the President of ANZCA, Professor Kate Leslie and the President of the Hong Kong College of Anaesthesiologists, Professor Michael Irwin.

The Conference Gala Dinner was a night of Chinese culture and tradition held in the Grand Hall of the HKCEC, the site of the Joint Sino-British Handover Ceremony. The 1530 guests attending were treated to a fabulous Chinese banquet and spectacular entertainment, including amazing contortionists, Chinese drummers, face changing and Brazilian dancers.

The healthcare industry (HCI) reception was also popular, with 870 attending.

The College Ceremony was attended by 930. At the ceremony, 208 new ANZCA Fellows, 17 new FPM Fellows (plus one honorary Fellow) and 33 new HKCA Fellows were presented. The College Ceremony orator was Dr John Chan, a well-known leader in Hong Kong who was chair of the famous Hong Kong Jockey Club.

Professor Paul Myles was awarded the prestigious Robert Orton Medal. Dr Zoltan Lett was conferred with honorary fellowship of the Hong Kong College of Anaesthesiologists and Dr Pongparadee Chaudakshetrin was awarded honorary fellowship of the Faculty of Pain Medicine.

The Renton Prize for the best primary examination candidates was awarded to Ann-Lynn Kuok (April 2008), Vivian Vy Nguyen (May 2010) and Lachlan Fraser Miles (September 2010). The Cecil Gray Prize for the best final examination candidates was awarded to Abhijett Bhalchandra Tandel (May 2010) and Sheila Hart (October 2010).

CSM 2011 wrapped up with a closing ceremony that followed the highly anticipated Australia vs Rest of the World vs VIPs quiz moderated by CSM 2011 Scientific Convenor Professor Warwick Ngan Kee and Assistant Professor Caroline Jenkins. The quiz was won by the Australians who finished just ahead of the Rest of the World. Just behind them were the VIPs (Professor Singer, Associate Professor Scott, Dr Yentis, Professor Leslie and Professor Yang). The winner of the main prize, an iPad 2, for the highest individual score was Dr Alistair Kan from the Gold Coast Hospital in Queensland.

## Communications

For the second year, ANZCA's Communications Unit produced daily e-newsletters for meeting delegates and Fellows and trainees of ANZCA and FPM not at the meeting. The e-newsletters also went to Fellows and trainees of the Hong Kong College of Anaesthesiologists not at the meeting.

They contained daily highlights of the meeting, interviews with all keynote speakers and a selection of other speakers, audio recordings of all keynote speaker presentations, daily messages from key ANZCA and FPM figures, photographs and daily media updates.

The *CSM E-Newsletter* was very well received, attracting many positive comments from Fellows both at the meeting and at home.

Back editions of the e-newsletter as well as audio and video presentations and photos can be found on the ANZCA website.

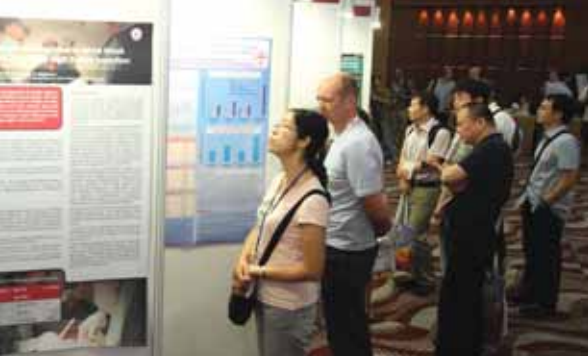
The CSM also attracted widespread media coverage, with more than 20 speakers interviewed, generating more than 25 stories in newspapers, more than 70 on internet sites, 15 radio mentions and two television features. The media coverage was estimated by Media Monitors to be worth nearly \$680,000 in equivalent advertising dollars.

This was due in part to the decision to host medical reporters from *The Australian* (News Ltd), *The Age* (Fairfax Media) and Australian Associated Press who produced several stories for their own publications that were often followed up by other media organisations.

For more details, please see "ANZCA in the news" on page 69.

From top: delegates viewing the posters; guests mingling ahead of the Gala Dinner; FPM Dean Dr David Jones, HKCA President Professor Michael Irwin and ANZCA President Professor Kate Leslie at the conference opening; guests enjoying the Gala Dinner; delegates in the Convention Hall.





## Snapshot

Full registrants: 1530

Total attendees: 2017

Day registrants: 46

New Fellows: 258  
(ANZCA, HKCA, FPM)

Presentations: 151

Sessions: 52

Workshops: 61

PBLDs and QAs: 47

## Prize winners

### Gilbert Brown Prize

Dr Paul Sadleir – “Sugammadex unlikely to attenuate rocuronium-induced anaphylaxis – evidence from an in-vivo model”.

### ANZCA Formal Project Prize

Dr Sharnie Wu – “Anterior sub-Tenon’s anaesthesia for cataract surgery”.

### HKCA Formal Project Prize

Dr Yee-Wah Tse – “Sudden blackout of the Dräger Zeus Anaesthetic Machine”.

### CSM 2011 Trainee Poster Prize

Dr Natalie Kruit – “25 year retrospective analysis of trends in management of liver trauma”.

### CSM 2011 Open Poster Prize

Associate Professor Ross Kennedy – “Use of intrathecal morphine does not influence ‘MAC-awake’ of sevoflurane”.

### Renton Prize

Ann-Lynn Kuok (April 2008)  
Vivian Vy Nguyen (May 2010)  
Lachlan Fraser Miles (September 2010)

### Cecil Gray Prize

Abhijett Bhalchandra Tandel (May 2010)  
Sheila Hart (October 2010)

## 2011 named lectures

### Ellis Gillespie Lecture

Dr Steve Yentis (ANZCA CSM Visitor), London, UK - “Evidence-based medicine: pearls of wisdom or fool’s gold?”

### Michael Cousins Lecture

Professor M. Catherine Bushnell (FPM CSM Visitor), Montreal, Canada – “Imaging pain: from research to clinical application”.

### Mary Burnell Lecture

Professor Vincent Chan (Hong Kong Visitor, Anaesthesia), Ontario, Canada – “Training, competency and certification in ultrasound-guided regional anaesthesia”.

### Australasian Visitors Lecture

Associate Professor David Scott (Australasian Visitor), Melbourne, Australia – “Anaesthesia and Cardiac Surgery: quo vadis?”

### Pain Medicine Visitor’s Lecture

Professor You Wan (Hong Kong Visitor, Pain Medicine), Beijing, China – “Treating acute pain: the wrath of peripheral firings”.

### Hong Kong College of

### Anaesthesiologists Visitor’s Lecture

Professor Homer Yang (Hong Kong College of Anaesthesiologists Visitor), Ottawa, Canada – “Prevention of Perioperative Myocardial infarction: where are we now and where are we going?”

### Hong Kong College of

### Anaesthesiologists Visitor’s Lecture

Professor Mervyn Singer (Hong Kong College of Anaesthesiologists Visitor), London, UK – “Destressing the distressed”.

### Society of Anaesthetists of Hong Kong Visitor’s Lecture

Professor Spencer Liu (Society of Anaesthetists of Hong Kong Visitor), New York, US – “Postoperative pain control: what to do after the PCSA?”



# HONG KONG CSM WRAP UP 2011

## Perth 2012

Perth is hosting the 2012 ASM, which has the theme "Evolution: Grow Develop Thrive", from May 12-16.

The convenors are Dr Tanya Farrell and Dr David Vyse, the scientific convenors are Dr Tomas Corcoran and Professor Michael Paech and the FPM Scientific Convenor is Dr Max Majedi.

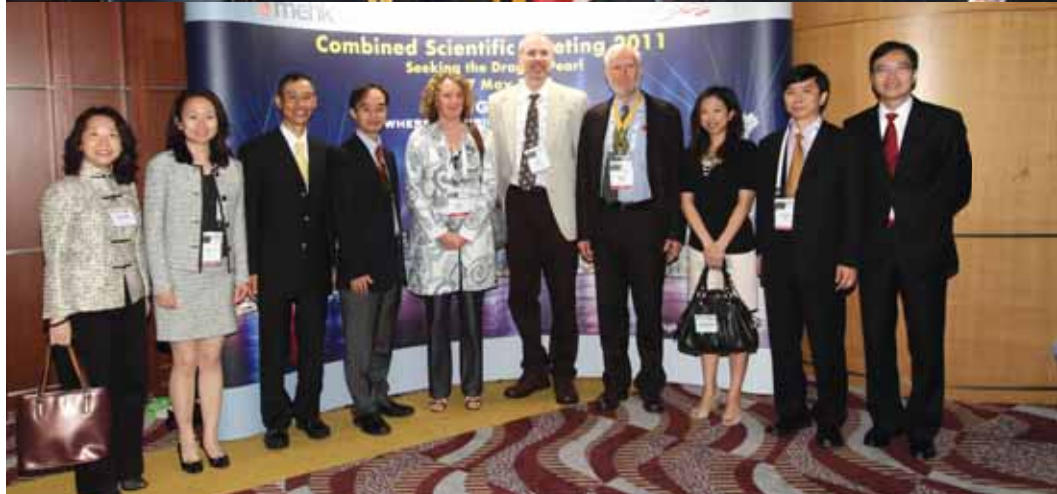
They have assembled a panel of world-renowned speakers from the US, Europe and Australasia and the scientific program will be covering a comprehensive range of topics in all areas of anaesthesia and pain medicine.

The social program will highlight the wonderful weather and fabulous wines and produce of Western Australia.

See page 35 for a report from Dr Vyse and Dr Farrell.



From top: the Conference Gala Dinner; (left) Dr Steve Yentis; (right) ANZCA President Professor Kate Leslie congratulating Professor Paul Myles on being awarded the Robert Orton Medal; new Fellows at the College Ceremony; Irene Law, Hong Kong Tourism Board, Dr Peggy Li, Social Convenor, Professor Warwick Ngan Kee, Scientific Convenor, Dr Steven Wong, Hong Kong Advisor, Professor Kate Leslie, ANZCA President, Dr Steve Yentis, ANZCA CSM Visitor, Dr David Jones, FPM Dean, Phoebe Shing, Hong Kong Tourism Board, Dr Phoon-Ping Chen, FPM Scientific Convenor and Dr Chi-Wai Cheung, Convenor.



# New Fellows Conference 2011



Life, by its nature, is a series of changes. Willingly or unwillingly, our surroundings, the people around us and even ourselves keep changing. Change doesn't necessarily equate to crisis, provided we know how to deal with it. Surrounded by the magical charm of the Hong Kong Disneyland Hotel, 31 delegates from around the world (Australia, New Zealand, Malaysia, Singapore and Hong Kong) participated in this year's New Fellows Conference to explore the meeting theme: "Manage the Change".

Our journey began with an art jamming session during which delegates were required to draw a painting with the theme "to change". Upon entering the function room filled with acrylic paints, brushes, canvas and easels, many of us couldn't help but exchange looks of hesitancy and anxiety. Fortunately, under the cheerful and relaxed atmosphere, our spirit of imagination, hidden artistic talents and creativity were gradually unveiled. Who would believe that we managed to turn the room into an art gallery by filling it with paintings of various styles: Impressionism, Realism, Fauvism, Abstractionism, Cubism and Romanticism?

At the end of the session, each of us made a five-minute presentation based on our painting. We shared our experiences of change in different aspects of our lives and the ways we feel and handle change in an open and genuine manner and gained a better understanding of ourselves and one another through the exercise.

The next session was a workshop entitled "Managing the change", chaired by one of our guest speakers, Professor Sherry Chan, a psychiatrist from the University of Hong Kong. Through various games and group discussions, Professor Chan introduced us to the concept of the "Myers Briggs personality type", which is a psychometric test to measure how people perceive the world and make decisions. By understanding different temperaments and the corresponding reactions to change, we began to gain a better idea of what we value, what we need, when we need help and how we cooperate with people of different personality categories. This is an essential tool for new Fellows as we face numerous challenges that bring about change in our living and working environments.

Another highlight of the conference was the tai chi workshop, "A Taste of the Tradition". As we get older and mature in life, it is difficult for us to ignore the cruel reality – the physical change of our body.

Tai chi is a kind of internal Chinese martial arts with well-known benefits on stress management and wellbeing. It demonstrates the perception of life in traditional Chinese culture with emphasis on harmony with nature. Through three hours of lively illustration and repeated practice, Ms Grace Ip and her colleagues, Mr Quentin Lau and Ms SaSa Mok, and senior coaches from the Hong Kong University Chinese Martial Arts Alumni Association, inspired our interest in this traditional Chinese wisdom.

Seeing how focused delegates were during the practice of "Parting the wild horses' mane", we couldn't help but be amazed by their enthusiasm and readiness to embrace different cultures. The session was concluded with a "Monkey Jump" in Dreamers' Garden.

In the College speaker session, we were delighted to have Dr Michelle Mulligan and Dr Justin Burke as our speakers. In keeping with our theme, they gave us a talk on the changes faced by the College and our profession. We also had an open discussion on how we could contribute to the College and increase our involvement in College affairs.

After spending three days at the Hong Kong Disneyland Hotel, our conference came to an end and we thank the delegates for their enthusiastic participation. With memories of delicious food, a relaxing and gracious environment, inspiring and entertaining workshops, open and genuine discussion, thunders of laughter and sweat from "exercise", we hold fond memories of the New Fellows Conference 2011.

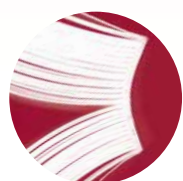
**Dr Patricia Kan**, Co-Convenor  
**Dr Timmy Chan**, Co-Convenor  
**Dr Natalie Smith**, Deputy Convenor

*Above clockwise from left: Delegates from Australia, New Zealand, Malaysia, Singapore and Hong Kong learn how to manage the change at the 2011 New Fellows Conference in Hong Kong; New Fellows relax their minds and bodies during a three-hour tai chi session, a Taste of the Tradition; Dr Nolan McDonnell presents at the New Fellows Conference.*

# ANZCA Curriculum Revision 2013

What has happened since the curriculum redesign project's update in the March edition of the *ANZCA Bulletin*?

The Curriculum Redesign Steering Group has continued to meet regularly and to work diligently on further developing key aspects of ANZCA Curriculum Revision 2013. Outcomes of this work included the presentation of a list of recommendations to the June Education and Training Committee and ANZCA Council meeting relating to transition arrangements and other matters. Key elements of the recommendations approved by council are outlined here.



**ANZCA  
Curriculum  
Revision  
2013**

## Transition arrangements for the revised curriculum project

Every endeavour will be made to ensure that trainees will not be disadvantaged by the introduction of ANZCA Curriculum Revision 2013.

Key elements approved by June Council relating to transition arrangements are outlined below.

### When will the changeover from the current curriculum to the revised curriculum 2013 take place?

ANZCA Curriculum Revision 2013 will be implemented at the start of the 2013 hospital year. The 2013 hospital year is the changeover time for new trainees in each jurisdiction in which ANZCA training occurs (that is, in December 2012 in New Zealand, from January 2013 in Australia, and in mid-year 2013 for Singapore, Malaysia and Hong Kong). The Curriculum Redesign Steering Group is working on the transition arrangements for trainees in each year of the current program. The first approved arrangements are outlined here.

### What transition arrangements have been approved for the primary examination?

The table below outlines the transition arrangements to be implemented for the primary examination.

The new primary examination must be taken and passed as a whole with no carrying of partial passes allowed. Council has previously agreed that the primary examination may only be taken whilst in training and after the Introductory Assessment of Anaesthetic Competence (IAAC) has been passed following three to six months of successful experience in the introductory anaesthetic practice component of basic training. The necessity for the completion of the IAAC prior to sitting the primary examination would not apply for any trainee who commenced training before the 2013 training year.

Council has previously agreed that the primary examination will examine elements of anatomy and anaesthetic equipment as well as physiology, pharmacology, statistics and measurement. Adjustments will be made between the primary and final examinations to balance the amount of material in the revised primary examination that takes into consideration the relationship of some of the topics to the timing of the associated clinical experience.

Exam	2012		2013		2014 onwards	
	1st Sitting	2nd Sitting	1st Sitting	2nd Sitting	1st Sitting	2nd Sitting
Current Primary	Yes	Yes Last chance to complete both parts of the current primary	Yes *Only for candidates who are carrying a partial pass. Last chance to complete current primary	N/A	N/A	N/A
New Primary	N/A	N/A	Yes *basic training year 1 (BTY1) (>3-6/12) and basic training year 2 (BTY2) only	Yes	Yes	Yes

### What transition arrangements have been approved for the final examination?

Advanced training year 3 (ATY3) trainees in 2013 who have not passed their final examination or completed their modules will be allowed to continue as ATY3 trainees for their fifth year of training, sit the new final examination in that or a subsequent year, and complete their other requirements for training.

Council has previously agreed that the final examination must be passed before advanced training can be completed and the provisional fellowship year commenced.

### Other significant changes to be introduced in the ANZCA Curriculum Revision 2013

Additional changes approved by council to training requirements under the ANZCA Curriculum Revision 2013 are outlined below.

#### Changes to EMAC and EMST requirements

Under ANZCA Curriculum Revision 2013, all trainees will be required to complete the Effective Management of Anaesthetic Crises (EMAC) course before completing training. The Emergency Management of Severe Trauma (EMST) course will continue to be encouraged but will only be mandatory for trainees unable to complete a trauma volume of practice (VOP) requirement.

#### Fifth year of training

Council has reintroduced the term “provisional fellowship year” for trainees in their fifth year of training. As mentioned above, this year of training may only commence after successful completion of advanced training, which includes successful completion of the final examination and all other aspects of advanced training.

Council also agreed that the provisional fellowship year trainees will be able to choose from a range of consolidated study units which are defined by the College or are proposed by a trainee with prospective approval. These study units will focus either on an ANZCA role, an ANZCA clinical fundamental or a specific area of anaesthetic practice, and will include a minimum of 20 per cent clinical time unless otherwise approved by council.

#### Timeline

A detailed timeline has also been approved to guide the implementation of ANZCA Curriculum Revision 2013. This timeline will be overseen by a program management team contracted to ensure that all of the infrastructure necessary to support ANZCA Curriculum Revision 2013 is in place and tested in time for the introduction of the revised curriculum.

#### What are the next steps in the curriculum redesign project?

The Curriculum Redesign Steering Group will continue to coordinate all aspects of the curriculum redesign process. The Curriculum Project Advisory Group (CPAG), comprised of heads of ANZCA’s operational and administrative units, will become increasingly involved in the redesign project to ensure the transition from the current curriculum to the revised curriculum will be as smooth as possible and with minimal disruption to all ANZCA operations connected to the project.

At this point, particular focus is being put on developing an appropriate information technology infrastructure to support the revised curriculum and to ensure that once implemented, it can be easily managed by all stakeholders affected.

These are exciting times for ANZCA and we envisage that all stakeholders, be they trainees or Fellows, will have their training and teaching experiences greatly enhanced by the changes and innovations introduced in the revised curriculum.

#### How can I contribute?

To ensure the changes best serve both trainees and Fellows, it is critical that we continue to receive input from all parties affected by the curriculum changes. ANZCA encourages all trainees and Fellows to actively engage in providing feedback. For further updates or to provide feedback, please visit the College website [www.anzca.edu.au](http://www.anzca.edu.au) or contact the Education Development Unit by email [education@anzca.edu.au](mailto:education@anzca.edu.au) or telephone: +61 3 8517 5361.

Now	2011	2012	2013
<ul style="list-style-type: none"> <li>• Learning objectives</li> <li>• Volume of practice</li> <li>• Transition arrangements</li> </ul>	<ul style="list-style-type: none"> <li>• Workplace-based assessment (WBA) suite development</li> <li>• Regulation revision</li> <li>• Professional document update</li> </ul>	<ul style="list-style-type: none"> <li>• Transition: preparation and delivery</li> <li>• Training: materials development and delivery</li> </ul>	<ul style="list-style-type: none"> <li>• Support</li> <li>• Monitor</li> <li>• Enhance</li> </ul>
Online learning system requirements	Vendor assessment	Develop and test	Implement
Communications and change management			

**Timeline:** A detailed timeline has also been agreed on to guide the implementation of ANZCA Curriculum Revision 2013.



# ANAESTHESIA IN WA

## SPECIAL REPORT: HEALTH REFORM AND ANAESTHESIA DEVELOPMENTS IN WESTERN AUSTRALIA

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



## ANAESTHESIA IN THE BIGGEST STATE



**DR JENNY STEDMON**  
WA REGIONAL COMMITTEE CHAIR  
DEPUTY HEAD OF ANAESTHESIA  
(EXTERNAL) FREMANTLE HOSPITAL

Western Australia is the largest state in Australia with Perth the most isolated capital city in the world. With the main population focused in Perth itself, but the rest spread wide over regional and rural areas, the WA anaesthetic community is faced with unique working conditions and challenges. The task of the regional committee to be relevant and supportive to those in rural and metropolitan practice whilst reflecting the policies and concerns of the College can be somewhat challenging. We are privileged to have the experience of ANZCA Past President Dr Wally Thompson and Dr Lindy Roberts, the current College Vice President. Dr Roberts keeps the committee up to date with the work of the Council, and her advice to us on terms of reference is very useful, as was the recent face to face meeting of the regional chairs with the Council at the Hong Kong Combined Scientific Meeting (CSM).

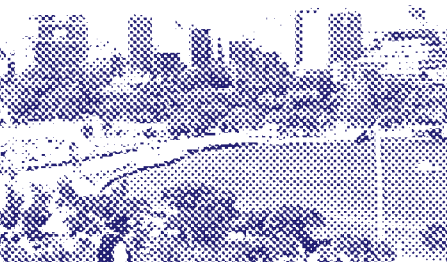
Early this year the WA ANZCA Secretariat was fortunate to move to new permanent premises. The new office provides improved facilities for meetings, examinations and other activities, and is shared with our colleagues in the Australian Society of Anaesthetists (ASA). The office was officially opened by the Honourable Julie Bishop MP, Deputy Leader of the Opposition, Shadow Minister for Foreign Affairs and Shadow Minister for Trade. The opening was well attended by current and retired specialists and trainees and gave us an opportunity to raise the profile of the specialty as well as to socialise with our colleagues.

Western Australia currently has one rotational training program catering for the needs of the steadily increasing numbers of trainees, 107 as of the start of 2011. Current and future concerns include the likelihood of a degree of "block" for some sub specialties, in particular paediatrics, cardiac and obstetrics. Regional education officer (REO) Dr Jodi Graham, Deputy REO Dr Jay Bruce and rotational supervisor Dr Steve Myles, together with the WA ANZCA Trainee Committee chaired by Dr Yvette Gainey are working hard to manage and continue to develop the scheme. Currently there is significant growth in infrastructure in Western Australia, and we expect this will provide new opportunities for training.

### **FIONA STANLEY HOSPITAL**

Progress in the building of the Fiona Stanley Hospital is on time and on budget, with the current projected opening in 2014 a reality. It is anticipated it will have the full facilities of a leading tertiary hospital, including cardiac, neurosurgery, trauma, paediatrics, obstetrics and burns which will create additional opportunities for our trainees to undergo sub specialty training. The recent development of enthusiastic and productive research departments at South Metro hospitals can be expected to continue with the research facilities at Fiona Stanley. The hospital site is adjacent to St John of God, Murdoch, which may offer additional training opportunities as well as foster intercollegiate relationships between colleagues in public and private practice. The development of clinical services has already begun, with the appointment of cluster lead roles and, importantly, there is representation of our specialty. Dr Gavin Coppinger, Head of Department of Anaesthesia at Fremantle Hospital, holds a cluster co-lead role with Professor David Fletcher, Clinical Director, Surgical Services Fremantle Hospital, for the development of surgical services across South Metro. Their cluster is concerned with the development of theatre facilities and both elective and emergency surgical services, throughout the entire South Metro region. This includes the Royal Perth, Fremantle, Armadale, Rockingham, Bentley and the new Fiona Stanley hospitals.

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## ROCKINGHAM HOSPITAL

The expansion of Rockingham Hospital was completed earlier this year, and included the opening of a level two intensive care unit. The Department of Anaesthesia continues to expand, and the current Head of Department, Dr Taylor Kooner, welcomed ANZCA approval of the facility for trainees as a satellite of Fremantle Hospital. The first trainees have almost finished their attachment.

## SWAN DISTRICTS HOSPITAL

Swan Districts Hospital also has an expanding anaesthetic department, and is attracting new consultant staff. The current Head of Department is Dr Lisa Chin. Swan Districts was also recently inspected on behalf of ANZCA for approval, as a satellite of Sir Charles Gairdner Hospital, for rotational trainees. The hospital will expect its first trainees in August this year. Further development includes a new hospital being built in Midland, and it is anticipated that this will be a bigger facility with increased surgical throughput.

## GERALDTON HOSPITAL

Geraldton Hospital, which is located four hours north of Perth, is also expanding, and has recently appointed two consultant anaesthetists - Dr Jo-Anne Mileham and Dr Justin Booyse - to an area of need. The hospital's CEO, Alison Capewell, has an ambitious expansion plan that would see increased numbers of specialists working full time at Geraldton Hospital, with increases in hospital beds, theatre throughput, renal dialysis facilities and other infrastructure. The population growth in Geraldton, spurred by mining and the Oakagee Project, has been a stimulus for growth.

There is also potential for expansion of health facilities in other rural centres including Broome, Derby, Port Hedland, Kununurra and Albany, which may lead to new and exciting training opportunities.

With the main population of WA centered in Perth, leading to the concentration of specialist services in the metropolitan areas many specialist services to rural and remote communities are on a "fly in, fly out" basis. This leads to some interesting anaesthetic work opportunities, which we hope will be translated to training opportunities in the near future. It also means that we are dependent on our Royal Flying Doctor Services and Care Flight, and the additional training experiences these institutions offer.

The isolation from our interstate colleagues requires us to create an excellent continuing medical education (CME) program for our trainees and Fellows. The combined WA ANZCA and ASA CME Committee have continued to perform sterling work in this area with the annual autumn and winter scientific meetings held locally and the country meeting held down south at Bunker Bay. The upcoming winter meeting is to be held at the university club at UWA on July 30 and is themed "Dealing with disaster". All three meetings are well subscribed with a number of interstate and overseas Fellows travelling to WA to attend.

The West Australian Airway Group (WAAG) recently organised a local Advanced Airway Course, which was held at Bunker Bay in March. We were also lucky to have the opportunity to attend the HART Trans Thoracic Echo course, which was held at Fremantle Hospital, also in March. Opportunities such as these are very important to the local anaesthetic community, as transport to and from distant courses is both costly and time consuming.

Perth is the host to the 2012 annual scientific meeting, and our convenors (Dr David Vyse and Dr Tanya Farrell) have been working hard with their organising committee to bring us an exciting and well organised event. It will also provide a golden opportunity for our international and interstate colleagues to explore WA's diverse and unique natural environment. For the really adventurous, it is whale shark season and the north is particularly appealing at this time of year. The meeting was launched at the Hong Kong Combined Scientific Meeting and the booth generated plenty of interest.

An area where we are yet to find a solution is simulation. The loss of the Clinical Training and Education Centre facility at the University of Western Australia, more than two years ago, disadvantages our trainees (and Fellows) considerably. WA is no longer able to run an Effective Management of Anaesthetic Crises course, which means our trainees must seek places interstate which are difficult to secure. Dr Richard Riley and Dr David Borshoff have sat on an Immersive Learning and Simulation Committee for more than 18 months, and have watched opportunities to rectify the situation come and go. Finally a tender for a new facility closed in November 2010, but to date no decision has been announced as to the successful applicant. Recently, however, government approval was given to the formulation of a state simulation plan, and anaesthetic input has been sought.

The next few years will present us with many exciting opportunities to expand and develop anaesthesia in WA while continuing to strive for the highest standards of practice, training and continuing professional development. The following articles illustrate the enthusiasm and diverse interest of Fellows in the state.



From left: Geraldton Regional Hospital, Princess Margaret Hospital for Children.

## INTERPROFESSIONAL PROGRAMS TO PROVIDE EVIDENCE AND SKILLS TO HEALTH CARE PROFESSIONALS AND CONSUMERS IN WESTERN AUSTRALIA



**DR STEPHANIE DAVIES**<sup>1,2,3,4,5</sup>  
DEPARTMENT OF ANAESTHESIA  
AND PAIN MEDICINE UNIT,  
FREMANTLE HOSPITAL



**DR ERIC VISSER**<sup>1,3</sup>  
DEPARTMENT OF ANAESTHESIA  
AND PAIN MEDICINE UNIT,  
FREMANTLE HOSPITAL

The ultimate aim for pain management services is for consumers to receive an appropriately prescribed combination of active self-management and biomedical strategies so the consumer achieves improved functional outcomes. Often, this requires services to be provided in a *parallel* (multi-disciplinary or inter-professional) rather than in a *linear* fashion (sequential mono-therapy).

Pain is a complex biopsychosocial phenomenon involving diverse processes. Managing the complexity of pain is best served by an expert interdisciplinary team approach throughout triage, assessment, and management. The consumer is a central part of the "expert team" and consumer-focused processes may need to be re-configured to provide both working knowledge and skills from which they draw conclusions based on specialist advice and information.

### KNOWLEDGE IS POWER

Consumer-focused processes provide the knowledge and skills for them to assess specialist advice and other information (or misinformation) relevant to their condition. Whilst all patients present with different needs and problems, certain common issues are addressed usefully and efficiently through early group education<sup>2</sup>. These processes aim to enable patients with persistent pain in

making sense of complex clinical findings and pain management options.

Two projects initially funded by WA Health via the State Health Research Advisory Council provided metropolitan-based Western Australians with evidence-based self-management strategies for pain: 1) Pre-clinic inter-professional group education for consumers attending tertiary pain medicine units via Self-Training Educative Pain Sessions (STEPS) which commenced in October 2007 and is ongoing; and 2) Inter-professional low back pain education programme for general practitioners (gPEP) in 2009.

In 2010 an inter-disciplinary spinal pain implementation working group within the Musculoskeletal Health Network (Department of Health, WA) prioritised the delivery of gPEP and STEPS to health care professionals (HCPs) and consumers, respectively, in regional WA by cooperatively funding and coordinating "The Rural Roadshow". The initiative aligned directly with the recommendations in the WA Spinal Pain Model of Care ([www.healthnetworks.health.wa.gov.au/modelsofcare/](http://www.healthnetworks.health.wa.gov.au/modelsofcare/))

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This "Rural Roadshow" kicked off in 2010-11, with WA Health funding three sites (Kununurra, Albany and Kalgoorlie) and Kimberley Division of GPs funding a one day gPEP program in Broome. Rural Health West co-ordinated and co-funded the health care professionals, whilst the Arthritis and Osteoporosis Foundation of WA contributed funds and logistical support as well as co-ordinating the consumer day. Sixty HCPs from four WA regional areas attended the interprofessional health care professional pain education program (gPEP) on the Saturday and more than 80 consumers attended the Sunday STEPS program. This program aimed to facilitate timely up-skilling of HCPs and consumers at the same sites at the same time, as well as opening a wide communication corridor for future health care professionals and their patients.

Evaluation of the Rural Roadshow is via Curtin University which is prospectively reviewing: 1) health care professional clinical knowledge and behaviours pre and post attendance; and 2) consumer attitudes, beliefs and behaviours pre and post attendance. Additionally a sub-set of consumers participated in a qualitative process involving an independent semi-structured telephone interview to identify key themes regarding knowledge they acquired, access to local health services and an evaluation of the forum.

The novelty of this service delivery and evaluation is the co-ordination of group education from metropolitan services directly to remote and rural WA. The aim is to reduce inequality of access to pain services across WA due to distance and cost of travel.

Metropolitan pain services across WA continue to provide a combination of active self-training programs in conjunction with biomedical interventions, to assist the patient achieving improved functional outcomes.

### RESEARCH AT THE COALFACE

Research at the "coalface" of service delivery aims to document patient and system outcomes. Fremantle Hospital has assisted with "fine-tuning" of a multi-site web-based database for patients which now has baseline data (de-identified) on more than 2000 patients and follow-up data on about 50 per cent of the patients attending the pain medicine unit at Fremantle Hospital ([www.researchaustralia.net.au](http://www.researchaustralia.net.au)).

