June 2010

ANZCA BULLETIN

ANZCA
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

FPM
FACULTY OF PAIN MEDICINE ANZCA

Special report:

CHRISTCHURCH ASM – NEWS, VIEWS, PHOTOS

Plus:

ANZCA FELLOWSHIP SURVEY – YOUR RESPONSE

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 represents more than 6000 Fellows and trainees across Australia and New Zealand and serves the community by ensuring the highest standards of patient safety.

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Cover: ANZCA Annual Scientific Meeting – College Dinner – Christchurch, New Zealand.

Photo: Matt Stead, Tandem Studios.

Contents

President's message

I had a yearning to begin my first *Bulletin* message with the quote *"Let the word go forth from this time and place that the torch has been passed to a new generation of Fellows"*. Unfortunately, I'm not quite young enough to say that, having been born in the last years of the "baby boom". I can claim, however, to be the youngest President of ANZCA so far. My age is the median age of ANZCA Fellows and I hope to urge those older than me onwards, whilst trying to keep ahead of the younger ones – at least for the next two years!

I raise the issue of age because I am concerned about the future.

Who will provide anaesthesia and pain management for the baby boomers when we are old, and who will look after our children and their children?

Our workforce studies show a widening gap between the number of specialists we are producing and the demand for our services. We need to close this gap by training more anaesthetists and pain medicine specialists. We know that there will be plenty of applicants as a result of increased medical school output.

How are we going to increase our training capacity?

Medical practice is dynamic – witness our embrace of ultrasound techniques from cardiology and radiology and our move into perioperative medicine. We need to ensure that other doctors who incorporate anaesthesia, sedation and pain management techniques into their practices do so safely because these doctors will be looking after us when we present to emergency departments and have medical procedures in the future.

How will this be done?

There is no doubt about where we stand now: our self-identity is clear and strong. We are the experts in anaesthesia and pain medicine. Our challenge is to expand our circle of influence by policy-making, training, research and advocacy, justifying our shares of the rewards and ensuring that our healthcare remains the best in the world for our patients.

My vision for the College is this: It's our future – we need to ENGAGE.

Of course, the College Council has a big role to play and the Council will continue to do its utmost to provide leadership, advocacy, resources, support and value for our Fellows and trainees. These goals are articulated in our Strategic Plan and have been communicated to you through our publications. The Council pledges to keep improving our communications with you and promises to listen to you, especially when we disagree. The results of our recent Fellowship survey, published in this issue of the *ANZCA Bulletin*, show that we are going well in many areas, but could do better in others, and we thank all who responded for their participation. However, the Council can't solve every problem.

That's why this vision is really about *"what you can do for the College as well as what the College can do for you"*.

I want to ENGAGE each and every one of you in the task of ensuring that we have a healthcare system that will look after us, our families and our communities in the future. ENGAGEMENT is built on the practice of every one of us – as clinicians, teachers, researchers, policy-makers and citizens. Here are some of the things that *every* Fellow can do to achieve this goal:

Embrace new training environments

Negotiate and influence people

Get involved

Advocate quality and safety

Give your support

Educate yourself and others

Embrace new training environments
We need you to embrace training in the private sector, and rural and remote areas. There are insufficient opportunities for trainees in metropolitan public hospitals and increased diversity of training settings can only benefit trainees.

Negotiate and influence people
We need you to be an ambassador of our specialty with every patient, healthcare provider and jurisdiction. This will ensure that our voice is heard, that our influence increases and that our standards form a benchmark for medical care.

Get involved
We need you to get involved by responding to research surveys and voting in elections. Only involvement will make the results representative. We also need you to engage in CPD events and participate fully in ANZCA's CPD program.

Advocate quality and safety
We need you to participate in quality and safety activities in your practice and in our up-coming Australasian incident monitoring system. Safe use of anaesthesia, sedation and pain management techniques by all doctors can be promoted if you make your colleagues aware of ANZCA's standards.

Give your support
We need you to support the ANZCA Foundation and the highly-valued research of our Fellows. The health outcomes of our indigenous peoples and near-neighbours fall far short of our aspirations: they need your support.

Educate yourself and others
Finally and most importantly, we need you to enhance your clinical teaching by teaching wherever you work. Whenever feasible you can choose to undertake a clinical teacher's course and be a great role model for our trainees!

Of course, there are many Fellows who contribute this much and more already, as committee members, examiners, lecturers, convenors, supervisors, inspectors, representatives, writers, policy advisors, researchers, reviewers, clinical teachers, mentors and more. I would personally like to thank you all for your fantastic contributions. But these Fellows and the Council cannot act alone to achieve success – every Fellow needs to contribute. And it is not possible for us to finish this work – it will always be a work in progress. However, we will know if we are doing a good job if we:

- Increase high-quality training opportunities in private hospitals and the bush.
- Increase the scope of our recognition and influence.
- Increase participation in survey research, CPD events and elections.
- Increase engagement of other specialities in safe anaesthesia, sedation and pain management practice.
- Increase our support for the ANZCA Foundation.
- Increase our participation in improving healthcare for our indigenous people and near-neighbours.
- Increase participation in the ANZCA CPD Program.
- Increase the quality of our clinical teaching workforce.

These goals may seem modest, but ultimately, all these things will improve patient care and I will be reporting to you on our progress over the next two years. As JFK said: "We stand today on the edge of a new frontier". I therefore invite you to join me in this vision for the future and to ENGAGE.

Professor Kate Leslie
President

Dr Leona Wilson steps down from ANZCA presidency

Dr Leona Wilson
ANZCA Council 2000 – present
ANZCA President 2008 – 2010

Dr Leona Wilson stepped down from the presidency of ANZCA at the Annual Scientific Meeting in Christchurch. She remains on the Council as Councillor and Chair of the International Medical Graduate Specialist Committee.

Leona Wilson's career has been highlighted by many firsts. She was the first woman to chair the Department of Anaesthesia at the Wellington Hospital, the first woman to chair the New Zealand National Committee, the first President of the College from New Zealand and the first woman to become the President of the College.

I can't let this point pass without highlighting the importance of being the first female president to our College. A quarter of our Fellows and nearly half of our trainees are women and yet Leona has been preceded by only five women on the Board of the Faculty of Anaesthetists, Royal Australasian College of Surgeons and the ANZCA Council – Dr Mary Burnell, Professor Tess Cramond, Dr Nerida Dilworth, Dr Moira Westmore and Dr Di Khursandi (see below). These woman and others such as our late CEO, Joan Sheales, and our late historian, Gwen Wilson, would be so proud of Leona's achievement.

Leona brought many female qualities to the presidency: along with wisdom and experience (and a love of shopping), she brought a preference for collaboration and consensus-building, an ability to juggle many things at once; patience, persistence and forbearance; and finally, and at all times, grace and good humour. Leona has raised the bar very high and will be a hard act to follow.

However, being the first President from New Zealand has been much more important to Leona, and it was therefore very fitting that she was farewelled in Christchurch. Leona is very proud of her country, in particular its progressiveness, its faith in democracy and the rule of law, and its respect for indigenous people. As ANZCA President, Leona has proudly promoted New Zealand and certainly must take some responsibility for, and pride in, the high rate of participation of our New Zealand Fellows and trainees in College affairs. The wonderful conference in Christchurch is a great example of that. It is fitting that Leona was recently made Officer of the New Zealand Order of Merit in the Queen's Birthday Honours.

Well done, Leona, and best wishes!

Professor Kate Leslie
President

Dr Mary Burnell
Board of the Faculty of Anaesthetists, Royal Australasian College of Surgeons
1955 – 1967
Dean
1966 – 1967

Professor Tess Cramond
Board of the Faculty of Anaesthetists, Royal Australasian College of Surgeons
1965 – 1977
Dean
1972 – 1974

Dr Nerida Dilworth
Board of the Faculty of Anaesthetists, Royal Australasian College of Surgeons
1976 – 1984

Dr Moira Westmore
ANZCA Council
1993 – 1998

Dr Di Khursandi
ANZCA Council
1998 – 2007

Queen's Birthday Honours

Members of the Order of Australia (AM)

Professor Teik Ewe Oh
For service to medicine, particularly through the development of protocols for the specialties of anaesthesia and intensive care, through leadership roles in clinical and academic practice, and with professional bodies.

Dr Haydn Perndt
For service to medicine, particularly in the field of anaesthesia, to medical education through the design and implementation of training programs for health care practitioners in developing countries, and to professional organisations.

Dr Lindsay Ian Worthley
For service to medical education, particularly in the area of intensive care medicine, as a clinician, mentor and educator, and through contributions to professional associations.

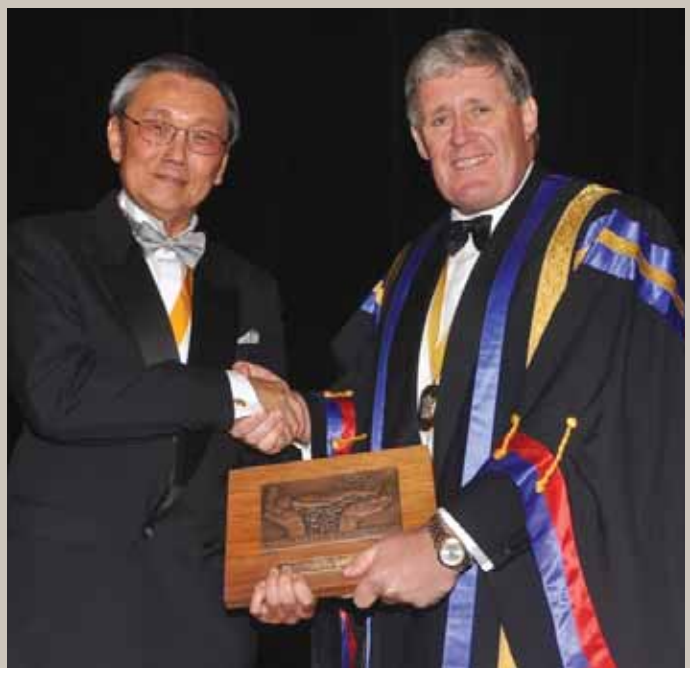
Officer of the New Zealand Order of Merit (ONZM)

Dr Leona Wilson
For services to medicine, in particular anaesthesia.

Inaugural CICM Medal

Professor Teik Ewe Oh was awarded the inaugural CICM Medal, the highest award of the College of Intensive Care Medicine of Australia and New Zealand, at their inaugural congregation on June 5, 2010.

Below: Professor Teik Ewe Oh receiving the CICM Medal from CICM President, Professor John Myburgh.



Awards

AMA (SA) Award – Associate Professor Pam Macintyre

The AMA (South Australia) each year recognises the significant contribution to medicine by a member who is notable for their commitment, leadership and contribution to medicine in the state. The award provides an opportunity for peers to honour the work of colleagues who have given outstanding service while receiving little recognition for their work. Those nominated have demonstrated a tireless dedication to the service of others, or their chosen field, or be pioneers who have worked without seeking recognition for their efforts. This year's award was given to Associate Professor Pam Macintyre, staff specialist in anaesthesia at Royal Adelaide Hospital. AMA SA President, Dr Andrew Lavender, presented the award at the AMA SA annual dinner at Botanic Garden Restaurant in Adelaide on Saturday, May 22. Reproduced below are remarks made by Dr Andrew Lavender.

"The recipient of this year's AMA (SA) Award works in an area of medicine that was once the principal focus of all doctors but which, with the rapid advances in technologies and treatments, had been long neglected.

This year, the AMA (SA) Award is going to a doctor who embodies and communicates a love of medicine – an avid researcher, teacher and clinician who has had as her focus, improving the care of patients who are often in the most frail and dependent times of their lives. A time when, more than any other they need and want good medical care but when, more often than not, that care came as an afterthought.

In presenting this award, the AMA (SA) recognises the contribution and commitment of an Adelaide doctor, who has single-handedly focused attention on research and evidence-based practice in acute pain management. Her work has improved the availability and consistency of post-operative care and pain relief to millions of people worldwide and through her strong focus on patient safety has no doubt contributed to reductions in post-operative morbidity and mortality that had previously cursed our communities.

She has been instrumental in raising the profile of acute pain medicine throughout Australia and the world through her dogmatic insistence on evidence-based practice in a field where everyone thought that they knew what they were doing, but in reality no one did. She has been a world leader in researching the medical literature and has actively filled in the gaps in that literature by conducting, supervising and publishing a number of clinical studies.

She is a staff specialist in anaesthesia at the Royal Adelaide Hospital (RAH), and has been the Director of the Acute Pain Service at the RAH since it was established at the beginning of 1989.

She is the author of *Acute Pain Management: A Practical Guide*, a standard reference on acute pain management in Australia the UK and US, and used worldwide, and co-editor of *Clinical Pain Management: Acute Pain*.

In 2006, this doctor was awarded the Robert Orton Medal by the Australian and New Zealand College of Anaesthetists for services to anaesthesia and pain medicine.

She was Chair of the Australian and New Zealand College of Anaesthetists and the Faculty of Pain Medicine Working Party responsible for the development of the 2nd and 3rd editions of *Acute Pain Management: Scientific Evidence*.

For her significant contribution to medicine, her commitment and her leadership, I am delighted to announce that this year's recipient of the AMA (SA) Award is Associate Professor Pam Macintyre."

ANZCA Undergraduate Prize in Anaesthesia

The ANZCA Undergraduate Prize in Anaesthesia was established to foster undergraduate and postgraduate teaching of anaesthesia, its related disciplines and perioperative medicine and to raise awareness of the specialty among medical students and recent graduates. Each year prizes are awarded within Australian and New Zealand medical schools to final year medical students who achieve the best overall performance in the anaesthesia module of their clinical curriculum. The prize comprises a certificate and $500 book voucher. The 2009 winners are listed right. The College congratulates them on their achievement and hopes this is the first of many successes in their medical careers.

Dr Grace Ng
Christchurch Clinical School of Medicine and Health Sciences, University of Otago

Dr Kurt Domuracki
School of Medicine, Flinders University of South Australia

Dr Charlotte Chen
School of Medicine, University of Auckland

Dr Sophia Rosser
Sydney Medical School, University of Sydney

Dr Gregory Orchard
University of Queensland

WA ANZCA/ASA Gilbert Troup Prize

The WA ANZCA/ASA Gilbert Troup Prize for 2009 was awarded to **Dr Greg Houghton**. The prize is awarded to the student who obtains the highest mark for the assessment in anaesthesia in IMED6681.2 Surgery Part 1/IMED6682.2 Surgery Part 2 in the course for the degree of Bachelor of Medicine and Bachelor of Surgery from the University of Western Australia. The prize was established to foster undergraduate and postgraduate teaching in anaesthesia, its related disciplines and perioperative medicine, and to raise awareness of the specialty among medical students and recent graduates from Western Australia.

Awards

continued

Robert Orton Medal

Professor Peter Chin-Aik KAM

The Robert Orton Medal is the highest honour that the College can award to its Fellows in anaesthesia. This award is made at the discretion of the Council, the sole criterion being distinguished service to anaesthesia. The award was announced at ANZCA's ASM in Christchurch in May.