These patient data and associated patient outcomes may be helpful in enabling health professionals and policy makers to better understand the importance of the "expert team" involving the consumer in targeted pain management. This clinical systems approach may also assist future benchmarking of best-evidence practice and act as an objective driver to optimise patient outcomes.

A true evidence-based approach requires: 1) practice in line with published outcome literature and accepted guidelines; and 2) practice that is informed by and responds to its own outcomes. The ideal is clinical practice

which is dynamic with audit processes in place to assess the system's own efficacy. Systems can then evolve, where meaningful clinical outcomes drive efficient resource allocation and effective choice of management options.

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From left: Royal Perth Hospital.

## RURAL PAEDIATRIC EAR, NOSE AND THROAT (ENT) HEALTHCARE IN WESTERN AUSTRALIA



**DR ALISON CARLYLE**  
CONSULTANT PAEDIATRIC ANAESTHETIST,  
PRINCESS MARGARET HOSPITAL

Otitis media with effusion (glue ear) is a huge healthcare problem for children in rural Australia which can lead to serious complications such as mastoiditis and perforation. Repeated attacks and chronic disease cause hearing loss with delayed speech and language development, and impair socialisation and performance at school. Many studies have shown that indigenous children suffer higher rates of otitis media and have more serious complications than non-indigenous children.

The Kimberley covers almost half a million square miles in northern Western Australia. One third of the region's population are Aboriginal or Torres Strait Islanders. Thirty per cent of the population is under the age of 15 years: this unusually high percentage reflects trends related to the demographics of Aboriginal Australia and the migration of young families to work in the region.

The Country Health Service in the Kimberley organises outreach ENT team visits to regional centres including Derby, Broome and Kununurra. The trips consist of pre and postoperative clinics (some of which take place in fairly remote communities), and operating sessions. The team originates from Perth and includes an ENT surgeon, an anaesthetist with an interest in paediatric anaesthesia and an audiologist. I was lucky enough to go on one of these trips to Kununurra late last year. I was keen to become involved as it was a good opportunity to see another aspect of the healthcare system in WA, and it also meant facing the challenges of working in a fairly isolated site away from my familiar tertiary hospital surroundings.

Kununurra is a regional town in the North East Kimberley on the Ord River downstream from the massive Lake Argyle. Its hospital has two wards, an emergency department, maternity and a single operating theatre. The theatre nurses are a competent and welcoming group who are well used to working with visiting surgeons of all specialties who fly in for one and two-week operating trips. Each day the nurses rotated surgical and anaesthetic assistant duties to maintain and improve skills. Resident GP anaesthetists from the hospital also had the chance to attend theatre sessions for up-skilling in paediatric anaesthetic techniques.

On our one-week trip the emphasis of the surgical work was on elective operations such as myringotomy and insertion of grommets, and myringoplasties, mainly in children, though we also performed a couple of unexpected "removal of foreign body" procedures (including an insect in an ear). On trips lasting two weeks, adenotonsillectomies are performed in the first week to allow for surgical intervention if there are secondary tonsillar bleeds. Mums and aunties generally accompany the children from remote communities and attempts are made to organise operations for siblings on the same trip. Preoperative assessments are made and operation lists are drawn up on day one, with the first operating session starting on the second day of the trip. After a couple of days' post-operative recuperation the patients return to their communities and are reviewed at the next clinic.

In addition to the elective ENT surgery, occasionally on these trips one may be asked to assist in emergency cases. I was unexpectedly called into the hospital in the early hours one morning to help with the resuscitation of a premature newborn who was delivered in a four-wheel-drive vehicle en route from one of the community clinics. The baby was estimated to be about 25 weeks gestational age and, although making some reasonable respiratory effort, required intubation and ventilation and umbilical venous and arterial line insertion before transfer to the Darwin neonatal intensive care unit. The intubation was quite straightforward but I was glad to have recently attended an advanced paediatric life support (APLS) course to brush up on my umbilical cannulation skills!

In summary, participating in rural healthcare in WA provides a unique opportunity to experience a beautiful, remote part of Australia whilst providing an invaluable service to local communities.



### RURAL AND REMOTE SPECIALIST ANAESTHESIA



**DR ALEX SWANN**  
DEPUTY HEAD OF DEPARTMENT  
– FREMANTLE HOSPITAL  
SENIOR CLINICAL LECTURER –  
UNIVERSITY OF WESTERN AUSTRALIA

Western Australia covers a huge area and land mass, and relies heavily on small peripheral centres for medical care.

Often these centres are tiny nursing posts or small hospitals services by GP Anaesthetists and Senior Medical Officers. The huge distances to travel to a tertiary centre necessitate the need for visiting specialists to run clinics and basic surgeries. Currently there are specialists from general

surgery, orthopaedics, obstetrics and gynaecology, ophthalmology and ear, nose and throat (ENT) visiting several centres most weeks of the year.

Over the last few years I have travelled once or twice a year with Dr Fiona Whelan to perform ENT surgery for the local population of Kununurra.

Kununurra is the largest town in Western Australia north of Broome, with the closest town being Wyndham, 100 kilometres (62 miles) away. Kununurra is 3040 kilometres (1889 miles) from Perth via the Great Northern Highway.

The town is situated in among the scenic hills and ranges of the far north-east Kimberley Region, having an abundance of fresh water, conserved by the Ord River Diversion dam and the main Ord River Dam. Amongst the industries, are huge mango farms, sandalwood plantations, chia crops, mining and tourism. It is an amazingly beautiful part of the world.

Kununurra has a transient population and including outlying areas and communities numbers about 7000. An influx in the dry season (From April to September), of tourists and itinerant farm workers pushes up the population to around 10,000 on any day during the dry season.

The hospital is small, with 35 beds and one theatre. There is a small emergency department staffed by a dedicated band of GPs and resident medical officers, and they deal with everything that comes their way including paediatrics and obstetrics.

Surgery is performed by the visiting speciality teams through the year, with the district medical officers tackling only the occasional emergency surgery. When stable enough for transfer, patients are flown back to Perth using the Royal Flying Doctor Service (RFDS), and there is an arrangement to transfer critically unwell patients to Darwin which is much closer.

Usually, we travel to Kununurra for a week long trip. "Glue" ear and recurrent ear infections are endemic in the local Aboriginal population and operations including grommets, myringoplasties and myringotomies form the majority of cases on a typical one week ENT trip. During this time we have three days in theatre, operating and several specialist and pre-operative assessment clinics. This allows the team to review patients with serious ENT problems and decide which we need to transfer to a tertiary centre for their surgery. Twice a year there is a two week long "tonsil" trip. We perform tonsillectomies on the first two days, and other ENT operations for the rest of the time. During the two weeks, we are constantly on-call for post-tonsillectomy bleeds.

The theatre is well equipped with modern anaesthetic machines, difficult airway equipment and well trained staff. The theatre team is multi-skilled, working with a diverse range of specialities, and extremely keen and enthusiastic! We have a lot of fun as well as working hard when we visit.



The all-round abilities of this dedicated group of doctors and nurses never ceases to amaze me. Recently they performed life saving burr hole surgery on a head injured patient under the guidance of a neurosurgeon in Perth watching over skype! On our latest trip, one of our lists was interrupted by the chief medical officer, as a local girl needed an emergency caesarian section. They were pleased to have a specialist anaesthetist available, and I was happy to assist with the anaesthetic, allowing the DMOs to perform the section and to successfully delivery two premature twins. This, again, was performed in consultation with the obstetric service at King Edward's Hospital in Perth, and the twins we're transferred to Darwin for further care. Mum and babies are now doing well.

The challenge of dealing with the local population is considerable. Diabetes and heart disease are rife and indigenous patients often present late with serious pathology. Currently there is a struggle with alcohol and moves are being made to minimise the availability of alcohol to local communities. Obstetrics is particulary difficult, with babies often being undersize, premature and affected by alcohol and drug use.

In our time away from the hospital, we are able to visit the sites within one hour of the hospital and enjoy some of the amazing scenery. The difference between the wet and dry is amazing, as the landscape changes from dry bright orange to luscious green. The DMOs and theatre staff are very hospitable and we have dined in the country club and been taken on several treks with the locals. There is a burgeoning indigenous artistic community in the Kimberly and the opportunity to see them work and purchase authentic artwork is well worth taking.

For anyone looking to work in rural and remote areas, Kununurra provides a safe and well-equipped entry into this field of anaesthesia. It also provides a wonderful training opportunity for juniors. I cannot speak highly enough of the staff who work in these communities, and am extremely grateful to be able to work with them, and also contribute to indigenous care where it's needed most.



*Above from top: The theatre setup with Dr Alex Swann on the right; Teaching.*



## FREMANTLE HOSPITAL: AWAKE FIBREOPTIC INTUBATION COURSE



**DR ANTHEA WILLIAM**  
AIRWAY FELLOW, FREMANTLE HOSPITAL

This twice-yearly course commenced at Fremantle Hospital in 2007 and is open to local anaesthetic trainees and consultants. The course uses participants as endoscopy subjects thereby providing practical training on human live subjects in the technique of awake fibreoptic intubation. The course is sponsored by Olympus who provide VISERA Intubation Videoscopes with viewing screens and lunch on the second day.

The course is held over two half days. There are two main supervisors, up to five lecturers, two anaesthetic technicians to assist with the practical procedures and a maximum of six participants.

The first afternoon includes a series of lectures covering the following topics:

- Indications and contra-indications of awake and asleep fibreoptic intubation.
- Equipment and physics of fibreoptic scopes.
- Anatomy of the airway.
- Preparation of the patient.
- Technique of AFOI and adjuncts used.
- Troubleshooting.

The lectures are followed by a fibreoptic endoscope dexterity session on mannequins.

The awake fibreoptic intubation session takes place the following morning in theatre with full resuscitation facilities available. All participants are instructed to fast for four hours and are advised that the procedure can be halted or abandoned at any point if they find it too uncomfortable. This has never happened in the four years that the course has been held.

The subject has non-invasive blood pressure, pulse oximetry and electrocardiogram (ECG) applied and recorded five-minutely. A 20-gauge cannula is inserted and IV glycopyrrolate administered for its antisialagogue effect. Topical lignocaine is limited to a maximum of 9 mg/kg. Co-phenylcaine is sprayed into each nostril followed by nebulized 4 per cent lignocaine. After this initial topicalisation, four of the five remaining participants takes turns in performing nasendoscopy with further airway topicalisation to the level of the larynx. The fifth participant then proceeds through the vocal cords to the carina and passes a soft-tipped size 6.0 fastrach endotracheal tube over the endoscope into the trachea. Using this routine, each participant performs four nasendoscopies and one endotracheal intubation and witnesses 20 nasendoscopies and five intubations. Airway anaesthesia usually lasts around 90 minutes and the supervisors ensure each participant has full sensation and laryngeal co-ordination prior to the commencement of the course lunch.

In the seven courses that have been run to date, there have been no major complications and endoscopy and intubation were well tolerated. Participants have enjoyed the course and all found it a valuable learning experience.





## TRANSTHORACIC ECHOCARDIOGRAPHY AND SCREENING



**DR MICHAEL VELTMAN,**  
JOONDALUP HEALTH CAMPUS

Intraoperative Trans Oesophageal Echocardiography moved from a new modality in the 1990s to become a standard of care in cardiac anaesthesia by the early 2000s. Over the last decade ultrasound technology has progressed dramatically, and is now smaller, cheaper and of far higher quality than anything available a decade ago.

Many anaesthetic departments have access to one, or more commonly several, ultrasound machines. Whilst they have usually been obtained for either vascular access or ultrasound

guided regional anaesthesia, there have been several sites in Australia and New Zealand that have been using surface ultrasound to assess cardiac and thoracic structures.

Based on the publications that have appeared in the literature, it appears that ANZCA Fellows are leading the world in using surface ultrasound for Trans Thoracic Echocardiography (TTE). The advantages, particularly in the non cardiac surgical setting, are substantial and allow perioperative assessment of cardiac status without needing invasive procedures.

Western Australia has been a state driving this change, with a number of major hospitals now using either TTE or a limited screening assessment to improve perioperative assessment.

Joondalup Health Campus (JHC) is a rapidly growing hospital 25 kilometres north of Perth that has been running an anaesthetic driven TTE service for several years in the perioperative assessment clinics. JHC anaesthetists are credentialed in echocardiography, employ technicians in a Medicare accredited ultrasound laboratory, and formally report perioperative TTE studies. The echo lab now serves as a basis for offering fellowship training in TTE for ANZCA and College of Intensive Care Medicine of Australia and New Zealand (CICM) trainees.

*Left: Fremantle Hospital.*

Similarly, at Sir Charles Gairdner Hospital, a long-standing training program in TTE has been running for ANZCA Fellows and trainees. This service is being expanded to use rapid screening techniques in the perioperative setting to identify high risk patients and improve outcome. Fremantle Hospital has likewise recently commenced training its fellows with a view towards developing a perioperative screening service.

With equipment now readily available to perform TTE in most anaesthetic departments, the limiting factor in adoption remains training. WA anaesthetists have contributed strongly to the academic literature, publications and courses available on TTE in the critical care and perioperative setting. This includes helping develop a rapid screening tool for perioperative assessment as well as certificate and diploma courses that are operated out of the University of Melbourne.

In summary, TTE has been incorporated into the perioperative practice of Fellows in WA in a number of leading hospitals, and training programs are being established for ANZCA Fellows to expand their ultrasound skills into cardiac assessment relevant to perioperative and critical care settings.



## RETRIEVAL FELLOWSHIP



**DR PREETI NIRGUDE**  
FORMER RFDS RETRIEVAL FELLOW,  
FREMANTLE HOSPITAL

During 2010 I undertook a fellowship year at Fremantle Hospital in Western Australia and as part of this I spent six months with the Royal Flying Doctor Service (RFDS). I can only touch the surface of the experience I gained working with RFDS within the scope of this report. The experience was extremely hands on, and I very much enjoyed practising medicine in such a varied way, not just restricted to critical care and anaesthetics. We were required to have a range of skills and experience including obstetrics, paediatrics, anaesthetics and emergency medicine, in addition to broad general practice skills. I gained a massive appreciation of the limitations faced by our colleagues outside the metropolitan areas and further afield in country WA, and the huge amount of skill within their ranks, as well the highly skilled and experienced colleagues within the RFDS itself. The distance between the extreme north and south of Western Australia

is the same as the distance between London and Moscow, albeit much less densely populated, yet the only intensive care beds, interventional radiology or interventional cardiology services are all in Perth. Also striking is the inequality in care between the metropolitan area around Perth and the rest of WA.

I was able to practise independently, supported by a highly skilled nurse when on retrieval, but also had good access to logistical and clinical advice amongst other RFDS doctors with alternative skills or more experience, or from hospital specialists who were always happy to help.

I also learned to practise outside the comfort of a hospital setting and its available services, often requiring a level of lateral thinking and ingenuity, and often in the physically challenging environment of an extreme climate. The clinical coordinator shift involved essentially being in charge of and overseeing which patients were being moved, by which staff, in what order, and by which of the 14 planes, one jet or one helicopter within the whole of WA. It also involved working with the other teams at the other bases and the coordinators at Jandakot to make sure retrievals occurred in a time appropriate manner within the guidelines as set out above – a huge level of responsibility.

I was able to experience first hand the amazing vastness of WA, its unique people and indigenous culture to which I would otherwise not have had access.



*Above right from top: The crew unloading on the tarmac – A St John Ambulance volunteer is assisting. Only 10 towns in Western Australia have a trained paramedic crew. The remainder of places have ambulance staff made up entirely of volunteers – this can be anyone from the local community. I met local bakers and mechanics fulfilling this role, and closing their business in order to do so. Community spirit is alive and well in Western Australia;*

*Inside a fixed wing aircraft taken from the doctor's seat on the way to a retrieval. This aircraft can accommodate two stretcher patients and a sitting patient or relative in addition to the doctor, nurse and pilot;*

*An example of one of the airports that we land at – Denmark Airport... Inside is a small area in which patients can be transferred from ambulance stretcher to airplane stretcher out of the sun in summer, and rain and wind in winter. We occasionally landed on outback highways, or on gravel strips handlit by flares for two to three kilometres.*





*Left: Regional Organising Committee for the ANZCA ASM 2012 in Perth.*

## PERTH ASM IN 2012

**DR TANYA FARRELL AND DR DAVID VYSE**  
CO-CONVENORS ANZCA ASM 2012

Perth is hosting the ANZCA annual scientific meeting (ASM) from May 11-16, 2012, which has the banner, "Evolution: Grow Develop Thrive". Being involved with the regional organising committee entrusted with hosting the meeting has thus far been an enjoyable and interesting experience. Like many things we do in our spare time, meeting organisation provides a different outlet for creative and lateral thinking.

As anaesthetists, we spend our lives planning. We hope for a smooth ride and a perfect outcome but have thought about, planned for and are ready to take on any eventuality. We are trained to work efficiently in a team environment and to communicate with our colleagues, other team members and anyone outside our nexus who is important in providing the outcome we desire. We work within rules, guidelines and protocols but still manage to individualise our care given our own skills, abilities and beliefs for each patient under our watch. We must be meticulous, particular and, dare I say, a little bit obsessive!

Given all these requirements in our daily practice, it is little wonder that taking on roles such as being involved in meeting planning sits well with our anaesthetic persona.

A convenor's involvement in an ASM commences with a tap on the shoulder or a nervous raised hand some three to four years prior to staging of the meeting. The first major task to fulfil is to convince yourself that this is a good idea. The second task is to convince your partner that this is a good idea. I'm still not sure which of these has been easier (or more successful). To enable these tasks, it is important to continue to remind oneself of the benefits to the anaesthetic community and ourselves – the opportunity to create an environment for growing knowledge, a conduit for planting the seed for someone else's genius to develop and for all to thrive from the synergy of input that comes when thousands of craftsmen combine. Australia and New Zealand (and Asia) are powerhouses of world research and the ASM is the primary opportunity for us to showcase this work and share it with our colleagues. It is an opportunity for us to come together with pride as a group in how we continue to advance and evolve our practice.

Anaesthetists work hard. We have lives in our hands as routine. We give of ourselves for the benefit of others constantly. We put up with surgeons daily! It is no wonder we look forward to the social benefits a meeting of this nature provides. The ASM is marked by many as a social highlight in their year. Organising the meeting allows an opportunity to provide this forum and stamp it with the individuality of the region. No doubt those who come to next year's ASM you will never forget the crispness of the air basking in the autumn sun. You will be captivated by the laziness of enjoying your favourite beverage as that sun sets over the world's most beautiful beaches. You will marvel at the gourmet delicacies and world famous wines. Being part of sharing these things with all delegates gives an organiser an inner glow already.

To engage is to enjoy! We have had the chance to engage and discover hidden talents amongst our colleagues, form new friendships and rekindle old ones. We would encourage all Fellows to get involved with projects like an ASM as your personal benefit far outweighs your input.

We look forward to hosting you all in Perth next year for a fabulous ASM!





# Frosty, muddy, shaking and glowing: 11 days in Japan with the NSW Urban Search and Rescue taskforce

Dr Geoff Healy, an anaesthetist at the Royal North Shore Hospital, went to Japan after the earthquake and tsunami in March. He describes the mission.

At about 1500 hours Japan Standard Time (1700 hours Sydney), March 11, 2011, a magnitude 9.0 earthquake occurred in the sea north east of Japan. Moderate to large infrastructure damage occurred following this event, with road, power, transport and communications the worst hit. However, the most catastrophic event was yet to occur. Soon after, a large tsunami swept against the Japanese coast, with waves recorded between 10 and 30 metres high (high water mark) with intrusion many kilometres inland.

Destruction was massive and widespread with little warning. In the large port town of Minamisanriku, with a population of about 20,000 people, locals recounted four minutes' warning



of a four metre tsunami. The wave that obliterated much of the town was at least 10 metres at the shore line, and up to 30 metres up the narrow valleys surrounding it. Up to 17,000 people are missing presumed dead from this town alone. Similar situations occurred for tens of kilometres both north and south of Minamisanriku, along the coastline of Japan.

Australian authorities, on the background of a recent deployment to an earthquake in neighbouring New Zealand, were quick to anticipate the potential need for a taskforce deployment to the emerging disaster. At about 2200 hours, discussions were held between Australian and Japanese government officials, with the definitive request for assistance received early Saturday morning, March 12. What followed was the efficient and rapid dissemination of this request and the formation of a large,

multidisciplinary, highly skilled team of rescuers that formed the NSW Urban Search and Rescue (USAR) taskforce 1.

Highly trained and skilled members of the NSW Fire and Rescue, NSW Ambulance, NSW Police, Department of Commerce Engineers, Qld Fire and Rescue Search Dogs, and doctors from the NSW Ambulance Service Medical Retrieval Service, responded. We were equipped and then deployed to Japan with the rapid assistance of the Royal Australian Air Force. Within 48 hours or so of the disaster, an Australian specialist disaster assistance response team was on the ground in Japan.

### Mission

On arrival in Japan, at the Yokota US Air Force Base outside of Tokyo, initial plans and logistical operations were set up to coordinate our tasking. We then made the trip from the Tokyo area through 30-40 km/h speed-

restricted (secondary to earthquake damage) freeways to the Miyagi Prefecture where we set up our base of operations. A reconnaissance team went by Black Hawk helicopter to the Minamisanriku area to assess and plan operations, along with a ground team. Accommodation and functional tenting (medical tent, logistics, meal tent) were set up, as were power generators and lighting. Liaison with the other international teams occurred rapidly and local medical resources were visited and assessed according to their ability to not only cope with the local crises but also if a critical injury occurred to an Australian team member. It became quite clear that the local medical resources were not in a position to provide external assistance to rescue teams, however, the deployment of an Australian medical and surgical team would not be required.

(continued next page)



**“Within 48 hours or so of the disaster, an Australian specialist disaster assistance response team was on the ground in Japan.”**

# Frosty, muddy, shaking and glowing: 11 days in Japan with the NSW Urban Search and Rescue taskforce continued



The days spent working in the Minamisanriku area became recovery rather than rescue, as environmental conditions extended the extremely slim survival chances to nothing. Snow was falling, it was cold and windy, and the devastation we were surrounded by was near total. It was hard to comprehend the town that was standing at the time of the tsunami, and the normal Japanese life that was carried out in the now flattened area. It was akin to a warzone, with barely perceptible concrete structures surrounded by wooden and minor structural litter spread across vast areas. There were personal effects: clothes, photos and shoes, littered everywhere. The majority of the cars we searched and cleared still had keys in the ignition, and wallets

and phones in them. The hospital we cleared was full of patients at the time of the tsunami, and in some buildings we discovered local residents, who had lost everything, had returned for shelter. Fishing paraphernalia was everywhere, as were oysters, abalone, and fish. The smell was more seafood than offensive loss of life, which the cold conditions more than likely held in check.

The culture of the Japanese people was astounding. There was no looting, yelling or screaming. In fact, there was no public show of emotions. They quietly and respectfully continued on, lining up silently, often holding their children in the snowy conditions, for hours for clean water or food, or slept in their cars queuing for the little available petrol. Everyone we came across

thanked us repeatedly. They went out of their way to express their gratitude for our presence. They are intensely proud, and their resilience and unwavering ability to cope in the face of adversity is a quality that will remain in my memory forever.

## Challenges

The everyday working environment in which we work cannot be more different to the pre-hospital or disaster zone situation. Safety for yourself and each other is paramount, and forms the backbone of USAR training. Hazards are littered everywhere, from the visible – LPG tanks, downed power lines, biological contaminants, jagged metal and heavy concrete – to the invisible – asbestos and silica particles and,

## Brief history of Urban Search and Rescue in Australia

Urban Search and Rescue (USAR) teams in Australia are among the most highly trained and sophisticated teams worldwide. USAR techniques have been used, developed and refined since the Thredbo landslide in 1997, and used worldwide throughout the earthquakes in China and Turkey, Hurricane Katrina, and the more recent Queensland floods and earthquake in Christchurch. The “heavy” designated USAR teams of NSW and Queensland are able to be deployed anywhere in the world, be self-sufficient (food, water, shelter) and with no

reliance on the local (often damaged or absent) resources, for a total of 10-14 days.

The heavy designation denotes the ability to use heavy rescue machinery and techniques to secure, shore and enter collapsed buildings or structures, and safely find, stabilise, treat and retrieve injured patients. The environment in which this occurs is potential highly dangerous, with hazards including biological, chemical and radiological contaminants. Extensive training, personal protective equipment, and maintenance of skills and equipment are vital to be able to work in this situation. Not only are they

an extension of skills used in our usual workplaces, they are novel, rarely used but potentially life saving practices that are offered by few other organisations.

The 74 person team in NSW consists of a structured command and control organisation, with a taskforce leader and incident management team. A large logistics component complements the two sub teams (alpha and bravo), providing the transport, wellbeing, decontamination, and just about anything else that can be required. Structural engineers are included in the team to provide assessment and advice regarding building and structural damage. Police liaison and/or disaster



**“It was akin to a warzone, with barely perceptible concrete structures surrounded by wooden and minor structural litter spread across vast areas.”**

in the case of the Japanese deployment, radiation.

Fortunately, the USAR team comprises not only trained personnel, but a team of safety officers to assess and mitigate risks, and a hazardous materials (HAZMAT) team to identify and manage potential exposure, decontamination, and guide appropriate treatment.

We were alerted early in the deployment to the nuclear reactor issues at Fukushima, and rapidly developed detection, monitoring and risk mitigation plans. This also involved regular liaison with the Australian regulatory bodies (ANSTO) associated with radiation and nuclear sciences, and access to medical literature regarding radiation medicine, from

the Director of the Medical Retrieval Service, Dr Ron Manning.

The ability to be able to communicate effectively and learn radiation medicine relatively in-depth displays not only the power of modern day communications, but also highlights the massive behind-the-scenes efforts that occur back in Australia during an overseas humanitarian deployment. This included daily or second daily briefings back to Australia, and regular updates to our family members to reassure them we were okay. Nothing in the world worries loved ones more than the media talking about nuclear catastrophes on every major station and bulletin when they are at home and we are in the “catastrophe”! Fortunately

these concerns were able to be managed by regular and reassuring updates, and from being able to communicate directly with our loved ones.

The next challenge we encountered was the local environment. The information available pre-departure mentioned local conditions from 4 to 15 degrees celsius in Japan. We were not quite expecting several nights of below -17 degrees celsius temperatures and heavy snow!

#### **The anaesthetist in the field**

The anaesthetist, as part of a multi-disciplinary team, makes an ideal pre-hospital clinician. We are used to dealing with a variety of different individuals, each with different priorities, akin to managing a busy (continued next page)

victim identification members, and specialist search dogs and dog handlers bring their services, in addition to specialist hazardous materials (HAZMAT) personnel from the NSW Fire Brigades.

The medical personnel consist of a team of eight special casualty access team (SCAT) intensive care paramedics, and two specialist pre-hospital care doctors. An additional specialised intensive care paramedic medical team leader coordinates activities and liaises with the incident management team.

The disaster cache consists of more than 20 tonnes of heavy and light rescue equipment, sustainability gear

(tents, food, water, amenities) and a large, well-equipped medical cache. Our medical abilities include the UN mandated capability to manage up to 10 critically ill patients, and up to 20 minor injured patients, in addition to the critical and primary medical care of our own USAR team. We can manage up to two ventilated patients, and provide critical care services and retrieval through to appropriate local resources or coordinate repatriation if needed.

#### **The role of the USAR doctor**

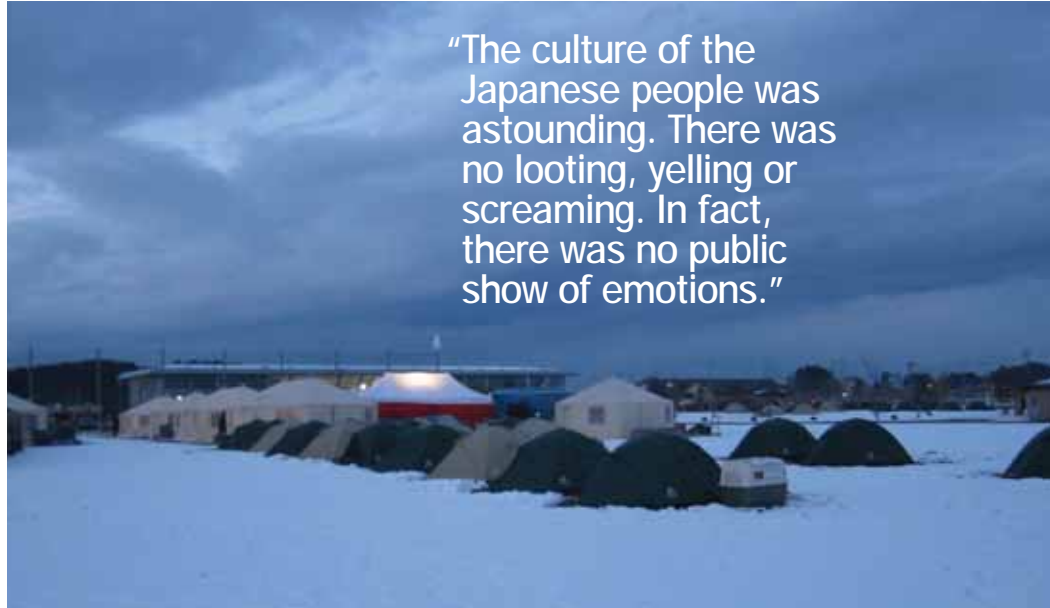
The primary role of the USAR doctor is the health and safety of the USAR team. The secondary role is the management

of injured patients encountered in the USAR environment. The additional role, if needed, is the reconnaissance, assessment and mobilisation of further medical resources (for example, the medical and surgical deployment team, AUSMAT) for humanitarian purposes. Interestingly, the role of the USAR doctor also includes the health and welfare of the search dogs!

The USAR doctors in NSW are collective trained pre-hospital clinicians from either emergency, intensive care or anaesthesia backgrounds, and work within the Medical Retrieval Service of the NSW Ambulance Service.

# Frosty, muddy, shaking and glowing: 11 days in Japan with the NSW Urban Search and Rescue taskforce continued

Below clockwise from top left: Radiation monitoring equipment displaying “background” radiation levels at our Base of Operations; The base of operations, in snow conditions, in Tome, Miyagi Prefecture; The Sun-Herald front page on the day of departure. An example of the media interpretation of what we would face.



“The culture of the Japanese people was astounding. There was no looting, yelling or screaming. In fact, there was no public show of emotions.”

theatre environment, and we have the ability to see the bigger picture. We are skilled critical care physicians, and can adapt and work in conditions in addition to our comfortable operating theatre homes (like the uncontrolled emergency department, ward or even the roadside). We can comfortably manage stand down time (some may disparagingly say that is most of our work!), and can rapidly shift to crisis management roles.

However, this environment is not for everybody, and certainly placing an anaesthetist without proper training, experience and equipment out into the

field would be undesirable – not only for the other rescuers, who would be responsible for their safety and well-being, but also for themselves. Surely another victim in a disaster situation is a hindrance not a help.

As such, as an organisation, we have a responsibility for each other and ourselves to have in place a structured, trained and equipped resource that can be deployed safely and appropriately into these disaster situations, and operate effectively. The USAR taskforce is such a resource, and it is a privilege to be included in such a team.

## Summary

I would like to thank all my colleagues at Royal North Shore Hospital, for their support and coverage of work responsibilities back in Australia while I was away on deployment. I would like to thank all the team members and colleagues within the Ambulance Service of NSW for their hard work and professionalism, and support during such a deployment. I would also like to thank Dr Ron Manning, Director of the Medical Retrieval Service in NSW, and Dr Karel Habig, Medical Manager of the Greater Sydney Area HEMS, for their support and guidance.

## SMEAC

**Situation:** Massive loss of life and infrastructure following earthquake and tsunami in Japan.

**Mission:** USAR deployment to provide specialist disaster assessment and assistance in the designated tasking area (Minamisanriku/Shizugawa area within the Miyagi Prefecture). Initial deployment to within the affected area will set up a Base of Operations (BOO) and reconnaissance team will assess the on ground effects and plan subsequent operations. A secondary process

will be to assess the local medical infrastructure, not only for assessment of evacuation of critically injured USAR patients or injured USAR team members, but also for humanitarian needs assessment.

**Execution:** 74 person multidisciplinary team, working within two teams (alpha and bravo) capable of 24 hour coverage (two 12 hour watches). Ability to provide “heavy” USAR capabilities to large scale infrastructure damage.

**Administration:** The logistics team will administer resources and provide sustainability requirements (including shelter, food and water rationing, and equipment).

**Command/Control/Communications:** The command and control structure is well defined, with a Task Force and Deputy Task Force Leader, Incident Management Team, and team leaders. All communications are disseminated through regular briefs, and through a structured communications system.



# Illuminating the intervertebral abyss with neuraxial ultrasound

Dr Nico Terblanche is a consultant anaesthetist at the Royal Hobart Hospital in Tasmania where he has an interest in ultrasound guided epidurals, a technique he learnt in South Africa and Canada. He has taught and researched the technique in Canberra and his work continues in Hobart. In this article he gives his views on the advantages of neuraxial ultrasound.



One of my favourite quotations is by Ralph Waldo Emerson who said “Life is a journey, not a destination”.

My anaesthetic journey began while I was doing a diploma in anaesthesia as part of a group of medical mates in Livingstone Hospital, Port Elizabeth, South Africa. Try to imagine an 800-bed referral hospital stretched to the limits by serving a multitude of people on the south-east coast of Africa. We had to mature and take responsibility quickly. This included regular night shifts in the labour ward theatre.

I’ll never forget the image of walking through labour ward on my way to theatre. Women were literally giving birth everywhere and if you were not careful you could become side-tracked and unintentionally end up playing midwife. This became a common introduction to an on-call production line of “rapid sequence spinal anaesthetics” for caesarean delivery.

Thinking back, I admit that this was a good environment to hone neuraxial anaesthesia skills. However this was a serious reality check with regards to the limitations of a “blind” technique, especially in the morbidly obese parturient with a potentially difficult airway.

A couple of years later I completed my specialist anaesthesia training at Tygerberg Hospital, Cape Town. At the time, urbanisation of rural Western Cape was placing an enormous burden on the resources of the labour ward as the delivery rate rapidly rose within a decade from only a couple of thousand to more than 6000 per year. This had implications for maternal morbidity and mortality and it motivated me to get involved in obstetric anaesthesia.

An audit of my high-risk obstetric anaesthesia practice over three years (2006-2008) revealed that 150 women had a body mass index (BMI) of more than 45. Of those patients 33 per cent had a BMI of more than 55 and 67 per cent had a BMI of more than 50. In theory you can advise colleagues that most of these patients should receive a neuraxial technique while sitting in your nice comfortable chair in the clinic, but in practice it is technically very challenging to execute.

A substantial proportion of these women have subcutaneous tissue distributed in large quantities over their spine, turning the successful application of the landmark technique into a lottery. In these patients, epiduralists

often do not know where the midline or the intervertebral space is, what the angle of the puncture should be and also how deep the epidural space is below the skin. This has implications for needle length selection. A couple of colleagues gently reminded me of the technical complexity of these patients by posing questions along the lines of: “Do you really expect us to consistently, successfully and safely place a needle into the epidural space?”

Professor Jose Carvalho helped solve the problem for me after I joined his group in Mount Sinai Hospital, Toronto, for an anaesthesia and research fellowship. He introduced me to pre-procedural neuraxial ultrasound.

From recollection, his journey was slightly different from mine. Epidurals suddenly became more challenging for him after he exchanged the body-sculptured backs of his pregnant cohort in Sao Paulo, Brazil, for his new obstetric anaesthesia practice in the Canadian heartland. His group showed that there is a good correlation between ultrasound and needle insertion depth in both non-obese and obese parturients<sup>1,2</sup>.



From left: Dr Nico Terblanche demonstrates preprocedural neuraxial ultrasound probe orientations on a pregnant model; The probe is held in the transverse plane; The scan is performed in the paramedian sagittal oblique plane.

**“An audit of my high-risk obstetric anaesthesia practice over three years (2006-2008) revealed that 150 women had a body mass index (BMI) of more than 45.”**

The challenges for practitioners posed by obesity are not confined to urban Africa where urbanisation has diet and weight gain implications, or to the fast-food society of North America. The obesity epidemic is now in Australian living rooms with more than 20 per cent of the population classified as obese.

When I moved to Canberra, the anaesthesia department at Calvary Hospital was very supportive of giving me the time and opportunity to teach and research ultrasound-guided epidurals and I focused on teaching the technique to anaesthesia trainees. This is the cohort with the highest prevalence of dural punctures of around 1.4 per cent as previous Australian research has shown<sup>3</sup>.

Research also has shown that ultrasound can improve the learning curve of trainees successfully performing epidurals<sup>4</sup>. However, a national audit of training practices in Australia by my Canberra Hospital colleague Dr Dane Blackford and myself in 2009 (73 per cent response rate; unpublished data) showed that none of the obstetric module supervisors who responded were using epidural ultrasound for training purposes despite

ultrasound being readily available from theatre, especially in urban centres. This may have improved slightly subsequently.

The reason for this is probably a lack of a critical mass of anaesthetists and programs teaching the technique. So how can we promote epidural ultrasound and in the process advance practice? I have developed a four-pronged approach:

1. Creating awareness: Doing departmental and anaesthetic meeting presentations. A national survey that we conducted created awareness among obstetric anaesthesia supervisors.
2. Distributing and creating material on how to perform the technique: Anaesthetist colleague Dr Rowena Lawson helped me to develop and validate an epidural ultrasound training program<sup>5</sup>, a narrated Powerpoint presentation of “the 10 easy steps to performing epidural ultrasound”.
3. Hands-on teaching: This includes one-on-one teaching on caesarean delivery lists, departmental workshops in the Royal Hobart Hospital and on invitation in Tasmania and elsewhere.

4. Conducting and publishing research in the area of neuraxial ultrasound in order to advance the technique and improve the safety of our patients.

There is also a perception that neuraxial ultrasound is an advanced ultrasonography technique that only a few can perform. Although it is true that in order to perfect the technique it will take a lot of practice, we know that it is possible to recognise important neuraxial structures and perform important tasks successfully after only a couple of scans.

A Canberra Hospital colleague, Dr Andrew Deacon, helped me with a study where we aimed to establish the number of practice scans required to reach competency in three important components of pre-procedural epidural ultrasound. We showed that the five trainees who participated could accurately identify the specified lumbar interspace and also the distance from the skin to the ligamentum flavum within 20 scans<sup>6</sup>. Consistent with previous research we showed that it was much more difficult to accurately mark the needle insertion point<sup>7</sup>.

(continued next page)

# Illuminating the intervertebral abyss with neuraxial ultrasound

## continued

In the past I have received comments that anaesthetists tried the technique for the first time on a morbidly obese patient and they could not identify any structures and therefore they did not find it useful. My response is that this practice is not helpful. We found that it is important to start practicing by scanning thin patients with easy sonoanatomy. This is imperative in order to master the skill.

I am of the view that anyone can confidently perform an epidural ultrasound scan. It is as simple as scanning from the sacrum upwards and when the desired interspace is identified turning the probe transverse. This is facilitated by pattern-recognising two images – in the paramedian (sagittal) oblique view a “sawtooth” pattern and in the transverse view a “flying bat”<sup>8</sup>. Ultrasound was discovered by Lazzaro Spallanzani in 1790 when he found that bats navigate with their ears rather than eyes in flight. One could argue tongue-in-cheek that ultrasound has now come full circle with the development of epidural ultrasound as we are looking for pictures of flying bats when performing the scan.

Preprocedural ultrasound is particularly useful for:

- *Identifying the exact interspace that the procedure is performed at.* Research has shown that anaesthetists who employ landmark techniques are only correct 30 per cent of the time in predicting the lumbar interspace in comparison to a criterion standard. Ultrasound can more than double this accuracy<sup>9</sup>.
- *Measuring the distance from the skin to the ligamentum flavum.* Studies have shown good correlation between ultrasound measurement and actual needle depth not only for the lumbar spine, but also the thoracic and cervical spine<sup>1,10,11</sup>. I routinely use ultrasound to facilitate placement of thoracic epidurals. The implication of this is that you can more easily anticipate when the needle will penetrate the ligamentum flavum when you are performing an epidural and also if a longer than standard needle is required in a morbidly obese patient.
- *Identify the needle insertion point.* It is important to note that this requires meticulous skin marking.

- *Recognising scoliosis via identifying asymmetrical intervertebral spaces.* If possible, perform the puncture on a symmetrical intervertebral space.
- The angle of the puncture by noting the angle of the probe while identifying all the important structures.
- *Recognising a preserved interspace in patients with previous back surgery*<sup>12</sup>.
- *Feasibility of performing a neuraxial technique.* If it is not always possible to recognise the important vertebral structures especially in patients with vertebral deformities and previous back surgery. An ultrasound scan might inform your decision-making process with regards to proceeding with the procedure safely. It is also important to note that not all patients have good images on ultrasound depending on their body water or habitus and the resolution of the equipment. Fortunately parturients have increased total body water, which can improve image quality.

Karmakar et al described a novel real-time technique for performing ultrasound guided epidurals<sup>13</sup>. Although it has some promise, it is still problematic to perform this technique as a single operator in advanced cases. The area of real-time epidurals is currently the focus and future of advances in the field and it remains to be seen if 3D ultrasound will be helpful.

In Australia and New Zealand we are international leaders in using ultrasound for limb and trunk blocks and also for performing heart scans. However, the pace of extending ultrasound to neuraxial anaesthesia has been slow. Although serious complications are low when performing these techniques, obesity presents us with a fresh challenge.

I believe that the time is ripe for neuraxial ultrasound to blossom and, in particular, that mothers will in future receive an ultrasound scan when requesting an epidural. Therefore, I propose that neuraxial procedures no longer have to be the proverbial stab into a dark intervertebral abyss.

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Roger Wong (photography) and Katrina Webster (pregnant model).

# High octane medicine



**From the Grand Prix racetrack to assisting in disaster relief efforts, Dr Roger Capps has participated in many diverse and high-pressured medical interventions. He tells Meaghan Shaw what inspires him to get involved.**

It's any rev head's dream – riding in the medical chase car during the Formula One Grand Prix at speeds of close to 200 kilometres an hour, following the drivers on their first lap when the likelihood of accidents is high as they jostle for position.

Lining up in the chase car behind the grid, ready to offer resuscitation assistance to injured drivers, Royal Adelaide Hospital anaesthetist Dr Roger Capps, with characteristic understatement, admits his pulse rate “probably went up a little bit”, watching the lights count down: Ready, set, go.

“It's quite a buzz actually,” he says. “The reality is I'm a big kid and it's time I grew up.”

For much of the past 25 years, Dr Capps has been involved in motorsports as a medical officer, either being driven in the chase car at the Adelaide and Melbourne grands prix, or acting as chief medical officer for the Clipsal 500 Adelaide, before retiring this year.

It's been a rewarding experience for Dr Capps that has combined excitement, the potential for high level medical intervention, snap decision-making and the satisfaction of working in a team. It has also complemented Dr Capps' other medical intervention work as part of retrieval rosters, disaster relief efforts and medical reserve work for the Royal Australian Air Force in war-torn countries.

But what drives him to get involved in such activities? Dr Capps laughs at the suggestion he's a thrill-seeker before admitting, “Perhaps so”.

He estimates he has been involved in “dozens” of medical interventions in motorsports, including the high-profile crashes of Finnish world champion Mika Hakkinen, British driver Martin Brundle and V8 Supercar driver Ashley Cooper, all of which he remembers for different reasons.

Hakkinen was critically injured during the 1995 Australian Grand Prix in Adelaide, and was saved by an impressive team effort that involved an emergency tracheostomy performed track-side. Dr Capps' role was to insert a femoral line for intravenous access and assist with intubation.

As Hakkinen was taken to hospital, the work of the Adelaide team was praised by legendary UK neurosurgeon and head of the Formula One on-track medical team, Professor Sid Watkins, who told Dr Capps that Adelaide would serve as the benchmark for medical intervention.

“To get that sort of report from someone of that standard, I thought was pretty good,” Dr Capps says with pride.



Another incident involved a spectacular crash during the first lap of Melbourne's inaugural grand prix in 1996, when Martin Brundle's car became airborne, somersaulted over other cars and crashed into the barrier, breaking up into smaller and smaller pieces until it came to a stop.

"We were on the scene within seconds," Dr Capps says, recalling the remnants of the car as resembling entrails hanging off an animal. "I thought there's no way this person can survive. But the next thing, there was this driver coming out and he's running towards us. He got in our vehicle and he was cleared and he drove again."

Dr Capps recounts the incident to explain how the physics of accidents, the design of vehicles and safety equipment fascinates him. "I love it," he says.

He describes his role as a registered Australian resuscitation expert in the chase car as being at the "sharp end" of medical interventions. He worked with the Formula One medical delegate,

who was also in the car, to make swift decisions as to whether an incident required intervention and the halting of the race, and then working with extrication teams and other specialists to treat the injured driver.

By contrast, the position of chief medical officer at the Clipsal and Adelaide Classic Car Rally was more of an oversight role.

In the case of Ulladulla driver Ashley Cooper, who was fatally injured when he crashed heavily into a barrier at the 2008 Clipsal, Dr Capps was in the race control centre, communicating with those on the track about what was required and ensuring everyone was in the loop, including the Royal Adelaide Hospital, which was on stand-by.

"A team of people scrambled to be involved, the patient was extricated from the vehicle, sent by ambulance to the hospital, and the timing from the incident to delivery at the resuscitation rooms at the Adelaide hospital was 17 minutes," he says. "When you look at accidents on tracks, that is about as fast as you can get to a mainline tertiary trauma centre."

Tragically, despite the impressive intervention effort, Cooper died. "It was an example of high level intervention which gave the best chance of survival," Dr Capps says.

Dr Capps' work on the track has been widely acknowledged. Veteran motorsport commentator Murray Walker visited the race control centre to pay tribute during Dr Capps' last Clipsal in March. Walker left a personal message in a commemorative book signed by all the drivers and was photographed talking to Dr Capps.

Dr Capps is clearly chuffed by the acknowledgement, just one highlight of an impressive anaesthetic career that has also seen him serve in military and disaster relief efforts, including helping those injured and evacuated after the Bali bombings, assisting in the 2004 tsunami relief effort in Banda Aceh, Indonesia, accompanying veterans returning to Gallipoli and the Western Front for the 75th anniversary of their respective campaigns, and medical service in the Gulf War, Rwanda, Bougainville and East Timor.

Arriving in Banda Aceh, he hadn't even had time to change his clothes before a Swedish surgical team asked him to administer a spinal block for a caesarean section, and then a local anaesthetic nerve block for a man with a serious hand injury.

**"I thought there's no way this person can survive. But the next thing, there was this driver coming out and he's running towards us. He got in our vehicle and he was cleared and he drove again."**

Being able to work in such austere environments impresses his friend and South Australian colleague Dr Thien LeCong, who jokes he was initially sceptical that Dr Capps could do a brachial plexus nerve block without a nerve stimulator until he saw footage of him doing just that on television.

"I thought he was just lying to us, but no," Dr LeCong quips.

He suggests few anaesthetists would know how to do such a block without a nerve stimulator or ultrasound machine, but Dr Capps had probably done hundreds, using a short bevel needle, with its bluntish end, to elicit a tingling in the nerve before injecting a block.

"Roger is the kind of anaesthetist I would want to be because you could just parachute him into the middle of nowhere and he would be able to do things – he would be able to thrive and function as an anaesthetist," Dr LeCong says.

"He is a legend ... Everyone knows the famous Dr Roger Capps in South Australia."

For his service, Dr Capps has received an Order of Australia (AM Military Division) in 2000, the Centenary Medal in 2003, and various military medals for recognition for service in Kuwait, East Timor, the Gulf War, South East Asia, Rwanda and Bougainville.

When asked why he gets involved in such projects, Dr Capps says he is motivated by a combination of there being a need, his training, "moral obligation, challenge and, at the end of it, some sort of satisfaction".

"Obviously, I'm a bit of a nutter," he concludes. "You never do something for nothing. All this altruism's a load of bull... I did it because I got something out of it. I did it because I like doing it."

*Above clockwise from top left: Dr Roger Capps (left) at the Clipsal 500; Dr Capps (left) and Glen Hanly at the track; Dr Capps (left) chatting with motorsport commentator Murray Walker (centre) in race control; in the passenger seat of the chief medical officer car; Dr Capps and others attending to Mika Hakkinen at the 1995 Australian Grand Prix in Adelaide. Photos courtesy of Steve Lam, the Royal Australian Air Force and Dr Roger Capps.*

# Anaesthetists train for disaster in Darwin



Seventeen anaesthetists joined international colleagues on an AusMAT Surgical and Anaesthetic Course (AusMATSAC) held at the National Critical Care and Trauma Response Centre in Darwin in April. Three New Zealand anaesthetists attended the course, two from each Australian state and territory, and one each from Fiji and the United Arab Emirates.

The course was designed to prepare civilian medical personnel to work in austere environments under extreme pressure with large numbers of patients – essentially responding to disasters. It focused on the safety and security of the medical personnel and the medical and surgical techniques likely to be required. The other participants included surgeons and theatre nurses.

The faculty included ANZCA Fellows Dr Haydn Perndt, from Tasmania, and Dr Brian Spain and Dr Phil Blum from Darwin, along with Dr Anthony Redmond, Professor of International Emergency Medicine at the University of Manchester (UK), and Dr Chris Giannou, a Greek-Canadian war surgeon and former chief surgeon for the International Committee of the Red Cross.

One of the New Zealand participants was Dr Bryce Curran, who spoke about his experience working in the field following the Christchurch earthquake in February (*ANZCA Bulletin*, March 2011).

Another Christchurch anaesthetist, Dr Wayne Morriss, and Auckland North Shore anaesthetist Dr Maurice Lee also attended. Dr Morriss is running the Real World Anaesthesia Course in Christchurch in August and Dr Lee represents ANZCA at New Zealand Ministry of Health meetings about disaster response preparedness. He was in Wellington attending an emergency management conference when the quake struck and was seconded to the Ministry of Health for 10 days to provide clinical advice as it responded to the disaster in Christchurch.

The Real World Anaesthesia Course is designed to provide skills for working in developing countries and in humanitarian and civil disaster situations. Previously known as the Remote Situation, Difficult Circumstance, Developing Country Anaesthesia Course, it will be held in New Zealand for the first time this year.

The three-day AusMATSAC combined classroom-based lectures, including anaesthetics in an austere environment. A field simulation component included an overnight deployment.

Dr Curran said the course was excellent, with a mix of lectures and field exercises designed to ensure participants were fit for deployment to a disaster zone, hostile environments or developing countries.

“We were able to cope in Christchurch with local resources but we were on the cusp of something much more significant for which we would have needed this sort of medical assistance team,” he said.

As well as medical issues and the practical requirements of setting up a field hospital, the course covered communications and security requirements and the psychological effects that can follow such a deployment.

For information about courses offered by the National Critical Care and Trauma Response Centre, visit [www.nationaltraumacentre.nt.gov.au](http://www.nationaltraumacentre.nt.gov.au).

**Susan Ewart**  
Communications Manager, ANZCA  
New Zealand

*Above clockwise from left: Setting up the field hospital tent; surgical simulation in the field hospital tent; checking urban search and rescue supplies.*

# Indigenous Health Committee

ANZCA's Indigenous Health Committee was established at the April 16, 2011 ANZCA Council meeting. The committee was established on the recommendation of the Indigenous Health Working Party as part of a detailed series of proposals to improve diverse health issues faced by indigenous peoples in urban, rural and remote locations in anaesthesia, pain medicine and intensive care.

The poorer health of indigenous peoples of Australia and New Zealand relative to non-indigenous people is well recognised (for the purpose of this article the term indigenous is used inclusively when referring to Australian Aboriginal people, Torres Strait Islanders, Māori and Pacific Islanders). Furthermore, indigenous people are under-represented in the healthcare professions, especially in medicine, and in particular the medical specialties. Fellows of ANZCA and FPM contribute individually to improved health for indigenous communities but until now the College overall has not had specific programs that support indigenous health.

There is a 10-12 year gap in life expectancy separating Aboriginal and Torres Strait Islander Australians from the wider population. That only 0.2 per cent of Australian doctors claim indigenous heritage while indigenous people make up 2.3 per cent of the population highlights the need to encourage more indigenous doctors and medical specialists. New Zealand provides a brighter picture, however, Māori are still highly under-represented making up only 1.9 per cent of medical specialists as opposed

to 15 per cent of the population. The Australian Committee of Presidents of Medical Colleges (CPMC) is focused on encouraging more indigenous doctors to specialise and ANZCA/FPM have been looking at ways to support increasing numbers of indigenous specialists.

In July 2010, an Indigenous Health Working Party was established to assess how ANZCA/FPM could support programs for indigenous health in Australia and New Zealand. Members were Dr Rod Mitchell (Chair, SA), Dr Penny Stewart (Alice Springs), Dr Jenny Stedman (WA), Dr Jack Hill (NZ), and Dr Ted Hughes (NZ). Recognising the limitations of one organisation's ability to address all facets of indigenous health, the working party focused on ANZCA/FPM's strengths, concentrating on building partnerships and contributing to existing programs where possible. The working party met on four occasions and submitted its proposal to support indigenous health in Australia and New Zealand to council in April 2011.

The diversity of health issues facing indigenous peoples in rural/remote and urban locations as well as across Australia and New Zealand make it challenging to arrive at single initiatives that address differences and meet ANZCA's strategic priority to 'Provide support for indigenous health'. The initiatives took into account these differences in an attempt to develop an equal commitment in each area. Considered input of indigenous organisations from each country assisted in the development of this proposal. The working group sought input from interested Fellows, and where possible supported CPMC Indigenous Health Subcommittee proposals.

The working party identified three broad positive outcomes that ANZCA/FPM could contribute to within anaesthesia, pain medicine and intensive care medicine, these being:

1. Improved access to services.
2. Improved safety within these services.
3. Facilitation of indigenous role models.

To achieve these outcomes the working party suggested 16 tangible actions that, in the coming years, ANZCA could undertake in areas of cultural competency, encouraging indigenous trainees/supporting indigenous Fellows, supporting clinicians working in indigenous health and advocacy. The working party endeavoured to produce targeted strategies with measurable outcomes. Some measures, such as advocating for workforce reform, whilst less tangible and difficult to measure, were also regarded as highly important.

## Cultural competence for trainees, international medical graduate specialists (IMGS) and Fellows

- Incorporate indigenous health and culture into the ANZCA revised (2013) training curriculum.
- Collaborate with the Royal Australasian College of Surgeons on the development of content for the 'Indigenous Health and Cultural Competency Online Portal'.
- Investigate the possibility of short-term training opportunities for ANZCA trainees in hospitals with a high concentration of indigenous peoples.
- Include a dedicated session on indigenous health and culture at selected future ANZCA annual scientific meetings.

## Encouraging indigenous trainees/Supporting indigenous Fellows

- Engage with medical students/interns to promote an increase in indigenous trainees.
- Provide funding for an anaesthesia training scholarship with research into issues surrounding indigenous anaesthesia.
- Establish a register of Fellows prepared to mentor indigenous students/trainees/Fellows.
- Monitor the number of indigenous trainees, against an agreed target benchmark.



### Support clinicians working in indigenous health

- Facilitate the production of hardcopy and electronic resources to improve understanding of anaesthesia and pain medicine for indigenous health workers.
- Advocate for an increase in indigenous health workers in theatre environments.
- Establish an ongoing committee of council to support indigenous health initiatives and practitioners.
- Promote a shift in thinking – a period of time spent working in a rural/remote area should be viewed favourably when a Fellow is seeking to re-establish practice in a major centre.
- Advocate for “partnering” large urban and small rural/remote hospitals.

### Advocacy

- Establish and maintain dialogue with key stakeholders.
- Advocate on matters related to indigenous health, specifically workforce and training issues.
- Work with partners to promote a clear message.

Support for the initiatives has been strong with the Australian Indigenous Doctors’ Association (AIDA) and the Honourable Warren Snowdon, Minister for Indigenous Health, amongst others, providing positive feedback. The inter-College ‘Indigenous Health and Cultural Competency Online Portal’ project has begun to take shape and will provide specialists, trainees and IMGs, with a focus on those in Australia’s rural and remote areas, with access to resources relevant to medical specialists. As a part

of the project ANZCA/FPM have applied for funding to develop anaesthesia and pain specific resources for the portal and have been approached to provide a representative for the project’s steering committee.

Currently all of the members of the working party will be continuing to work as part of the new Indigenous Health Committee. Fellows, IMGs and trainees interested in additional information, working with the committee, or available to assist with specific initiatives are encouraged to contact Paul Cargill, Policy Officer, at [pcargill@anzca.edu.au](mailto:pcargill@anzca.edu.au) or +61 3 8517 5393.

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**Paul Cargill**  
Policy Officer, ANZCA  
(on behalf of the Indigenous Health Committee)



# Perioperative Medicine Special Interest Group

By Dr Vanessa Beavis,  
Interim Executive Committee Chair



I am delighted to chair the new Perioperative Medicine Special Interest Group because I firmly believe that perioperative medicine is the way of the future for the specialist anaesthetist.

If we don't extend our role to cover the whole perioperative period, I think we risk being sidelined as little more than "technicians". With governments keen to find alternative (cheaper) models of care, especially for the more routine matters, specialist anaesthetists need to emphasise their wide range of skills and knowledge. Perioperative medicine offers us the opportunity to do that.

Perioperative medicine encompasses the full range of pre, intra and postoperative assessment and care of the patient. Preoperative preparation and postoperative care is where significant gains can be made in better quality patient outcomes when accompanied by sound intraoperative care. Anaesthetists' leadership in improving care of patients in the crucial 12-24 hour postoperative period is particularly important.

The Perioperative Medicine SIG was set up last year after a perioperative medicine taskforce survey showed clearly that Fellows were keen to be involved in the "medicine" of looking after patients from the time of presenting for surgery until specialist "medical" management was no longer needed. The SIG aims to enhance Fellows' and trainees' knowledge and skills in the area of perioperative medicine.

The interim executive committee of the Perioperative Medicine SIG has been meeting regularly, usually via teleconference, discussing the parameters for this new special interest group. Other members of the committee are Dr Catherine Sayer (NZ), Dr Dick Ongley (WA), Dr Jane Trinca (Vic), Dr Patricia Goonetilleke (Vic), Dr Ross Kerridge (NSW), Dr Su Jen Yap (NSW), Associate Professor David Story (Vic) and Dr Kathryn Hagen (NZ).

Our immediate plans are to:

- Call for membership.
- Elect a chair and executive (during an annual general meeting to be held at the 2011 Australian Society of Anaesthetists' National Scientific Congress being held in Sydney September 8-11).
- Launch the SIG formally on the website and to the Fellowship.
- Plan an education meeting for 2012, along the lines of a single theme meeting.
- Source resources to be made available through the website.

Initial discussions among committee members have indicated a considerable variance in who takes responsibility for preoperative and postoperative care, with anaesthetists at the forefront in New Zealand but physicians having more of a role in Victorian private hospitals, for instance.

It is clear that we have considerable work to do if anaesthetists are to win recognition generally in both countries as being the specialists in perioperative medicine.

We encourage all anaesthetists to take up membership of this SIG so that we can have really productive discussions on this vital area of practice.

Membership of the Perioperative Medicine SIG is open to ANZCA Fellows and trainees, and to members of the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists. Fellows of other colleges, practitioners and allied health professionals are encouraged to participate as associate members.

To join, complete the application form available through the special interest group's page on the ANZCA website. Contact Kirsty O'Connor (phone +61 3 8517 5318 or email [koconnor@anzca.edu.au](mailto:koconnor@anzca.edu.au)) at ANZCA for further information.

*Dr Beavis is the Director, Anaesthesia and Operating Rooms at Auckland City Hospital (New Zealand's largest) and has chaired ANZCA's New Zealand National Committee for the past three years.*



# Assessing the effectiveness of training



In recent years, the Anaesthesia and Pain Medicine Foundation has awarded several research grants to Associate Professor Jennifer Weller, MBBS, MClined, MD, FRCA, FANZCA, above, who is the head of the Centre for Medical and Health Sciences Education at the University of Auckland. The grants are assisting research essentially into the effects and effectiveness of training. The projects awarded grants are:

2009: A simulation grant of \$34,812 for research entitled, "Validity of performance in the anaesthesia patient simulator as a measure of performance in the operating room".

2011: A project grant of \$50,000 for research entitled, "The effectiveness of video-based training to improve teamwork behaviours in acute care: a randomised controlled trial".

2011: A simulation grant of \$22,800 for research entitled, "The impact of assessment on life and learning".

Here, Associate Professor Weller reports on her research.

The project, "Validity of performance in the anaesthesia patient simulator as a measure of performance in the operating room," compares individual anaesthetists' teamwork behaviours in clinical settings with their behaviours in routine and crisis simulations.

We want to answer two questions: do anaesthetists behave in the same way in the simulated environment as they do in the clinical setting; and does behaviour in routine cases predict behaviour in a clinical crisis? This has implications for using simulated environments to learn teamwork skills and, furthermore, may suggest the need to assess response to crises in a simulator.

Our surgical colleagues have produced a considerable amount of evidence to support the validity of surgical procedural simulators but with the more complex integrated anaesthesia simulators, this evidence is harder to produce, although there is some support for the validity of anaesthesia simulations based on activity patterns.<sup>1</sup>

In this study, we have videotaped 17 anaesthetists and anaesthetic assistants in three settings: (1) an operating room during a routine list; (2) a simulation modelled on typical cases; and (3) a simulated case with an intraoperative crisis.

We have developed and validated a coding framework to analyse interactions between anaesthetists and the operating room team and have now completed all the coding – the analysis of our very

large data set has just begun and we look forward to seeing what patterns emerge.

From participants' perspective, they considered their behaviours in the simulator as realistic or very realistic, and scored specific teamwork behaviours as occurring at a similar frequency in the simulations and the operating room.

We are now planning to rate all the simulations again, this time using a teamwork behavioural rater our group developed and validated in a previous ANZCA-funded grant.<sup>2</sup> We have managed to find a willing group of assessors and have the assessor training day arranged. This will be no small task for them but they should be able to tell us, among other things, if behaviour in routine cases predicts behaviour in a clinical crisis.

Previous work from our group has focused on the development of robust instruments to measure teamwork behaviours,<sup>3,5</sup> in order, first, to see if we can assess performance, and secondly to see if interventions to improve teamwork are effective. We have shown improved teamwork in intensive care unit (ICU) teams following simulation training, and even identified improvements in specific components of teamwork.<sup>6</sup>

Following on from this work, our next project is to assess "The effectiveness of video-based training to improve teamwork behaviours in acute care: a randomised controlled trial". Here we want to drill down to very specific behaviours associated with improved teamwork, and see if we can teach these using videos role-modelling desirable models of communication.



And finally, and not entirely unrelated, is the new project on “The impact of assessment on life and learning”. This idea sprang from previous work evaluating the mini-Clinical Evaluation Exercise (mini-CEX), and the impact it had on trainees and supervisors,<sup>7,8</sup> and also from my involvement as chair of the Assessments Committee for ANZCA, and as a final examiner.

So far we have published a background paper<sup>9</sup> and are now working to finalise the survey instrument. An important part of this study will be in-depth interviews of trainees, seeking their views on the various assessment requirements and how they approach learning for these different assessments. Ultimately, the goal is to propose an approach to assessment that supports and enhances learning while satisfying requirements for progression through the training scheme.

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## Anaesthesia and Pain Medicine Foundation update



### Dr Roderick Deane joins the foundation board

Dr Roderick Deane, above, has taken up an appointment to the board of the Anaesthesia and Pain Medicine Foundation effective from May 2011. Dr Deane has had an extensive career in business as a chair and director of a number of major New Zealand and Australian companies and earlier senior roles in the public sector and central banking. He also has had a substantial

involvement with charitable and cultural organisations.