Madam President, it is my great honour and pleasure to present Peter Chin-Aik Kam for the award of the Robert Orton Medal.

Professor Peter Kam is well known to the anaesthesia community in Australia, New Zealand and South East Asia. He has made major contributions to the profession over the last three decades particularly in the area of undergraduate and postgraduate teaching of anaesthesia and the basic sciences.

Peter was born in Malaysia, the eldest of four children. He attended medical school at the University of Malaya and was awarded his MB BS in 1970. He then spent time in the United Kingdom and was awarded FRCA in 1974, later returning to Malaysia where he worked as a senior lecturer in anaesthesiology at the University of Malaya. He was awarded his FFARACS in 1975 and in 1977 he migrated to Australia.

Peter's work in Australia began at Blacktown Hospital and then the newly opened Westmead Hospital. He played a pivotal role in the establishment of the Department of Anaesthesia at Westmead, particularly the establishment of anaesthesia and perfusion services for cardiothoracic surgery.

The opening of Westmead Hospital was associated with a dynamic group of medical professionals taking up the challenge of establishing a new hospital and it was during this time that Peter developed a unique working relationship with the Foundation Professor of Surgery at Westmead Hospital, Professor Miles Little.

Professor Little, retired in surgery but still active in the field of medical ethics, remembers Peter as an outstanding colleague and clinician. Outstanding because of his extraordinary knowledge of clinical pharmacology and pathophysiology, his technical skill, his wisdom, his judgement and his remarkable gentleness.

While many surgeons claim to have their own anaesthetist, Professor Little extended the ultimate compliment about his former colleague, stating that it was his privilege to be able to claim that for one wonderful period of his surgical life he was Peter Kam's surgeon.

For many now-renowned anaesthetists their time working with or under Peter is still a clear and happy memory. He was an enthusiastic teacher, particularly of physiology and pharmacology, as he felt that the way to be a good anaesthetist or intensivist was to develop a solid understanding of the basic sciences.

As a tutor for the Primary Exam he was an icon for over a generation, with a probing Socratic style of questioning in trial vivas that made registrars tremble but which made the actual exam seem like light work.

As a clinician he worked long hours and yet was always available to discuss cases. He is well known for holding tutorials at 6am on a public holiday or cold winter's morning! Many people say that they love teaching but few really do, and many think they are great teachers but few are. Peter has never said that he loves teaching nor that he is gifted – he does not need to, as his actions speak for themselves.

Peter was an examiner for the Primary Exam from 1987 to 1999 and the Deputy Chair of the Primary Exam Committee from 1991 to 1995. In addition to his contribution to the ANZCA Primary Examination, Peter has an ongoing role as an external examiner in Singapore, Malaysia and Hong Kong.

Peter is a virtual celebrity in Hong Kong and Singapore where his teaching skills are legendary, and where everyone knows him as "THE Professor", but to Australian and New Zealand trainees he is more affectionately known as Yoda.

Peter has a strong interest in research with over 90 publications in peer-reviewed journals and five book chapters. His current research is focused on kinetics of coagulation factors during massive transfusion, perioperative platelet dysfunction and on clinical governance issues of early warning systems and leadership in improving quality and safety in hospitals. He is an active lecturer and has presented at many national and international meetings. Peter was the Australasian Visitor at the Australian Society of Anaesthetists National Scientific Meeting in 2007.

Peter has a long history of editorial activities – in Australia and New Zealand, Hong Kong and North America. He remains a member of the editorial board of *Anaesthesia and Intensive Care*. He has been a reviewer and assessor for the Cochrane Anaesthesia Group since its formation in 1999. In 2001 Peter published his book – *Principles of Physiology for the Anaesthetist*. It has become essential reading for all those preparing for the physiology part one examination. The

second edition of his book, published in 2008 was awarded first prize in the Anaesthesia Section of the British Medical Association Book Awards.

Peter has held senior posts at several anaesthetic departments in major Sydney teaching hospitals over the past 30 years. In 2002 he was appointed to the inaugural Chair of Anaesthesia at the University of New South Wales at St George Hospital in Sydney, and in 2006 he was appointed the third Nuffield Professor of Anaesthetics at the University of Sydney, Royal Prince Alfred Hospital. He continues his clinical work taking a particular interest in anaesthesia for peritonectomy and liver surgery, acute pain management and anaesthesia for major joint surgery.

He has a wonderful wry smile and active eyebrows that speak volumes. The glasses he wears are multifunctional – he can see much more than what is presented to him. He is a great analyst of human nature.

In the limited relaxation time he affords himself Peter enjoys pruning roses, mowing the lawn on his ride-on mower, church-related activities and listening to classical music. In a rare spare moment he watches music and opera on a tiny flickering cathode ray television from about 1960. According to his brother he has a penchant for bargain shopping.

His wife, Florence, has supported Peter throughout his career. She shares with him a love of gardening and they spend weekends in Camden cultivating their roses.

The greatest contribution that Peter has made is not written within the constraints of a CV but is known by those who have been privileged enough to train under him or work with him as a colleague. He gives endlessly of his time to individuals, encouraging and inspiring them to give of their best. He has quietly guided a generation of anaesthetists across Australia, New Zealand and South East Asia to be the very best they can be. In the words of one of his trainees he is "Anaesthesia's Tenzing Norgay", quietly facilitating the best possible performance without fuss or glory just as Tenzing did for Hilary.

Madam President, it is my great honour and pleasure to present Peter Chin-Aik Kam for the award of the Robert Orton Medal.

Dr Nicole Phillips

ANZCA Medal

Dr Diana Coraline Strange Khursandi

The Australian and New Zealand College of Anaesthetists' Medal is awarded at the discretion of the Council in recognition of major contributions to the status of anaesthesia, intensive care, pain medicine or related specialties.

Madam President, it is my great honour to present Dr Diana Coraline Strange Khursandi for the award of the ANZCA Medal.

Dr Khursandi is recognised for her contributions in the areas of doctors' health and welfare, rural and regional anaesthesia services, anaesthesia workforce challenges, gender issues in medicine, and education and training.

Following completion of her BA with Honours in physiology at Oxford University in 1963, Dr Khursandi became a medical student at the Royal London Hospital, graduating MA, Bachelor of Medicine and Bachelor of Surgery from Oxford University in 1966. She was admitted to Fellowship of the Royal College of Anaesthetists in 1972 and, following migration to Australia, to Fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons (1983), and subsequently to the College (1992). From 1977 to 1997, she was a specialist in Maryborough, Queensland, as a Visiting Medical Officer to the Base Hospital and in private practice. From 1997 to her retirement from clinical practice in 2004, she was a full time senior specialist at Caboolture Hospital, Queensland.

Dr Khursandi has served as a College Councillor (1996 – 2007), chairing and contributing to many committees including Continuing Education and Quality Assurance (chair 1997 – 2006), Education and Training (chair 2006 – 2007; member 2001 – 2007), Workforce (chair 1997 – 2006) and Training Accreditation (member 1999 – 2007). She was a founding member and chair of the Rural Special Interest Group (1997 – 1999; 2005 – 2008), and ANZCA representative on the Joint Consultative Committee on Anaesthesia, the tripartite body that oversees the training of general practitioner anaesthetists (2000 – 2007). She oversaw the development of Anaesthesia Clinical Indicators Version 4 (2006) for the Australian Council on Healthcare Standards.

She has been very active at a state level as a longstanding member of the ANZCA Queensland Regional Committee (1993 – 2007) and the Australian Society of Anaesthetists (ASA) State Committee (1988 – 2007). Her roles have included development of College and health department professional and clinical guidelines, medical advisor for the Pre-Employment Structured Clinical Interview

Awards

continued

(PESCI) for the Queensland Department of Health (2009 – current), membership of the Postgraduate Medical Council of Queensland Accreditation Committee and Assessment Subcommittee (2004 – 2008), and ANZCA Area of Need Assessor (2005 – 2008). Since 1998, she has been a senior lecturer at the University of Queensland.

Worthy of particular note, and possibly most widely known amongst Dr Khursandi's many achievements, is her contribution to the profile and cause of doctors' health and welfare. She has been a committed campaigner for changes in our approach to looking after ourselves and our colleagues.

With Dr Genevieve Goulding, in 1995, she was a co-founder of the Welfare of Anaesthetists' Special Interest Group (ANZCA/ASA/New Zealand Society of Anaesthetists), and its inaugural chair, returning to the role in 2009. Since 1998, she has been a member of the Queensland Doctors' Health Advisory Service (DHAS) Management Committee.

She has published about anaesthesia and gender (an ASA-commissioned survey "Does gender matter in the pursuit of a career in anaesthesia?"), depression, safe working hours, career choice and substance abuse. Her contributions and leadership in these areas have moved the cause of anaesthetists' health and welfare from the margins of innovation to the centre of practice; for example, it is now recognised as an important (and examinable) aspect of the ANZCA training program.

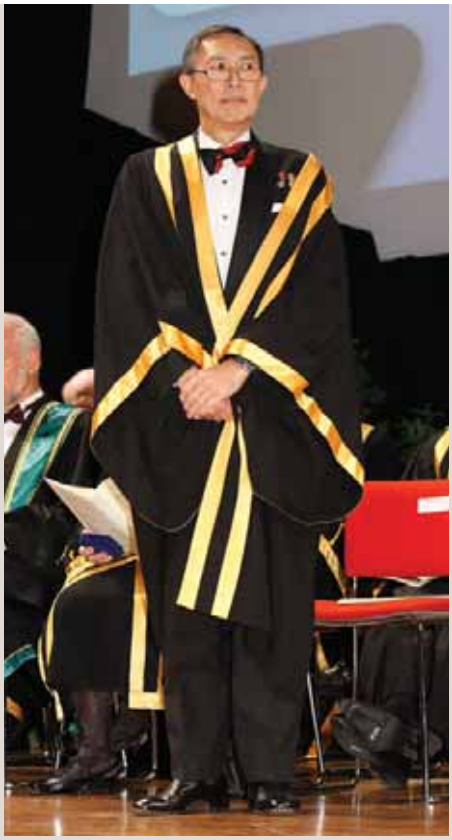
Among all her other activities, Dr Khursandi maintains a strong commitment to the support and education of individual junior doctors and international medical graduates, through her current roles as Eminent Specialist to Queensland Health, and Deputy Director of Clinical Training at Caboolture Hospital. She has contributed to the Professional Development Program for registrars, both as a member of the advisory committee (2006 – 2007) and facilitator (2007 – current). She is a tireless presenter at hospital, regional and national meetings on doctors' health and welfare, in areas as diverse as substance abuse, performance and impairment, managing stress, communication, leadership, critical incident support, fatigue and retirement.

Di is married to Emeritus Professor John Gibbs, also an ANZCA Medallist. Her three daughters Isobel (medicine), Catherine (veterinary science), and Alice (social work) have all pursued careers in the caring professions.

Di's hobbies are music (she sings and plays the violin in amateur chamber music groups and orchestras), reading (non-fiction mainly), patchwork, glass bead making, gardening and "of course, travelling and grand-daughters!"

Madam President, the discipline of anaesthesia has been changed by Di Khursandi's compassion, leadership and vision – she continues to be an outstanding role model. It is a great privilege, and a personal honour, to present, for the Award of the ANZCA Medal, Dr Diana Coraline Strange Khursandi.

Dr Lindy Roberts



ANZCA Medal

Dr Robert Manching WONG

The Australian and New Zealand College of Anaesthetists' Medal is awarded at the discretion of the Council in recognition of major contributions to the status of anaesthesia, intensive care, pain medicine or related specialties.

Madam President, it is my great honour to present Dr Robert Manching Wong for the award of the ANZCA Medal.

Dr Wong has been pivotal in establishing and developing diving and hyperbaric medicine in our region through his work in Western Australia, with the Australian Defence Force and through the establishment of the Diving and Hyperbaric Medicine Special Interest Group and Certificate in Diving and Hyperbaric Medicine of ANZCA.

Bob Wong's family has a long history in Australia. His great-grandfather arrived from China in 1859 as an indentured labourer and worked in the Victorian goldfields. Bob's grandfather was a successful merchant in Sydney and his uncle was the second Chinese medical graduate from the University of Sydney. His father, although born in Sydney, graduated in medicine from the Edinburgh University.

Bob attended the De La Salle College in Melbourne. He studied medicine in the pre-clinical years at the Melbourne University, subsequently transferring to study science and then medicine at the University of Western Australia, graduating in 1969. His resident years were spent at the Royal Perth Hospital, and his anaesthesia training was undertaken in the Western Australian anaesthesia training scheme.

Bob was awarded Fellowship of the Faculty of Anaesthetists in 1975 and immediately took up a staff position at the Royal Perth Hospital. He remained in this post until 2005. During this time, Bob's principal clinical interests were cardiac anaesthesia, and diving and hyperbaric medicine.

Bob's interest in diving and hyperbaric medicine arose through his love of books on "frogmen" during his school days and subsequent involvement with the navy's diving team. He trained in diving and hyperbaric medicine at the School of Underwater Medicine at HMAS Penguin in Sydney in 1980 and furthered his studies in the UK and Canada. He was awarded the Diploma in Diving and Hyperbaric Medicine by the South Pacific Underwater Medicine Society in 1988. He has served the specialty through various roles in Western Australia, in the Australian Defence Force and at the College.

In 1998, the College established a Special Interest Group in Diving and Hyperbaric Medicine. Bob has been an executive member of this SIG since its inception and is a past chairman. He initiated a formal qualification in Diving and Hyperbaric Medicine in ANZCA in 2003 due to his concern about the lack of formal training and recognised qualifications in the discipline.

Furthermore, there was concern that other Colleges might initiate such a qualification before ANZCA, although most directors of hyperbaric medicine units in Australia and New Zealand were run by anaesthetists. This activity culminated in the establishment of the certificate in 2003.

Bob has worked tirelessly since that time as a member of the governing committee for the certificate, as an examiner and as a member of the accreditation team for hospitals seeking recognition for Diving and Hyperbaric Medicine training. He has represented ANZCA with distinction on the Medicare Services Advisory Committee and the Australian Standards Committee.

Bob joined the Citizens' Military Force in 1971, and transferred to the Australian Navy in 1978 as a Surgeon Lieutenant, rising through the ranks to Commander. He was a specialist in underwater medicine from 1981 until 1989 and Senior Medical Officer Western Australian Region between 1989 and 2000. Bob was a consultant in underwater medicine to the Director General of the Naval Health Services 1989-91, consultant to the Royal Australian Navy 1991-97 and consultant to the Director General of the Australian Defence Health Services 1997-2000. He was awarded the Reserve Force Decorations in 1986, 1991 and 1996 and the Australian Defence Force Medal in 2007.

Bob has also been a leader in Diving and Hyperbaric Medicine in Western Australia. He was appointed consultant at the Fremantle Hospital's Hyperbaric Unit in 1989 and was its Director from 1999 until 2009. Since 1987, he has also been a consultant to the Pearl Producers Association where, through research, he modified their dive practice and drastically reduced the high prevalence of decompression sickness among the pearl divers. This work was recognized through awards by the Undersea & Hyperbaric Medical Society of USA, and other industry awards.

Bob was the Personal Diving Physician to HRH, the Prince of Orange of the Netherlands, who used his visit to Western Australia in 1996 to see some of the Dutch ship wrecks along the coast of Western Australia.

Bob has published more than 30 papers on diving and hyperbaric medicine, has contributed to textbooks in the field and has served on various editorial boards and international examination panels.

Apart from his work in diving and hyperbaric medicine, Bob has served the College well in the fields of trainee education and assessment. In 1976, he initiated a Primary Exam Course for anesthesia trainees in Perth. He was a member of the Primary Examination Panel in physiology from 1992 until 2003, and was an executive member and Chair of the Medical Education Special Interest Group between 1994 and 1999. He received an ANZCA Citation in 2001 for his services to the College in Western Australia.

Madam President, Dr Robert Manching Wong has been a driving force in our region for research, education, expert clinical care and advocacy in Diving and Hyperbaric Medicine. He is highly respected by his peers, trainees and staff and has been definitive resource person on Diving and Hyperbaric medicine in the College. It is my great honour and pleasure to present him for the award of the ANZCA Medal.

Professor Kate Leslie

FPM Refresher Course Day

More than 110 pain specialists attended the Faculty of Pain Medicine's Refresher Course Day at the Rydges Hotel in Christchurch on Friday, April 30 to hear 12 speakers give presentations on sessions titled "Pain and empathy", "Age, gender and pain", "Regional anaesthesia and acute pain" and "Clinical applications of advances in research". There were three international speakers – FPM ASM Visitor, Professor Jeffrey Mogil, the E.P. Taylor Professor of Pain Studies at McGill University, Canada; FPM Christchurch Visitor, Professor Richard Rosenquist, Fellowship Director, Department of Anaesthesia, University of Iowa Hospitals and Clinics, Iowa, USA and Dr Roger Knaggs, Advanced Pharmacy Practitioner, Anaesthesia and Pain Management, Nottingham University Hospitals, NHS Trust, UK.

Clockwise from top left: Dr Penny Briscoe, Professor Jeffrey Mogil and Professor Michael Cousins; Dr Carolyn Arnold, Associate Professor Leigh Atkinson and Dr Phoon Ping Chen; Glenda Salmon, Dr Daryl Salmon and Professor Stephan Schug; Dr Dilip Kapur and Maggie Meaks; Professor Tess Cramond, Dr Sharon King and Dr Humphry Cramond; Crystal Set entertained delegates at the FPM Annual Dinner.

Airway Management SIG meeting

The inaugural meeting of the Airway Management SIG was held from March 19-21, 2010 at the Mantra Erskine Beach Resort in Lorne. It was a great success with a record number of delegates – 210 – for a SIG meeting in attendance.

The international guest speaker was Dr Peter Charters, from the Aintree Hospital, Liverpool UK. Dr Charters' talks were on the use of the Bonfils Fibreoptic scope, Remifentanil for sedation for fibreoptic intubation and airway management in oral/dental abscesses. The meeting also featured many local speakers, with topics ranging from the history of intubation, the difficult obstetric airway, facial trauma, epiglottitis, airway training and evidence based management, problems with the DAS algorithm, laryngeal tumours, airway problems to the envenomed patient.

In addition, there was an excellent presentation by Dr Andy Heard, from the Royal Perth Hospital, on the management of the 'Can't intubate, can't oxygenate' scenario. The speakers were practical, enthusiastic and approachable. A number of workshops were held concurrently which were popular, allowing delegates the chance to get hands on with the latest in airways technology.

Clockwise from top left: Dr Fiona Sharp, Dr Peter Charters, Marianne Moreau, Cathy Moriarty, Professor Andre van Zundert and Dr Chris Acott; delegates at the workshop; Dr Tony Diprose and Dr Reny Segal; delegates participating in a workshop.

New Fellows Conference 2010

The Heritage Hotel, Hanmer Springs was a great choice for the New Fellows Conference with accommodation, conference facilities and activities all easily accessible. Even the weather remained moderate, although wind on the tops was fresh for one intrepid hill climber!

The unanimous highlights of the meeting were the individual presentations. Delegates had been asked to prepare a short talk relating to the theme of Anaesthesia and Adventure. As hoped, interpretation of the topic was broad ranging from the harrowing to the hilarious. It quickly became apparent that it was important to let these talks unfold in their own time - despite intentions of ruthless timekeeping. As well as being informative and entertaining, the presentations gave valuable insight into what motivates us, both personally and professionally and demonstrated the breadth of interests and talents of the group.

Day 2 featured Mark Inglis – first running "The Choice" workshop (planning and decision-making for a virtual mountain climb), then later delivering a keynote speech in the evening – both were well received. The afternoon was spent at "The Hanmer Challenge" in which teams completed a range of activities in order to reach a final (winning) hurdle. Tasks ranged from orienteering to puzzle solving, to feats of physical and vocal coordination, from the sublime to the ridiculous. We enjoyed 100% participation and a great deal of fun and managed to break the course record!

The NFC is described as a "think – tank" rather than a series of didactic presentations and the intervening sessions addressed the roles of, and involvement in the college, the choices and challenges of new Fellows and giving something back. These sessions were informal and took their own direction, sometimes raising more questions than they answered. In keeping with the relaxed atmosphere, the hot pools proved to be a popular location for ongoing discussions, debriefing and reviving at the end of the day.

At the outset of the meeting, I was asked what my objectives were. My response was 'to stimulate some thought and discussion, and to have fun.' I am happy to report that these goals were achieved – thanks to the enthusiastic participation of the delegates and to the sponsorship of the college. Our final lunch was held at Pegasus Bay Winery en route to Christchurch – a fine meal and the perfect segue from the NFC to the ASM.

Karen Ryan
New Fellows Convenor, 2010

Delegate Nolan McDonnell gives his impressions of the New Fellows Conference on page 60.

Clockwise from top left: The conference venue, the Heritage Hotel in Hanmer; a team about to set off for the "Hanmer Challenge", a team building exercise consisting of physical and mental challenges; guest speaker at the conference, Mark Inglis, who in 1982 became trapped for 13 days close to the summit of New Zealand's highest mountain, Mount Cook; enjoying dinner after the Hanmer Challenge.

Final Fellowship Examination presentation

The successful candidates of the Final Fellowship Examination held from May 28-29 were presented to the Court of Examiners at ANZCA House where they celebrated with their family, friends and peers.

A full list of successful candidates from the Primary and Final Fellowship examinations can be found on page 62.

Clockwise from top: Dr Mark Priestley (left), Chair of the Final Examinations sub-committee congratulates successful candidates; successful candidates mingle with examiners; Dr Simon Maclaurin, Dr Keith Greenland and Dr Moira Westmore.

NZ ASM WRAP UP 2010

More than 1000 people gathered in Christchurch for this year's Annual Scientific Meeting. Entitled "How Meets Why – Clinical Practice and the Science Behind It", the event was held at the Christchurch Convention Centre between May 1-5. Enjoying beautiful Christchurch Autumn weather, delegates experienced a memorable and informative meeting with a diverse scientific program and an excellent social program that culminated in the College Dinner.

Planning for the 2010 ASM started almost four years ago so it is hard to believe it is all over now. Hopefully those Fellows amongst the 1000 delegates found some wisdom to apply in your practice and in your personal life. We hope Fellows enjoyed the meeting and the social events, made the most of the opportunities to meet new and old friends, found out what the trade has to offer and were able to enjoy some spectacular autumn weather and possibly some South Island scenery.

For us the two key components to running a successful meeting were a clear picture of the type of meeting we wanted to run and having a strong hard working team.

Our picture of the meeting we wanted to create came from involvement in meeting as delegates, presenters and organisers, and generally as consumers of the ASM product (science and social). Every meeting has high and low points, things done the right way and things that did not quite work and we tried to learn from the experience of others. At the 2009 meeting we were often asked if we had come to learn. In fact because of the scale and timelines of a meeting this size, by the time of the 2009 meeting most details of the 2010 meeting were already in place.

We had a great team putting this meeting together. The different aspects of the meeting were looked after by separate groups within the Regional Organising Committee, each with a strong view of how the individual components of the meeting, particularly the scientific and social programs should work. This devolved approach meant that no one individual had to concentrate on all the detail and allowed us the freedom to think about different ways of doing things. We were supported in all of this by a fantastic PCO "team" who just got on and sorted much of the essential minutiae.

Most would agree that the AV support and visuals were great. The AV company's approach was typical of everyone involved in the meeting; enthusiastic, keen to try new things and aiming to help produce a world class event.

So what were the high points? For me, it was the whole meeting, the way so many people gave so much time and effort to make it all work. Every component takes a lot of organising and even "simple" things like workshops take time and effort to put together and present. Remember that every Fellow involved in the meeting gave their time and effort for free and paid their own way to the meeting and that while running a workshop you can't get to any of the other sessions.

All our speakers were great. We did appreciate the way most of the overseas visitors involved themselves in the whole meeting and participated in a variety of sessions and the social events. The social program was varied and had some new twists on the traditional formats. I know a lot of work went in to getting the food and entertainment right, and to match it to the wide range of ages and tastes from the over 200 trainees and new Fellows to retired Fellows.

The moderated poster sessions were a new format for the ASM. The turnout was much better than at free paper sessions in recent years. Our hope of more interaction between presenters and with high profile moderators was realised.

Things we would have done differently in retrospect: not a lot! The demand for workshops is enormous but these consume a lot of room space and people to run. As it was, we accommodated 760 delegates in 50 workshops on 30 separate topics and 394 attended the 41 PBLD and QA sessions. We were able to offer most registrants at least two places. We also had a couple of sessions which overfilled the allocated rooms but although we came close to moving mountains at times, we could not shift the walls out.

We have had a lot of feedback, from the survey and directly. The comments and assessment are generally positive with the "very enthusiastic" ratings vastly outweigh the rare negative rating. Several comments relate to the basic structure of the meeting, which is primarily determined by the College. We appreciate the feedback and all the comments, which will be passed on to the College and to the Convenors of the forthcoming meetings.

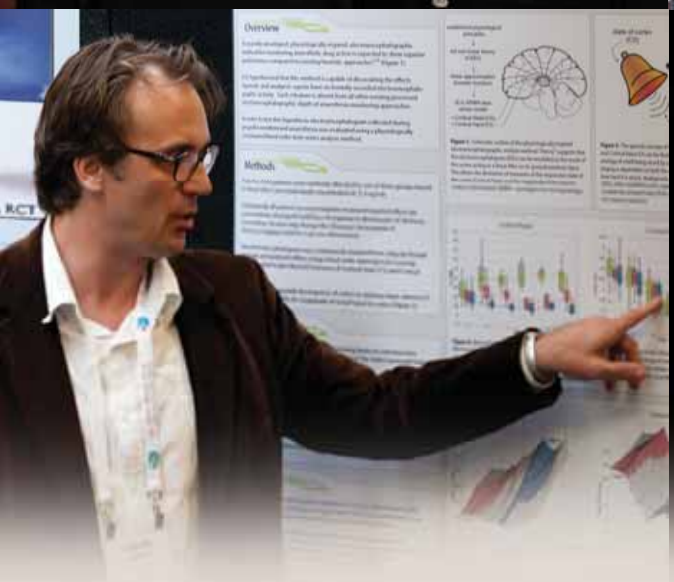
Thank you again to all those who attended and everyone who contributed – we couldn't have done it without you! I hope you enjoyed the meeting as much as we enjoyed putting it all together for you.

Associate Professor Ross Kennedy
Convenor

NZ ASM WRAP UP 2010

Clockwise from top left: Victoria Square Fountain in Christchurch; Professor Paul Myles addresses the delegates; Dr Mark Waddington, rugby great Robbie Deans and Associate Professor Ross Kennedy; Dr Paul Wrigley and Professor Alan Merry; Dr Fiona Gilmour and Dr Lisa Chapman; Captain Cook statue in Victoria Park, Christchurch.

NZ ASM WRAP UP 2010



Clockwise from top left: Dr Vangy Malkoutzis presents her poster at a session; Professor Steve Shafer; Professor Kate Leslie and Dr Leona Wilson; morning tea on the last day of the ASM; Dr Terasa Bulger, Dr Nathan Kershaw, Dr Sabine Pecher and Dr Jennifer Taylor; Dr David Liley; Dr Anja Werno; Robbie Deans giving the oration at the College Ceremony.

NZ ASM WRAP UP 2010

Opposite page clockwise from top: The College Dinner at Westpac Arena; Dr Pamela Flood, Dr Mark Waddington, Associate Professor Ross Kennedy, Professor Talmage Egan and Professor Steve Shafer; delegates enjoying morning tea; "Lord of the Rings" entertainment at the College Dinner; Dr Leona Wilson.

This page clockwise from top: dancing after the College Dinner; Dr Tuong Phan, Dr Alicia Dennis and Dr Forbes McGain; Dr Leona Wilson with a prop used to promote the Hong Kong CSM 2011; Hong Kong meeting Convenor Dr Chi-Wai Cheung and Carmen Mai; New Fellows at the College Ceremony.

NZ ASM WRAP UP 2010

Media coverage

A range of subjects covered by speakers at ANZCA's Annual Scientific Meeting in Christchurch generated a great deal of media coverage in the last quarter – gender and pain, the origins of anaesthesia, the extraordinary limits to which ironmen push themselves and the medical story of conjoined twins Trishna and Krishna attracted most attention.

Canadian researcher Professor Jeffrey Mogil, one of the Faculty of Pain Medicine's keynote speakers, did eight interviews on gender and pain on radio and for several newspapers both in Australia and New Zealand. This story was picked up internationally online by several news services in India and the US and was referred to on New Zealand television.

The mysteries surrounding how anaesthesia works, which was covered in a paper by another keynote speaker Professor Steven Shafer from New York, also proved popular. Lincoln University's Associate Professor Mike Hamlin's talk titled "Ironman or madman? The physiological demands and consequences of extreme ironman, triathlon and ultra-endurance training and racing" was also covered extensively.

The insatiable interest in the remarkable separation of conjoined twins Trishna and Krishna at the Royal Children's Hospital last November was also evident in New Zealand. Interviews with the RCH's head of anaesthesia and pain medicine, Dr Ian McKenzie, were included in several news reports.

Other topics of interest included anaesthesia and obesity and interviews with anaesthetists doing work in developing countries.