He holds a PhD in economics and a B Com (Hons) in economics with first class honours, and is a Fellow of the NZ Institute of Accountants, the Chartered Institute of Secretaries and the NZ Institute of Management. Dr Deane was awarded an honorary doctorate from Victoria University of Wellington.

**The Anaesthesia and Pain Medicine Foundation is dedicated to raising funds to support research initiatives which are crucial in continuing to make important discoveries and improvements for patient safety.**

The objectives of the foundation are:

- To raise funds for medical research and education in Australia, New Zealand and internationally.

- To foster contributions to the foundation from Fellows, medical colleagues, industry and philanthropic organisations and individuals.
- To promote and raise awareness of anaesthesia, perioperative medicine and pain medicine research and education.

Financial support to the foundation goes in its entirety towards medical research and education projects that are conducted in leading hospitals and universities in Australia, New Zealand and internationally.

To make a donation, bequest or to become a patron please contact:

**Susan Collins**  
Acting General Manager  
Anaesthesia and Pain Medicine Foundation  
Email: [scollins@anzca.edu.au](mailto:scollins@anzca.edu.au)  
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## Acetazolamide sodium

Phebra has informed the College the supply of Glaumox (acetazolamide sodium) is critically short, and has advised normal supply could possibly resume in October 2011. Acetazolamide for Injection USP 500 mg (in the form of a powder for injection) has been sourced from a manufacturer in the US, this product is approved by the FDA. This product is not currently registered in Australia.

Prior to use of this product please ensure you discard the package insert and refer only to the **Australian Product Information for Glaumox** available on the Phebra website [www.phebra.com](http://www.phebra.com) or the TGA website [www.eds.tga.gov.au](http://www.eds.tga.gov.au).

If you have any questions in relation to this information, please contact the Phebra sales representative or Customer Service Department:

Vic, Tas, SA, NT: Gios Auteri  
0458 096 318

Qld, NSW, WA: Vikki Pennington  
0434 124 766

Phebra Customer Service: 1800 720 020

## Warning

Esmolol Hydrochloride, concentrated Injection Ampoule 2500mg in 10 mL. This is a new product and Phebra Company Ltd draw attention to the risk of error as the drug presentation is 25 times the concentration of standard Brevibloc, which preparation has esmolol hydrochloride 100mg in 10 mL. Extreme caution should be exercised by all clinicians, pharmacists and nursing staff if this formulation is to be introduced to the hospital.

## 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. Maquet-SERVO-i and SERVOS Ventilator Systems may malfunction if employed during high dose radiotherapy, with the potential for hypoventilation and hypoxia. Maquet states that there have been no reports of patient injury as a result of this problem.
2. Phillips Invivo-Expression Magnetic Resonance Imaging Systems: The display control unit may become disengaged from the docking plate due to the nuts falling off over time and close scrutiny is recommended.
3. Spacelabs-Model 91387 Patient Monitors: The circuit that supplies backup power may be faulty and if a power interruption occurs the 3 minute backup may not operate and changes to alarms may be lost. If power loss is >3 minutes the modules will return to default settings which Spacelabs states are considered safe in most applications and the company has not received any reports of adverse outcomes.

4. Phillips-Microstream Infant/ Neonatal Filter Line and Vital Line Breath Sampling H Sets. The airway adaptor may contain fine plastic strands which have the potential to be dislodged and inhaled, and may cause a local inflammatory response or granuloma formation. Phillips states that while the possibility of a strand breaking free is high the probability of patient harm is low.
5. Phillips HeartStart XL and HeartStart MRx may transmit a message of "No Shock Delivered" when there is high transthoracic impedance. However the message does not adequately describe why the shock was not delivered, which has the potential to delay treatment. Transthoracic impedance may be intrinsically high in some patients but more commonly it is due to the electrode pads being incorrectly placed or insufficient pressure being applied to the paddles.

Dr Patricia Mackay  
Communications/Liaison Portfolio

## National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines

In August 2010, the Australian Commission on Safety and Quality in Health Care released a publication entitled National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines. This publication and related resources have been endorsed by ANZCA and are available at [www.anzca.edu.au/resources/endorsed](http://www.anzca.edu.au/resources/endorsed).

## Australian and New Zealand Tripartite Anaesthesia Data Committee (ANZTADC) news



### Personal profile: Heather Reynolds – data analyst

I was born in Brisbane, Australia, and I have settled here, and share five picturesque acres with my partner and our dogs near Lake Kurwongbah, on the northern outskirts of Brisbane. I spent my formative years in Brisbane where I attended Clayfield College for my secondary education. I then pursued an early career in secondary teaching and completed a Bachelor of Arts at the University of Queensland.

While travelling in the United Kingdom, I visited a community nursing facility in Bristol, England, which created an interest for me in the challenge of caring for people. I later commenced nursing in Bristol in 1980, following travel in Japan, Europe and Russia. After returning to Australia and establishing my nursing career, I was ready for a challenge. I decided to learn about the complexities of intensive care. I worked for 10 years in intensive care unit (ICU) nursing, and then

commenced anaesthetic nursing in 2000 to learn further aspects of nursing care in the operating theatre.

I later started higher degree studies, and completed Master of Nursing (Administration, Anaesthetics, and Recovery) in 2006, and Master of Advanced Practice (Health Care Research) in 2010 (Honours 1). I have since begun PhD Candidature at Griffith University, Brisbane in August, 2010, and am investigating the use of tissue adhesive to secure arterial catheters in the operating theatre.

Recent proud achievements have been Best Poster at the Peri-Operative Nurses' Association of Queensland Annual Conference, 2010, and Best Acute and Critical Care PhD Research Student Oral Presentation awarded by the Research Centre for Clinical and Community Practice Innovation, Griffith University at the Gold Coast Health and Medical Research Conference, 2010.

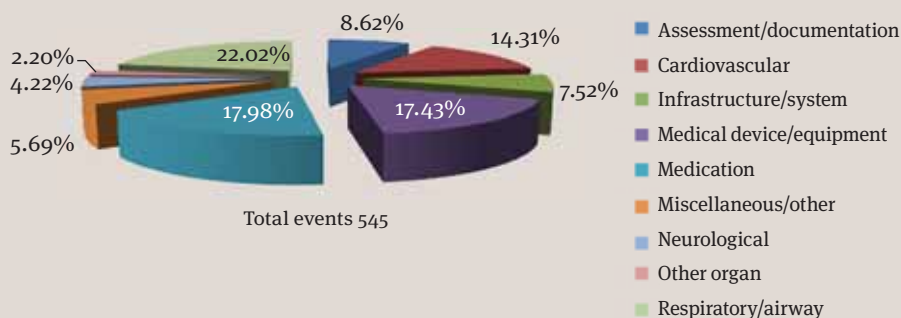
In my moments of relaxation I am an avid dog enthusiast. I enjoy dog showing and am an accredited registered breeder of German Shorthaired Pointers. As with all endeavours, I believe careful study of the fundamentals provides a sound foundation for success.

I work clinically at the Wesley Private Hospital, Brisbane, and also in the Anaesthetic Department at Royal Brisbane and Women's Hospital providing research assistance. My interest in data management developed

during my study of quantitative and qualitative research methodologies, and while performing research work. My role as data analyst for ANZTADC provides a marvellous opportunity to apply these skills, and allows for ongoing insight into the complexities of clinical practice. This work involves the initial data cleansing which is important in order to remove typographic errors, expand abbreviations and to remove any surrogate identifiers. The latter task involves removing accidental references to individuals, hospitals or possible unique locations such as "operating theatre 10 (cardiac theatre)" which may inadvertently identify a particular hospital. The narrative of the incident is also compared with other recent incidents to see if any narratives match, and that there may therefore be a double entry of the same incident.

After this initial cleansing, the coding of the incident is checked against the accompanying narrative. Lastly, a further sub-categorisation of the incident is performed prior to analysis by the full ANZTADC analysis subcommittee. Table 1 shows the results of the main categories as of May 2011. Respiratory incidents are the most frequent with 22 per cent (120 incidents) followed by medication 17.98 per cent, medical devices/equipment 17.43 per cent and cardiovascular 14.31 per cent. Although the other categories are less frequently reported they are (continued next page)

Figure: Main category coding, September 2009 – May 2011



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equally important to improving quality and safety. At the recent combined scientific meeting in Hong Kong a presentation from ANZTADC regarding medication errors was given in the session titled “Development of sound patient management systems”. This presentation will be made available on the ANZCA website.

At the Australian Society of Anaesthetists’ national scientific congress in September this year there will be a session devoted to patient safety called, “Safety gets the green light”.

In this session three presentations will be made. Firstly, “Prevention and management of assessment and documentation errors,” by Dr Greg Deacon. Secondly, “Prevention and management of respiratory errors,” by Dr Michal Kluger. And finally, “The development of new crisis management tools,” by Adjunct Professor Martin Culwick. It is also planned to submit a series of articles for publication in the *Anaesthesia and Intensive Care* journal later this year.

I enjoy maximum flexibility, working from home when most convenient and I also very much enjoy face to face meetings with ANZTADC colleagues. I am very proud to have been selected to be involved in the development of the highest standards for the safety and quality of anaesthetic practice.

## Heather Reynolds

BA, BHlthSc (Nurs), MN, MAP (Health Care Research), CertTeach, CertCCN

## Airway crisis after extubation

**This is the third and final case report concerning a “can’t intubate, can’t oxygenate” scenario following extubation of a patient who had previously undergone surgical drainage of Ludwig’s angina. Similar to the previous reports<sup>1,2</sup>, the intention is to review the possible system failures leading to a patient’s death. It is not my purpose to criticise individuals. Indeed these cases are examples of common clinical management strategies that occur in many hospitals throughout Australia and the world. By examining individual events I hope to highlight some practices and suggest alternatives that may improve our standard of care.**

### Case report

Patient X was aged 27 years at the time of his death at a tertiary referral hospital in Australia. He was in good health during the months preceding his death apart from a severe toothache.

He first attended the emergency department of his local hospital having had a toothache for the previous week. He was provided with analgesics and told to contact the dental clinic that was part of the nearby tertiary hospital. Six days after this episode, the patient returned to the same local hospital stating that he was still awaiting dental extraction by the dental clinic. He was again provided with analgesics and discharged.

The patient presented a third time to the local hospital. At this time he had been suffering from his toothache for two months. He had been seen six weeks previously at the dental clinic at which time he had been informed that he would have to have the tooth extracted or repaired. He was waiting for an appointment time but had not heard from the dental clinic. The medical officer at the local hospital described the

tooth as “rotten and shattered” but there was no sign of infection or abscess. He recorded that the patient was given clove oil, Panadeine Forte and injection of lignocaine. It was recommended to the patient that he should be seen at the dental clinic the following day. The patient’s tooth was extracted in the dental clinic after this episode.

The day after the patient’s dental extraction the patient’s mother noticed that the swelling of his face was becoming worse and was across his neck and face. The patient consequently attended the emergency department of the local hospital. The patient’s complaints included swelling to the lower jaw, inability to open his mouth and dental pain. At this point there was no stridor or other evidence of immediate airway compromise. The resident diagnosed Ludwig’s angina. He was to be kept overnight and transferred to the tertiary hospital the following morning.

The patient was ultimately transferred by means of his mother’s private vehicle to the tertiary hospital rather than by ambulance. The medical resident was later asked in the coroner’s inquest about the appropriateness of the patient being transferred in his mother’s car to the tertiary hospital. He responded that it might have been considered as the patient had been stable throughout the night and there was “a notoriously long wait for ambulance transfers and non-urgent patients”.

The admitting doctor at the tertiary hospital noted that the patient was able to talk and there was no stridor or drooling. The patient stayed in the tertiary hospital emergency department for 10½ hours. The patient was later admitted to the ward in the early hours of the evening. His mother left the hospital and telephoned the patient several times during the late afternoon and evening. She noted that her son was having difficulty speaking on the phone to her during this time.

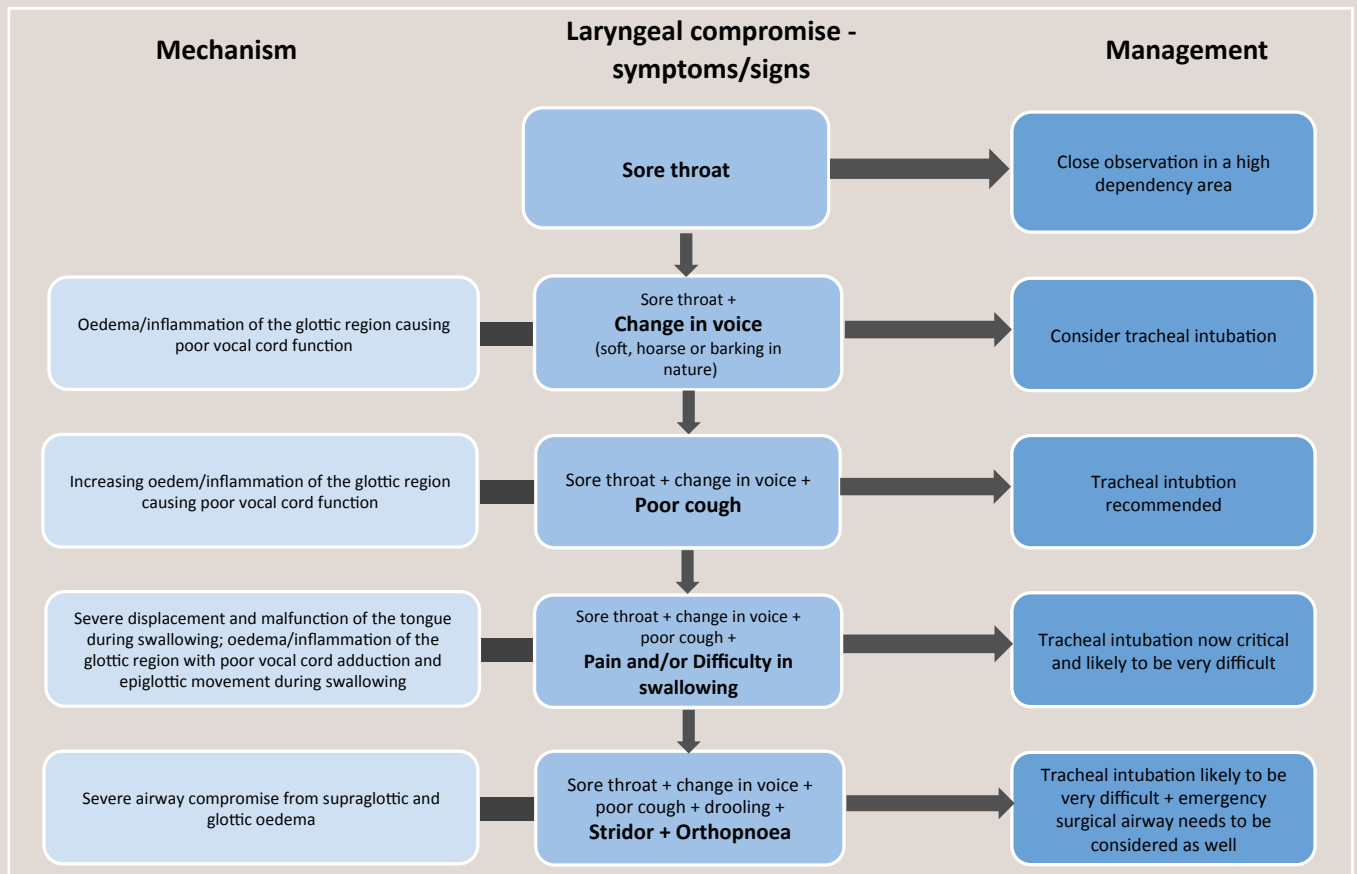


Figure 1: a suggested algorithm for the acute management of an obstructing airway.

The patient's preoperative assessment by the anaesthetist revealed that he was able to speak but had some limitation of his mouth opening. There was no stridor or drooling. The anaesthetist performed an awake fiberoptic intubation as a teaching exercise for the anaesthetic trainee. The anaesthetist felt that the patient's clinical condition was not an indication for the awake fiberoptic intubation. The fiberoptic view revealed a normal appearance of the vocal cords.

The surgeons drained a right submandibular and sublingual abscess. Following the surgical procedure, the anaesthetist examined the airway with a laryngoscope and could see his epiglottis and the posterior part of

his vocal cords. The anaesthetist was confident that he could re-intubate the patient if that was necessary. The patient was extubated and transferred to the recovery ward following the surgery.

The anaesthetist reviewed the patient in the recovery ward at approximately 5.30pm. At this time he was sitting upright in his bed and the anaesthetist asked him how he was going, to which he responded "fine". The patient on direct questioning denied any pain. Despite this, the records show that the patient received 32 milligrams of morphine in four milligram doses while in the recovery ward. The patient did not have any stridor. His tongue was slightly swollen. The anaesthetist then asked the

consultant anaesthetist in charge of the recovery ward to supervise the patient's care. She reviewed him and discharged the patient to the general ward.

After arrival in the ward at 6.10pm the nurse assisted the patient to have a shower and changed his dressing. She stated that he responded to her with yes or no answers but did not converse. The nursing observations were performed immediately after the patient's arrival in the ward and then at 7pm and 8pm. These observations included temperatures, oxygen saturations and blood pressure. The nurse also said the patient was alert and orientated at 8pm and he was given some morphine for pain relief.

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Shortly before 8.55pm, the nurse saw the patient in the nurses' station. When asked was he having trouble breathing, he said "yes". The nurse escorted him back to his bed. When they arrived at his bedside, the nurse noted the patient had stridor. Patient X had stopped breathing and his pupils appeared fixed and dilated. The nurse called for help and positioned the patient for CPR. Another nurse arrived together with two doctors who happened to be on the ward. A registered nurse made a call for the medical emergency team to attend.

During the attempted resuscitation, the patient was cyanosed, with fixed and dilated pupils. They could not ventilate him with a bag and mask. No view of the vocal cords could be obtained with a laryngoscope. There was gross facial and submandibular swelling. A surgical cricothyroidotomy was performed and resuscitation continued for 20 minutes. Death was finally certified at 9.15pm.

#### **Author's comments:**

This case again is an example of the confusion amongst medical and nursing staff when considering the clinical management of the "obstructing" airway (in contrast to the "obstructed airway" that frequently requires an immediate emergency surgical airway).

The validity of performing direct laryngoscopy prior to extubation has never been substantiated scientifically. It is feasible that the tracheal tube may push the glottis posteriorly and produce an improved glottic view. It is also possible oedematous airway mucosa may close over the glottis following extubation. This in turn may make subsequent emergency laryngoscopy and intubation more difficult.

Over the years a variety of techniques and devices have been described for managing extubation of the difficult airway. Further work is still required but the cornerstone to safe patient care is the belief that every extubation is a trial and the patient needs close monitoring after the tracheal tube has been removed. Both the frequency and duration of this airway assessment should be directly proportional to the potential level of difficulty of emergency re-intubation.

Medical and nursing staff should be reminded that pulse oximetry is a poor clinical monitor of upper airway obstruction. Certain clinical signs such as poor voice, poor cough and poor swallow (drooling) are early indicators of impending airway obstruction. If the medical practitioner waits for the patient to be sitting up, breathless and stridulous before re-intubating the patient, there will be a high chance supraglottic intubation will be difficult or impossible and an emergency surgical airway is likely.

I have included a suggested clinical algorithm for the acute airway management of patients with an obstructing airway<sup>2</sup> (fig. 1) that may be considered as a guide for such cases. Further data analysis is urgently required to investigate the clinical history where rapid airway obstruction may occur. Clinical scenarios such as laryngeal trauma, acute epiglottitis and carcinoma of the airway should be examined to delineate their history and possible airway management strategies.

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**Dr Keith Greenland FANZCA**

#### **Reference:**

1. Greenland KB Emergency surgical airway in life threatening acute airway emergencies – why are we so reluctant to do it? *Anaesth Intensive Care* 2011 (in press).
2. Greenland KB, Acott C, Segal R, Riley RH, Merry AF Delayed airway compromise following extubation of adult patients who required surgical drainage of Ludwig's angina: comment on three coronial cases. *Anaesth Intensive Care* 2011; 39: 506-508.



## Airway Management

As the third report on airway disasters appears in this edition of the *Bulletin* it is timely to review the groundbreaking project of the 4th National Audit Project (NAP4) of the Royal College of Anaesthetists (RCoA). This collaborative study, involving the RCoA and the Difficult Airway Society (DAS), was a one-year prospective audit of serious airway complications in anaesthesia, intensive care and emergency departments for all 309 National Health Service Hospitals in the UK, with an expert panel being appointed to assess every report.

The full report is available on the RCoA website<sup>1</sup> and the *British Journal of Anaesthesia* has both an excellent editorial<sup>2</sup> and two articles reporting on complications related to general anaesthesia<sup>3</sup> as well as to intensive care and emergency departments.<sup>4</sup>

Major complications related to general anaesthesia were identified in a total of 133 cases which the authors assess as 1/22000 cases, assuming an estimated denominator of 2.9 million general anaesthetics administered annually. During this one year period there were 13 deaths and three cases of irreparable brain damage. Even with this carefully planned survey the authors concede that there may be under-reporting and that as few as 25 per cent were reported. This would certainly be the experience of the Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM). The indicators for inclusion in the study were death, brain damage, the need for an emergency surgical airway, unplanned admission to ICU or prolongation of stay in ICU. Obesity was considered an important risk factor and was defined as a body mass index of  $>30 \text{ kg m}^{-2}$  which was identified in 42 per cent of reports. Also of note was that over half of the patients were ASA P1-2 and under the age of 60 and most events occurred during elective surgery while under the care of consultant anaesthetists.

The most common primary airway problems in anaesthesia were failed intubation, aspiration of gastric contents and, importantly, problems related to tracheal extubation or removal of a supraglottic airway. Aspiration of gastric contents was the single most common cause of death and occurred in 14 cases with a supraglottic airway and eight cases with a tracheal tube, indicating that risks of aspiration have not always been adequately assessed when a supraglottic airway is employed.

In 58 cases an emergency surgical airway was attempted. Twenty-nine of these cases underwent surgical tracheostomy as a primary event while cricothyrotomy was attempted in 29, of which 15 failed and required surgical rescue: cricothyroidotomy performed by anaesthetists had a high rate of failure.

The second section of the NAP4 report relates to airway incidents in emergency or intensive care departments. Inclusion criteria were the same as for the anaesthesia related events but also included events occurring during transport between departments. Thirty-six reports concerned patients in ICU and 15 in the emergency department. Of these there were 18 deaths and four cases of brain damage in ICU patients and four in the emergency department.

Of the ICU patients 61 per cent were aged less than 60 and 22 per cent were ASA P1-2. Invasive ventilation had been established in 19 patients and non invasive in eight and there was a BMI of  $>30 \text{ kg m}^{-2}$  in 47 per cent. Of note was the occurrence of 46 per cent of incidents out of hours with many managed by junior doctors without training in airway management. This problem was less common in emergency departments where anaesthetists were more often available and where emergency consultants were on duty 24 hours a day. In ICU the main primary airway events were tracheostomy related problems, tracheal tube misplacement and failed intubation and there were three unrecognised oesophageal intubations, two of which were fatal. Poor planning

and training were identified in many of these cases as well as the unavailability of equipment, notably capnography. In recent years the majority of airway incidents reported to VCCAMM have occurred in areas outside the operating theatre and VCCAMM has repeatedly recommended that whenever the patient is intubated and there is artificial ventilation, capnography is essential. NAP4 has claimed that it is likely that over 79 per cent of airway deaths in ICU could have been prevented had continuous capnography been used. Even now it is not known how many intensive care units in Australia still do not have the capability of continuous capnography in all ventilated patients. However it must be recognised that equipment alone is not sufficient and that there must also be training in the interpretation of absent or altered CO<sub>2</sub> waveforms and that the possibility of equipment error is small and must not distract from the need for urgent action.

NAP4 is a seminal project with enormous implications for improvement in airway management, particularly outside the operating theatres, and the articles in the *British Journal of Anaesthesia* are highly recommended reading as well as the web site of the RCoA.<sup>1</sup>

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### Dr Patricia Mackay

Communication/Liaison Portfolio

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1. RCoA Website. [www.rcoa.ac.uk/index.asp?PageID=1089](http://www.rcoa.ac.uk/index.asp?PageID=1089)
2. Norris AM, Hardman JG, Asai T Editorial: A firm foundation for progress in airway management. *Br J Anaesth* 2011; 106: 513-516
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4. 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

# Continuing Professional Development

## CPD tips – heart failure

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

With the assistance of Dr John Lee, a provisional Fellow at Royal Prince Alfred Hospital, he continues his series of articles directing Fellows to convenient places to collect continuing professional development (CPD) credits. This is the second article of a 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.

The series was chosen because the curriculum survey identified that most Fellows felt the existing ANZCA curriculum under-represents medicine during the training period.

### The management of acute and chronic heart failure

The most recent guidelines were published in the *European Journal of Heart Failure* (2008), 933-989. Because of its length, the article, “ESC Guidelines

for the diagnosis and treatment of acute and chronic heart failure 2008”, should qualify for a minimum of two hours of CPD credits in category one, level one.

### Introduction

Improved medical therapy combined with successful prevention and education programs has improved survival in patients with heart failure but it also has meant an increase in the overall prevalence of the disease. Combine this with an ageing population and we can expect to have more patients presenting to our perioperative clinics with both diagnosed and undiagnosed heart failure. It would seem prudent to remain current with the medical management of heart failure.

### Definition

Many definitions of heart failure have been used, but more recently, emphasis has been placed on the fact that it is a complex syndrome in which patients have the symptoms, signs and objective (functional or structural) evidence of heart failure. Key features of the clinical history may include typical symptoms such as shortness of breath and fatigue, but less commonly may include cachexia, cool peripheries and confusion. A history of ischaemic heart disease, in particular, should also alert a clinician to the likelihood of co-existing heart failure. Ischaemic heart disease is the most common cause of heart failure, being the initiating cause for approximately 70 per cent of patients with heart failure.<sup>1</sup> Still, a wider range of risk factors should alert us to the possibility of co-existing heart failure. Less known risk factors are conditions such as cerebral vascular disease, peripheral vascular disease and valvular disease or dysfunction. The above article has a comprehensive list of risk factors that would be worthy of reviewing.

The article also stresses that, as part of the history, the cause for heart failure should always be sought, as some may require specific treatment and may include ischaemic heart disease, hypertension, various cardiomyopathies, drugs and toxins and others.

Descriptive terms of heart failure are commonly used, such as acute or chronic, systolic or diastolic and one also based on exercise capacity and symptoms, for example, the New York Heart Association (NYHA) functional classification. Furthermore, the distinction between systolic and diastolic heart failure is “somewhat arbitrary”, with most patients with heart failure having evidence of “both systolic and diastolic dysfunction at rest or on exercise”.

### Diagnosis

Expert consensus opinion suggests a minimum of clinical examination, electrocardiogram, chest X-ray and echocardiography in diagnosing patients with heart failure. Various signs to support heart failure may include atrial tachycardia, Q waves, atrial ventricular block and left ventricular hypertrophy on the ECG. Further detail is beyond the scope of this summary.

One diagnostic tool that many may not be aware of is Plasma B-Natriuretic Peptide (BNP). BNP concentrations can be used to guide therapy in patients where the diagnosis is uncertain. This useful biomarker rises in response to an “increase in myocardial wall stress” and thus a normal concentration in an untreated patient has a “high negative predictive value and makes heart failure an unlikely cause of symptoms”.

Evaluating left ventricular ejection fraction in echocardiography is the “most practical measurement of ventricular function for distinguishing patients with systolic dysfunction and preserved systolic function”. Also, assessment of diastolic function using the ventricular filling pattern and Doppler echocardiographic indices (for example, Early/Atrial Systole or E/A ratios) is essential, as “diastolic dysfunction may be the predominant pathology in those with heart failure with preserved ejection fraction”.

Other non-invasive imaging tests mentioned include cardiac MRI and CT, radionuclide ventriculography and cardio-pulmonary exercise testing.

### **Treatment**

A multimodal approach to the treatment of heart failure is advocated. Most studies have involved elderly patients with systolic dysfunction with an arbitrary cut off of an ejection fraction of 35 to 40 per cent. Management also is influenced by the presence of co-existing diseases. For example, in patients with heart failure and diabetes mellitus “an elevated blood glucose should be treated with tight glycaemic control” (class of recommendation I, level of evidence A).

### **Non-pharmacological**

Comprehensive education and counselling regarding heart failure, adherence to treatment, achieving and formulating goals, rehabilitation and close follow up have been linked with positive outcomes. Expert recommendations take into account lifestyle modifications such as improved diet and nutrition, weight reduction, alcohol moderation and smoking cessation.

### **Pharmacological**

The key agents used in heart failure are ACE inhibitors, such as Ramapril, enalapril and captopril, and B Blockers, such as metoprolol, carvedilol and bisoprolol. Many studies (multiple randomised controlled trials and meta-analyses) strongly support their use. Other agents, such as aldosterone antagonists, digoxin, hydralazine, nitrates and diuretics, can be used in addition to or substituted in cases where there are significant side effects.

### **Heart Failure**

**ACE inhibitors (ACEi)** should be used in all patients with “symptomatic heart failure and a LVEF less than 40 per cent”, unless there is a contraindication. The article will provide key references to studies that have shown it reduces risk of death, symptomatic heart failure and improves quality of life. Important side effects that may be of issue in the perioperative period include worsening of renal function, hyperkalaemia, cough and angioedema. Ramapril is the most commonly used ACEi in Australia with a starting dose of 2.5mg once daily and a target dose of 5mg twice a day.

**B-blockers** should be used in all patients with the same conditions as outlined above and can be used in combination with an ACEi. These agents again reduced mortality and hospital admission for worsening heart failure. It is important to start at a low dose and titrate every two to four weeks until an evidence-based target dose is reached, observing for side effects. Contraindications include asthma and second or third-degree heart blocks. Metoprolol is the most commonly used beta-blocker in Australia with a starting dose of 12.5-25mg once daily and a target dose of 200mg daily.

**Angiotensin receptor blockers (ARBs)** are recommended in patients as an alternative in those who are intolerant to ACEi. They have been shown to improve exercise capacity and reduce death and hospital admissions for worsening of heart failure. Candesartan is the most commonly used ARB in Australia with starting doses of 4-8mg once daily and a target dose of 32mg daily.

### **Optimisation**

Specialists should consider other options in the management of heart failure where there are specific indications such as valvular surgery, pacemaker insertion, cardiac re-synchronisation therapy and implantable cardiac defibrillators. Treatments other than revascularisation may be appropriate prior to elective surgery, and we might consider a perioperative cardiology opinion on patients other than those with ischaemic heart disease.

In summary, these guidelines should assist the anaesthetist in recognising undiagnosed heart failure, assessing the severity of known heart failure and managing patients with heart failure in the perioperative period. We would encourage all Fellows interested in medicine to read this quarter’s highlighted article.

**Dr John Lee**, Provisional Fellow, NSW  
**Dr Vincent Sperando**, FANZCA, NSW

### **Reference**

1. ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure 2008. *European Journal of Heart Failure* (2008), 933-989.

## **CPD participation**

It is pleasing to report that 99.6 per cent of our Fellows in both anaesthesia and pain medicine are participating in ANZCA’s continuing professional development (CPD) program.

Completing a CPD program became mandatory for all ANZCA Fellows in 2009 and affected all Fellows.

The ANZCA CPD program is completed in three-year cycles (a triennium). If you have not enrolled in your 2011-2013 cycle please remember to click “Start new cycle” on your portfolio menu on the ANZCA website. We suggest that you start by entering your CPD plan for the triennium online.

Attendees at the recent Combined Scientific Meeting (CSM) of ANZCA, FPM and the Hong Kong College of Anesthesiologists in Hong Kong should remember to enter their activities in to their CPD portfolio. Please refer to the CSM brochure for advice on the correct categorisation of these activities.

Should you have any queries relating to CPD please contact the CPD team on +61 3 9510 6299 or email us [cpd@anzca.edu.au](mailto:cpd@anzca.edu.au) All communications will be responded to within 48 hours.