Breaking news

This year ANZCA broke new ground this year with its comprehensive coverage of the ASM. With a small team on the ground in Christchurch and our communications unit working around the clock in Melbourne, ANZCA was able to deliver the most up to date news to both conference attendees and people outside the meeting. Video interviews and audio files were uploaded quickly on the ANZCA website which featured a banner and links to essential information on the home page. This was supplemented by a special edition of the ANZCA E-newsletter at the end of each day. The daily ANZCA ASM newsletter, included multimedia (video, audio, photos) and a wrap up of each day's proceedings as well as looking ahead to what was happening the next day with links to abstracts. "The response from Fellows and trainees has been fantastic and quite gratifying. We wanted to not only provide an excellent service for those attending the ASM but to our colleagues who, for whatever reason, could not make it to New Zealand. We wanted to give a flavour of what was happening but also to push the boundaries, be innovative and set a new benchmark in terms of conference reporting. We were helped greatly by the willingness of speakers to be interviewed. It was a great team effort", Nigel Henham ANZCA's Director of Communications said. Staff working on the newsletter and ASM coverage included Nigel Henham, Nick Philips, Ben Grantham and Tandem Media in Christchurch and Liane Reynolds and Christian Langstone in Melbourne. Audios of the Plenary sessions and more than 30 interviews are available for viewing on ANZCA's website – **www.anzca.edu.au**

"I look for a combination of things - something directly relevant, something that looks at some of the bigger philosophical and other issues that affect my practice, something that is of interest but which is more to keep me up to date and then there's just the general interest stuff. Christchurch ASM therefore ticked all the boxes for me."

"The opportunity to meet with like minded colleagues was invaluable and much of the best value from the conference was in unstructured opportunistic conversations."

Feedback

What I hope to get from attending conferences has changed over the years since gaining my fellowship in 2003. Initially I focused only on information that was directly relevant to my day to day practice. Now I look for a combination of things - something directly relevant, something that looks at some of the bigger philosophical and other issues that affect my practice, something that is of interest but which is more to keep me up to date and then there's just the general interest stuff.

Christchurch ASM therefore ticked all the boxes for me. As both a FANZCA and FFPMANZCA with limited time, I attended the Pain refresher day and the weekend until Monday morning. My focus tended towards pain medicine.

I enjoyed the conference as a whole but the main highlights included Professor Jeffrey Mogill who made sex, gender and mice all seem relevant ,informative and entertaining, if not now, then in the future.

I found Professor Peter Joyce's review of the evolving neurobiology of depression unexpectedly fascinating for its relevance and crossover to pain medicine and our patients and society in general.

The final session on addiction was compelling with an extra speaker giving the perspective of his own addiction. The challenges of this problem and how to deal with it in a sympathetic but practical way were highlighted.

Finall, I presented a poster- a learning experience from go to whoa.

In general I found the location and the organisation excellent including the social options, food and so on. Well done to the organisers.

Dr Anne Jaumees
Staff Specialist
Westmead Hospital, Sydney

My favourite session was a workshop on ultrasound guided upper limb regional anaesthesia which was very well run and showed me some tricks to help boost my success rate. In practice it does seemed to have helped with no failed blocks since. The trade fair was the biggest I have seen yet. There was a lot on show as always but the interaction between trade and attendees also appears to have improved. Most stands appeared to be busy fielding enquiries for the majority of the time. The posters were interesting but I did not get to attend any of the moderate presentation sessions. This appears to be a good way to advertise one's research. With respect to the talks, I cherry picked a few which related to perioperative cardiac optimisation and intraoperative monitoring. These were well done but didn't seem to indicate that there are any compelling practice altering developments, apart from more expensive ways to invasively monitor intraoperative cardiovascular status.

The visibility was poor in some parts of the conference centre and the popularity of some sessions did not correlate well with the seating available. Having said that, the opportunity to meet with like minded colleagues was invaluable and much of the best value from the conference was in unstructured opportunistic conversations. Some of my best learning and best ideas for future directions came from chance meetings over a coffee in the hall.

Dr James French
Consultant Anaesthetist
Canberra Hospital

Survey

Around 500 registrants responded to a survey which asked whether attendees expectations were met.

Scientific Program: Whether the Christchurch ANZCA/FPM ASM met, exceeded or failed to meet your expectations.

	Met my expectations	Exceeded my expectations	Did not meet my expectations	Not applicable
Anaesthesia Invited Speakers	57.1% (284)	36.4% (181)	4.8% (24)	1.6% (8)
Pain Invited Speakers	36.2% (179)	15.2% (75)	2.2% (11)	46.5% (230)
Anaesthesia Concurrent Sessions	67.9% (339)	20.8% (104)	4.2% (21)	7.0% (35)
Pain Concurrent Sessions	27.9% (136)	5.9% (29)	2.3% (11)	63.9% (312)
Workshops	39.3% (192)	18.4% (90)	4.3% (21)	37.9% (185)
PBLD Sessions	27.8% (135)	10.1% (49)	3.5% (17)	58.6% (284)
QA Sessions	22.0% (103)	5.1% (24)	2.1% (10)	70.7% (331)

NZ ASM WRAP UP 2010

ASM Snapshot:

1051 Registrants

209 Sessions

82 Workshops and PBLDs

Prize Winners

Gilbert Brown Prize:
Dr Forbes McGain
Financial and environmental costs of drug trays

Formal Project Prize:
Dr Peter John Carlin
Midwife management of epidural analgesia in 2nd stage labour – a survey

Renton Prize:
Alexander Smirk, April 2009
Tung Hoi Ying Queenie, September 2009

Cecil Gray Prize:
James Jarman, May 2009
Louise Ellard, October 2009

Regional Organising Committee

Name	Position
Assoc Prof Ross Kennedy	Convenor
Dr Richard French	Deputy Convenor
Dr Mark Waddington	Scientific Convenor
Prof Ted Shipton	Faculty of Pain Medicine Convenor
Dr Paul Smeele	Treasurer
Dr Andrew Marshall	Health Care Industry Liaison Officer
Dr Sue Nicoll	Social Convenor
Dr Debbie Goodall	Social Convenor
Dr Chris Brett	Workshop Coordinator
Dr Jennifer Woods	PBLD Coordinator
Dr Karen Ryan	New Fellows Convenor
Prof Alan Merry	ANZCA Councillor
Dr Richard Waldron	ANZCA ASM Officer (until Aug 2009)
Dr Nicole Phillips	ANZCA ASM Officer (from Sept 2009)

2010 Named Lectures

Ellis Gillespie Lecture

ANZCA ASM Visitor: Prof Talmage Egan from the USA

Pharmacodynamic interactions: hypnotics and opioids

Michael Cousins Lecture

FPM ASM Visitor: Prof Jeffrey S Mogil from the USA

What's wrong with animal models of pain?

Mary Burnell Lecture

ANZCA New Zealand Visitor: Prof Michael "Monty" Mythen from the UK

Why is it easier to get doctors to the top of Mount Everest than it is to change their clinical practice?

Australasian Visitors Lecture

Australasian Visitor and Douglas Joseph Professor: Prof Paul Myles

Stochasticity in clinical medicine

Pain Medicine Visitor's Lecture

Prof Richard Rosenquist from the USA

Perineural catheter techniques for postoperative pain management at home

The ASM Committee Lecture

Prof Steve Shafer from the USA

Unsolved mysteries of anaesthesia

How Meets Why
Clinical Practice and the Science Behind it

In the weeks after the 2010 ASM we are looking back with considerable satisfaction on a meeting that was a great success.

It goes without saying that any meeting is utterly reliant on those people who contribute to the program. The amount of effort that all speakers made to make their presentations engaging and informative was obvious from the outset. We cannot overstate how grateful we are to all the people who contributed to the scientific program.

The involvement of our keynote speakers in all aspects of the meeting (from audience to podium to “Adrenalin Forrest” to a Blues piano performance and all places in between!) was fantastic. Their palpable enjoyment was contagious for delegates and organizers alike and was one of the reasons for the positive ‘buzz’ that was pervasive from Day One.

While we were saddened that Monty Mythen was unable to join us in person (due to health issues), with the help of modern telecommunications we were able to have him ‘virtually’ at the meeting. This was a new experience for us all and proved very successful.

Feedback from delegates has been resoundingly positive about the wide variety and high quality of practically relevant concurrent sessions, workshops and PBLD/QA sessions. We took it as a great endorsement that lecture halls were sometimes overflowing with people and that the trade display was usually empty during sessions. High attendance, even higher demand and positive feedback attest to the great range of workshops that were provided.

As a new innovation at this meeting we ran formally Moderated Poster Sessions (in place of oral presentations) for free papers. With an opportunity to present their own novel research and quality improvement data and get ‘up close and personal’ with some of the biggest names in Australasian & world anaesthesia, presenters found this hugely rewarding. The large audience at each of these sessions shows the potential for poster sessions at future meetings. The ROC congratulates Assoc Prof Graham Hocking (WA) and Dr David Law (WA) as recipients (respectively) of the ROC Best Fellow’s Poster Prize and the ROC Best Trainee’s Poster Prize for the ASM.

Another highly successful innovation was initiated by the ANZCA Communications department. The series of daily ASM e-newsletters including photos, video and podcasts of lectures was followed by hundreds of people around the world who were otherwise unable to attend the meeting.

A consistent and gratifying message that was fed back to me during the meeting was that delegates struggled to choose which set of lectures they would attend and which ones they would regrettably miss during each concurrent session. My personal highlight from the meeting was the historical session entitled “On the Shoulders of Giants”. This session was in equal parts fascinating and hilarious as Professor Kate Leslie re-enacted the role of Mr Harvey Cushing’s “etherist” in 1910, Professor Steve Shafer took us back to anaesthesia in the 1940’s at the bombing of Pearl Harbor and Dr David Sidebotham provided a unique insight into anaesthesia with Christian Barnard in the 1960’s.

The final day of the conference was in many ways a fitting end to the conference. In the long tradition of ‘lighter’ presentations following the Gala dinner, the day began with a series of mini-debates.

Particularly memorable were Dr Richard French’s VLFTS (very low fidelity TIVA simulator – an empty cardboard box) and Dr Tim Pavy’s attempt to put his own head where the sun does not shine….. in an effort to prove their points. While humour was a widely employed medium, the importance of each underlying issue was not lost on the audience.

The final session was a memorable counterpoint to the early morning flippancy. The “Last lecture I’ll ever give (at this meeting)” allowed our keynote speakers an opportunity to impart some parting wisdom on delegates. One could not help but be inspired by a look at our profession from the ‘other side of the mask’ by Talmage Egan and his moving and poignant reminder that our job extends beyond the mere provision of drugs and manipulating physiology. Equally compelling was Steve Shafer’s challenge for us all to become better mentors.

In looking back over the scientific program for ASM 2010 we are proud of what delegates tell us was an informative, inspiring and interesting range of content. We would like to thank all the delegates for supporting our meeting and I would once again like to thank all of those people who contributed to the program and my colleagues in the ROC who helped the scientific program to come together.

Dr Mark Waddington
Scientific Convenor ASM 2010

Combined Scientific Meeting 2011, Hong Kong

Important dates

August 2010	Online abstract submission opens
November 2010	Online registration opens
February 11, 2011	Deadline for abstract submission
March 18, 2011	Deadline for early-bird registration
May 14-17, 2011	Meeting dates

The Combined Scientific Meeting of ANZCA, the Faculty of Pain Medicine and the Hong Kong College of Anaesthesiologists will be held from May 14-17, 2011 at the Hong Kong Convention and Exhibition Centre which is conveniently located at the heart of Hong Kong, overlooking the beautiful and famous Victoria Harbour.

The preparation of the Hong Kong meeting next year is well under way. We have invited an array of renowned speakers including Dr Steve Yentas (ANZCA ASM Visitor) and Professor Mervin Singer (HKCA Visitor) from the United Kingdom, Professor Spencer Liu (SAHK Visitor) from the United States, Professor Catherine Bushnell (FPM ASM Visitor), Professor Homer Yang (HKCA Visitor) and Professor Vincent Chan (Hong Kong Visitor, Anaesthesia) from Canada, Professor You Wan (Hong Kong Visitor, Pain Medicine) from China and Associate Professor David Scott (Australasian Visitor) from Australia. Professor Warwick Ngan Kee, our Scientific Convenor and the Scientific Program Committee are working hard on the workshops, PBLDs and the scientific program. Detailed information will be released in November.

Hong Kong is such an interesting and multi-faceted place so you should not miss visiting us next year. Hong Kong, being the Pearl of the Orient, is also a city that never sleeps. We have prepared an exciting and colourful social program. In addition, we will have a satellite meeting in Shanghai which is about three hours' flight from Hong Kong.

The program of CSM 2011 is guaranteed to inform, stimulate and inspire. Please visit our website regularly in order to get the most up-to-date information. Please join us in "Seeking the dragon pearl". We are looking forward to welcoming you at CSM 2011 in Hong Kong.

Dr Chi-Wai Cheung
Convenor
CSM 2011, Hong Kong

Australia's health reform: Opportunity or threat?

Recently announced health reforms in Australia will have a major impact on Australia's health care system and how services are delivered. Health economist and former Productivity Commissioner, Helen Owens, examines the reforms and what they mean for patients and the medical profession.

The Australian government has invested a considerable amount of political capital in developing a major reform package for Australia's health system. It did so at the risk of damaging its commitment to cooperative federalism during its recent Council of Australian Governments (COAG) negotiations with the states and territories.

Prior to the 2007 election, Labor promised to assume responsibility from the states for public hospitals if their performance did not improve. Following the election, the government began delivering a number of initiatives to improve the system. In 2008 it signed an agreement with states that delivered a 50% increase in health and hospitals funding. It also provided $1.1 billion to train more doctors, nurses and allied health workers, as well as funds for an elective surgery waiting list reduction plan, emergency departments and sub-acute facilities.

In 2008, the Government also established the National Health and Hospitals Reform Commission (NHHRC) to undertake a wide-ranging review of the health system. The Commission's final report, released in June 2009, included 123 recommendations for immediate and long-term reforms.[1] The Prime Minister and Health Minister subsequently engaged in an extensive round of consultations with the community and health professionals. A reform package - a National Health and Hospitals Network - was then developed, based in part on the NHHRC report recommendations, to take to the COAG meeting in April.[2]

A final agreement with all states except Western Australia, reached after two days of heated negotiations at COAG, was outlined in a communique.[3] It is reflected in a revised National Health and Hospitals Network reform package tabled with the May Budget Papers.[4] The Government also announced further reforms after COAG and in the May Budget.

Rationale for major reform

Both the Commonwealth and NHHRC cited a number of compelling reasons for the introduction of significant national Health reforms (Box 1).

Box 1: Reform rationale

1. To **meet future challenges** from:
   (i) An ageing population—the proportion of Australia's population aged over 65 is forecast to increase from 14% to 23% between 2010 and 2050.
   (ii) Population growth—from 22 million today to 36 million by 2050.
   (iii) The burden of chronic disease.
   (iv) Rising health costs.
   (v) Workforce shortages.
2. To address **duplication**, **cost-shifting** and **blame-shifting** between the Commonwealth and the states.
3. To improve **service access** and **co-ordination**, particularly for the chronically ill, residents of rural and remote areas and indigenous populations.
4. To alleviate pressure on **public hospitals** and health professionals.
5. To address **unsustainability** of long-term funding.
6. To provide incentives for **efficiency** improvements.
7. To facilitate **local and clinical engagement** in decisions about service delivery.

References: 1 and 4

"The Budget allocation to train specialists represents under 10% of total workforce funding."

Another important driver of reform, not noted explicitly by the Commonwealth, is the rapid rate of dissemination of new medical technologies and associated community expectations regarding access. These have the potential to drive a revolution in care delivery and higher health costs in future.

Of particular note is the potential application of stem cell therapies and nanotechnologies, and the promise of targeted therapies and personalised medicine facilitated by the human genome project and the subsequent drop in whole genome sequencing costs.

Many of the pressures identified by the Commonwealth and NHHRC are already apparent. For example, in the public sector we are witnessing growing pressures on emergency departments, an increased demand for elective surgery and associated increases in waiting times, bed blockages due to a shortage of suitable residential accommodation for elderly patients, the struggle to fund capital equipment and capital works, medical and nursing workforce shortages and the constant juggling to break even or minimise deficits.

It is apparent that we can no longer continue down the incremental reform path and that fundamental systemic reform is required. It is also apparent that health reform is a national issue requiring national solutions.

National Health and Hospital Network reforms

Key elements of the wide-ranging health reform package announced by the Commonwealth in May are summarised in Box 2.

Box 2: Proposed national health reforms

1. **Funding**

(i) Commonwealth Government dominant funder of public hospitals
60 % of national efficient prices (services to public patients) – Activity Based Funding.
60% block grant support for small regional and rural hospitals.
60% research and training recurrent expenditure.
60% buildings and capital equipment.
up to 100% national efficiency prices of primary health equivalent outpatient services.

(ii) One-third GST revenue redirected from states/territories to health spending.

(iii) From 2014-15, Commonwealth assumes responsibility for majority of growth in health costs; guarantees benefits to states of $15.6 billion to 2019-20.

(iv) Commonwealth assumes full funding responsibility for GPs, primary care and aged care.

(v) States responsible for 40% of national efficient prices plus additional hospital costs.

(vi) Funds pooled into National Funding Authority Pool and State Based Funding Authority Pools.

(vii) Independent Hospital Pricing Authority determines efficient prices and block grant allocations.

2. **Governance**

(i) Commonwealth assumes policy responsibility for primary care and aged care.

(ii) States have policy and industrial relations responsibilities for hospital systems.

(iii) Hospitals run locally through Local Hospital Networks (LHNs) and States responsible for appointing LHN boards.

(iv) Clinician and local involvement in LHNs.

(v) Medicare Local - new Local Primary Healthcare Organisations to drive service integration and improve access.

3. **National accountability and performance framework**

(i) Performance standards cover access to public hospitals, GPs and safety and quality.

(ii) Transparent public reporting.

(iii) National Access Targets:

Emergency department – four hours for category one patients

Elective surgery guarantee – by 2015, 95% treated within clinically recommended times.

4. **Primary care**

(i) After hours GP/primary care access supported by Medicare local.

(ii) Build 23 more GP super clinics.

(iii) Upgrade existing 425 GP facilities to enable team-based care.

(iv) Diabetics able to enrol with GP of choice.

5. **Workforce**

(i) Training places for GPs and allied health specialists (see Box 3)

(ii) Half new GP and specialist training places in rural and remote communities.

6. **Mental health**

$123m over five years for mental health nurses, care packages for people with severe mental illness etc.

7. **Ehealth**

$467m over two years for personally controlled electronic health records.

Reference: 4

Australia's health reform: Opportunity or threat?

continued

Analysis of the main reforms

So does the Commonwealth's reform package meet the key objectives outlined in Box 1? I would argue that while it is not perfect, it is a good start. In its favour, I would argue that if properly managed, many of the key objectives could be addressed. However, some significant gaps and risks are still apparent.

Financial sustainability

Past block funding arrangements between the Commonwealth and states, under the health service agreements left sole responsibility for hospital funding risks with the states. There was a clear need for the Commonwealth to assume a greater share of the risks associated with an ageing population, technological change and other system stresses outlined above. Commonwealth projections identified that by 2045-46 health spending alone would absorb more than the entire own-source tax revenues collected by the states.[4] They would thus be required to raise more revenue from their own inefficient taxes.

However, while the Commonwealth has committed to taking responsibility for funding the majority of the growth in health and hospital costs directly and guaranteed benefits to the states from 2014-15 to 2019-20, the states face a possible sovereign risk in the medium to longer term. A new government could come to power before 2020 and withdraw from the commitment or after that period the government of the day may decide not to renew it.

Under the Activity Based Funding arrangements states have been guaranteed they will be made no worse off in the short term but their long-term position remains unclear. Much rests on how the nationally efficient prices are determined by the Independent Pricing Authority. If set too low, for a range of reasons some states may struggle to lift their hospital efficiency to the level expected and will suffer financially as a consequence.

Workforce shortages

While the Commonwealth has acknowledged the limitations placed on the delivery of healthcare by workforce shortages, it has primarily focused on the Budget announcements on funding initiatives centred on nursing, GPs and allied health with a particular focus on rural and remote areas and aged care services (Box 3).

Box 3: Workforce initiatives

2008 COAG Agreement

(i) 35% increase in GP training places by 2011.
(ii) 73 additional specialist places per annum in the private sector.
(iii) Increased funding to train nurses, allied health and medical supervisors.

2010 Budget (over four years)

Nurses

(i) $132 million to upgrade skills, fund additional enrolled nursing training places and undergraduate scholarships in aged care, rural locums and nurse practitioners in aged care.
(ii) $390 million practice nurse grants initiative.
(iii) $211 million to increase registered and enrolled nurses in residential aged care.

Allied health

(i) $6.5 million to double scholarships in rural and remote areas.
(ii) $5.3 million to introduce a rural locum service.

GPs

(i) $150 million prevocational GP Placement Program.
(ii) $345m to increase GP training places.

Specialists

$145 million to expand Specialist Training Program

Reference: 5

The Budget allocation to train specialists represents under 10% of total workforce funding.

Specific initiatives to increase specialist training places to meet government expectations regarding improving public hospital performance, as reflected in its targets for elective surgery and emergency departments, have been largely overlooked.

It has failed to recognise that an adequate supply of specialists, especially surgeons and anaesthetists, form the necessary "platform" for meeting such targets in the future. In this regard, it has also failed to recognise that while certain measures may be successful in redirecting some patients from hospitals to GPs, sub-acute services and aged care, the ageing population will continue to place significant pressure on our hospital system.

The budget allocation of $145 million to train specialist doctors is relatively low when spread across all specialities and is largely directed to training specialists in settings outside traditional public teaching hospitals. It is expected to deliver another 680 specialists in the next decade.

The ANZCA/ASA combined *Australian Anaesthesia Workforce Study* by Access Economics concluded that there could be a shortage of around 2287 anaesthetists by 2028 under its base case assumptions.[6] It is unlikely that these additional places will be sufficient to plug the identified gap once they are distributed across all specialities.

Cost shifting/blame game

The incentives for cost shifting between the Commonwealth and states have been diluted through the Commonwealth assuming full responsibility for primary care and aged care and major responsibility for hospital care. Having both Commonwealth and state representation on the national and state-based Funding Authority Pools will reinforce this. However, while we have a federal system and a need to ration services under a Medicare system that offers free public hospital services, eliminating the blame game is an unrealistic goal that can never be met. We can always expect hospital queues. The difference now is that the Commonwealth will share not just more of the risk, but more of the blame.

Coordination of patient care

The Commonwealth's proposal to assume 100% policy and funding responsibility for primary care and aged care, and the majority of responsibility for hospital funding, should ensure that many of the systemic blockages to coordinated and patient-centred care are reduced.

The Budget allocation for more super clinics and to upgrade existing GP practices, as well as the introduction of Medicare Locals, could help to ensure

"The budget allocation of $145 million to train specialist doctors is relatively low when spread across all specialities and is largely directed to training specialists in settings outside traditional public teaching hospitals."

Australia's health reform: Opportunity or threat?

continued

greater patient access to multidisciplinary care that will be of particular benefit to the chronically ill. However, this will depend on the speed with which the Government rolls out its super clinics which to date has been glacial. Once established, they could provide an excellent "home" for multidisciplinary pain management services. It will also depend on the relationship between the Medicare Locals and Local Hospital Networks and how the Networks are constituted. Individual states will have a major say in their size and coverage. Ideally they should cover not just hospitals but a full range of services as currently occurs in Victorian health network system.

Ehealth

The personally-controlled electronic records initiative is also fundamental to the delivery of better coordination across acute, primary and community services. They are also critical to improving the quality of patient care and avoiding the unnecessary duplication of services. Retaining consumer control of their own record should alleviate potential privacy concerns. However, realistically the introduction of ehealth could still face many obstacles. In the UK the introduction of provider-based electronic patient records has been delayed by four years and to date has cost $A22 billion. The allocation of $467 million over two years for ehealth may prove to be very conservative.

Local and clinician engagement

Greater local and clinician engagement can be facilitated through the LHNs and their boards. While I acknowledge the undoubted value of direct clinician involvement in network boards it would be desirable that such board members work outside the catchment area. Governance structures should be developed to facilitate internal senior clinical advice to the board through board subcommittees. It is also important that LHNs be as autonomous as possible from state health departments. Under the COAG Agreement these lines of accountability appear to be blurred.

Efficiency and accountability

Activity based funding will increase further the pressures on hospitals to become more efficient. This, in turn, will place added strains on the health workforce. At the same time hospitals will be subject to higher performance standards relating to financial performance and quality and much greater scrutiny.

The performance of individual hospitals and LHNs will be measured and publicly reported. For the first time government and patients will be able to benchmark services on a nationally consistent basis. Meeting the access targets for emergency departments and elective surgery could prove particularly challenging for many health services, especially under existing and future workforce constraints.

In addition, the four-hour emergency department target for category one patients could compromise good clinical care given the vagueness of the "out" clause – "where clinically appropriate". There is also the danger that focusing on such targets could redirect attention from other important areas of hospital activity such as research and training.

Concluding comments

As the Government has noted this is the biggest reform to Australia's health system since the introduction of Medicare. We can expect to see major changes to the operation of the system with the changing incentives faced by all parties.

How the reforms are implemented will be critical to their success. It relies on the successful establishment of a number of new bodies at the Commonwealth and state levels and some inevitable upheaval as the LHNs are formed. It relies on the Commonwealth successfully assuming its new roles and responsibilities and a clear demarcation between those of the states and LHNs so the latter can be truly autonomous.

The states and hospital systems face some sovereign risks if a future Commonwealth government were to shift the goal posts. There are still many gaps. There is little mention of the private sector, except in the context of training more specialists and treating public patients if elective surgery targets are not met. No mention was made of the future of the increasingly costly and open-ended private health insurance subsidy.

> "It has failed to recognise that an adequate supply of specialists, especially surgeons and anaesthetists, form the necessary "platform" for meeting such targets in the future."

The inadequate attention to specialist training is a regrettable oversight. The reforms fail to provide a framework for new models of care, especially targeted therapies, and have given insufficient priority to mental and dental health.

Finally, the underlying "platforms" or enablers – such as ehealth, supply of specialists and medical research - need to be nurtured or the successful outcome of the reforms will be jeopardised.

Helen Owens
Health economist, Director Southern Health Board, Victoria;
Member, Victorian Cancer Agency;
Former Commissioner, Productivity Commission.

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5. Australian Government, Budget Measures 2010-11, Budget Paper No. 2, Part 2, "Expense Measures", May 2010.
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Maternity collaboration – anaesthetists must be involved

In recent months, ANZCA has been actively engaged in the Commonwealth Government maternity services review.

The College has outlined the key requirements for optimal maternity care services. These must:

- be centred on the woman;
- be accessible and equitable;
- offer choice and proper informed consent;
- be multidisciplinary; and
- be safe and of high quality.

ANZCA also responded to the Federal Government's Maternity Services Report that was released subsequent to the consultation process, and is represented on the *Core Competencies and Educational Framework for Maternity Services Project Steering Group* (Department of Health and Ageing).

The College was, therefore, both surprised and concerned that it was not directly contacted regarding the important consultation process on the *National Guidance on Collaborative Maternity Care*, recently released by the National Health and Medical Research Council (NHMRC). The *Guidance* makes little, if any, reference to the role of the anaesthetist in maternity care.

With assistance from the Obstetric Anaesthesia Special Interest Group, ANZCA prepared a submission at short notice, outlining the above concerns and highlighting the role of the anaesthetist in maternity care.

The consultation document is centred on collaborative care, which ANZCA endorses in principle, subject to the

acknowledgement of all key players in the field. Teamwork, collaborative learning and training are all emphasised, and safety issues are addressed in broad terms. However, it is disappointing that the critical role of the anaesthetist appeared to be significantly reduced in the *Guidance*. *All* health professionals need to be involved in collaboration in maternity care. The College informed the NHMRC that they had overlooked specialist anaesthetists and pain medicine specialists – a group of health professionals who provide specialist care critical to maternity care services, often preventing serious consequences for women and babies.

ANZCA's submission outlined the key components of a world class maternity care service:

- The availability of skilled anaesthetic (and surgical) services.
- The choice of labour analgesia for women.
- The critical role of anaesthetists in the resuscitation and ongoing management of critically ill women.
- The critical role of anaesthetists in the management of women with high risk pregnancies.
- The importance of interaction of other maternity providers with anaesthetists as part of a multidisciplinary approach.
- The experience of anaesthetists in the development of team-based clinical management.
- The experience of anaesthetists in safety and quality activities. It will be most important for anaesthesia-related, critical care and maternal morbidity data to be included in the national data collection.

Further sections of ANZCA's submission emphasised the role of anaesthetists when attending to complications, the importance of education with provision of unbiased information to women, and ready access to all maternity services. As the emphasis is on mutual respect, collaboration and woman-focused care, there needs to be frank and open discussion with each woman about what services can be provided for her, for example access to epidural analgesia or to surgical services (particularly after-hours access or not), access to a blood bank and intensive care should she require such services.

Clinical standards were highlighted and ANZCA's record in this area, its commitment to professional standards development (Professional Documents) and contribution to the high level of health outcomes enjoyed by most Australians were reinforced.

It is disturbing that ANZCA was not part of the working party overseeing the development of the NHMRC document (the *Guidance*) and was not formally invited to comment.

Given the importance of the issues involved, the College subsequently issued a media release pointing out that anaesthetists are involved in the care of half of the maternity cases in Australia such as providing epidural pain relief, yet their role had been all but ignored in the new draft guidelines.

As a result of our concerns it was pleasing to receive a response from the NHMRC acknowledging ANZCA's submission and acknowledging the role of the anaesthetist in maternity care. The NHMRC has since pointed out that the *Guidance* is not a clinical practice guideline, but is being developed in preparation for the new arrangements on November 1 when newly defined "eligible" midwives are able to access Medicare and have limited prescribing rights.

Further, the *Guidance* provides information on what collaborative maternity care means and how maternity clinicians can collaborate to provide better care for women, enhancing women's choice and access to safe, quality maternity care. The response from NHMRC to our unsolicited submission has been pleasing and the College looks forward to engaging in the project at a higher level. NHMRC has acknowledged the need to include anaesthetists in this collaboration.