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**Glenn Rosier**  
CPD Manager

# ANZCA Trials Group update

One of the important core activities for the Trials Group is the annual scientific meeting. This year the combined scientific meeting, CSM 2011, held in Hong Kong from May 14-17 included two Trials Group sessions, the annual Trials Group lunchtime meeting followed by the Trials Group Executive Committee meeting.

The Chair of the Trials Group, Associate Professor David Story, chaired the first session on Saturday morning. Dr Craig Noonan set the scene with an informative talk on risk, chance and ratios. Professor Kate Leslie followed with a presentation on the rationale behind the Perioperative Ischemic Evaluation-2 (POISE 2) study of which she is the national coordinator for Australia and New Zealand. Professor Matthew Chan completed the session with a compelling talk on persistent pain after surgery, something that may affect approximately 18 per cent of patients. The session was well attended and attracted a lively question time following the presentations.

The annual ANZCA Trials Group lunchtime meeting followed and was attended by more than 30 participants from Australia, New Zealand and Hong Kong, including research nurses associated with trials group research. Topics discussed included the Aspirin and Tranexamic Acid for Coronary Artery Surgery (ATACAS) trial, the Nitrous Oxide Anaesthesia and Cardiac Morbidity after Major Surgery II (ENIGMA-II) trial, POISE 2, the Restrictive Versus Liberal Fluid Therapy in Major Surgery (RELIEF) trial and the Balanced Study. This was followed by a meeting of the Trials Group Executive Committee where the agenda focused on the program for the upcoming Strategic Research Workshop in Palm Cove from August 12-14, 2011.

Professor Matthew Chan chaired the second session, held on Monday afternoon. Associate Professor Tim Short gave an update on the Balanced Study, that examines the depth of anaesthesia guided by BIS monitoring.



Associate Professor Story discussed the current “crisis” in survey research and how low response rates undermine the importance of surveys as a useful research tool. The final speaker was Associate Professor Tomas Corcoran who presented his ongoing work on dexamethasone and post-operative infection risk using two observational studies including a matched case control study.

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## Pilot grants

The ANZCA Trials Group is pleased to announce that a second pilot grant of \$5000 for 2011 has been awarded to Associate Professor Steve Bolsin and Dr Cameron Osbourne (Victoria) for “Geelong Rosuvastatin & Incidence of Myocardial Infarction Pilot Study,” or the GRIMIP Study. Congratulations to the investigators.

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## Publications

“Inconsistent survey reporting in anaesthesia journals,” by Associate Professor Story, Dr Veronica Gin, Vanida na Ranong, Stephanie Poustie, Dr Daryl Jones in *Anesthesia and Analgesia*. INPRESS

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## POISE 2 update

The Human Research Ethics Committee (HREC) approval for the POISE 2 study has been granted in Victoria (nine sites), NSW (two) and Tasmania (three). Other sites in Queensland, SA, WA and NZ have their ethics processes under way, making a total of more than 20 participating sites.

If you are interested in participating in POISE 2, the Trials Group will assist you with your ethics process,

the Clinical Trial Notification and the Clinical Trial Agreements. If you are in Victoria, NSW or Queensland you may be added to the existing National Ethics Application Form (NEAF) approval without having to undergo full HREC review. For further information please contact Ms Stephanie Poustie at [spoustie@anzca.edu.au](mailto:spoustie@anzca.edu.au) or Professor Kate Leslie at [kate.leslie@mh.org.au](mailto:kate.leslie@mh.org.au).

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## Events

A reminder to new and emerging researchers, as well as those established in the field, that the Third Annual Strategic Research Workshop is being held at Palm Cove, Queensland from August 12-14, 2011. The aim of these meetings is to present, mentor and encourage new ideas for multicentre research in anaesthesia, perioperative and pain medicine.

Updates are given on existing research and this year we have two expert speakers. They are Professor Andrew Forbes, Head of Biostatistics, Department of Epidemiology and Preventive Medicine, Monash University, and Professor Rinaldo Bellomo, intensivist, Director of ICU Research, Austin Health, Foundation Chair Australia and New Zealand Intensive Care Society (ANZICS) Clinical Trials Group and Co-Director of ANZICS Research Centre, plus many leading anaesthesia researchers in Australasia.

We also encourage anaesthesia research nurses and co-ordinators to attend. We have programmed breakout sessions for this group, and will also provide a session on the POISE 2 study. For further information please contact Stephanie Poustie at [spoustie@anzca.edu.au](mailto:spoustie@anzca.edu.au) or see [www.anzca.edu.au/resources/trials-group](http://www.anzca.edu.au/resources/trials-group).

# Anaesthesia and Perioperative Care Network



## NSW Agency for Clinical Innovation

Collaborative efforts to develop an agreed minimum education standard for anaesthetic assistants have been given new impetus following the first meeting of the NSW Agency for Clinical Innovation (ACI) Anaesthesia and Perioperative Care Network. The inaugural meeting of the wider membership of the network, attracted more than 100 anaesthetists, other health professionals and consumers, including many from outer metropolitan and rural hospitals across NSW.

The meeting, in April, heard reports on parallel projects being driven by the ACI in NSW and Queensland's Statewide Anaesthesia and Perioperative Care Clinical Network (SWAPNET). The theme of the day was patients, carers and clinicians working together to find solutions to fix broken linkages in current health systems. The meeting was an outstanding success, laying the foundation for strong NSW-wide collaboration for clinical improvement.

In line with the ACI's charter, the network has been driven from the ground up by clinicians from anaesthesia-led multidisciplinary care teams who felt that a dedicated network for front line health professionals and consumers could make a real difference to the care provided, equity of access, and outcomes for patients.

That enthusiasm was evident at the inaugural meeting, which provided a great launching pad for the network's objective of helping deliver better and more effective patient care by working together to develop and promote implementation of evidence-based best practice models of care.

The network's priority projects are:

- Staged implementation of *PS9 Guidelines on Sedation and Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures* in NSW public hospitals.
- Advising NSW Health on minimum requirements for safe sedation.
- Developing and implementing competencies for the anaesthetic assistant.

- Identifying and addressing issues associated with regional and rural anaesthesia in collaboration with the Rural Doctors Network and the Clinical Education and Training Institute (CETI).
- Researching and developing materials from patient and carers' experiences in anaesthesia and surgery to support clinician education and implementation of best practice models of care.

## ACI Anaesthesia and Perioperative Care Network Reports from Working Groups

### Anaesthetic Assistants

The need for action to address inconsistent educational standards among health professionals who assist the anaesthetist has been identified by the working group. The NSW working group is looking to collaborate with SWAPNET in Queensland which has developed a set of core competencies for an anaesthetic support officer. At the network meeting, Simon Maffey from Queensland gave examples from the SWAPNET discussion paper. The NSW group is aiming to work with Queensland to introduce an educational minimum standard for an anaesthetic assistant which may be applicable more broadly. There was an acknowledgment of the industrial barriers and the need to include all existing stakeholders. The eventual goal is a distinct position with independent registration and appropriate award conditions to assist the drive to improve patient care during anaesthesia and the perioperative period.

### Safe Sedation Working Group

Tracey Tay outlined the network's strong focus on safe sedation. More procedures requiring sedation are occurring outside the operating theatre. More surgery is being replaced with interventional procedures which may be complex and long, leaving patients – who are generally sicker – at higher risk.

However, there are barriers in applying the principles of College document PS9 (which is endorsed by seven specialty groups), including patchy acceptance of the gap between

evidence and current practice by clinicians, managers and funders; inadequate recognition, reporting and documentation of clinical incidents; insufficient patient awareness of risk; and a wide gap between recommended and current resources.

To address this the ACI network is advocating the staged introduction of PS9, including a check-list ensuring that there is a trained person present solely to monitor the patient, someone capable of bag-mask ventilation and pre-procedure assessment and triage. The ultimate goal is to improve care provided to patients receiving sedation in NSW.

### Regional, Rural And Remote Anaesthesia

General practitioners Scott Finlay and David Scott gave a confronting presentation detailing the strain on a rural hospital receiving two patients from a recent aviation accident in Moree. They described the shortages within the rural workforce and the fragility of existing systems of care, and outlined results from a pilot survey of a representative group of rural hospitals. Their working group aims to survey all regional, rural and remote anaesthesia services in NSW and propose solutions to the looming rural workforce crisis.

### Patient and Carers' Experiences

NSW has received ethics approval for a statewide research project developed to ensure the experiences of patients and carers are front and centre in the network's deliberations. The project was demonstrated using an actor and fine arts painter to show the need to look at health care delivery from the viewpoint of patients and their carers. Storybooks will be developed covering patients and carers and professional development, as well as accompanying training programs.

For further information on the work of the ACI contact (02) 8644 2200 or visit: [www.health.nsw.gov.au/gmct/anaesthesia/index.asp](http://www.health.nsw.gov.au/gmct/anaesthesia/index.asp).

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**Dr Michael Amos, FANZCA**  
Executive Member, Anaesthesia & Perioperative Care Network of ACI  
Member, ANZCA NSW Regional Committee

# Teaching in Papua New Guinea



If you mention Papua New Guinea (PNG) to most Australians and New Zealanders it conjures images of coconut-lined beaches, lush rainforests or the rugged rainforests of the highlands made famous by World War II battles in the Owen Stanley Ranges. However it is its very diversity of ecology and ruggedness of geography that makes provision of healthcare in PNG so difficult. Half of the almost 7 million population live in traditional rural village settings. According to the World Health Organization almost 10 per cent of children die before the age of five years. One in 25 women now die in childbirth. This is on par with sub-Saharan Africa and Afghanistan.

Despite being richly endowed with natural resources, poverty is widespread and reflected in the health sector. Annual health expenditure in PNG is only 3.1 per cent of GDP, or \$US50 per capita, as opposed to the regional average that is more than 10 times that amount and in Australia 40 times as much. There are severe staff shortages with only nine consultant anaesthetists for the entire country.

Anaesthetic services in PNG are mostly provided by anaesthetic scientific officers (ASOs) who are non-physician anaesthetists who have completed a one-year diploma course offered by the University of Papua New Guinea. For medical graduates the University of Papua New Guinea also offers a one-year Diploma In Anaesthesia (DA) and a four-year Masters in Medicine (MMed) which is closest to the College training program.

Since the mid 1990s ANZCA has had an extended interest in the development of anaesthesia in Papua New Guinea. ANZCA has committed to assisting the education and training of ASOs (Diploma of Anaesthetic Science) and anaesthetic registrar training (DA and MMed) by supporting a Fellow to undertake lectures and workshops with the local students.



Early in February this year I was fortunate enough to be asked by Dr Michael Cooper to undertake an intensive one-week teaching trip to Port Moresby. The teaching program for this trip consisted of three days teaching the anaesthetic scientific officers, two days with the anaesthetic registrars and one day with the MMed candidates who were preparing for their final examinations.

Given the limited time for teaching and the significant problems with infrastructure, equipment and monitoring, the teaching was focused primarily on safety, pre-operative assessment, common surgical problems and airways. Lectures were held in the mornings and hands on sessions in the operating theatres in the afternoon to provide some air-conditioned reprieve from the humidity and allow the students to apply what they learnt in the morning.

All the students were provided with comprehensive course notes on USB sticks along with a number of electronic textbooks and hard copies of some of the more popular anaesthetic handbooks.

Despite the challenges faced by the local physicians and ASOs in providing anaesthetic services to their local community, I was at all times impressed by their enthusiasm, professionalism and compassion for the patients they served. The ongoing support of ANZCA and the Overseas Aid Committee is critical to the growth of the profession in the region. Furthermore such work is essential if the College is to stay true to its mission statement: "To serve the community by fostering safety and

quality patient care in anaesthesia, intensive care and pain medicine".

Finally I would like to thank the ANZCA Council for their commitment to aid in the region, Dr Michael Cooper (Children's Hospital Westmead) for his encouragement, wisdom and expertise, Dr Robert Woog (Royal Prince Alfred Hospital) for providing leave from my regular work commitments, and Baxter and Abbott Pharmaceuticals for donations of USB memory sticks to provide e-textbooks and course notes for the participants.

**Dr Michael Stone** BMedSc MB BS(Hons)  
M Med(Pain) PGDipEcho FANZCA  
Consultant Anaesthetist  
St Vincents Hospital, NSW and  
Royal Prince Alfred Hospital, NSW

#### References:

Cooper M. and Morriss W. ANZCA Bulletin, June 2010, p56-57.  
World Health Organization. Papua New Guinea: health profile. Last update April 4, 2011. [www.who.int/countries/png/en/](http://www.who.int/countries/png/en/)

*Above clockwise from top left: Port Moresby General Hospital; The Diploma of Anaesthetic Sciences course students, from left: Israel Lehani, Jerry Duni, Norman Kambo, Elani Namel, Rachael Toniui, Tom Wapulo, Jenny Mulli, Homeless Manitore, Justus Jack and Mafi Asipeli; Anaesthetic scientific officers confirming the correct placement of the tube by symmetrical inflation of the lungs and manual pressure check of the pilot tube; A quick stroll around the wards of the hospital quickly initiates the inexperienced as to some of the challenges face by the local doctors; One of the students trying to troubleshoot a deliberately faulty anaesthetic circuit.*



## New test for pain tolerance

By **JULIA MEDEW**  
HEALTH EDITOR

WOMEN preparing to give birth may soon be able to have a genetic test that predicts how much pain they are likely to

other women. In some cases, these women consumed three times the amount of morphine compared to the others. There was also an association between the genetic variant and how much a woman experienced side-

could take a drop of blood to know ... their requirement for analgesia and pain relief," he said, adding such a test could be in use within five to 10 years.

Professor Sia said this would be particularly helpful in mater-

Two television programs, Channel 10's *The Circle* and *7pm Project*, have set out to debunk some of the mysteries of anaesthesia and discuss the incidence of awareness during anaesthesia procedures.

For the programs, ANZCA President Professor Kate Leslie and Royal Children's Hospital anaesthetist Associate Professor Andrew Davidson were filmed in surgery explaining how an anaesthetic is administered and how patients are monitored for signs of awareness.

The television features were just two of the media follow-ups to come out of last month's combined scientific meeting in Hong Kong, which attracted widespread media interest.

Three medical journalists from mainstream Australian media outlets attended the meeting and covered such topics as opioid misuse, anaesthesia and the ageing mind, a genetic test for pain tolerance in childbirth, improving patient care in intensive care units, and the effect of psychological factors on pain perception.

These stories prompted further debate and discussion in the media back home. Melbourne's St Vincent's Hospital's Director of Anaesthesia, Associate Professor David Scott, hit the airwaves, responding to many requests for radio interviews following his paper on making anaesthesia as safe as possible for the elderly, especially those who may be in the very early stages of dementia.

Media releases sent to media outlets in Australia, New Zealand and Hong Kong were also followed up, leading to coverage on issues such as parallels between anaesthesia and aviation training, and epidural research.

All up, the meeting generated more than 25 stories in newspapers, more than 70 on internet sites, 15 radio mentions and two television features. More than 20 speakers were interviewed and ANZCA greatly appreciates their contribution. Media Monitors estimated that the media coverage was worth nearly \$680,000 in advertising dollars.

In the lead-up to the meeting, *The Age* ran a large feature on recent fraudulent medical research and quoted ANZCA Fellows Dr Neville Gibbs and Professor Paul Myles on lessons to be learnt from such cases.

Media releases distributed by ANZCA since late February

"New online training program to tackle pain" (June 2)

"De-stressing the distressed: is the ICU making patients sick?" (May 16)

"Bridging the gap: helping patients control postoperative pain" (May 15)

"Anaesthesia and the ageing mind" (May 14)

"Flying high: lessons from the aviation industry" (May 13)

"East meets west at pain medicine meeting" (May 12)

"Anaesthetists share pearls of wisdom in Hong Kong" (May 9)

"ANZCA Bulletin out now – anaesthetists on the frontline, eyes on Ethiopia" (April 4)

Since late February 2011, ANZCA has generated...

**28 print stories**

**72 online stories**

**21 radio mentions**

**2 television stories**

Earlier this month, the Faculty of Pain Medicine and the Royal Australian College of General Practitioners jointly received \$200,000 from the Bupa Health Foundation to develop an online learning program to help GPs treat people with chronic and acute pain.

Faculty of Pain Medicine Vice Dean Dr Brendan Moore was interviewed by several journalists resulting in radio coverage in NSW (2UE, 2SM and WAVE FM), Canberra (2CC), Adelaide (5AA) and Perth (RTR FM), which have a combined listenership of more than 100,000 people.

In April, *the Courier Mail's* weekend magazine, *Qweekend*, ran a feature on doctors, substance abuse and depression, which looked at the welfare of doctors and the impact of mandatory reporting. The article quoted the chair of the Welfare of Anaesthetists Special Interest Group, Dr Diana Khursandi, and Queensland Regional Committee chair Dr Sean McManus.

**Meaghan Shaw**  
Media Manager, ANZCA

## NZNC strategic campaign

A New Zealand National Committee (NZNC) subcommittee has developed a campaign to advance the committee's position on the future of New Zealand's anaesthesia workforce and ANZCA's role in setting and maintaining high standards of training and practice. Subcommittee members attended a brainstorming workshop on May 30 with a communications and lobbying specialist and have developed a draft plan. The plan was discussed with ANZCA's head office staff this month and will be put to the NZNC meeting on July 8 and 9. Committee members will host a cocktail function for stakeholders prior to the meeting on July 7, as part of the campaign. The NZNC also will take part in the annual joint meeting with the executive of the New Zealand Society of Anaesthetists on July 8.

## Assessment fees

The Medical Council of New Zealand (MCNZ) is consulting its branch advisory bodies, of which ANZCA is one, about the fees it pays them to assess international medical graduate specialists (IMGS) for registration in a vocational specialty. The fees have not been adjusted for seven years. Following consultation, the proposed new fees will go to the Minister of Health for approval and formal gazetting.

## Pharmac consultation

Pharmac, the New Zealand Government's pharmaceutical management agency, has asked the New Zealand National Committee for advice about which pharmaceuticals used for cardiology treatments should be included in a national preferred list of cardiovascular medicines to be funded within district health board hospitals. Pharmac is reviewing all pharmaceuticals used within public hospitals following the government's decision that Pharmac should be responsible for funding hospital pharmaceuticals.



## New Zealand's health budget

Vote Health received the largest proportion of government spending and was one of the few areas to win an increase in a tight government budget delivered on May 19.

The budget delivers an extra NZ\$2.2 billion to public health services over four years, including an additional \$585 million in 2011/12.

"Vote Health is the biggest recipient of Budget 2011," Health Minister Tony Ryall, above, said.

"This demonstrates the government's strong commitment to protecting and growing our public health services, despite the difficult economic times.

"In the next financial year, we are providing \$585 million for health initiatives – made up of \$420 million of new money, plus around \$165 million from savings (in the health sector) going straight back into healthcare."

District health boards will receive around \$400 million – \$350 million in population-based funding plus over \$50 million for service contracts from the Ministry of Health.

The \$2.2 billion extra over four years will fund new initiatives including:

- \$18 million for 40 extra medical training places – part of a promise to boost the number of medical training places by 200 over five years.
- A further \$54.5 million for maternity initiatives to improve safety and quality, and extra WellChild visits, with a particular focus on first-time mothers. This allocation includes \$18.4 million to improve safety and quality of services for mothers and babies by bringing maternity professionals together for regular clinical reviews of all births and increasing the number of midwives in hospitals as well as the number of on-site and on-call medical specialists.
- \$80 million to increase access to medicines. The \$20 million increase for 2011/12 is included in the funding increase to district health boards.
- \$68 million for elective surgery.
- An additional \$40 million for dementia care, which is expected to provide almost 200 extra beds over years and extra respite care.
- \$40 million for mental health, including \$4 million for dementia-related respite care.
- An extra \$130 million for disability support services to meet rising needs and costs.
- \$80 million extra from district health boards for GP visit subsidies and \$14 million to increase the number of people qualifying for programs such as very low cost access and free under-sixes.





## Council of Medical Colleges (CMC)

The Council of Medical Colleges meeting on May 13 was very useful with comprehensive discussions on the place of vocational practice assessments for international medical graduates, the possibility of Australian medical graduates taking New Zealand training positions and the concept of a single medical college for New Zealand. HWNZ Executive Chair Professor Des Gorman addressed issues such as trainee funding, the dislocation between undergraduate and postgraduate medical education, his concerns about trans-Tasman colleges and workforce planning models. New Zealand National Committee member Dr Nigel Robertson, above, represented ANZCA at the meeting.



## Reduced supervision for UK graduates

The Medical Council of New Zealand (MCNZ) has asked the New Zealand National Committee to consider reducing the supervision period for UK-trained doctors applying for vocational registration. The MCNZ is proposing that supervision be reduced from 12 to six months for doctors registered within a provisional vocational scope of practice (supervision pathway), which includes doctors assessed as having qualifications, training and experience equivalent to a New Zealand-trained Fellow. An MCNZ branch advisory body could still advise if a doctor needed more than six months of supervised practice.

## BWT Ritchie Scholarship applications

Applications for the BWT Ritchie Anaesthesia Scholarship, which assists New Zealand final-year trainee anaesthetists or those in their first year of fellowship to study overseas, close at the end of the month. The 2011 scholarship is valued up to NZ\$25,000, depending on the program of the successful applicants. Applicants must be nominated and supported by their training department. For an information pack, contact Rose Chadwick at the New Zealand Anaesthesia Education Committee ([nzaec@anaesthesia.org.nz](mailto:nzaec@anaesthesia.org.nz)) or download the information from the committee's website ([www.anaesthesia.org.nz/nzaec](http://www.anaesthesia.org.nz/nzaec)). Applications should be sent to Rose Chadwick, NZAEC, PO Box 25506, Panama Street, Wellington 6146 by June 30.

## Doctors' prevocational training under review

The Medical Council of New Zealand (MCNZ) and Health Workforce New Zealand (HWNZ) are reviewing prevocational training for PGY1 and PGY2 doctors.

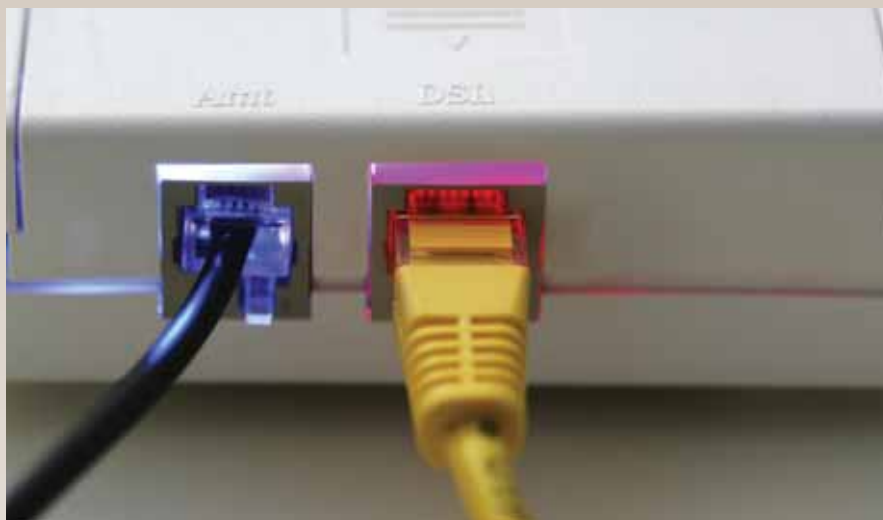
The review builds on the work of previous groups charged with exploring workforce education and training. It explores the issues and drivers behind the need for change, and the purpose and objectives for the first two postgraduate years, and recommends key features of a prevocational training framework.

The MCNZ has released a discussion paper, *Prevocational Training Requirements for Doctors in New Zealand: a discussion paper on options for an enhanced training framework for discussion and feedback*, which raises questions and proposes options for change. Each of the four options will give a varying exposure to the skills that anaesthesia trainees need before beginning FANZCA training.

Following discussion and feedback, the MCNZ will further develop the education and training framework for all PGY1 and PGY2 doctors. As a result, future PGY1 and PGY2 doctors may experience modifications to the curriculum, modifications to the clinical runs and different settings for training.

The MCNZ is holding meetings around New Zealand in June and July to discuss the issues raised in the paper, which can be downloaded from their website, [www.mcnz.org.nz](http://www.mcnz.org.nz). The website also contains information about the meetings.

Comment on the paper closes on Friday July 22. Submissions may be made online or by email to [prevocationalconsultation@mcnz.org.nz](mailto:prevocationalconsultation@mcnz.org.nz). You may also send comments to ANZCA's New Zealand office ([gm@anzca.org.nz](mailto:gm@anzca.org.nz)) for consideration as part of ANZCA's New Zealand National Committee submission.



## Broadband boost for healthcare services

Healthcare services will make huge gains thanks to the New Zealand Government's ultra-fast broadband initiative, according to the Health Minister, Tony Ryall.

Mr Ryall says ultra-fast broadband (UFB) will make the transfer of information and services much simpler and faster.

The government awarded the final two contracts for the roll-out of ultra-fast broadband around New Zealand last month, and awarded a contract in April for broadband in rural areas.

New Zealand Minister for Communications and Information Technology Steven Joyce says the government has prioritised healthcare centres for the roll out.

"We know that this technology will transform healthcare in this country, so we've committed to providing access to all registered healthcare centres by the end of 2015," he said.

While some large hospitals use fibre, few health premises have access. The government's plans will see more than 6000 health premises able to access broadband speeds of 100 Mbps plus.

## Cancer patients seen sooner

Ninety nine per cent of patients ready for cancer radiation treatment were starting treatment within four weeks, according to the latest results on the New Zealand Government health targets.

New Zealand Health Minister Tony Ryall said that three to four years ago patients could be waiting up to 15 weeks to start radiation treatment and many had to travel to Australia.

"Four weeks is the gold standard worldwide for starting cancer radiation treatment. From January to March, 99 per cent of patients started their cancer radiation treatment within four weeks and 100 per cent started within six weeks," Mr Ryall said. "Right in the middle of the period we had the Canterbury earthquake, which makes this result even more impressive. It's a tribute to the DHBs (district health boards), and the South Island regional cancer centres in particular."

Another highlight of the third quarter of the 2010/11 health targets was an increase to 89 per cent of emergency department patients admitted, discharged or treated within six hours.

## Anaesthesia workforce review

A summary of the report from the Anaesthesia Workforce Review has been posted on Health Workforce New Zealand's website (see [www.healthworkforce.govt.nz/our-work/workforce-service-reviews/anaesthesia](http://www.healthworkforce.govt.nz/our-work/workforce-service-reviews/anaesthesia)). The full report is also available on that website.

The review report was compiled by an Anaesthesia Resource Review Group (ARRG) set up by the New Zealand Society of Anaesthetists but later widened to include ANZCA New Zealand National Committee representation.

The group was charged with identifying ways in which the existing workforce can better meet increasing demand for services with limited resourcing.

Its key findings and recommendations included that:

- Measures to increase operating room productivity are as necessary as changes to the anaesthesia workforce.
- Any proposal to use allied health professionals to complement the physician role in anaesthesia must not compromise quality of care or cause disengagement of the current anaesthesia SMO workforce, and must be embedded in a doctor-led model.
- Better use can be made of the existing workforce, especially across district health board boundaries to overcome mal-distribution.

Health Workforce New Zealand, which funds specialist medical training in New Zealand, is analysing the findings and says its recommendations will influence investment strategy, leading to changes in workforce training, development and skill mix.

# New horizons at the NZ Anaesthesia ASM 2011

Online registration is open for the New Zealand Anaesthesia Annual Scientific Meeting 2011 being held in Auckland from November 2 to 5. Earlybird registration is available until September 30.

Abstract submission is also open with authors invited to submit until August 26. They will be notified about their success by September 14.

The ASM jointly hosted by ANZCA's New Zealand National Committee and the New Zealand Society of Anaesthetists (NZSA) with the organising committee coming from the Department of Anaesthesiology and Perioperative Medicine at Waitemata District Health Board (North Shore Hospital), led by FANZCA Dr Michal Kluger.

Keynote speakers have been asked to explore innovation and new thinking in anaesthesia in line with the meeting theme, "new horizons".

Speakers include clinical psychologist and TV personality Nigel Latta and New Zealander of the Year 2010 Ray Avery.

The faculty also boasts Dr David Bogod (UK), a former editor of *Anaesthesia*, along with Dr Ross Kerridge (Australia) and Professor Guy Ludbrook (Australia), who will look at innovative models of care and new models of drug delivery.

Professor John Myburgh (Australia) will look at innovations in intensive care medicine, while Professor Ken Whyte (NZ) will bring a physician's perspective to topics such as sleep apnoea, pulmonary hypertension and sleep medicine.

The NZSA Invited Speaker is Professor Alan Merry, who will discuss safety, improving outcome strategies and media issues.

Workshops will cover cardiac exercise testing using the CPX methodology, peripheral nerve ultrasound techniques, transthoracic cardiac echocardiography and sessions on the new WebAIRS online web-based incident recording system. Dr Kluger says that the workshops will be interactive, with participant numbers

limited to ensure as much exposure to each topic as possible. World leaders in their fields will facilitate the workshops.

There will be an emphasis on research at the ASM with the Ritchie Prize and trainee free paper being given a combined session and a free poster session under the new horizons theme. The best poster (trainee or specialist) will receive a \$500 prize. There will also be plenty of networking opportunities.

The social program includes an evening in the Maritime Museum on Auckland's waterfront, a M\*A\*S\*H-themed bar where participants can relive the world of Hawkeye, Hot Lips and Klinger and a spectacular conference dinner.

The meeting has attracted strong support from the industry with all exhibition space sold and exhibitors undertaking to work within the new horizons theme.

The ASM's main sponsors are Covidien and Baxter Healthcare.

For further information or to register, visit [www.nzaasm2011.co.nz](http://www.nzaasm2011.co.nz).

## New South Wales



## Australian Medical Association careers day

Members of the ANZCA NSW Regional Committee and Trainee Committee attended the NSW AMA careers day on March 19 at the AJC Convention Centre, Randwick Racecourse.

The day was designed to introduce the various careers available to junior doctors. Approximately 300 junior doctors and medical students attended the event. The NSW ANZCA table was well attended by interested participants where questions varied from "How do I become an anaesthetist" to "How do I pass the primary exam" and "How do I get a trainee job".

Highlight of the day was the retrieval demonstration by Careflight who flew in to extricate an injured patient from a mock up car accident in the rain. This generated great interest in attendees when it was revealed that anaesthetists are part of the retrieval team. Many thanks to NSW ANZCA staff and doctors who gave up their Saturday to talk about anaesthetics.

## Part Zero: An induction to anaesthesia takes off

The 2011 "Part Zero: An Induction to Anaesthesia" course on March 12, 2011 was a very popular way to spend a quiet Saturday afternoon. Despite clear sunny skies outside, more than 110 interns, residents and registrars flocked to the Royal Prince Alfred's Education Centre to learn more about the exciting life of an anaesthetic registrar. Numbers were well up from last year, generating some concern about whether everyone would fit in the allocated conference room, but with thorough planning and the judicious use of a shoe horn there was space for all.

After an initial welcome from the NSW Regional Trainee Committee, the day kicked off with Doctors Katherine Jeffrey, Simon Martel and Minh Tran ably reminding us what being an anaesthetic trainee was about, as well as the various prestigious organisations a budding young anaesthetic trainee could join. This was followed by Professor Gordon Parker of the Black Dog Institute, who educated and entertained with his twin lectures on Depression and Happiness, as bipolar as that may seem (*pardon the pun!*).

After a refreshing afternoon tea and surmounting some audiovisual challenges, the day was filled with important highlights such as Dr Natalie Smith covering the structure of training, Dr Michael Stone's now-famous exam tricks and tips lecture, and Dr Ken Harrison of Careflight's guide to career choice (*as well as his family photo album!*). Dr Greg Knoblanche rounded off the afternoon by bringing us back down to earth with his presentation on the ins and outs of medicolegal defence.

Despite squeezing a lifetime's worth of information into five hours, morale remained high thanks to the entertaining and informative lectures. The day was rounded off with a question and answer session followed by drinks at the local. Thanks go to all the presenters, the 2010 Regional Trainee Committee, and Tina Papadopoulos from the NSW ANZCA office for all her work behind the scenes.