As part of our continuing commitment to this initiative, the College has compiled case studies to inform the consultation process and we welcome ongoing involvement. ANZCA is very keen to participate in the development of clinical standards such as a proposed multidisciplinary guide/handbook on consultation and referral in maternity care, as well as provide comments on proposed consumer information. We have requested that ANZCA be included in the ongoing discussions at a steering group level and hence be considered an active part of this collaboration process. We hope and expect that our input is reflected in the final document so that women and babies are protected and receive the best care available.

John Biviano
Director, Policy, Quality & Accreditation

The College's submissions to the maternity services review and the NHMRC are available on the ANZCA website: **www.anzca.edu.au/news/submissions-to-government/ANZCA%20SubMSA-Final-20081031.pdf.**

ANZCA Fellowship Survey – your response

Enhancing engagement has been identified as a key strategic priority for the College. Seeking views of the Fellowship is an important element in achieving that objective.

In early 2010, ANZCA's Fellowship Affairs Committee chaired by Dr Michelle Mulligan, decided to conduct a confidential survey of all active Fellows in order to obtain a comprehensive and independent assessment of their views. The College's CEO, Dr Mike Richards, commissioned independent research company ANOP Research Services to conduct the survey to analyse the perceived effectiveness of the College in its broad range of activities and to identify our strengths and any areas for improvement.

A quantitative survey of all active ANZCA Fellows was conducted from late March to late April 2010. Fellows were given the choice of completing the survey either online or on hard copy and thus were sent the survey in two formats: 4196 hard copy surveys were distributed by mail, and 4063 by e-mail (a minority of Fellows did not have e-mail addresses). A total of 1988 surveys were completed: 1126 online and 862 hard copy. An excellent response rate of nearly one in two was achieved.

In addition to the quantitative survey, ANOP conducted four focus groups with a very good spread of Fellows by region, seniority and position, at the 2010 Christchurch Annual Scientific Meeting from May 2-3.

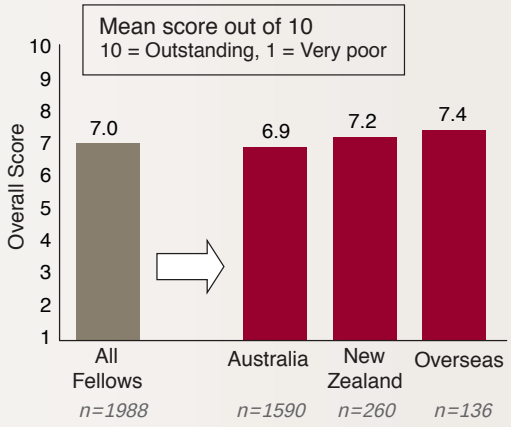
ANOP's executive summary has been reproduced in full in the following pages. ANZCA Council will be considering the survey findings over the next few months and will announce its response to the survey's findings in the September issue of the *ANZCA Bulletin*.

ANZCA 2010 Fellowship Survey - ANOP Executive Summary

Overall satisfaction with ANZCA

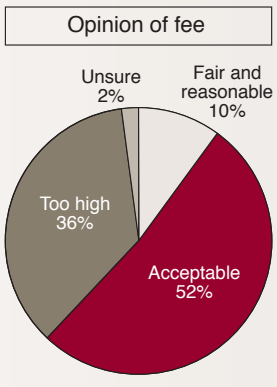
1. There is a good level of satisfaction with ANZCA overall. 71% of Fellows are satisfied with ANZCA overall, giving ANZCA scores of 7, 8, 9 or 10 (out of 10). Another 19% are lukewarm, rating ANZCA overall as 5 or 6; and only 8% are dissatisfied, giving scores of 1-4. The mean overall satisfaction score is 7.0 out of 10, representing a good level of overall satisfaction. Fellows in New Zealand (7.2) and overseas (7.4) are slightly more satisfied than those in Australia (6.9).

Satisfaction with ANZCA overall



2. Six in ten regard the annual subscription fee as at least acceptable. A total of 62% indicate the level of the fee is "acceptable" (52%) or "fair and reasonable" (10%), whereas 36% are of the opinion that the fee is "too high". This is a relatively good result for a question about fees, as some dissension is natural and expected. Also not unexpectedly, concerns about value are most pronounced among those less satisfied with ANZCA overall.

Annual subscription fee

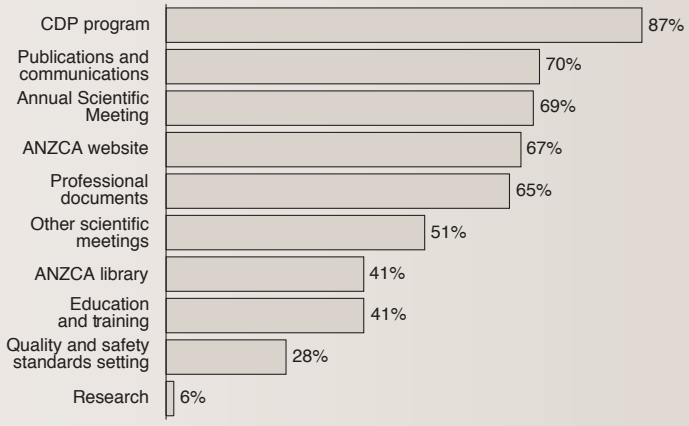


3. ANZCA is perceived as being professional, reputable and credible. The positive words most frequently associated with ANZCA are professional (73%), reputable (50%) and credible (42%), followed by accessible and relevant (both 33%). On the other side of the ledger, the main negatives are bureaucratic (33%) and a feeling of remoteness from ANZCA (to an open-ended question there was around 10% in each case suggesting an absence of personal representation, or a lack of personal relevance or a view that ANZCA is remote). ANZCA is also seen as conservative (33%) but this is not necessarily a negative as this perception is not strongly related to dissatisfaction.

ANZCA's specific roles and services

4. There is good usage of many ANZCA services. This indicates ANZCA's relevance and usefulness to the profession. As would be expected, the most frequently used service is the continuing professional development (CPD) program (87% reported usage). A large majority of Fellows also report using publications and communications (70%), the Annual Scientific Meeting (69%), the ANZCA website (67%) and professional documents (65%). The College clearly satisfies a variety of needs.

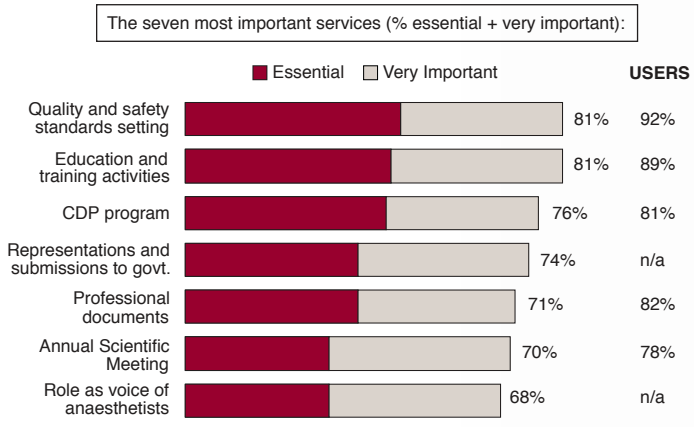
Usage of ANZCA services



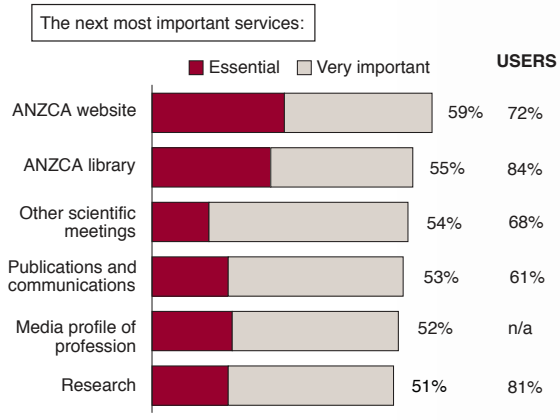
5. ANZCA's most important roles are seen to be quality and standards setting, and education and training. A total of 81% of all Fellows rates these as "essential" or "very important". High levels of importance are also attached to the CPD program (76% essential/very important), representations and submissions to government (74%), professional documents (71%), the ASM (70%) and ANZCA's role as the voice of anaesthetists (68%). Importance ratings are higher among users of each service, particularly the ANZCA Library (55% among all Fellows: 84% among users) and research (51% all Fellows: 81% among users).

ANZCA Fellows Survey – your response continued

Importance of ANZCA's roles and services

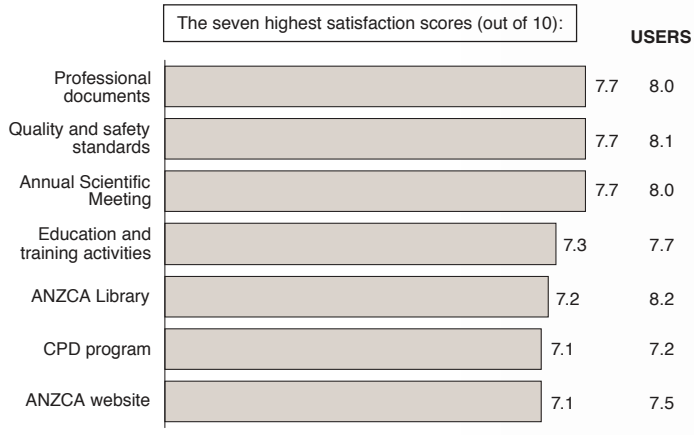


Importance of ANZCA's roles and services



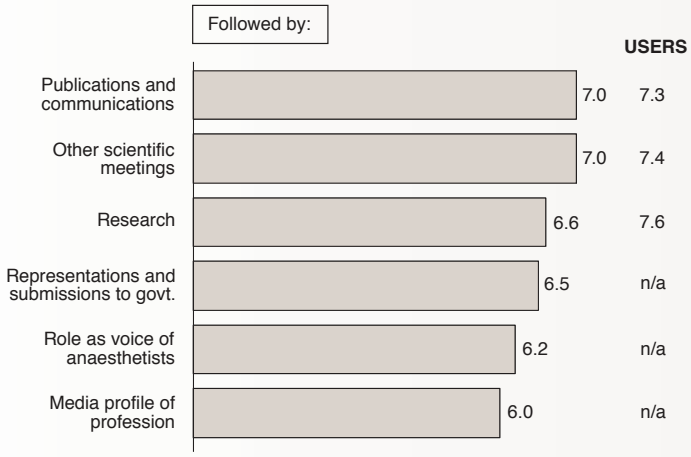
6. ANZCA is seen as performing very well in the provision of professional documents, its quality and safety standards setting and the ASM. Each of these services scored 7.7 out of 10. Satisfaction is at good levels for education and training (7.3), the library (7.2), the CPD program, the website, (both 7.1), publications and other scientific meetings (both 7.0).

ANZCA's performance in its roles and services



7. Users of individual services attach higher importance to the services they personally use and are more satisfied with them than non-users. All individual services receive higher importance and performance ratings among their users, especially the ANZCA Library (84% essential/very important; 8.2 satisfaction score among users) and research (81% essential/very important; 7.6 score among users). This indicates that ANZCA's services are well targeted and that it is meeting a wide range of specific needs. It also suggests that ANZCA's library and research are hidden gems.

ANZCA's performance in its roles and services

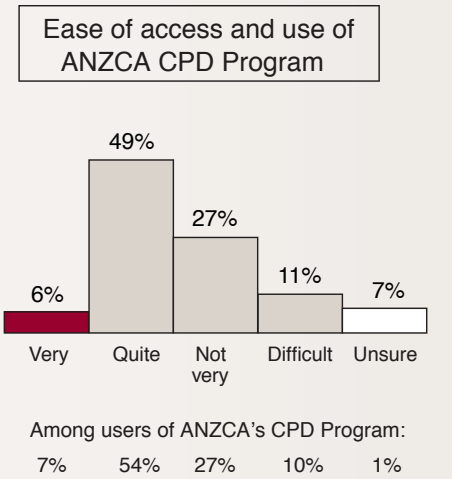


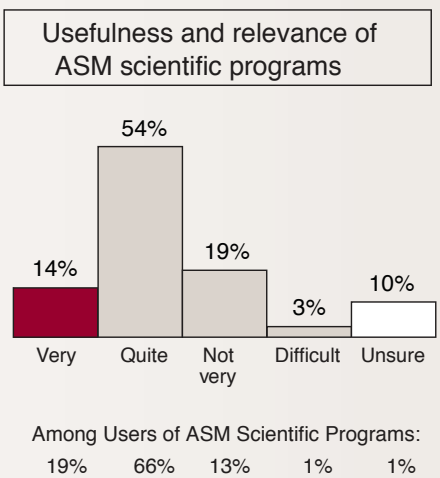
8. The comparison of the importance and performance rankings shows that **particular ANZCA strengths are its professional documents, the ASM, the library, and publications and communications** – these services rank higher on performance than importance – **whereas weaker areas for ANZCA are the CPD program, representations and submissions to government and its role as the voice of anaesthetists.** These services and roles rank higher on importance than performance.

Continuing Professional Development (CPD)

9. There is scope to improve further the ease of access and use of ANZCA's CPD program. As would be expected, the great majority of Fellows are involved in the CPD program. While there is a good level of satisfaction with the program (7.1 all Fellows, 7.2 users), it is a lower-order service in terms of performance ratings but it is perceived as one of ANZCA's more important services. When specifically asked about ease of access and use of the program, over half (55%) indicate it is very or quite easy to use, whereas nearly four in ten (38% of all Fellows, 37% of users) experience some difficulties.

Continuing Professional Development





10. As mentioned, **the Annual Scientific Meeting is one of ANZCA's strengths.** The ASM receives very good satisfaction scores (7.7 all Fellows, 8.0 users) and it ranks higher on performance than importance. When specifically asked about the usefulness and relevance of ASM scientific programs to continuing education needs, nearly seven in ten (68%) give positive ratings and only two in ten (22%) negative ones. In line with the strong satisfaction score, there is a very positive response among ASM users (85% very/quite useful). Six in ten (61%) of all Fellows report receiving good value at the ASM, and this rises to nearly eight in ten among users (77%).

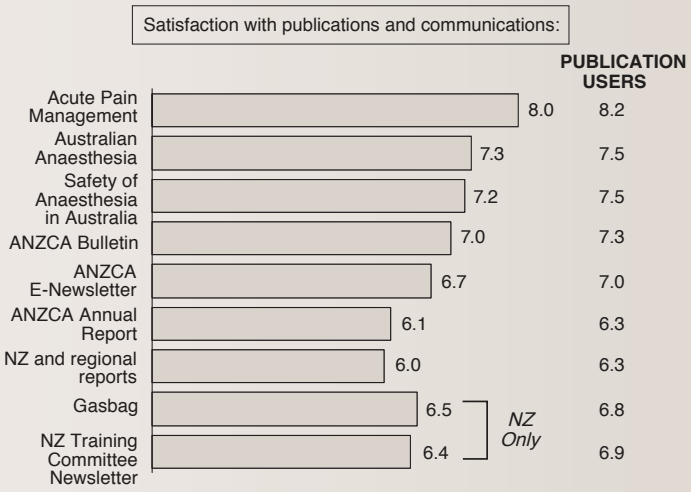
11. The clear majority regard locally organised programs as useful and relevant. Two-thirds (65%) rate locally organised programs as useful and relevant to continuing education needs, whereas nearly one-quarter (24%) do not.

Publications and communications

12. ***Acute Pain Management: Scientific Evidence*** **is the most highly regarded ANZCA publication.** It receives an excellent score of 8.0 out of ten among all Fellows. Good levels of satisfaction are evident for *Australian Anaesthesia* (7.3), *Safety of Anaesthesia in Australia* (7.2 all Fellows, 7.3 Australian Fellows) and the *ANZCA Bulletin* (7.0). The E-Newsletter receives moderate satisfaction ratings overall (6.7), as do the New Zealand publications, *Gasbag* (6.5) and the *Training Committee Newsletter* (6.4), while the annual reports are the lowest-rated publications – *ANZCA Annual Report* (6.1) and New Zealand and regional annual reports (6.0). The large majority (70%) of Fellows who report using publications and communications give higher satisfaction scores to all publications (generally by +0.2 or +0.3).

13. As mentioned, **the *ANZCA Bulletin* receives good satisfaction ratings** (7.0 all Fellows, 7.3 publication users). There is a slight preference for receiving the *ANZCA Bulletin* as hard copy as opposed to online – 48% prefer hard copy, 37% online and 14% both. This reflects a diversity of communications delivery preferences among Fellows and differences in their level of comfort with technology. When asked about areas for greater coverage in the *ANZCA Bulletin*, the top preference is for greater coverage of CPD news and opportunities (63%) and quality and safety (54%). There is also interest in greater coverage of health policy and submissions (47%), stories about new research (40%) and special features on the work of the profession (39%). Thus, there is a reported preference for topical, core information.

Publications and communications



ANZCA Fellows Survey – your response continued

14. **Fellows would like the E-Newsletter to keep them up to date primarily with information about CPD opportunities and safety alerts.** When asked about areas for greater coverage in the *E-Newsletter*, the three top desired topic areas are events and conferences, education and CPD (both 55%) and safety alerts (54%). This again reflects the personal relevance to Fellows of CPD and the maintenance of safety standards.There is also interest in greater coverage of careers/positions vacant (36%), general news about the profession (35%) and media news about the profession (31%).

15. **The majority prefer to receive the *Annual Report* online.** Nearly three-quarters (73%) indicate that they prefer to receive the *Annual Report* online. This reflects the view expressed in the focus groups that the *Annual Report* is neccesary but is not a highly relevant, "to keep" publication. The lower satisfaction ratings given to annual reports similarly reflect this lower level of perceived relevance.

16. As found for ANZCA publications generally, **satisfaction with the ANZCA website is sound.** The website is a middle-order service in terms of both perceived importance and performance. It receives a good satisfaction score from all Fellows (7.1), and a very good one among website users (7.5 among the 67% of users). The great majority report that the website is easy to navigate and use (74% of all Fellows, 81% of users).

Involvement in, and awareness of, the College

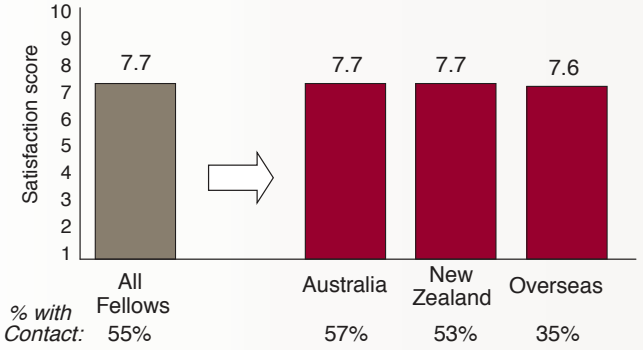
17. **Over half - 55% - report having undertaken pro bono roles.** The most frequently reported pro bono involvement is as a SIG member (28%) or lecturer (25%), followed by a supervisor of training (18%), a committee/Council member or organiser (both 14%). An important finding is that those involved in pro bono roles are slightly less satisfied with ANZCA overall (6.9) than those who have not been involved (7.1).

18. **Nearly eight in 10 - 78% - are involved in teaching trainees.** "Younger" Fellows are more likely to be involved in teaching (92% of Fellows with less than five years, 84% of five-nine year Fellows). The average number of reported hours (in informal in-theatre teaching and formal sessions) is 9.4 per week. Involvement in teaching trainees has no impact on satisfaction with ANZCA overall.

19. **There is very good level of satisfaction with College staff.** Over half - 55% - report having had contact with College staff in the last twelve months. The satisfaction score among these Fellows is very good, with a mean score of 7.7 out of ten. The main positive comments are that staff are helpful and supportive.

Experience with College staff

The 55% of Fellows who reported having had contact with College staff in the last 12 months rated their experience with the staff on the 1-10 scale.



20. **Understanding of College roles and responsibilities is relatively low.** Only around four in 10 feel that they are well informed about the roles and responsibilities of committees and SIGs (44%) and the ANZCA Council (39%) – or about how to participate in these forums (36%). However, 66 percent of Fellows report being aware of the ANZCA Foundation and its purpose.

ANOP Research Services, May 2010

Conclusion and next steps

A further article on the Fellowship survey will be published in the September issue of the *ANZCA Bulletin* following further consideration of the survey results by ANZCA Council. This will outline the steps that the College will take to address some of the issues identified in the survey.

I would like to take this opportunity to thank all Fellows who responded to the survey and to those Fellows who gave so freely of their time during the recent Annual Scientific Meeting to participate in focus groups. Your contribution in delivering the strong response rate of around 50% is greatly appreciated. The fact that so many Fellows responded to the survey indicates an ongoing commitment and interest in the College and a desire to see the organisation succeed.

The survey shows that the College is performing very well in a number of key areas while there is also work to be done to improve the level and quality of services that the College provides. The survey will play an important role in ANZCA's strategic planning to ensure our services meet the needs and expectations of Fellows. The 2010 survey will serve an important baseline by which to measure progress and continuously improve all that we do to meet Fellows' future needs.

Dr Michelle Mulligan
Chair, Fellowship Affairs Committee

Dr Brian Spain: Working in the Top End

While medical colleagues come and go, Dr Brian Spain has no plans to leave the Royal Darwin Hospital any time soon. He spoke to Clea Hincks.

Dr Brian Spain, the Director of Anaesthesia at the Royal Darwin Hospital (RDH) is a 14-year "veteran" of the Northern Territory health system and its unique issues and believes there is still much to be done, both locally and overseas.

At 350 beds, the RDH is a medium-sized hospital serving a population of 150,000. The Aboriginal population is 28% but makes up more than half of the hospital's inpatients.

Of the surgical workload, 55% is emergency work and there is a high incidence of trauma with road accidents accounting for a large number of admissions. The retrieval of patients over long distances means the conditions of patients have often become more serious by the time they get to hospital.

"The work side of things is very varied – you have to deal with everything that comes through the door," Dr Spain said. "Although the population is relatively small there is three times as much trauma per capita as the rest of Australia.

"The indigenous population has a poor level of health and there are diseases you just don't see in the rest of Australia like tropical diseases and the complications that go with them.

"We see a lot of developing world problems but we have the medical facilities to be able to deliver the highest levels of care."

The hospital also deals with relatively young patients compared to other Australian hospitals. This is partly explained, says Dr Spain, by the fact that the Aboriginal population has a high fertility rate but low life expectancy.

Nearby military bases housing young families and a trend for older people to leave Darwin and retire to the southern cities also helped keep the average age of patients lower.

Dr Spain is very conscious of closing the gap between the health of the Aboriginal population and the rest of Australia.

"There's a huge gap between the delivery of healthcare to Aborigines and the rest of the population," he said.

"It's tricky because Aboriginal health issues are so complicated. Part of it is taking the time to learn how to communicate better with traditional Aboriginal communities.

"With traditional Aboriginal groups, language is a big one – the whole structure is different and numbers are not a big part of things so explaining things like risks associated with surgical procedures is difficult.

"They generally have a good understanding of anatomy because of their experience in dissecting animals but they often have a limited understanding of how the body functions.

"Another part of it is taking the time to learn about the culture. There is a huge focus on community in the Aboriginal population. The well-being of the group is a higher priority than the well-being of the individual – for example, they will think nothing of leaving hospital in the middle of treatment to go to a funeral.

"So you have to have an open mind – their whole upbringing has a much stronger focus in looking after the group and if someone has assets or food or money there is a strong expectation that it will be shared among others and not just the nuclear family but the wider group."

Dr Spain said a key part of improving the health of the Aboriginal population was helping them to improve their understanding of health issues and giving them more confidence and control over the level of healthcare they received and a sense of ownership in decision-making about health issues.

Dr Spain is involved in delivering a higher level of healthcare in more remote locations – particularly in the areas of ear and dental health – through increased training of GP anaesthetists.

He also coordinates rotations of anaesthetists to the Gove and Katherine hospitals – usually in one week blocks every two months – under a Northern Territory Department of Health and Family program.

If these rotations can't be staffed locally, Dr Spain relies on his network of doctors who have worked in Darwin (and thus have experience working with Aboriginal people) but have moved back to the southern cities. These doctors either form part of the rotations or fill in at the RDH while the locals work in the regions.

Dr Spain did his medical degree at the University of Melbourne, winning several obstetric prizes and the Senior Medical Staff Award for the highest overall mark at the Austin-Repatriation Clinical School and the Smith and Nephew Prize in Surgery.

He trained in emergency medicine in the late eighties but eventually ended up in anaesthesia, winning the Renton Prize for the most outstanding candidate in the part 1 examination in 1992.

"I liked the broad range of medical practice associated with anaesthesia and the practical skills that went with it," he said.

Working overseas and helping establish self-sufficient specialist medical services in developing countries is a passion of Dr Spain's – he did a medical elective in surgery and obstetrics in Papua New Guinea for 12 weeks as part of his medical degree in 1985 and three years later was part of Operation Raleigh in Kenya as an expedition medical officer.

Since 1999, when East Timor gained independence, Dr Spain has been part of the Australia Timor Leste Program of Assistance for Specialist Services (ATLASS) team setting up specialist anaesthetic services there.

He said since 2001, there had been an AusAID-funded anaesthetist based permanently in East Timor and an East Timorese doctor was due to finish his Masters of Medicine (M Med, Anaesthesia) in Fiji at the end of next year, qualifying him to provide very competent anaesthesia. Dr Spain also assisted with the establishment of the Nurse Anaesthetist Development Program which teaches basic anaesthesia skills to nurses over 12 months.

With momentum building in East Timor, Dr Spain has started looking further afield to "put my energies into". He visited Cambodia last year but felt medical services were already working at a relatively high level.

Darwin's northern location means the RDH is often the first major Australian hospital to receive patients when disaster struck – such as the Bali bombings in 2002 and 2005 and last year's refugee boat explosion at Ashmore Reef.

"Planning for disasters is at the forefront of health here," he said.

Darwin is also a cyclone zone and in the past 10 years there have been three category five cyclones – bigger than Cyclone Tracey – that have come within 100km of Darwin. On each of these occasions, Dr Spain and his family have prepared to spend the night camped in his office at the hospital.

Cyclones aside, a typical day in the life of Dr Spain involves getting up early before it gets too hot and going for a walk with his wife, Dr Jenny Davis, before cycling 2km to work.

Dr Spain said his wife, a GP who worked in Darwin as a resident and has a strong interest in Aboriginal health, was the driving force in the couple's decision to return 14 years ago.

"We arrived with a seven-month-old baby and now have another two – it's a great place to bring up children," he said.

"You don't have to travel big distances to get around the city, there are no traffic jams – you get all the benefits of a country town with the services of a capital city.

"The work is challenging and varied and you meet a lot of people. There is a relatively high turnover of medical staff which means you can have more involvement in hospital issues and strategic planning – the hospital isn't steeped in tradition, so you can have more of an impact on how healthcare is practiced."

The former Melbourne couple and their children – Nick, 13, Becky, 11, and Maddy, 9 – are very comfortable in bucking the trend to make Darwin their home.

"We find friends often provide the sort of support you'd get from your family and part and parcel of being here is that we will come back to Melbourne to visit family and they will often come and visit us. In the end we keep busy enough with day to day things," Dr Spain said.

"One of our watersheds in deciding whether to stay or go was when we had to decide on a secondary school for our son when the time came."

"We decided to go locally and we figure that has given us another 10 years here!".

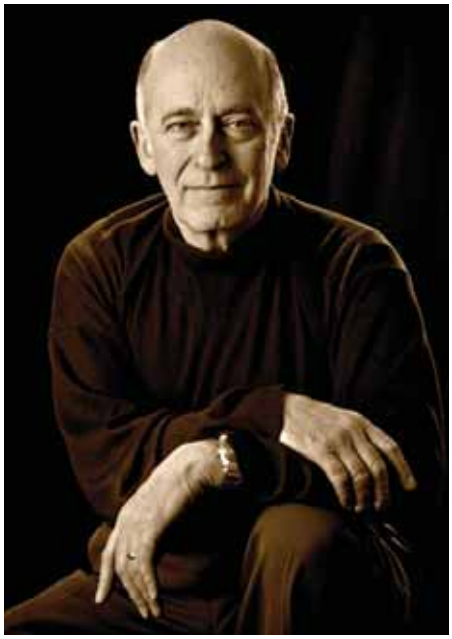
"Although the population is relatively small there is three times as much trauma per capita as the rest of Australia."

Above from left: Gove Hospital in the Northern Territory; Dr Brian Spain, third from right, with surgical and anaesthesia teams at the Angkor Hospital for Children in Cambodia.

A life in patient safety: A conversation with Professor Jeff Cooper

What has NATO got to do with safety in anaesthesia? How does an engineer come to be a Professor of Anesthesia at Harvard Medical School? Who developed the first electronic anaesthesia machine?

In the first of a two-part conversation, Dr Cate McIntosh, Director of Simulation at the Hunter New England Skills and Simulation Centre, and Consultant Anaesthetist in the Department of Anaesthesia, Intensive Care and Pain Medicine at John Hunter Hospital in Newcastle speaks to Professor Jeff Cooper, Executive Director of the Centre for Medical Simulation in Boston, and Professor of Anesthesia at the Harvard Medical School and in the Department of Anesthesia, Critical Care and Pain Medicine at the Massachusetts General Hospital. Professor Cooper is visiting Australia in August 2010 and will be keynote speaker at the SimTecT Health meeting. Professor Cooper has dedicated his career to improving patient safety and is one of the pioneers in diffusion and innovation in healthcare simulation.