*Above clockwise from top left: Dr Simon Martel; Professor Gordon Parker; Dr Simon Martel; Dr Michael Stone.*

## Agency for Clinical Innovation, Pain Management Network Update, April 2011

The Agency for Clinical Innovation (ACI) was established by the NSW Government as a board-governed statutory health corporation in January 2010, in direct response to the Garling Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals. The new agency works to improve public health care services in NSW by engaging clinicians and consumers to drive clinical innovation across the system.

Building on the work undertaken by the Greater Metropolitan Clinical Taskforce (GMCT), the ACI uses the expertise of its clinical networks to design, cost and recommend innovative, evidence-based improvements to NSW public health care services, for implementation on a statewide basis.

The ACI works closely with the NSW Department of Health and health services to support implementation of the ACI's recommendations to improve the effectiveness, safety and cost-effectiveness of health care services in NSW.

## Pain Management Network

At the time of the establishment of the ACI a Pain Management Network was also formally recognised. This was the result of meetings and negotiations during the previous year. The ACI Pain Management Network is the peak advisory body to NSW Health on pain related matters ([www.health.nsw.gov.au/gmct/painmgmt/index.asp](http://www.health.nsw.gov.au/gmct/painmgmt/index.asp)).

On establishment, support was provided by the ACI to develop the network including provision of a half-time manager and meeting facilities. Negotiations via the executive staff began with the Department of Health to recognise pain management as a health priority for the state.

Since its formation in 2010 the network has achieved many things:

1. Identification of priorities and the development of a working plan.
2. Establishment of an executive committee and statewide membership.
3. The establishment of working groups to action the work plan.
4. The first statewide meeting was held in November 2010.

5. Support from the Director General of Health with
  - Listing pain management as a priority area for the ACI.
  - Financial support to employ a project officer to coordinate the development of an integrated model of care for chronic pain management in NSW.
6. A submission has been made for funding from the Motor Accidents Authority to review the pain literature particularly with regards to models of care.

7. A survey of hospital pain services is currently underway. Recognition of pain as a health priority within the ACI and health department funding are the landmark achievements. At the end of the first year of formation we now face the welcome challenge of using these resources to advance the quality and sustainability of pain services throughout NSW.

It is important to note that the strength of the Pain Management Network lies in its members. All those actively involved in the delivery of pain services throughout NSW are invited to contribute to the network. To join the network and receive updates on new developments please email: [Cassandra.smith@aci.health.nsw.gov.au](mailto:Cassandra.smith@aci.health.nsw.gov.au)

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**Dr Paul Wrigley**

Royal North Shore Hospital, NSW

## Western Australia



### WA Airway Group Advanced Airway Management Workshop

The West Australian Airway Group (WAAG) is a non-profit organisation aimed at improving airway management and training across Western Australia. It held its inaugural Advanced Airway Management Course at the Quay West Resort Bunker Bay on April 9.

The workshop was convened by Dr Andrew Heard (WAAG Chair, Royal Perth Hospital) and was run by 21 facilitators from hospitals across WA.

This was the first time such a workshop had been held in WA and the aim was to provide delegates with the skills to manage difficult airway situations via small group training and with maximum hands-on experience. It was run along the lines of Dr Pierre Bradley's AAAMRC course in Melbourne with the aim of standardising airway course training across the country.

Dr Shannon Matzelle (WAAG secretary, Sir Charles Gairdner Hospital) and Dr Patrick Eakins (Royal Perth Hospital) coordinated the surgical airway station with a team of facilitators consisting of Dr Andrew Heard, Dr Iain Gilmore (Bunbury Regional Hospital) and Dr Catherine Fuller (Joondalup Health Campus). Dr Heard gave a short presentation on the "cannot intubate, cannot oxygenate" (CICO) algorithm, including the basis for the techniques to be taught and the required equipment.

Then, using cricothyroidotomy trainers and a jetting model, candidates were taught techniques from the algorithm, including cannula insertion, Cook Melkertm 5.0 insertion, the scalpel bougie technique, and safe jetting oxygenation practice for an emergency scenario.

Dr Gordon Chapman (Royal Perth Hospital) and his team of Dr Jonah Desforges (Fremantle Hospital), Dr Jim English (Fremantle Hospital), Dr De-Wet Van Riet (Rockingham Hospital) and Dr Bill Williams (Royal Perth Hospital) coordinated the fiberoptic workshop. The session started with lectures on the important aspects of fiberoptic intubation. These were followed by hands-on training by participants, who were grouped in pairs.

Each pair shared state-of-the-art Storz and Olympus fiberoptic scopes, which were used to complete a couple of modules of endoscopic training. Each pair of participants had access to a facilitator, which gave everyone an excellent opportunity for teaching and discussion. The end of the session was dedicated to intubation techniques through a laryngeal mask.

Associate Professor Richard Riley (WAAG vice-chair, Royal Perth Hospital) headed the simulation station. His team of dedicated instructors, all with simulation experience, comprised Dr Holger Holldack (Sir Charles Gairdner Hospital), Dr Kevin Elks (Fremantle Hospital/Royal Perth Hospital), Dr Tania Rogerson (Sir Charles Gairdner Hospital), Dr Wim Smithies (Royal Perth Hospital) and Dr Angela Palumbo (Sir Charles Gairdner Hospital).

Two Laerdal SimMen and one 3G SimMan were transported to the venue with several containers of equipment to complement the scenarios.

Each participant experienced an airway emergency in each room as the principal anaesthetist. They also were called in to assist in one of the scenarios as the need arose. The participants appreciated the opportunity to experience the real-time pressure of airway emergencies.

Dr Alex Swann (Fremantle Hospital) and Dr Roger Browning (King Edward Memorial Hospital) facilitated the indirect/videolaryngoscopy workstation. In addition, we were fortunate to have two invited experts to assist – Dr Chris Acott from Royal Adelaide Hospital, an expert in the CMAC and Bonfils devices, and Dr Pierre Bradley, an airway specialist from The Alfred in Melbourne.

Dr Bradley presented recent papers on indirect laryngoscopes and highlighted the differences between devices available on the market.

Participants then rotated through stations featuring the CMAC & Bonfils laryngoscopes, the Airtraq & Pentax AWS, the Glidescope and the AP Advance laryngoscope. Another station was set up as a scenario of a car accident, with a mannequin in a sitting position in bright sunlight. Participants were invited to attempt to intubate the mannequin with any of the available devices.

The day ended with a gala dinner at the beautiful Lamonts winery where delegates and facilitators enjoyed a night of fine food and wine – a welcome wind-down after a long and intense day.

From verbal and written feedback the Advanced Airway Management Course was very well-received by the participants who were enthused by the hands-on small group teaching and reported that they had got a lot out of the workshop. All participants indicated they would recommend this course to their colleagues!

Thanks and acknowledgements to Dr Pierre Bradley and Dr Chris Accott, who travelled a long way to lend their expertise, Dr Gavin Teague (WAAG secretary) who had the difficult task of managing our finances, Dr Denise Yim who coordinated the smooth running of the workshop, our sponsors, Dr Andrew Heard, Dr Shannon Matzelle and all the facilitators who made this day a success.

*Above left: Dr Iain Gilmore and Dr Shannon Matzelle teaching the scalpel bougie technique WAAG article.*



## Western Australian Autumn Scientific Meeting 2011

The Western Australian Autumn Scientific Meeting was held on Saturday March 19 at the University Club of the University of Western Australia and represented the first of a two-part series of meetings with the theme "Disasters in Anaesthesia".

Convened by Dr Angela Palumbo, the meeting focused on the causes and prevention of anaesthesia disasters and will be followed in July by the Winter Scientific Meeting, which will consider what to do when a disaster occurs.

Our plenary speaker was Professor Jan Davies, from Canada, who gave a very interesting lecture on "A Human Factors Approach" to disasters in anaesthesia. This was followed by an enlightening presentation from senior registrar Dr Emily Walker, entitled "Lessons from an Airway Disaster". Dr Andrew Miller then spoke informatively on "Current Medicolegal Hazards."

The morning free paper session consisted of five very interesting and well-presented papers by anaesthesia trainees. The Nerida Dilworth Prize, for the best presentation of scientific material by a trainee, was awarded to Dr Jakob Chakera, and was presented by Dr Dilworth. Due to the high number of quality papers submitted, a second free paper session was held in the afternoon and this was also well received.

Small group sessions and PBLD sessions covered topics such as "dental disasters", "case files of a habitual blocker", "ALS in action" and "disasters in evolution". Presenters included Dr Steve Watts, Professor Ray Williamson, Dr Wim Smithies, Dr Joe Ng, Dr Jonah Desforges, Dr Dick Ongley and Dr Angeline Lee. Dr Andrew Gardner presented an interesting case-based retrospective review of "Anaesthesia Mortality 100 Years On."

The DRC (Bunny) Wilson Memorial Lecture was delivered by Dr Lynley Hewett, who gave a very entertaining talk entitled "Sometimes a Mysterious Honour".

The meeting was very well subscribed, attended by 111 consultant anaesthetists, 23 trainees, 21 GP anaesthetists and 65 technicians. Many stayed to finish the day with a sundowner overlooking the picturesque Swan River.

The WA Continuing Medical Education Committee thanks all presenters, sponsors and attendees for making the Autumn Scientific Meeting 2011 a success.

*Above clockwise from top left: Speakers Dr Lynley Hewett and Dr Andrew at the Western Australian Autumn Scientific Meeting in March; Western Australia's regional committee chair Dr Jenny Stedmon, centre, with Dr Michele Moore and Dr Anton Van Niekerk; Dr Nerida Dilworth with Dr Jakob Chakera, who won the prize awarded in her name for the best presentation of scientific material by a trainee; Delegates Dr Tai Ma, Dr Sidney Lau and Dr David Law were among 111 consultant anaesthetists, 23 trainees, 21 GP anaesthetists and 65 technicians who attended the autumn meeting.*

## Official opening of the WA ANZCA office

The Deputy Leader of the Opposition Mrs Julie Bishop has officially opened the Western Australian ANZCA office, which moved to new premises Unit 20/127 Herdsman Parade, Wembley, in October.

Guests at the official opening on April 19 included active and retired Fellows, trainees and members of the Australian Society of Anaesthetists.

Among those in attendance were the deputy chair of the WA ANZCA Regional Committee, Dr Alison Corbett, who represented the President of ANZCA, Professor Kate Leslie, past ANZCA presidents Dr Wally Thompson and Dr Neville Davis, chair of the WA Australian Society of Anaesthetists Committee Dr Andrew Miller and chair of the ANZCA Western Australia Trainee Committee Dr Yvette Gainey.

The cocktail function offered an opportunity to promote the role of the College in providing training, education, standards and research in anaesthesia and pain medicine.

The office is part of a new "green" building, built to an environmentally friendly brief. It has office space for staff, a large boardroom that doubles as a room for exams plus a small kitchen and bathrooms. It is located close to the city, freeway and central hospitals and has plenty of parking.

The Western Australia regional office services all WA ANZCA and Faculty of Pain Medicine business and also houses the WA branch of the Australian Society of Anaesthetists.

*Above from left: Dr Neville Davis, Dr Wally Thompson, Dr Peter Platt, Deputy Leader of the Opposition Mrs Julie Bishop and Dr Tim Pavy.*

## Western Australia continued



### Inaugural Combined ANZCA/Australian Society of Anaesthetists WA Dr Wally Thompson Undergraduate Medical Prize in Anaesthesia

Dr Lachlan Nave, above, was awarded the inaugural ANZCA/ASA WA Dr Wally Thompson prize for 2010. The prize is awarded to the most outstanding final year medical student in the discipline of anaesthesia from the University of Notre Dame in WA. The prize has been named in honour of Dr Wally Thompson who is a prominent and well respected anaesthetist in Western Australia, a past ANZCA President and a recipient of the Member of the Order of Australia for 2011. Dr Thompson was on hand to present the prize at the University of Notre Dame's School of Medicine prize giving ceremony.

## Queensland



### 14th Annual Queensland Registrars Meeting

The Combined ANZCA/ASA Continuing Medical Education Committee of Queensland held the 14th Annual Queensland Registrars meeting on April 16 in the ANZCA premises at West End, Brisbane. This is an opportunity for the trainees in Queensland to showcase their endeavours in working towards the requirements of module 11 Education and Scientific Enquiry. It is also an interesting day for delegates, providing relevant continuing medical education for trainees and fellows.

Presentations were diverse this year ranging from hemidiaphragmatic paresis in interscalene block to discussion on the anaphylaxis and other implications of blue dyes in anaesthesia. Congratulations to Dr Nathan Goodrick who was awarded the Tess Cramond Prize for his project "Audit of pre-drawn emergency Anaesthetic Drugs". This project has provided evidence being used in current statewide discussions of standardised dilutions and presentation of pre-drawn drugs such as metaraminol. The other prizes awarded were the Axxon Health Award to Dr Jacqueline Evans and the ASA Chairman's Choice Award to Dr Jason Howard.

#### Dr James Hosking

*Above from top: Presenters with Professor Tess Cramond at the 14th Annual Registrars Scientific Meeting, from left, Dr Philip Stagg, Dr Vanessa Rich, Professor Tess Cramond, Dr Jacqueline Evans, Dr Monn Lee and Dr Jason Howard; Dr Mark Young presenting the ASA Chairman's Choice Award to Dr Jason Howard; Dr Nathan Goodrick, who was awarded the Tess Cramond Prize for his project "Audit of pre-drawn emergency Anaesthetic Drugs".*



## South Australia and Northern Territory



### Bariatric issues meeting

On April 13 2011, the SA & NT CME Education Committee held "The Big Issue – Bariatric Issues from a Surgical Perspective" presented by guest speakers Associate Professor Chris Rayner and Mr Jacob Chisholm. There were approximately 40 attendees at the meeting. The ANZCA Regional Committee AGM was held prior to the CME Meeting.

*Above clockwise from left: Dr Anu Raju and Dr Alison Brereton; Dr Rod Mitchell and Andy Bernssen; Guest Presenters Jacob Chisholm and Associate Professor Chris Rayner with Dr Bill Wilson (CME Chair); The SA and NT region had 100 per cent pass rate at the recent sitting of the Final Exam; Dr Roger Capps and Dr Thien LeCong (Regional Committee Chair SA & NT).*



## Victoria



## Primary Fulltime Pre-Fellowship Course

Rhonda Teoh has vacated her position as the Victorian Regional Committee course coordinator. For the past two and a half years she has organised the VRC courses with cheerful efficiency and she will be greatly missed.

We are very lucky however to welcome Minh Lam as Rhonda's replacement. Minh grew up in California and has been living in Australia for three years. She has embraced her new role with confidence and organised the Primary Fulltime Pre-Fellowship Course (May 30 to June 10) with great success and a record attendance of 52 candidates (up from 36 last year). This course is run biannually to assist trainees preparing for the primary written exams.

I am grateful to Minh as well as the lecturers and mock viva examiners, new and established, who have worked hard to maintain the excellent reputation of the course.

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**Dr Adam Skinner**

Convenor

Primary Fulltime Pre-Fellowship Course

*Above clockwise from left: Dr David Olive, second from left, with a group of trainees; Dr John Graham at the whiteboard; Trainees take a break from the pre-fellowship course; Associate Professor David Story, second from left, with trainees who participated in the Primary Fulltime Pre-Fellowship Course.*

# Special Interest Group event

## Australian Capital Territory



## Cardiovascular workshop

On August 20 the ACT Regional Committee will be holding a one day workshop 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 hand-on simulation sessions. The content is aimed at both Fellows and trainees, with limited places available. Further information, including how to register, will be available on the ACT website shortly at [www.act.anzca.edu.au/events](http://www.act.anzca.edu.au/events).

## Tasmania

## 2012 ANZCA/ASA joint CME meeting

The Tasmanian Regional Committee is gearing up for the ANZCA/ASA joint CME meeting, to be held from February 17-19, 2012 at the Tramsheds in Launceston. The convenor is Dr Stuart Day from Launceston.



## 2nd Airway SIG meeting a big success

The 2nd Airway SIG meeting was held at the Hyatt, Coolum from March 18-20. The theme was "Everything Airways" and the guest speakers were Professor Friedrich Pühringer (Germany) and Professor Carin Hagberg (USA).

With 280 delegates it was the largest special interest group meeting ever held. Sixteen companies from the healthcare industry supported the meeting, which is extremely helpful in maintaining the high standard of the workshops.

The presentations, over one and half days, were entertaining and informative covering topics including extubation planning, an update of videolaryngoscopes and supraglottic airway devices and airway control in a space capsule and diving bell. Dr Andy Heard's data on the use of a needle cricothyrotomy or tracheotomy in the CICO (can't intubate can't oxygenate) scenario is extremely important and contradicts the NAP4 recommendations.

The workshops proved extremely popular and delegates planning to attend next year are advised to book early.

I would like to thank my co-convenors, Dr Keith Greenland and Dr Reny Segal, for their help in organising the meeting. I would also like to thank the presenters and the workshop demonstrators who made it such a success. Special thanks go to Kirsty O'Connor and Hannah Burnell from the College.

The 2012 meeting will be held from March 9 to 11 at the Mantra, Erskine Beach Resort, Lorne, Victoria.

**Dr Chris Acott**  
Convenor

*Above from top: Dr Wendy Teoh, Dr Richard Lea, Professor Carin Hagberg, Professor Friedrich Pühringer and Dr Chris Acott at the Airways SIG Conference at Coolum; Dr Frank Parker and visiting Professor Friedrich Pühringer from Germany at the Airways SIG Conference; Delegates practice hands-on techniques at the Airway SIG Conference.*

# ANZCA Council meeting report

## April 2010

Report following the council meeting of the Australian and New Zealand College of Anaesthetists held on April 16, 2011

Council welcomed Dr Vanessa Beavis, NZ National Committee Chair, Dr Yvette Gainey, ANZCA Trainee Committee co-Chair, and Dr Andrew Schneider, Australian Society of Anaesthetists (ASA) Executive Councillor attending on behalf of the president.

### Death of Fellows and trainees

Council noted with regret the death of the following Fellows:

- Dr Noel Johan Colin-Thome (VIC), FANZCA 1999
- Dr Ruth Molphy, MBE (QLD), FANZCA 1992, FFARACS 1952

### College Elections

Dr Kerry Brandis, Professor Kate Leslie, Professor Alan Merry and Associate Professor David Scott have been re-elected to council, with Dr Richard Waldron as the unsuccessful candidate. The results will be ratified at the Annual General Meeting in Hong Kong.

Dr David Jones has been re-elected as the Dean of the Faculty of Pain Medicine.

### College Honours

Associate Professor Tony Quail has been appointed Professor and Conjoint Chair of Anaesthesia and Intensive Care at the University of Newcastle.

### Admissions to Fellowship

Since 2007, the work of the assessor has been officially delegated to the Director of Professional Affairs (DPA) Assessor and, since 2010, the DPA Deputy Assessor. Although by custom, the president has checked and signed off all files along with the DPAs, the ANZCA regulations do not stipulate a role for the president in the admissions process apart from as a member of council. Council resolved that this role for the president is no longer required and that the role of the assessor will be abolished in the constitutional revision.

### Education and Training

**E-Learning Working Group:** With the disbandment of the distance education and clinical teaching development working groups, Council supported the formation of an E-Learning Working Group (ELWG) for the period May 2011 to April 2013. Details will be made available on the College website.

### Supervisor of Training Working Group

**Group:** Council approved that a working group be established to develop a process for the selection, induction, training, support and tenure of supervisors of training, reporting to the Education and Training Committee (ETC).

### Fellowship Affairs

The Fellowship Affairs Committee (FAC) resolved that the locations for the 2015, 2016 and 2017 annual scientific meetings are to be:

- 2015 – Adelaide
- 2016 – Auckland
- 2017 – Brisbane

### Internal Affairs

Dr Mike Richards announced his resignation as Chief Executive Officer, with July 15, 2011 to be his last day at the College.

**Knowledge Resources Review:** A management review of the Knowledge Resources Group (archives, library and museum) was initiated in November 2010 and undertaken by Mr Allan Meers. Council indicated its support for the general direction of the recommendations and a copy of the report will be made available on the ANZCA website.

### Indigenous Health Committee:

Council supported the transformation of this working group into a committee. Terms of reference and membership details will be made available on the ANZCA website.

**ANZCA regulations:** Regulations 2.3, 2.4, 2.5, 3, 4, 6, 9, 11, 12, 16, 24, 25 and 34 have been amended to incorporate voting rules and definition of a quorum.

### Professional Documents

#### **PS3 – Guidelines for the Management of Major Regional Analgesia:**

This document has been approved by Council and will be circulated to regional/national committees and relevant special interest groups for comment.

#### **PS39 – Minimum Standards for Intrahospital Transport of Critically Ill Patients:**

The document development group will consist of a representative from ANZCA, the College of Intensive Care Medicine of Australia and New Zealand (CICM) and the Australasian College for Emergency Medicine (ACEM), along with Dr Peter Roessler in his capacity as DPA Professional Documents. Associate Professor Paul Forrest has been invited to be the ANZCA representative.

**TE23 – Guidelines for the Selection of Trainees:**

Council approved the development of a new professional document for the selection of trainees, with the document development group comprising: Dr Patrick Farrell (Chair), Dr Phil Byth, Dr Richard Horton, Dr Colin King, Dr Angela Palumbo, Dr Peter Roessler and Dr Jeneen Thatcher.

**TE Professional Documents:** A training and educational document development group to revise the training and educational professional documents as a result of the introduction of the redesigned ANZCA curriculum will comprise: Dr Lindy Roberts (Chair), Dr Genevieve Goulding, Dr Mark Reeves, Dr Suzanne Bertrand, a trainee committee representative (TBA), a head of department (TBA), the DPA Assessor and the DPA Professional Documents. An interim report will be provided at the October 2011 Council meeting, with the final report to the February 2012 Council meeting.

**TE17 – Policy on Advisors of Candidates for Anaesthesia Training:**

Professional document TE17 was withdrawn as, since the accreditation of departments rather than posts, the role of advisor of candidates for anaesthesia training is obsolete.

**CPD Committee and mandatory**

**compliance:** Council supported the amendment of regulation 2.9 to increase the Continuing Professional Development (CPD) Committee membership to include the chair of FAC and up to four additional members. Council approved a CPD mandatory compliance policy as follows: any registered medical practitioner anywhere in the world may now participate in the ANZCA CPD program and, if they fulfil the requirements of

the program, they will be issued with an ANZCA CPD certificate. If a Fellow of the College chooses not to undertake the ANZCA program, they will not be issued with a certificate and it will become their responsibility to demonstrate to the Medical Board of Australia (MBA) or the Medical Council of New Zealand (MCNZ) that they have participated in CPD that meets the required standard.

Date of next meeting:  
Saturday June 18, 2011

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**Professor Kate Leslie**  
President

**Dr Lindy Roberts**  
Vice-President

# Successful candidates



## Primary Fellowship Examination

February/April 2011

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

Adam Eslick	ACT
Babu R. Shankar	ACT
Benjamin Jay Brabin	ACT
Candida Francesca Marane	ACT
Arathi Ajith Rajan	NSW
Claire Burrows	NSW
Dammage Hasith V. Wickramaratne	NSW
David Dao	NSW
David Ziggy Fyfe	NSW
Donald McLachlan	NSW
Douglas Dong	NSW
Emma Culberston	NSW
Erin Chamberlen-Sofair	NSW
Felicity Kate Stone	NSW
Florian Paturi	NSW
Hui Joo Heng	NSW
James Yeates	NSW
James Zi Keng Xian	NSW
Jennifer Lee	NSW
Jie Chuan Wu	NSW

Katherine King	NSW
Kim Rackemann	NSW
Lloyd Kwanten	NSW
Matthew Ho	NSW
Nanki Singh	NSW
Natalie Janette Purcell	NSW
Neha Aggarwala	NSW
Nicholas Maytom	NSW
Paul Andrew Drakeford	NSW
Peter Smith	NSW
Phillip Lee	NSW
Phoebe Epstein	NSW
Pragya Ajitsaria	NSW
Robert Bishop	NSW
Robert McMonnies	NSW
Sarah Bowman	NSW
Tao Yuen Alan Yam	NSW
Timothy Weston	NSW
Vinay Kumar Rao	NSW
Gwendolyn-Mary Stewart	NT
Adam Suliman	QLD
Bernadette Louise Lupton	QLD
Bridget Hogan	QLD
Catherine Traill	QLD
Chrishley Goonewardane	QLD
Daniele Lazzari	QLD
David Fung	QLD
Dwane Jackson	QLD
Gemma Slykerman	QLD

Grant James Turner	QLD
Jennifer Taylor	QLD
Kate McCrossin	QLD
Liam Michael Ring	QLD
Madeleine Hanly	QLD
Peter Casey	QLD
Peter Larsen	QLD
Pieter Weemaes	QLD
Shannon Laycock	QLD
Tawona Dhlakama	QLD
James N M Trumble	SA
Kate Douglas	SA
Nicole Robyn Dyson	SA
Shu Ying Lai	SA
Stuart A Keynes	SA
Swati Sethi	SA
Tsai-Sheng Lee	SA
Alan C.K. Ch'ng	TAS
Michael Lumsden-Steel	TAS
Tin Win	TAS
Ailin Mohajeri	VIC
Dale F Murphy	VIC
Emma Boden	VIC
James Malycha	VIC
Jennifer Liddell	VIC
Jonathan Evans	VIC
Katrina Pirie	VIC
Laurie Dwyer	VIC
Mark Joseph Heynes	VIC
Megan Patricia Farrell	VIC
Michelle Yvonne Fehlberg	VIC
Rachel Ann Corris	VIC
Sang Yee Lee	VIC
Vaughan Edward Bertram	VIC
Andrew Lamb	WA
Heong-Chong Kwah	WA
James Miller	WA
Joel Thomas Adams	WA
Katherine Smither	WA
Kristie Juliana Mornadell	WA
Neil Francis Collins	WA
Rory Walsh	WA
Si Ning Zhao	WA
Tamsyn Williams	WA
Alexis Ghisel	NZ

Ayantha Ranasinghe	NZ
Chang Joon Kim	NZ
Clare Louise Smith	NZ
German Yakushkin	NZ
Jean-Paul Marc Banae	NZ
Nola Veda Ng	NZ
Richard More	NZ
Richard Walsh	NZ
Roana Donohue	NZ
Robert Lindsay Gray	NZ
Ross Scott-Weekely	NZ
Albert Chan	HKG
Alvin Man Ho Yu	HKG
Chak Lam Lee	HKG
Chun Kwong Eric Chung	HKG
Febbie Pui Wah Chung	HKG
Henry Jeffrey Yuen	HKG
On Ki Chan	HKG
Wong Fung Ping	HKG
Brian Mun Wei Hue	MAL
Jiaming Liu	SING
Deborah Khoo	SING
Ong Say Yang	SING
Tan Keng Tiong Jerry	SING
Wong Wan Yi	SING

#### Renton Prize

The Court of Examiners recommended that the Renton Prize for the half year ended 30 June 2011, be awarded to:

Katrina Pirie	VIC
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#### Merit certificates

Merit certificates were awarded to:

##### **Pharmacology**

Timothy Weston	NSW
Vinay Kumar Rao	NSW
Jolyon Bond	QLD
Jonathan Evans	VIC
Kristie Juliana Mornadell	WA

##### **Physiology**

Marcin Teisseyre	NSW
Trylon Tsang	NSW
Stephen Francis Watty	VIC
Megan Patricia Farrell	VIC
Chang Joon Kim	NZ
Wai Hui Cheng	HKG

## Final Fellowship Examination

### March/May 2011

One hundred and forty three candidates successfully completed the Final Fellowship Examination and are listed below:

Steven Chi-Ming Siu	ACT
Amanda Elizabeth Diaz	NSW
Anand Ajith Rajan	NSW
Anand Jog Pudipeddi	NSW
Andrew James Cluer	NSW
Anna Antonas	NSW
Anna Frances Pedersen	NSW
Caroline Shadbolt	NSW
Catherine Marie Ashes	NSW
Clement Wei Ming Tiong	NSW
Colleen Therese Bruce	NSW
Emily Stimson	NSW
Fiona Mary Reardon	NSW
Gisele Marie Louise Mouret	NSW
Jennifer Claire Dixon	NSW
Jeremy David Field	NSW
Joshua Simon Rath	NSW
Katrina Alexandra Kanesalingam	NSW
Laurent Anthony Wallace	NSW
Lisa Deanne Hendy	NSW
Lucas John Fox	NSW
Malini Magesan	NSW
Marc Angeles Logarta	NSW
Marianne May Yean Chan	NSW
Mario Salvador Henriquez	NSW
Martine Patricia O'Neill	NSW
Mary Pui Fung	NSW
Melissa Johnston	NSW
Melissa Judd	NSW
Michael John Wirth	NSW
Nancy Malek	NSW
Pavithra Pasupathy	NSW
Rodney Alexander Martin	NSW
Rosa Meng-Chen Hou	NSW
Sachithanathan Kuganathan	NSW
Saul Evan Judelman	NSW
Timothy Oscar Holliday	NSW
Vincent Ching So	NSW

William Chuk Kit Ng	NSW
Anton Willis Gerard Booth	QLD
Benjamin Andrew Crooke	QLD
Benjamin Cerutti	QLD
Benjamin Martin Darveniza	QLD
Brett Elliott Fabian Segal	QLD
Christopher Andrew Turnbull	QLD
Dennis Ling-Hsiang Huang	QLD
Eva Barton	QLD
Gaurangkumar Ranjitsinh Barot	QLD
Gavin Lionel Jones	QLD
Gerard Stuart Ariotti	QLD
Jamin Michael Mulvey	QLD
Jason Deric Howard	QLD
Jigna Hapani	QLD
Jonathan Peter Samaan	QLD
Julia Slykerman	QLD
Kah Lynn Elene Chan	QLD
Michelle Terese Daly	QLD
Nicole-Maree Margaret Sheridan	QLD
Willem Basson	QLD
Andrew Gethyn Thomas	SA
Anthony Paul Guterres	SA
Bikash Agarwal	SA
David Bednarczuk	SA
Islam Mohamed Elhalawani	SA
Lee Min-Qi	SA
Rebecca Anne Lewicki	SA
Rowan Mary Ousley	SA
Ruta Nerlekar	SA
Scott Chern Yaw Ma	SA
Timothy James Hannam Crichton	SA
Henning Els	TAS
Michael John Challis	TAS
Shakeel Meeran Kunju	TAS
Shona Mary Bright	TAS
Adam Feldman	VIC
Allanah Catherine Scott	VIC
Andrew John Magness	VIC
Andrew John Marriott	VIC
Anne Wai Li Chew	VIC
Chee Teik Lee	VIC
Chong Seng Ong	VIC
Christopher James Stokes	VIC
Emma Jane Morris	VIC

# Successful candidates continued

Fiona Maree Lathleiff	VIC
George Kantianis	VIC
Heidi Marie Liesegang	VIC
Indunil Anjali Kumarasinghe	VIC
Jai Nair LePoer Darvall	VIC
Kimberley Anne Browne	VIC
Kristine Anne Moser	VIC
Kym Nicole Saunders	VIC
Lisa Ku	VIC
Lisa Xenia Nasis	VIC
Lloyd Antony Roberts	VIC
Martin Duffy	VIC
Meena Mittal	VIC
Michael Andrew Tsiripillis	VIC
Michael Kluger	VIC
Michael Lee Bassett	VIC
Michelle Harris	VIC
Peter John Clarke	VIC
Peter Joseph Bainbridge	VIC
Rachel Elizabeth Cowell	VIC
Rani Chahal	VIC
Saejin Kim	VIC
Samuel Patrick Frost	VIC
Stanley Tay	VIC
Su May Koh	VIC
Sutharshan Suresh Sundaram	VIC
Suzanne Cook	VIC
Tze Ping Tan	VIC
Zoe Moina Keon-Cohen	VIC
Andrew Stewart Hunt	WA
Angela Helen Tan	WA
Chong Woon Shin	WA
Dana Stanko	WA
Daniel William Ellyard	WA
Fiona Germaine McManus	WA
Usha Nanthini Kolandaivel	WA
Amir Javed Haq	NZ
Andrew Fletcher John Good	NZ
Andrew James Warnock	NZ
Andrew John Paul Martin	NZ
Bevan James Vickery	NZ
Catherine Lisa Purdy	NZ
Charlotte Jane Hill	NZ
Christopher David Walker	NZ
Daniel Edward Boyd	NZ



Daniel Richard Mattingley	NZ
David Harvey	NZ
David Koskuba	NZ
Gillian Claire Mann	NZ
James Jonathan Tuckett	NZ
Kathryn Mary Hagen	NZ
Keng Hsin Lo	NZ
Luke Robert John Mercer	NZ
Nicholas James Lightfoot	NZ
Robin David Young	NZ
Rosemary Kaye Duckett	NZ
Sheila Greer Barnett	NZ
Steven James Mitchell	NZ
Sukhpreet Singh Sihota	NZ
Tiffany Sheryn Glass	NZ

## Cecil Gray Prize

The Court of Examiners recommended that the Cecil Gray winner for the half year ended June 30 2011, be awarded to:

Jai Nair LePoer Darvall	VIC
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## Merit certificates

Merit certificates were awarded to:

Benjamin Andrew Crooke	QLD
Lloyd Antony Roberts	VIC
Daniel William Ellyard	WA
Catherine Marie Ashes	WA
Catherine Lisa Purdy	NZ
Kathryn Mary Hagen	NZ



# Dean's message



What a fantastic Faculty Refresher Course Day and combined scientific meeting (CSM) we had in Hong Kong! The number of FPM registrants (158) for the Refresher Course Day was well up on previous years, and more than 200 delegates attended the final concurrent session focusing on acute perioperative pain. In the Refresher Course Day we heard 12 speakers in four themed sessions on “Neurobiology”, “Challenges in Opioid Therapy”, “Outcomes in Pain Management” and “Eastern Influences”. I would like to repeat here our thanks to the international invited speakers, Professor Catherine Bushnell from Montreal, Professor You Wan from Beijing and Professor Spencer Liu from New York. In addition we owe a debt of thanks to Dr PP Chen, our Scientific Program Convenor, along with all who worked to make the meeting as a whole a great success.

I hope that as you read this *Bulletin*, you will have by now read the message from the president about the benefits from fellowship. If you have not, it would be good to go back and do so before continuing here! I fully endorse that message, and know you will be able to identify with many of the benefits you may not have previously realised were there for you. In addition to the more tangible ones, I sensed while meeting many of you at the CSM what a great opportunity it was to share ideas and information about what we do in our day to day practices that we could otherwise take for granted. Belonging to a strong professional body like ours adds

opportunities for exchange of ideas, and opens up new contacts willing to help with such things as patient information resources they have developed and are willing to share. I have never come away from an annual scientific meeting (ASM) without learning a new beneficial “trick” to improve my practice, and which would not have come my way without listening or talking with one of our attendees at the meeting – that is an un-measurable benefit of “fellowship”.

I am pleased to record that The Dean's Prize, awarded for original work judged to be the most significant contribution to pain medicine and/or pain research, presented by a trainee or a Fellow within eight years of fellowship, was this year awarded to Dr Rohan Russell for his paper, “A comparison of postoperative opioid requirements and effectiveness in methadone-maintained and buprenorphine-maintained patients”. In addition, the Best Free Paper Award for original work judged to be the best contribution at the Faculty of Pain Medicine Free Paper session went to Dr Allyson Browne from Western Australia for her paper, “Screening for Acute Factors That Predict Pain Post Trauma: A Pilot Study”. Dr Browne, a clinical psychologist, is a repeat attendee at our ASM. We wish these two award winners well in their careers, and hope to hear more from them in the future.

The Bupa Health Foundation recently awarded \$200,000 to a partnership between the Faculty of Pain Medicine and Royal Australian College of General Practitioners in support of a cutting edge online GP education program in the area of pain management. This supports a strategic objective of the Board to upskill the primary care sector especially in better assessment and early intervention before pain becomes more problematic. I would like to acknowledge the continuing work of the Vice-Dean, Dr Brendan Moore, towards this venture. Both organisations will themselves contribute in addition to the award such as in intellectual content and existing infrastructure for delivery of the program. A launch is envisaged for the second half of 2012.

This initiative is important because we know that the prevalence of pain which has become persistent is actually huge, its burdens high, but also a large proportion of it is preventable or reducible – by earlier recognition of those which are not resolving well, and better decisions and management at earlier times. There will never be enough specialists in this area, and it is our vision to help those who are there right at the source/beginnings of these problems to tackle them in ways which could reduce chronicity and severity in the future. I don't mind if I am done out of a job, so to speak, if there were no more people with persistent pain to fill our clinics! That would be success. But so too would be to halve the problem – as per the commonly stated goal of pain management.

I expect the next time we will have an opportunity to exchange with our Fellows will be at the Faculty's 2011 Spring Meeting at the Park Hyatt Hotel, Canberra, on October 28-30. The meeting theme is “An exploration of the Pain/Musculoskeletal Polemics – Policies, Procedures and Pragmatics”. Professor Lars Arendt-Nielsen, of the Centre for Sensori-Motor Interaction at Aalborg in Denmark, who will be well known to many of you for his human experimental pain research, will be our international invited speaker, supported by many other excellent contributors. I look forward to continuing that sense of “fellowship” when we meet there soon. Look after yourselves and those around you meanwhile.

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**Dr David Jones**  
Dean  
Faculty of Pain Medicine



## Fellowship training and examination dates for 2011

### Examination date:

November 25-27, 2011

The Royal Brisbane and Women's Hospital, Queensland

Closing date for registrations:

October 7, 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

Closing date for registration:

September 9, 2011

## Admission to fellowship

Dr Renata Bazina, NSW

Dr Trudia Disney, Tas

Dr Venugopal Kochiyil, SA

Dr Rebecca Martin, NSW

Dr Christopher Orlikowski, Tas

Dr Sachin Shetty, NSW

Dr Roger Cheng Wah Tan, WA



## Refresher Course Day

The Faculty's Refresher Course Day, held in conjunction with the combined scientific meeting (CSM) in Hong Kong, was a tremendous success with 158 delegates registered for the day and good support from the health care industry. The program combined a unique blend of eastern and western influences for the many issues related to pain. The day was completed with a dinner at Jumbo Kingdom floating restaurant which gave attendees a taste of local cuisine and entertainment, which was enjoyed by all.

## FPM trainee lunch

The Faculty invited all pain medicine trainees registered for the CSM to attend a buffet lunch during the CSM with the aim of providing an opportunity for FPM trainees to get together and meet key people from the Faculty. The Dean (Dr David Jones), Vice-Dean (Dr Brendan Moore), Assessor (Dr Frank New), Chair of Examinations (Dr Meredith Craigie), the Director of Professional Affairs (Associate Professor Milton Cohen) and the Administration Officer (Ms Penny McNair) also attended to respond to questions about the training program. Faculty trainee, Dr Luke Murtagh spoke about his Faculty examination experience which provided valuable insight to current trainees.

## Dean's Prize and Best Free Paper awards



The Dean's Prize is awarded at the Faculty of Pain Medicine's annual general meeting to the Fellow or trainee judged to have presented the most original pain medicine/pain research paper. This year's winner was Dr Rohan Russell, an ANZCA trainee from South Australia, for his paper titled, "A comparison of postoperative opioid requirements and effectiveness in methadone-maintained and buprenorphine-maintained patients". Dr Russell was awarded a certificate and a grant of \$1000 for educational or research purposes.



The Best Free Paper Award is awarded for original work judged to be the best contribution to the Free Papers session of the Faculty of Pain Medicine. The Faculty Free Paper session is open to all annual scientific meeting registrants. This year's winner was Dr Allyson Browne from Western Australia for her paper titled, "Screening for Acute Factors That Predict Pain Post Trauma: A Pilot Study". Congratulations to both Drs Russell and Browne.

## Honorary Fellow

**Associate Professor Pongparadee Chaudakshetrin, Thailand**

### Honorary Fellowship

*“The Board of the Faculty of Pain Medicine admits from time to time distinguished persons who have made a notable contribution to the advancement of the science and practice of pain medicine, who are not practicing pain medicine in Australia or New Zealand.”*

### Pongparadee Chaudakshetrin

BSc (Mahidol) 1972; MD (Madihol) 1976; FRCAT 1980.

Associate Professor Pongparadee Chaudakshetrin was born and grew up in Bangkok, Thailand. She completed her science degree in 1972 and felt the calling of the medical profession. She trained in her beloved Siriraj Hospital where she graduated from the Faculty of Medicine, Mahidol University, in 1976. After her internship in Siriraj Hospital, she underwent specialist training in anaesthesiology and was awarded the Fellowship of the Royal College of Anaesthesiologist of Thailand in 1980. In those early days, improving pain management in her patients started a stirring in her heart. Realising the much deficient state of pain management at that time, she sought out further training to equip herself. She trained firstly in Guy's Hospital, London, in 1985 and then, in 1989, she furthered her training at the Multidisciplinary Pain Centre at the University of Washington in Seattle, US. In 1991, she was appointed Associate Professor and the Director of the Pain Management Centre in the Department of Anaesthesiology, Faculty of Pain Medicine, Siriraj Hospital and Mahidol University, a position she holds to this day.

Associate Professor Chaudakshetrin has worked tirelessly and championed the cause of pain control over the past 30 years. She built and organised the clinical pain services in Siriraj Hospital to the modern level it is today.



She made oral morphine syrup available for cancer pain in 1987 which was the first in Thailand. An anaesthesiology-based acute pain service and a comprehensive multidisciplinary team in the pain clinic were set up in the early 1990s. This was pioneering work, and she led her country where many were to subsequently follow. Her centre in Siriraj continues to be the premium centre for training local pain specialists in Thailand.

Associate Professor Chaudakshetrin's work also took her to the national and international stage. She was the founding member of the Thai Chapter of the International Association for the Study of Pain (IASP) and is still serving as its president for the past eight years. She also served on various national boards and taskforces responsible for the development of guidelines for pain of terminal cancer, palliative care, neuropathic pain and opioid availability. At an international level, Associate Professor Chaudakshetrin was active in the IASP, serving on a number of taskforces on cancer pain, pain in AIDS, pain in the elderly, pain in developing countries as well as the World Health Organisation Cancer Pain Relief Program. Her passion for improving pain in the Asian region was also recognised by the IASP. She was awarded grants for the “Initiative for Improving Education in Developing

Countries”. With the grants, she has trained numerous local physicians from neighbouring countries such as Bhutan, Mongolia, Indonesia, Malaysia, Myanmar, Laos and Vietnam which in turn has a big multiplier effect for effective pain management in the region. She also helped establish local pain chapters in Mongolia, Myanmar and Laos.

Despite all her commitments in her work at Siriraj Hospital, she still manages to deliver more than 30 invited lectures on the subject at major national and international meetings and published some 29 papers on various pain topics in local and international peer-reviewed publications.

Associate Professor Chaudakshetrin is truly a legend in pain medicine. Much of the good work in acute pain, cancer pain, palliative care and management of persistent pain in Thailand and neighbouring countries can be traced to her pioneering work and her positive influence. In no small way, she has reduced pain and suffering in countless millions. On a personal level, she is very charming, friendly and approachable. She is always smiling, always willing to help and ever ready to impart and share her knowledge derived from her long experience. Her contemporaries in Thailand address her as “ajarn” meaning teacher.

## Exam preparation course

On the weekend of May 21-22, Barwon Health Pain Management Unit in Geelong hosted their third exam preparation course for FPM trainees. The aim of this weekend is to highlight the approach required when preparing for examination and the fellowship year. The participants are directed in the techniques that might be employed in tackling each section of the examination.

Turnout was again very pleasing, with 13 trainees from around Australia making the trip to the far south coast.

Some supplemental sessions included information about the Gait, Arms, Leg, Spine (GALS) musculoskeletal screening tool, news about the new case report format and brainstorming about possible written question topics for the



approaching FPM exam. Presenters were Drs Michael Vagg, Diarmuid McCoy and Melissa Viney (senior supervisor of training).

The participants were provided with morning and afternoon tea and a light lunch. Feedback from the participants is welcome and will help in developing

this course. The exam preparation course will likely be held earlier in the year in 2012 so prospective exam candidates are advised to keep an eye out for an announcement early in the year for a date in March.

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**Dr Michael Vagg and  
Dr Diarmuid McCoy**

# FPM board meeting report

## May 2011

### Faculty Board

The Faculty Board met on May 12 in Hong Kong and the new board met on May 15 for the purpose of appointing office-bearers and committee chairs. Committee membership will be confirmed by chairs within the coming weeks.

The Faculty's 2011 Scientific Convenor, Dr PP Chen, and Hong Kong College of Anaesthesiologists Board of Pain Medicine Chair, Dr Steven Wong, met with the board and gave an overview of the HK Pain Medicine Board's Diploma program and plans to develop a fellowship program in pain medicine. Dr Chen was congratulated on developing an excellent pain program for the Faculty's Refresher Course Day and combined scientific meeting.

### Relationships Portfolio

#### ANZCA

The board noted Dr Mike Richards' resignation as ANZCA Chief Executive Officer and expressed appreciation of his revamp and modernisation of ANZCA, along with support to the FPM, ANZCA during his tenure.

The role of the FPM treasurer was discussed and there will be liaison with ANZCA on how this role could be made more effective with a view to being meaningfully involved in budgetary decision making.

Dr Jane Trinca has agreed to represent the Faculty on the ANZCA Quality and Safety Committee.

### Bupa Health Foundation submission for GP education

The joint FPM/Royal Australian College of General Practitioners' submission to the Bupa Health Foundation for funding to develop an on-line modular educational program for primary health care professionals has been successful. Bupa awarded \$200,000 to a partnership between the Faculty and the Royal Australian College of General Practitioners, which will be used to develop a cutting edge online GP education program in the area of pain management.

Representatives of the Faculty, RACGP and Bupa Foundation met in Sydney on May 20 to discuss how the organisations will work together to ensure successful delivery of this project.

Bupa announced the winners of their 2011 health awards at the Sydney Opera House on June 1. Eleven successful applicants were awarded from nearly 400 applications. Dr Brendan Moore, FPM Vice Dean, represented the Faculty. A joint media release was prepared with the support of the ANZCA communications unit.

### Liaisons with pain societies

The New Zealand Pain Society has now formally endorsed Faculty professional document *PM1 (2010): Principles regarding the use of opioid analgesics in patients with chronic non-cancer pain*.

### Corporate affairs

#### Board election

Dr Frank New was elected unopposed as Royal Australian and New Zealand College of Psychiatrists (RANZCP) representative to the board. A postal ballot was conducted for the three remaining places. Dr Brendan Moore, FANZCA (Qld), Dr Chris Hayes, FANZCA (NSW) and Professor Ted Shipton, FANZCA (NZ) were successful.

### Regional Committees

#### Western Australia

There being no Western Australian representation on the board following the election, the board resolved that a nomination of the Faculty's Western Australian Regional Committee be accepted. The board resolved that Professor Stephan Schug be co-opted to the board as the WA representative.

Dr John Akers has been elected Chair of the WA Regional Committee, taking over from Dr Max Majedi. Other officer bearers are: Dr Donald Johnson (WA Secretary) and Dr Max Majedi (WA Treasurer).

Dr Majedi was thanked for his contributions to the Faculty Board and for progressing activity of the FPM WA Regional Committee during his time as Chair.

### Queensland

The board was updated on the progress of the Queensland Statewide Persistent Pain Steering Committee and advised that full time directors positions have been advertised for the new pain clinics in Nambour, Townsville and the Gold Coast, and other multidisciplinary staff are now being recruited for these and the existing clinic at Princess Alexandra Hospital. The board expressed congratulations to the Faculty's Queensland Regional Committee on spearheading efforts over the past three years for a persistent pain strategy in Queensland and were hopeful that Fellows would take a leadership role and step up to these full time public hospital positions.

### New South Wales

The NSW Government has adopted a pain policy. The NSW Agency for Clinical Innovation is proceeding with plans to consolidate resources in the state's nine tertiary multi-disciplinary pain clinics and the development of a best practice model of care to better manage patients at primary care level.

### South Australia

The board supported the committee's plans for establishment of an educational program for local Fellows. Dr Andrew Zacest was congratulated on convening an excellent pain section of the Royal Australasian College of Surgeons (RACS) Annual Scientific Congress on May 5-6.

### National Pain Strategy

PainAustralia is still in the phase of establishment. An office has now been set up, and the interim board composition has recently been finalised with Diana Aspinall (nominee of the Consumer Health Forum) and Elizabeth Carrigan (nominee for the Australian Pain Management Association) appointed as community directors.

The focus of the strategic plan is the recognition of people in pain as a national health priority, with its three high priority objectives:

- Establish a national body involving all stakeholder groups to identify partnerships, frameworks and resources required to build capacity and deliver proposed outcomes.
- Destigmatise the predicament of people with pain, especially chronic non-cancer pain.
- Achieve federal and state government recognition of chronic pain as a chronic disease in its own right.

The board envisaged that PainAustralia and the Faculty would have complementary roles, noting that the primary role of PainAustralia is one of advocacy.

A protocol has been established for responding to issues at a government level to ensure appropriate sign off by the member organisations.

The ANZCA/FPM representative on the PainAustralia Board will keep the Faculty Board informed of development.

**Medicare Telehealth Advisory Group**  
“Connecting health services with the future: Modernising Medicare by providing rebates for on-line consultations.”

FPM/ANZCA made a submission in support of telehealth consultations for pain patients, especially chronic pain, although the potential to contribute to the management of post-operative pain in remote hospitals was also identified.

The Faculty Director of Professional Affairs attended a third meeting of this group in early May. A document is under development outlining technical aspects of the implementation. The principles are safety, effectiveness, security, privacy and evidence-based practice. Challenges are tools, support, cost, evidence and change in practice. The Department of Health and Ageing is looking to the colleges to help develop guidelines for e-consultations. The aim is to complement, not replace, face-to-face meetings. There is a political imperative to implement this program on July 1, 2011.

## Research

### National Pain Outcome Initiative

To advance the Faculty’s strategic initiative for the development of a National Pain Outcome Initiative, a sub-committee met with Professor Kathy Eagar at the Centre for Health Service Development, University of Wollongong, and reported back to the board. Based on their track record with the Australian Rehabilitation Outcome Centre (AROC) and Palliative Care Outcomes Centre (PCOC), their strategic relationships and their enthusiasm for the project, the board resolved to work with the University of Wollongong to move forward with this initiative.

It is hoped that the development of a National Pain Outcome Initiative can facilitate comparable improvements (to AROC and PCOC) in the quality and effectiveness of services for people with persistent pain in Australia.

A stakeholder meeting/workshop is proposed during the spring meeting in Canberra to finalise outcome measures.

### Communications

The Faculty Refresher Course Day generated significant media interest with seven speakers interviewed by interested journalists, resulting in more than 10 articles in print and online, and generating more than \$50,000 worth of media coverage.

The announcement of the Bupa Health Foundation’s \$200,000 grant to the Faculty of Pain Medicine and the Royal Australian College of General Practitioners was also well-received, with the Vice Dean, Dr Brendan Moore, doing several interviews resulting in radio coverage in NSW (2UE, 2SM and WAVE FM), Canberra (2CC), Adelaide (5AA) and Perth (RTR FM), which have a combined listenership of more than 100,000 people.

Synapse is to regularly seek input from Fellows on potential keynote speakers for Faculty events.

### Fellowship Affairs Portfolio

#### Fellowship

Since the February board meeting, the following have been admitted to fellowship by Training and Examination:

Dr Renata Bazina, FRACS (NSW)

Dr Trudia Disney, FRACGP, FANZCA (Tas)

Dr Roger Chen Wah Tan, FANZCA (WA)

Dr Christopher Orlikowski, FRAC (Tas)

Dr Rebecca Martin, FANZCA (NSW)

Dr Sachin Shetty, FAFRM (RACP), (NSW)

Dr Venugopal Kochiyil, FAFRM (RACP), (SA)

Dr Milana Votrubic, FRACGP (NSW) was elected to fellowship of the Faculty.

This takes the total number of admissions to 306.

### Continuing Education and Quality Assurance

#### Scientific Meetings

*2011 Combined Scientific Meeting – Hong Kong*

The Faculty’s Refresher Course Day and CSM programs were well received. One hundred and fifty-eight registrants attended the refresher course to hear 12 speakers give presentations on sessions titled “Neurobiology”, “Challenges in Opioid Therapy”, “Outcomes in Pain Management” and “Eastern Influences”.

The Faculty’s CSM program was well attended, with more than 200 delegates attending the final concurrent session focusing on acute perioperative pain. The Dean’s Prize, awarded for original work judged to be the most significant contribution to pain medicine and/or pain research presented by a trainee, or a Fellow within eight years of fellowship, was awarded and presented at the Faculty’s annual general meeting to Dr Rohan Russell, an ANZCA trainee from SA, for his paper, “A comparison of postoperative opioid requirements and effectiveness in methadone-maintained and buprenorphine-maintained patients”.

The international speakers attracted significant media interest with a number of interview requests from print and radio coordinated very effectively by ANZCA’s Media Manager, Meaghan Shaw.

# FPM board meeting report

## continued

The Best Free Paper Award for original work judged to be the best contribution to the free paper session of the Faculty of Pain Medicine was awarded and presented at the annual general meeting to Dr Allyson Browne, a clinical psychologist from Western Australia, for her paper, "Screening for Acute Factors That Predict Pain Post Trauma: A Pilot Study".

### 2011 Spring Meeting

Registration brochures for the Faculty's spring meeting at the Park Hyatt Hotel, Canberra, on October 28-30 will be circulated with the June *Bulletin*. The meeting theme is, "An exploration of the Pain/Musculoskeletal Polemics – Policies, Procedures and Pragmatics".

### 2012 Annual Scientific Meeting – Perth

The Faculty's Scientific Convenor, Dr Max Majedi, and the local organising committee are well advanced with development of the Faculty's Refresher Course Day and ASM programs, led by Dr Dan Bennett (FPM ASM Visitor) and Dr Henrik Kehlet (FPM Perth Visitor).

### 2012 Spring Meeting

The board resolved to convene the 2012 spring meeting in Coolool, Queensland, in October. It is hoped to launch the joint RACGP/FPM online educational program at that meeting and opportunities will be explored to make this a joint meeting with rural general practitioners or general practitioners with a special interest in pain management.

### 2013 Annual Scientific Meeting – Melbourne

Professor Edzard Ernst (UK) was confirmed as the FPM ASM Visitor and Professor Fabrizio Benedetti (Turin) as the FPM Melbourne Visitor for 2013.

### Continuing Professional Development

The board resolved that each FPM Fellow should comply with the CPD requirements of the primary specialty college and/or the ANZCA CPD program and that this be reviewed in three years' time.

A framework for CPD has been developed by ANZCA which is adaptable to other specialty needs. The Faculty Director of Professional Affairs, Associate Professor Milton Cohen, is working to define the standards required of a specialist pain medicine physician.

Dr Penny Briscoe was appointed as FPM Continuing Professional Development Officer and will represent the Faculty on the ANZCA CPD Committee.

### Professional

#### New Zealand Application for Specialty Recognition

A scope of practice for pain medicine in New Zealand has been provided to the Medical Council of New Zealand (MCNZ), along with the advice that the qualification should be recognised for vocational registration by Fellows of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (FFPMANZCA). That has yet to be gazetted by the MCNZ, and feedback sought from the wider community, as per usual. The remainder of the Stage II responses are nearing completion, including indicating how FPM ensures cultural competence in training and for Fellows, for submission by June 30.

#### Australasian Guidelines for Neuromodulation in Chronic Pain

Draft Faculty professional document *PM9 (2011): Neuromodulation (Spinal Cord Stimulation) in the Management of Patients with Chronic Pain* was viewed by the board. It is pending further scrutiny by the Neuromodulation Group before being finally accepted as a professional document.

#### National Pharmaceutical Drug Misuse Strategy

The Faculty has representation on the Expert Reference Group and it was acknowledged that the group is well informed. Submissions were invited by May 27. The Faculty has made a submission.

#### Pharmaceutical Benefits Advisory Committee (PBAC) Opioid Stakeholders Meeting

The Faculty Director of Professional Affairs attended the stakeholder meeting on April 5 and a strong submission highlighting Faculty professional document *PM1 (2010:) Principles Regarding the Use of Opioid Analgesics in Patients with Chronic Non-Cancer Pain*, has been made.

#### National Medicines Policy Partnerships Forum

The Faculty will be represented at this forum on July 29 in Canberra.

### Trainee Affairs Portfolio

#### Training requirements for intensive care trainees and Fellows

The board resolved that Fellows of the College of Intensive Care Medicine of Australia and New Zealand who wish to train for FFPMANZCA be required to undertake 12 months of structured training in a Faculty of Pain Medicine accredited unit.

#### Recognition of FPM training by the primary specialty

The board confirmed that the Faculty accepts cross-crediting recognition of training of Faculty trainees concurrently training in their primary specialty and is happy with other requirements of those colleges with respect to on-call requirements. The Faculty welcomes dual training recognition for higher trainees and at every circumstance has tried to facilitate it. Trainees are referred to Faculty Regulation 4.2.3: "When pain medicine training is concurrent with training in one of the primary specialties, advice should be obtained from both the parent College/Faculty and the Faculty of Pain Medicine".

#### Education Podcasting

Three podcasts were recorded in Hong Kong and will be made available on the Faculty website:

Professor You Wan  
Treating acute pain: the wrath of peripheral frings

Professor Spencer Liu  
Does postoperative analgesia improve postoperative outcomes?

Dr Meredith Craigie  
FPM examination and case report

After editing, the podcasts will be published on the Faculty website at [www.anzca.edu.au/fpm/resources/e-learning-resources-for-fpm-trainees-fellows.html](http://www.anzca.edu.au/fpm/resources/e-learning-resources-for-fpm-trainees-fellows.html).

#### FPM/ANZCA Mentoring Program

The Faculty of Pain Medicine strongly encourages mentorship and a proposal for a Faculty mentoring program was accepted by the board. Strategies will now be developed to implement the program and to encourage relationships between more experienced people and junior colleagues.

### Examination

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.

### Professional Documents

The board resolved to update Faculty professional document *PM4: Guidelines for Patient Assessment and Implantation of Intrathecal Catheters, Ports and Pumps for Intrathecal Therapy*.

### Training Unit Accreditation

The Training Unit Accreditation Committee was given approval to progress 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.

Tier 2 hospitals would be units able to offer good training opportunities, but not sufficient to meet all components of PM2. They would be suitable for a maximum of six months of training. They would be required to have a relationship with a Tier 1 hospital such that both supervisors of training would be overseeing the trainee.

Following successful reviews, Alfred Health Pain Services (Vic) and Liverpool Hospital (NSW) were accredited for pain medicine training. The Royal Prince Alfred Hospital (NSW) was re-accredited for training.

Dr Richard Burstall was appointed Supervisor of Training at the Hunter Integrated Pain Service.

### Resources Portfolio

#### Finance

The Faculty continues to track closely to budget for 2011. Timing issues account for the most significant variations in expenses and income.

### Board and committee appointments

#### Board Members:

Dean, David Jones

Vice Dean, Brendan Moore

Assessor, Frank New

Continuing Professional Development Officer/Assistant Assessor/ Annual Scientific Meeting Officer, Penny Briscoe

Chair Education Committee, Ted Shipton  
Chair Examination Committee, Meredith Craigie

Chair Training Unit Accreditation Committee, Carolyn Arnold

Chair Research Committee, Chris Hayes

Chair Continuing Education & Quality Assurance Committee, Guy Bashford

Treasurer/Scientific Meeting Officer, Leigh Atkinson

Co-opted WA Representative

Stephan Schug

Co-opted Member representing ANZCA, Lindy Roberts

#### Other Officers:

Senior Editor Pain Medicine/ FPM

Director of Professional Affairs, Milton Cohen

#### Executive Committee/Portfolio Chairs:

Chair Relationships Portfolio, David Jones

Chair Trainee Affairs Portfolio, Ted Shipton

Chair Fellowship Affairs Portfolio, Brendan Moore

Chair Resources Portfolio, Leigh Atkinson

General Manager FPM, Helen Morris

#### Committee Chairs:

Education Committee, Ted Shipton

Examinations Committee, Meredith Craigie

Training Unit Accreditation Committee, Carolyn Arnold

Research Committee, Chris Hayes

Continuing Education and Quality Assurance Committee, Guy Bashford, Peter Rofe

#### Sub-Committee and Working Party Chairs:

Supervisors of Training Sub-Committee, Melissa Viney

Paediatric Pain Medicine Working Party, Meredith Craigie

Palliative Medicine Working Party, David Gronow

#### Representation on ANZCA Committees:

Examinations Committee, Meredith Craigie

Primary Examination Sub-Committee Meredith Craigie

Education and Training Committee, Ted Shipton

Research Committee, Chris Hayes  
Fellowship Affairs Committee, Penny Briscoe

IMGS Committee, Frank New

Overseas Aid Committee, Roger Goucke  
Quality and Safety Committee, Jane Trinca

Training Accreditation Committee, Carolyn Arnold

ANZCA Trials Group, Stephan Schug

#### Regional Committees:

Queensland, Richard Pendleton

New South Wales, Lewis Holford

Victoria, David Scott

Tasmania, Gajinder Oberoi

South Australia, Pamela Macintyre

Western Australia, John Akers

New Zealand National Committee, Kieran Davis

Australian Capital Territory, Geoff Speldewinde

ANZCA/FPM Constitution Review Working party, Penny Briscoe, David Jones, Chris Hayes

#### External Committees

#### & Organisations:

Australasian Anaesthesia, Penny Briscoe

Correction: On page 89 of the FPM board report in the March *Bulletin*, the first paragraph contained the line "this did not mean that specialists would not be required to complete two programs". It should have read "this did not mean that specialists would be required to complete two programs".



# Library update

## New titles February 2011

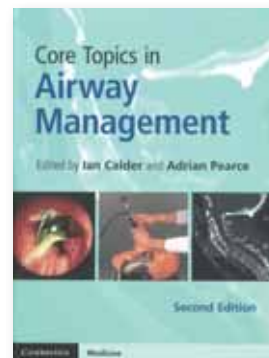
Books can be requested via the ANZCA Library catalogue: [www.anzca.edu.au/resources/library/book-catalogue.html](http://www.anzca.edu.au/resources/library/book-catalogue.html)

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.



**Anesthetic pharmacology:** Basic principles and clinical practice / Evers, Alex S. [ed]; Maze, Mervyn [ed]; Kharasch, Evan D. [ed]. -- 2nd ed -- Cambridge: Cambridge University Press, 2011.



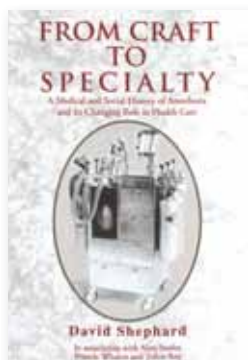
**Core topics in airway management** / Calder, Ian [ed]; Pearce, Adrian [ed]. -- 2nd ed -- Cambridge: Cambridge University Press, 2011.



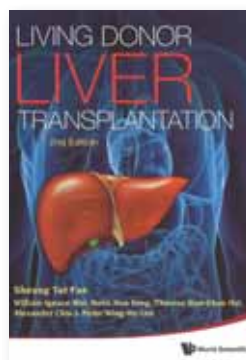
**Clinical ethics in anesthesiology:** a case-based textbook / Van Norman, Gail A. [ed]. -- Cambridge: Cambridge University Press, 2011.



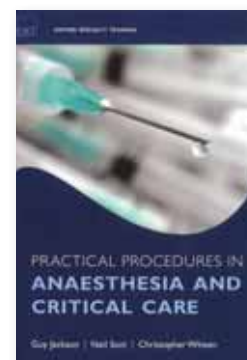
**Drugs in anaesthesia and intensive care** / Smith, Susan; Scarth, Edward; Sasada, Martin. -- 4th ed -- Oxford: Oxford University Press, 2011.



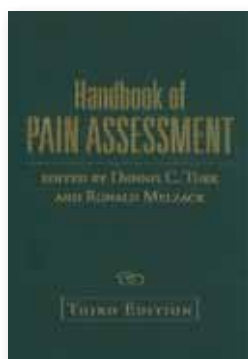
**From craft to specialty:** a medical and social history of anesthesia and its changing role in health care / Shephard, David. -- Thunder Bay, Ontario: York Point Publishing, 2009.



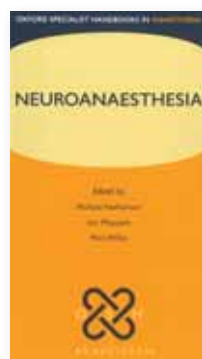
**Living donor liver transplantation** / Fan, Sheung Tat [ed]. -- 2nd ed -- Singapore: World Scientific, 2011. *Kindly donated by co-author Dr Boon-Hun Yong*



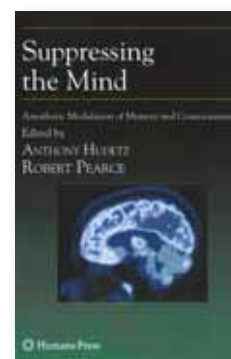
**Practical procedures in anaesthesia and critical care** / Jackson, Guy; Soni, Neil; Whiten, Christopher. -- 1st ed -- Oxford: Oxford University Press, 2010.



**Handbook of pain assessment** / Turk, Dennis C [ed]; Melzack, Ronald [ed]. -- 3rd ed -- New York: The Guilford Press, 2011.



**Neuroanaesthesia** / Nathanson, Michael [ed]; Moppett, Iain [ed]; Wiles, Matt [ed]. -- 1st ed -- Oxford: Oxford University Press, 2011.



**Suppressing the mind:** anesthetic modulation of memory and consciousness / Hudetz, Anthony [ed]; Pearce, Robert [ed]. -- New York, NY: Humana Press, 2010.

## The ANZCA Library by numbers

Did you know that in 2010, the ANZCA Library:

- held more than 2500 books in the collection
- issued 645 book and audio visual (AV) loans to Fellows and trainees around Australia
- provided access to almost 200 journals online
- assisted with more than 200 literature searches for patient care and research
- Fellows and trainees accessed the e-book collection with over 24,000 hits
- Fellows and trainees downloaded over 224,000 articles from the journal collection
- Fellows and trainees visited the library website more than 178,000 times
- Fellows and trainees performed more than 128,000 searches using the library databases

The ANZCA Library plans to promote the services even further by using technology to ensure that all Fellows and trainees, whether in New Zealand or remote Australia, have equal access to resources and information support. All financial Fellows and trainees of the College have free access to the ANZCA Library resources.

Visit the ANZCA Library online today: [www.anzca.edu.au/resources/library](http://www.anzca.edu.au/resources/library) (College ID log-in required)

## 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, February 2011*

- Best and safest pain relief: ratings for 9 patient-controlled analgesic pumps
- Real-Time Locating Systems End-user Software

*Health Devices, April 2011*

- Health Devices is 40!

*Health Devices, May 2011*

- Surgical video displays and booms

*Operating Room Risk Management*

- Fighting Airway Fires
- Informed Consent
- Warning: Patient Safety Under Construction

## Evidence-Based Practice Corner

Log-in to the ANZCA Library website to access these journals articles and guidelines.

*Lamotrigine for acute and chronic pain.*

Wiffen PJ, Derry S, Moore RA. Cochrane Database of Systematic Reviews 2011, Issue 2. Art. No.: CD006044.

*Celiac plexus block for pancreatic cancer pain in adults.*

Arcidiacono PG, Calori G, Carrara S, McNicol ED, Testoni PA. Cochrane Database of Systematic Reviews 2011, Issue 3. Art. No.: CD007519.

*Intra-articular lignocaine versus intravenous analgesia with or without sedation for manual reduction of acute anterior shoulder dislocation in adults.*

Wakai A, O'Sullivan R, McCabe A. Cochrane Database of Systematic Reviews 2011, Issue 4. Art. No.: CD004919

*Propofol for procedural sedation/ anaesthesia in neonates.*

Shah PS, Shah VS. Cochrane Database of Systematic Reviews 2011, Issue 3. Art. No.: CD007248.

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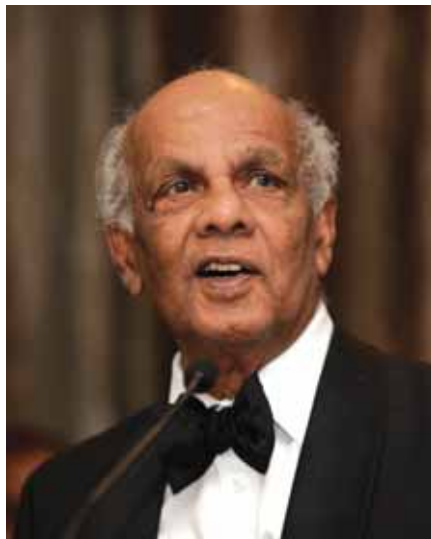
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# Dr Rajagopal Rajaratnam

## 1933 – 2011



Dr Rajagopal Rajaratnam hailed from Jaffna, a major cultural and educational centre in Sri Lanka, then known as Ceylon. He was the eldest male child in a family of nine children, which bestowed on him the responsibility of main provider after his father. It was a responsibility he never forgot until his last days. His father was a humble railway stationmaster and his mother a homemaker, but they strived hard to educate their nine children. They succeeded in educating all children, five of whom attended medical school. He was educated at St John's College which was a premier educational institution for boys, and alma mater to many a successful Sri Lankan professional from that era. He was a good student and a keen scout. His peers remember him as a consummate mimic and prankster who also had a good sense of humor – a quality that many appreciated as it helped to focus on the lighter side of life.

He went on to study medicine at the University of Ceylon, Colombo. He graduated in 1958 and spent his early postgraduate years practising general medicine in places considered to be exotic locations such as Nuwara Eliya, Kandy, Trincomalee and Jaffna. He married Baleswary Somasunderam in these early years as a sole practitioner, and soon became proud father to their first daughter.

The scope of Dr Rajaratnam's practice was mainly in community and rural medicine, but he was able to secure some hospital sessions in Jaffna where he had his initial taste of anaesthesia. He set up a general practice and

a small nursing home (in those days, the nursing home was equivalent to that of a small hospital), which had some basic theatre facilities. He ran this for several years with the help of two of his brothers. His interest in anaesthesia grew and he eventually left this successful practice to pursue higher qualifications in anaesthesia. As life goes, the opportunity to travel to the UK arose and Dr Rajaratnam grabbed it with both hands. He worked tirelessly to gain recognition in a foreign land – working at King's Lynn General Hospital, Walsgrave Hospital in Coventry and Doncaster Royal Infirmary. During this time, he and Baleswary were blessed with two more daughters. He then obtained his Diploma in Anaesthetics from the Royal College of Surgeons of England in 1980 and his Fellow of the Faculty of Anaesthetists of the Royal College of Surgeons (FFARCS) in 1981, and enjoyed a successful career as a specialist anaesthetist.

In 1983, he moved to Hong Kong and worked initially at Queen Elizabeth II Hospital. He subsequently worked at the Prince of Wales Hospital and The Chinese University of Hong Kong, dividing his time between clinical work and teaching as an honorary clinical lecturer. He worked alongside Professor J. Andrew Thornton, who was at the time professor and chair of anaesthesia at the university. In a letter dated January 6, 1996, Professor Thornton reminisced about their time in Hong Kong and acknowledged Dr Rajaratnam for his contribution to anaesthesia: "Thanks to your help, intensive care is well entrenched within anaesthesia in Hong Kong".

He left Hong Kong in 1987 for Australia, venturing into a much slower pace of life as he worked as an anaesthetist at Port Augusta Hospital, South Australia. The slower pace of life was still rich with clinical experience but due to his eldest daughter and her family living in Melbourne, Dr Rajaratnam and his family made the move to Gippsland in Victoria. Dr Rajaratnam was Director of Anaesthetics at the Gippsland Base Hospital in Sale from 1990 until his retirement in 2006. He was the only resident specialist anaesthetist in Sale for several years and was responsible for training many GP anaesthetists who continue to provide anaesthetic services in much of rural Victoria. His special interest was intensive care and obstetric anaesthesia.

He was known as "Dr Raj" and was well known and respected in the community. Local residents often stopped him in the street for a friendly chat. In 2008, Dr Rajaratnam and Baleswary moved to Sydney.

Dr Rajaratnam is also well known within his own ethnic community, particularly for his capacity to extend a helping hand to those struggling to establish a foundation in life. Being trained overseas and then making a new start in a new country is not an easy feat, but Dr Rajaratnam was able to do so because of his ability to adapt. He helped many in a similar situation to become established and live successfully in this great land of opportunity.

In his work, he was best known as being laid-back and unassuming but in times of dire emergencies, would step up to the plate with the calm and even-headedness of a seasoned player. His downtime was spent passionately enjoying cricket, following world politics and spending quality time with his family and friends. He was a devoted husband, father and grandfather and never forgot his extended family, whom he supported in different ways as best as he could. Sadly, he succumbed to cancer on March 13, 2011. He passed away peacefully whilst surrounded by family and close friends. He was an ardent believer in buckling down and weathering any storm because as he always said in his mother tongue, Tamil: "What will be, will be".

Dr Rajaratnam is survived by his wife, Baleswary; his three daughters, Sumathy, Komathy and Suhanthy; his sons-in-law, Aynkaran Sivaratnam, Mayooran Theivendran and Rajkumar Rajalingam; and his grandchildren, Ashwin Sivaratnam, Nisha Sivaratnam and Alisha Rajalingam. He will be missed dearly by all who knew him and who were touched by his generosity and loyalty. He will be fondly remembered for his sense of humour, love for humanity and respect for all human beings.

**Dr Amutha Samuel MBBS, FANZCA**

*(Appreciation is extended to Mrs Komathy Theivendran, Dr Suhanthy Rajalingam and Dr Selvam Thavasothy for their help in this compilation)*

# Dr Ingrid Dzendolet-Carlton

## 1944 – 2010



Ingrid Ellen Dzendolet-Carlton was born in Sydney in 1944. She attended Terry Hills Primary School, where she became dux of the school despite being a year younger than her peers. She then moved to Willoughby Girls High School, where she excelled in art and was a keen basketballer. She was again awarded dux of the school and, not surprisingly, won a Commonwealth scholarship for tertiary education.

Ingrid enrolled in medicine at the University of Sydney, graduating in 1966. Her first appointment was at Royal Newcastle Hospital, where she completed her residency, then undertook her training in anaesthesia. She was awarded Fellowship of the Faculty of Anaesthetists in 1972.

Ingrid then travelled to Europe to engage in further post-fellowship training, working in hospitals in London and Rotterdam, gaining expertise in paediatric anaesthesia at the latter.

She returned to Australia and commenced work as a full time salaried staff specialist in anaesthesia at the Newcastle Mater Misericordiae Hospital in 1975, so commencing her life-long relationship with her beloved Mater hospital.

Ingrid was the sole staff anaesthetist at the Mater for over 10 years. In addition to her anaesthetic duties, she ran a small intensive care unit (ICU), taught both medical and nursing staff,

and often roamed the hospital as a one person medical emergency team. Ingrid often spent many late nights and weekends at the hospital when not on call. As the sole anaesthetist/intensivist, Ingrid simply made herself available.

About this time she met Robert, her future husband. He was a marine engineer, and often away at sea for long periods. This allowed Ingrid the time to continue her enormous commitment to the Mater hospital. They married in 1977 and started their family in 1979.

In 1981 the hospital had clearly recognised the value of Ingrid's work. It provided funding to allow her to establish a dedicated, purpose built six bed ICU, which soon became the Hunter region's paediatric and obstetric ICU. Ingrid at this stage gave up anaesthesia to concentrate on the dual roles of intensivist and mother.

Ingrid's practical, no-nonsense approach to medicine was best demonstrated on the day of the Newcastle earthquake in December 1989. The region's main teaching hospital and trauma centre, Royal Newcastle Hospital, was knocked out of action, something not considered in the disaster manuals. The Mater had to be the receiving centre for everything, despite smashed windows and cracked walls. With panic and chaos all around, Ingrid calmly went down to Accident and Emergency and took charge, quietly organising, triaging and planning for whatever might eventuate. Fortunately, the casualty toll that day was nowhere near as bad as it could have been, but Ingrid was ready for anything. Later in the day, when it was thought the chaos had subsided, engineers discovered that the section of the building the ICU was located in was damaged and vulnerable to collapse. Ingrid, despite the dangers, then supervised the orderly transfer of patients, staff and equipment back to a safe location.

In 1991 the John Hunter Hospital opened nearby, and many of the Mater's functions transferred to the new hospital. The Mater's main role now became that of regional oncology centre. However this created a new crisis, as many of the medical staff also left to

join the new teaching hospital and referral centre. Ingrid, however, simply dusted off her old anaesthetist's hat and resumed her dual roles from years before, becoming sole staff specialist, and director of both intensive care and anaesthesia.

Over the next 12 years other anaesthetists gradually returned, but Ingrid remained the sole intensivist, with all the pressures that entailed. She often found it very difficult to obtain cover to allow her to take leave, but she remained committed to the Mater hospital and public medicine. Even in her most exasperated moments, Ingrid could not contemplate private practice, always believing you "could not charge people for being sick".

It is a measure of Ingrid's skill as a clinician that she diagnosed her own illness in 2003, and a tragic irony that after supporting her hospital for so many years, she now became a patient there. Knowing full well what was ahead of her, she retired in 2003 to fight her own personal battle, facing surgery and chemotherapy with her usual steely resolve. At least she was able to step back and spend quality time with her loving family, and enjoy her other interests such as gardening, bushwalking and travel. She was also able to develop her long dormant love of art, and commence her second career as an artist, even staging several successful exhibitions of her works. She told a group of colleagues in 2007 that, despite having suffered many side-effects from her treatment, "if you ever find yourself in my position, go for it, take the treatment, every extra day you get makes it all worthwhile".

Ingrid lost her battle on February 23, 2010. She is survived by her husband Robert, and children Astrid, Conrad and Alexis, and deeply missed by a large circle of family, friends and colleagues.

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**Dr Jeffrey Taylor, FANZCA,**  
Newcastle, NSW

# Dr Geoffrey Lewis Perkins

## 1954 – 2010



Geoffrey Lewis Perkins was for many years an anaesthetist at Gold Coast Hospital.

Geoff was born in Nambour, Queensland on July 6, 1954. He was educated at schools in south-east Queensland and attended the University of Queensland where he completed the medical course in December 1977.

After graduating, he worked in Bundaberg, Brisbane, Bamaga and QE2 hospitals before marrying Wendy at the age of 24. In a busy 1982, he worked in Roma with the Royal Flying Doctor

Service, took time off to study for and pass the anaesthetic primary exam, started on the South Brisbane training scheme, worked for the first time at the Gold Coast Hospital and his first daughter Kate was born. In 1986 he completed his training in anaesthesia and another daughter Zoe was born.

His first years as a consultant were spent at Toowoomba Base Hospital and then Kirwan Hospital. He had a fulltime consultant position at Gold Coast Hospital from 1989 until his death. While here, he established and coordinated the acute pain service from 1989 until 2000, the first chronic pain service from 1989 to 1996, and was the director of the Day Surgery Unit from 1991 to 1997. He was the department's clinical indicators coordinator from 2004.

In 2000, Geoff took study leave and was an assistant professor at the McGill University in Montreal, Canada. He subsequently completed the North American National Board of Echocardiography Diploma in 2002.

In 2007 he completed a masters of bioethics from Monash University. His particular topic area was "medical maleficence in the treatment of 'enemy combatants' during the Bush administration's War on Terror".

Geoff had an eclectic set of interests outside of work. He read widely, and his interests included ethics, Buddhism, skiing, gardening, bushwalking, kayaking, camping, boating and taking his granddaughters rock climbing. In 2007, he developed a passion for motorbike riding.

Geoff sponsored a World Vision Child for many years, and donated each year to a hospital in India. Between 1994 and 1998 he visited the Philippines several times with "Operation Hope", providing anaesthesia for cleft palate surgery.

Geoff was a quiet and very private person. He had a few friends with whom he was close. In comments he wrote for his 2002 medical school reunion profile, Geoff wrote: "... my ambition is to survive until retirement. Now I'm just looking at cutting back on work and doing more enjoyable pastimes".

Sadly, Geoff committed suicide on December 31, 2010. He is survived by his partner, Jane, daughters, Kate, Zoe and Briony, and grandchildren Grace, Taneisha and Chasely.

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**Dr Kerry Brandis**

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If you are concerned about yourself or a colleague, contact the Doctors' Health Advisory Service Hotline nearest to you.

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Information about the Welfare of Anaesthetists

Special Interest Group can be found at: [www.anzca.edu.au](http://www.anzca.edu.au)

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# Dr Ruth Molphy

## 1924 – 2011



At the Garden Chapel at the Crematorium at Albany Creek, the inaugural president of the Australian and New Zealand College of Anaesthetists, Dr Peter Livingstone, and past president of the Australian Society of Anaesthetists Dr David McConnel joined anaesthetist colleagues and their spouses, surgeons, neighbours and representatives of community organisations to honour the life and service to medicine and the community over 64 years by Dr Ruth Molphy, MBE.

Ruth Molphy was born in Toowoomba on February 9, 1924, the only child of Agnes and James Molphy.

She had no siblings but her life was enriched by the friendship and support of the late Dr Dorothy Bowman for whom Ruth provided exemplary care during Dorothy's terminal illness.

She grew up on the family farm "Nunkulla" at Cambooya, a small township west of Toowoomba. Ruth attended primary school at Wyreema before spending six years as a boarder at St Hilda's School, Southport, from 1936 to 1941.

One can imagine the change in lifestyle for this young country girl. Even a trip to Southport was an adventure, negotiating the descent of the Toowoomba Range by the old Toll Bar. The alternative was rail motor to Toowoomba, then steam train to Brisbane and Southport.

Ruth excelled in maths and science but to undertake the science subjects she had to attend the Southport School. The St Hilda's girls went by horse and buggy to cope with the Southport School boys

as well as the mysteries of the science! So it is significant that the science wing at St Hilda's was named in her honour in 1991 – the Ruth Molphy Centre.

As well as being dux of the school, Ruth's quiet efficiency and a formal, friendly but never familiar approach led to her appointment as a school prefect and these attributes were demonstrated throughout her distinguished medical career.

She enrolled in science at the University of Queensland in 1942, residing at the Women's College. She did so well in science I that she was permitted to transfer to medicine II.

One of the other Women's College students of that year recalls Ruth's willingness to give of her time to coach the slower students so that they could cope with the mathematics component of science I.

She graduated in October 1947 at the completion of the shortened war-time course – one of two women among the 19 graduates.

I well remember the graduation ceremony on the Medical School lawn. The women students served afternoon tea and helped with the washing up! We had no "hang-ups" about a sexist role. We were thrilled to be part of the celebrations.

Ruth was appointed to the Brisbane Hospital – its official title until 1967 – and commenced training in anaesthetics in 1949 and 1950.

She met the challenge of attaining an internationally recognised higher qualification in anaesthetics by travelling to the United Kingdom where she completed the two-part Diploma in Anaesthetics in 1952, subsequently working in Durham and Sweden.

What an eye-opener it must have been for her to see the staff establishment in the National Health Service and the important influence of consultants. Ruth was the second Queensland graduate to obtain a higher qualification in anaesthetics. Dr Joan Dunn had attained this accolade in 1951 and Ruth was to succeed her as anaesthetics supervisor in 1953.

When the Faculty of Anaesthetists of the Royal College of Surgeons was established in 1954, Ruth was elected to its fellowship and subsequently to fellowship of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons. When the faculties became independent Colleges, Ruth was elected to their fellowships.

Accepting the importance of guiding the development of a new specialty,

she accepted the responsibility of an administrative role in the Australian Society of Anaesthetists of which she was state chair in 1964 – and of which she was a proud honorary life member.

Ruth served on the Queensland Regional Committee of the Faculty of the Anaesthetists for 15 years and served as its chair twice, in 1964-65 and again in 1967-68.

Ruth returned to Brisbane Hospital in 1953 as anaesthetics supervisor (the title was changed to director in 1960) and continued in this demanding role until 1963 when she accepted the challenge of directorship at the Chermide Chest Hospital (later the Prince Charles Hospital) 1963-1984.

With full-time staff establishment minimal, Ruth depended on the support of visiting staff – Roger Bennett, Drury Clarke, Ken Wilson, Averil Earnshaw, Miriam Stocks and the group I joined, Joan Dunn, Ray Robinson, Judy Foote and Hilary Fisher. We were known as the "Queensland girls". Mrs McLelland, who founded the group, said she didn't mind our being called "the girls", as long as she wasn't regarded as "the madam"!

Ruth had one deputy director – Margaret Paterson – and the Women's and the Children's were staffed from Royal Brisbane. Then, in 1956, South Brisbane Hospital opened further depleting her inadequate staff establishment.

It is difficult for young anaesthetists and surgeons to appreciate what Ruth had to overcome to establish a department and a new specialty.

This was the era of the introduction of new anaesthetic techniques, including intravenous induction agents and muscle relaxants, anaesthetic machines and rudimentary ventilators, all with an inadequate staff establishment, demanding surgeons, budgetary restrictions, overcrowded wards, shortage of equipment and poor physical facilities. This was the time of development of neurosurgery, controlled hypothermia, the surgery of abdominal aortic aneurysms, peripheral vascular surgery and carotid endarterectomy at Brisbane Hospital. The anaesthetic challenges were formidable.

There were 20 operating theatres in eight different areas of the hospital so organising supervision was a nightmare!

Seat belts and crash helmets were yet to be introduced so the emergency theatres often functioned all night – the night staff watched the sunrise over Victoria Park – no Block 8 to stop the view!

Against opposition from some less enlightened surgeons and some nurses, she established a recovery room on a shabby closed in veranda of the old 4G theatres.

She soon demonstrated the value of one-to-one nursing supervision and on-the-spot anaesthetist support.

In 1960 with characteristic vision and tenacity of purpose, she opened the respiratory unit, a forerunner of the modern intensive care unit. Here, patients with tetanus, poliomyelitis, chest injuries, drug overdose and myasthenia gravis were ventilated achieving world-class results.

There were no facilities for estimation of blood gases, no pulse oximeters – the outcome the result of Ruth's constant observation, meticulous attention to detail and her fantastic clinical acumen – and simple Radcliffe ventilators.

It was Ruth who developed the concept of a cardiac arrest team at Royal Brisbane Hospital but the anaesthetic department could not keep up with the demands because of theatre responsibilities so the emergency department undertook the role.

It was the good fortune of the Prince Charles Hospital that Ruth was appointed its first director of anaesthetics in 1963. Initially the commitment was to thoracic surgery but with the arrival of Dr Mark O'Brien in 1967, the cardiac unit developed rapidly. Ruth became the perfusionist with an ongoing commitment to anaesthetics.

Intensive care was undertaken in the postoperative ward with input from the cardiac surgeons as well as Ruth and her colleagues. It is significant that they had the awesome responsibility for paediatric patients without the luxury of a developed paediatric infrastructure and paediatric equipment.

She contributed in no small way to the very high regard in which the Prince Charles Hospital's cardiothoracic unit is held nationally and internationally.

During her directorship, Ruth was responsible for the training of 250 specialist anaesthetists. I was privileged to be one of her initial trainees in 1953.

Her professional colleagues at the three hospitals speak with admiration of the respect she earned from medical and nursing staff, patients and their carers.

Her balanced, non-confrontational arguments were revealed when it was stated that Queensland was training too many anaesthetists; she quickly rebutted that heresy.

She knew how to manage "cranky" surgeons. She told them to "get on with the surgery for which they were

trained" – and gave them a score on her "grizzle graph"!

Never a "women's libber", Ruth avoided involvement in industrial matters but was an active member of the committee that worked to achieve secure employment for married women employed in government and semi-government positions. The positions held by married women were classified as temporary with no rights to superannuation and their jobs were advertised each year. If a male or a single woman with the same qualifications were available, the incumbent lost her job.

Ruth's friends can look back on a life of service to medicine and the community, recognised appropriately by admission as a Member of the Order of the British Empire in 1987.

What of Ruth's other interests apart from the superb clinical care of individual patients? She took over the lectures to medical students previously given by a surgeon and a physician – at least the physician had trained in anaesthetics in Edinburgh! Her commitment to teaching students the principles of the care of the unconscious patient and the importance of pre-operative assessment rather than just anaesthetic techniques was revolutionary.

Her contributions to the formal preparation of registrars for the examinations for both the primary and the final fellowship were marked by their diversity but always integrated basic science with clinical care.

She always emphasised the maintenance of standards yet the importance of never putting at risk, justice to the trainee whom she assessed perceptively – illustrated when she recognised the innate ability of Wally Biggs as she organised the crash course to prepare him for his role as anaesthetist to the Flying Surgeon.

She encouraged general practitioner anaesthetists to accept placements in the department so they could update their anaesthetic skills.

Ruth had remarkable technical skills not only in the day-to-day maintenance of anaesthetic machines, ventilators and monitors. I remember being mesmerised when as a registrar she told me that she had installed a hot water system at home at the weekend. So it was no surprise when I heard that she had taught a young neighbour how to do a grease and oil change on his truck, confirmed when he attended her funeral service – not

the usual entry on the CV of a director of anaesthesia!

Ruth appreciated the need for an organisation to represent the views of the whole profession. She joined the British Medical Association as a student member in 1945, attained full membership in 1947 and was delighted to receive honorary life membership of British Medical Association/Australian Medical Association in 1997.

Equally she was proud to be a 50-year member of the Australian Society of Anaesthetists and of the Medical Women's Society.

Ruth's major interest outside of medicine was her cats.

With her colleague, the late Dr Dorothy Bowman, she established the Merlin line of Uki Russian blue cats – and these lordly creatures won numerous awards over many years and had pride of place in her home.

There were delightful messages on attractive wall plaques letting visitors know who was most important:

"This house is for the comfort of our CATS. Visitors must take second place.

"If you love cats, you will understand, if not, what are you doing here?"

"People who don't like cats were probably mice in an earlier life."

Ruth loved the Australian fauna and flora – as she sat on her front veranda doing a cryptic crossword or reading the paper, she found joy in hearing the songs of the native birds in the trees she had planted – not a rose, camellia or azalea in Ruth's garden – just the native trees she had nurtured.

Sadly, her last years were marred by a debilitating illness. She elected to remain in the home her parents had bought for her when she was six. This was made possible by the selfless support of her dedicated neighbour. Home visits by her general practitioner and geriatrician supported by personal carers and Karuna Home Nursing Service ensured her comfort and dignity.

So as we reflect on Ruth's life, her medical practice and service to the community over 64 years, we salute a gifted, dedicated clinician, a wonderful teacher, an innovator, a researcher and a loyal friend.

She exemplified her school's motto – "non nobis solum" – "not for ourselves alone" – and the philosophy of the school's patron, St Hilda of Whitby: "Leadership through excellence".

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**Professor Tess Cramond**



# Dr Johann Colin-Thomé

## 1961 – 2011



Our much loved friend and colleague, Johann Colin-Thomé, died peacefully in the palliative care unit at Austin Hospital, Melbourne, on February 28. In late 2007, he had become unwell and was subsequently diagnosed with an inoperable brain tumour. We will always remember the manner in which he dealt with this dreadful confrontation, his strength, his tenacity, his dignity and above all his courage.

One of us (David Tremewen) first met Johann more than 25 years ago when we were both medical students at the Austin Hospital. Our paths separated after graduation. Early in his medical career, he moved to the United Kingdom and then later to Adelaide to further a career in anaesthesia. In 1998, for the final year of his anaesthesia training, he returned to the Austin where he gained his fellowship and went on to be appointed as a full-time staff anaesthetist.

Those were simpler times when CVs didn't come with photographs much less Facebook pages. We remember that when his application for employment at the Austin was accepted there was considerable speculation about the man coming from overseas via South Australia with the exotic name of "Johann Colin-Thomé". When he arrived and introduced himself he must have been fully expecting the surprised looks because his eyebrows lifted over his characteristic impish smile as he said, "Perhaps you were expecting someone taller...or fairer... or with a Swedish accent."

A gentle sense of fun underpinned Johann's professional and personal life. Of course you need to have a sense of humour to support the Richmond Football Club and he could see no wrong in his beloved team. At least, like the rest of us, he could see no wrong in March each year. August was a different story, although even then he could always see some little brightness in the season to follow.

Johann had a strongly positive outlook on life in general. He could see good in everyone and in almost every situation. Positivity and good humour were the basis upon which he built so many lasting friendships within the department of anaesthesia, the wider hospital and the even-wider health-care community. Always "up" for a coffee and a chat downstairs or if time allowed, a quick lunch at Romano's pizza restaurant, he added an extra touch of humanity to the Austin.

He brought a little style to our world. At least he tried to and we definitely needed it. Carefully purchased clothes, leather trousers, tailored coats. Colours

that matched, no less. And of course the famous earring. Style too when choosing and discussing his high-end audio equipment, his music collection and indulging his and Kerry's love of speedy automobiles.

Friendships made in the workplace were carried through to his personal life and many of us have been the recipients of his family's hospitality in their homes, first in Ivanhoe and more recently in Eltham. There was no better way to spend a sunny Sunday afternoon than with Kerry's roast chicken lunch, a bottle or two of finest red wine selected by Johann from his excellent cellar and the warmest of conversation.

Johann was an excellent clinician. He had a fierce intelligence, was quick to assess and manage clinical problems and was highly technically skilled. He was a genuine "all-rounder" equally at home allaying the fears of a frightened elderly patient having a minor day-case operation as he was providing anaesthesia for the most complex of surgical procedures in the most desperate of situations. He was one of a small number of anaesthetists who participated in all the anaesthesia sub-specialties at the Austin, most notably anaesthesia for open-heart surgery and for liver transplantation. All this provided at the highest clinical level with a minimum of fuss, and with remarkable modesty.

He had an amazing work ethic. When there was an extra operating session to support, or a gap in the roster to fill in a department like ours, a list of people who "might help out" runs through your mind. Not everyone is on that list. Johann was always top of that list. He always said "yes" and he did so with grace.

Inevitably, with such a talent we couldn't keep him all to ourselves and in time he undertook a small private practice. Over a number of no doubt challenging and, we would guess, sometimes late-night clinical situations at Warringal Hospital, he developed an enduring professional relationship and friendship with Malcolm Douglas, a general surgeon.

Johann was well read professionally and maintained a strong academic interest in anaesthesia. His particular interest was in quality assurance in health care and he managed this portfolio for many years for our department. He coordinated audit, professional development meetings and followed up on the delicate matter of adverse clinical incidents, always with a gentle diplomacy. Throughout his career, he remained very interested in teaching and was universally regarded by anaesthesia trainees as both an excellent mentor and a delight to work with.

Faced with an illness that was a challenge of ultimately insurmountable odds, he set about staying as well as possible for as long as possible despite the need for difficult painful treatments day after day, month after month and year after year. While watching this struggle, we took some small solace in the knowledge that his operative, medical, nursing and ultimately palliative care was the best available anywhere in the world and was provided with kindness and love.

For Johann was, far above all else, a family man. He fought his illness long enough to see Allegra and Ronan grow to the really great kids they are today and to see Byron establish a highly successful career in the armed forces

that made him burst with pride. He ensured that his family's future was secure and that they had, as much as can ever be possible, come to terms with his dreadful illness. Most importantly, he fought to have as many good times with his family as possible in the time available. A trip to Hamilton Island and a central Australian adventure were notable examples. Of course he didn't fight alone and the support and love given to him by all his family, but especially his wife and soul mate Kerry, has been nothing short of superhuman. Even after watching in awe firsthand, none of us can fully appreciate the courage and strength required to assist a loved one through such a time.

To all Johann's family, most especially Kerry, Byron, Allegra and Ronan, on behalf of all who knew and loved him at Austin Health, express our deepest condolences. He was a friend and colleague like no other. Thank you for sharing him with us. We'll miss him always.

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**Dr David Tremewen, FANZCA**

**Associate Professor Larry McNicol**  
FRCA, FANZCA