Professor Jeff Cooper's contribution to patient safety includes the co-founding of the Anesthesia Patient Safety Foundation, the application of human factors engineering principles to the design of anaesthesia equipment, pioneering the critical incident analysis technique and developing the first set of anaesthesia safety standards. Professor Cooper is the author of a large body of research including the classic papers "Preventable anesthesia mishaps: a study of human factors"[1] (1972), "Critical incidents associated with intraoperative exchanges of anesthesia personnel"[2] (1982) and "An analysis of major errors and equipment failures in anesthesia management: considerations for prevention and detection"[3] (1984).

This edition of the *ANZCA Bulletin* provides an insight into how Professor Cooper got started with patient safety. In the September edition he will talk about optimism and the achievements in patient safety made so far, as well as outlining his thoughts on the work that still needs to be done.

Professor Cooper demonstrates the importance of nurturing academic anaesthesia departments. Departments where collaboration between leaders in different fields of endeavour can flourish and make a difference to the science of anaesthesia.

Your background is intriguing. You are an engineer and now a professor of anaesthesia...what kind of engineer are you and how did you come to be involved in the anaesthesia department?

I'm an odd duck. I'm not sure I could ever explain my journey in a short story and still convey how it all happened. The story is in some detail in a memoir in the book *This is No Humbug: Reminiscences of the Department of Anesthesia at the Massachusetts General Hospital*.[4] Briefly, my undergraduate degree was in chemical engineering. I got an MS in biomedical engineering, during which I had a smattering of medical school courses including anatomy, physiology, did some animal surgery and other exposures that were enough to give me a grounding in medicine.

In 1972, I arrived at the Massachusetts General Hospital (MGH) to work in the Anesthesia Bioengineering Unit, a group that was established to support technology development for researchers in the department who needed various kinds of engineering to facilitate experiments.

But, our group went off in its own direction. I got lucky and fell in with a group of really smart clinicians and other engineers and scientists (I'm no genius; my best stuff came from being part of a great team, with people who were generative and generous in addition to being super smart).

One of them, an anaesthesiologist just finishing his training, took me to the OR often. It was through his eyes that I learned enough to understand that many dangers lurked from human error in anaesthesia. One thing led to another. The story of how we came to use the critical incident technique is told below.

How did your "engineering eyes" see healthcare when you first became involved at MGH? Were you surprised by anything you saw in the world of anaesthesia?

Frankly, it's so long ago I can't really recall what I thought. I do know I was intimidated just to be there. I didn't feel like I belonged. I had the good fortune to land in a collaborative, multidisciplinary team with some very smart, insightful, creative people. Ron Newbower (then a member of the Anesthesia Bioengineering Unit at MGH), who had undergraduate and graduate degrees from MIT and Harvard, became a mentor and close colleague. I can't imagine that I'd have been able to get too far were it not for his guidance and ideas as part of our team. There were others as well, like Renny Maier. I think that what I brought to the team was some of my chemical engineering practical background that was useful when we were developing the first microprocessor based anaesthesia machine (it was probably one of the first microprocessor-based medical devices as well; it was only a prototype, but it was a catalyst

for companies to begin integrating some human factors and system concepts into their machines, starting long ago).

I think what the engineering aspects of my education brought to the mix was simply a way of looking at problems, of asking questions about why things were they way they were and seeking to understand more about why.

Unlike in medical school, engineering courses don't require much in the way of memorising. Our tests were mostly open-book. You could bring in anything you wanted. The tests were about understanding, about knowing what tools to bring to solve a problem. More importantly, and this came from Ron, I learned not to take anything at face value, to ask deep questions about why things were the way they were and not to assume that they had to stay that way. I don't think that's changed at all for me.

Is there any particular past experience that pushed you towards patient safety?

There was an incident early in my career that must have had something to do with my getting involved in patient safety, although I attribute most of the influence to the environment I was in and especially to the anaesthesiologist who mentored me early on.

The incident involved an anaesthesia machine that had been rigged with faults for a resident training workshop near the end of my first year at the MGH. To make a longer story short (the longer version is in the memoir I mentioned above) I had a role in allowing that machine to get back into service without being repaired first.

I was "just following orders" from a senior anaesthesiologist, the one who was teaching the workshop. But, I should have listened to my intuition and taken some action to prevent it. That was an important lesson.

Another pivotal event wasn't an incident but rather a chance meeting at a Halloween party. I happened to sit next to someone who was organising a meeting on human factors in healthcare, sponsored by NATO in 1974. I talked to him about what I was doing and he invited me to speak at the meeting, which was in Portugal. Dick Kitz, then the Chair of Anesthesia at MGH, somehow found support for me to attend that meeting. I gave a talk on "The anesthesia machine, an accident waiting to happen."[5] Someone in the audience came up afterwards and told me I had a great laboratory to study

these problems and led me to the critical incident technique. And, I was off and running.

How did you become interested and involved in human factors, and when did you start using the Critical Incident technique of Flanagan?

This story is told in the *This Is No Humbug* book chapter[4]. Briefly, I got interested in how to make anesthesia machines safer through the insights introduced to me by an anaesthesiologist fresh out of his residency, Renny Maier.

Renny took me around the OR and helped me to understand not just the basic technology issues but also the complexity of patient care that contributed to them. He had the ability to see things not just from his own perspective, but from the perspective of his colleagues, what motivated them to do things the way they did.

Then there was the serendipitous meeting that I alluded to previously (1974 NATO), the one at the Halloween party. The person who approached me suggesting that we use the operating room as a laboratory was Mel Rudov.

He worked at the American Institutes for Research (AIR), which had been founded by John Flanagan. AIR was based on his work using the critical incident technique, which he had developed and published in 1954.[6] These kinds of basic social science methodologies were essentially unknown in medicine and certainly to our team, but that's what we ended up using. We just followed our instincts and applied good objective methodology so that it had credibility and substance. These attributes came mostly from my colleague, Ron Newbower. We had a great team and good things came from that.

What has been your greatest challenge?

While on the scale of human tragedies, I've had few of what I'd call "struggles". I have more than once been in situations that made me feel the future was bleak for the things I hoped to accomplish. There isn't enough space here to tell the story thoroughly but I'll try to summarise it in a way that gives the main message of perseverance, support of family and friends, and perhaps a competitive spirit.

Ron Newbower and I had together built an effective, respected Department of Biomedical Engineering at the MGH. We wanted it to be like an academic medical department in having good research. To that end and mostly by Ron's efforts, a chair of iomedical engineering was steered to the MGH. The person selected to

Above: The Boston Anesthesia System and its team of engineers in 1976. From left: Josh Tolkoff, Jeff Cooper, Ph.D., Ronald S. Newbower, Ph.D., and Jeff W. Moore. Not shown are Edwin D. Trautman and W.Reynolds "Renny" Maier, M.D.

A life in patient safety: A conversation with Professor Jeff Cooper

continued

fill it seemed friendly and smart enough. But he had another agenda that didn't fit with ours. Our happy, productive, family-like department turned into something of a nightmare for me. My world turned upside down. I had to get out. I could have left the hospital, but I didn't want to give up what I had. So, I moved over and stuck it out.

I went back to my home in anaesthesia (I had been split between the two before) and my basic work in patient safety and technology development.

The whole affair took a huge toll on my psyche and left some permanent scars (one was the loss of the tips of two fingers from an accident that was surely related to the stress I was under). What got me through that was, most importantly, the unwavering and loving support of my wife, good friends, the loyalty of Dick Kitz and I suppose a spirit of not wanting to lose; something competitive in me.

I came out much stronger as a result, no question. I think many or perhaps most of us need experiences like this in our lives to learn what we're made of, what we're capable of doing. Some grow from it; others perhaps are crushed by it. The difference might have a lot to do with the factors that I think enabled me to come out on top of it. I wish there were a way to learn it without the pain.

Why do so many "patient safety initiatives" fail to make an impact? Are we choosing the wrong interventions, or is the problem with the execution, or the evaluation? Or all of the above? Why is this stuff so hard?

This is a question about "stickiness" about why some things stick and most things don't. There are a few books written about it. I surely don't have anything but some unscientific opinions from my observations and experiences in life.

First and perhaps foremost, most adults don't change easily. That's well known. People find things that work for them; those things usually have roots in Maslow's hierarchy of needs.

Most people need security, of their ability to earn a living in order to have food on the table and a roof over their heads. If you do things that are perceived to threaten that, they resist the change.

In healthcare, there is a need to preserve safety. People have found ways that they feel protect themselves and their patients. If you try to change things, they don't know if that will screw things up. They mostly don't know why things generally seem to work, so they aren't sure if the change will make things less safe.

Yet, some simple ideas do take off seemingly on their own and other ideas clearly can be made to work with the right strategy and effort.

Malcolm Gladwell gave some insights in his book *The Tipping Point*.[7] I won't try to summarise that here. I'll just suggest that people read it. The hard stuff is easier to explain: If it's a good idea and someone takes the lead, it'll stick. But, it's hard work and usually takes a while. Just look at so many things that have taken hold. The glass is really more than half full. Seat belts, far less rates of smoking, and, in of all places, Boston, the drivers are now hugely polite to pedestrians! It's truly amazing.

In healthcare, hand hygiene is much better than it was and in some places, it's now part of the culture I think. I watched it happen in my own hospital via a combination of measurement, marketing, financial incentives competition. It really can work. But for most things, there's not enough energy or perseverance or an enduring leader to ingrain the change in the culture.

Why is there a dogged persistence in emphasising the "measurable" rather than the "important"? What do you think is the right "measurable" in patient safety?

I wish I knew the answer to this one. Safety is so tough to measure. We primarily only know when things aren't safe (outside the obviously unsafe). For most things, all we can do is measure surrogates, like incidents and attitudes. For some things, like infection rates, it's a bit easier, but in some respects they are more quality than safety measures, i.e., they aren't about catastrophic, error-induced events but rather systematic process failures on a regular basis. For us safety folks, we have to live with the knowledge that the world is a risky place and that we always run the risk of being seen as "Chicken Little" type folks. So, we have to be careful about not over-reacting but rather picking what to make visible and which battles are worth fighting.

I have come to appreciate that tracking of serious adverse events, ones that almost always have elements of preventability, is a reasonable measure of how we are doing. Wrong-sided surgery, serious medication errors, and other so-called "never events" as the National Quality Forum in the US defined, are a pretty good indication of how often bad things are happening. Since hospital-acquired infections are tracked so carefully, that's another good example of a good measure of how well the organisation is paying attention to safety issues, even though they aren't the type of clearly error-induced events that I feel are more in the safety camp.

Certainly, monitoring near-misses and other sorts of "incidents" needs to be done. I'm a bit less enamoured with the emphasis on those because I think that the resources required to investigate each event are out of proportion to the benefit. We know a lot already about the problems. I'd rather see our limited resources put more toward fixing systems than intensely investigating each new event.

Let's talk about the role of simulation... how did you become interested in simulation? Do you think the non-technical training we are doing with simulation is making a difference to the "medical culture"? In what ways do you think simulation can make the biggest impact?

I'll take this set of questions as a group and give a general answer about simulation and its impact on patient safety.

Simulation became one of the main ways I felt that I could help to shift safety culture.

I was frustrated that, despite the positive changes that had occurred in anaesthesia over the years, the culture change wasn't as deep as it needed to be, nor had it migrated further into perioperative care.

Then, when we created the research program in the Anesthesia Patient Safety Foundation (APSF), the magic happened immediately.

I had only modest hopes for what APSF funding could do. After all we were only giving out $35,000 per grant. These were nothing compared to the much larger government grants and those from many other foundations.

But, in the first two years of the APSF research program, we funded three simulation-based projects, one from the David Gaba and his group at the Palo Alto VA associated with Stanford Medical School, another from Michael Good,

who worked under J.S. Gravenstein at the University of Florida in Gainesville, and the third from Howard Schwid at the University of Washington. All three were different approaches: Gaba was studying human performance; Good was interested in teaching about failures of anesthesia machines; and Schwid was building a screen-based simulator for teaching clinical skills of various kinds.

Each of those projects has grown into a primary line of some of the most important innovations in simulation (there's not enough time or space here to do the history justice; you can read some of it in the history article I wrote a few years ago[8]). I feel great that the APSF program has had the huge impact over time. It's a great story of how small amounts of funding at the right time can create huge dividends.

My own entry into simulation came about when Dave Gaba invited me to see what he was doing. I made a site visit there in 1991 in my APSF role (I was chair of the scientific evaluation committee that funded the grants). I watched a CRM program he put on for his residents, using an early version of his simulator (it was only the upper half of the body.) I was totally blown away by the excitement and power of it. I recall then flying back to Boston and thinking, if we could transfer a program like this from Stanford to Harvard that would both prove the value of the concept and greatly speed the diffusion of the innovation.

I convinced the chairs of the five Harvard affiliated teaching hospitals to send a delegation to Stanford to assess the program. Eleven of us went there in 1992. Dave put on a course in which eight of them participated in simulations. They all agreed that this was an important idea that we should work to transport to our own academic environment.

Dave had a sabbatical coming up so I invited him to spend half of it in Boston, with his simulator. Once again the Harvard anaesthesia chiefs took a risk and put up the money for it. Dave spent about three months with us during which 70 anaesthesiologists, residents and CRNAs (nurse anaesthetists in the US) experienced his ACRM program. That sold the idea.

The chiefs agreed to support building a joint simulation program. We got funding from a private foundation to build it out and the chairs supported the operations. The name of the program was the Boston Anesthesia Simulation Center. As we expanded the programs to other specialties, we changed the name to the Center for Medical Simulation (www.harvardmedsim.org) and later made it an independent non-profit corporation. We've been at it now for more than sixteen years.

I don't have scientific evidence to support any quantitative statement about the impact of simulation on patient safety. Yet I don't think there's any doubt that the impact has already been substantial. I've seen the evidence close up myself. I can't go into detail here, but I have countless examples of people who have told me how their simulation experience has changed their practice, altered the way they think about safety or was responsible for a specific event prevention or rescue, by using CRM type actions that came from their simulation training. I've seen the language the people use change.

It's already an extensive diffusion but the full impact that's needed still isn't there. I'm now completely confident that it will happen because the march to ubiquitous teamwork training in healthcare is now inexorable.

It's happening for perioperative teams in our own ORs in the Harvard-affiliated hospitals and I know it's happening elsewhere. It's so obviously the right thing to do. The technology, while far from perfect, is adequate to get it moving. The teaching methods are available. And we're training the faculty in greater numbers. I have no doubt that when everyone is getting this kind of training the culture will shift in dramatic ways, the kinds of ways that will make healthcare the kind of safety culture that it needs to be.

As I said earlier, I've come to believe that the most important element of this diffusion of safety culture is the development of the faculty. They are the ones who will make it happen, in simulation but more importantly in what they learn by teaching with simulation. They'll learn ways to teach and model these behaviours in their everyday clinical lives. That's how change really happens. And that's what led me to develop such a faculty development program at CMS.

What is your role in the simulation center? How do you spend your time?

I'm the executive director, which means I lead the organisation. We have the equivalent of a chief operating officer, who is relatively new, but I'm managing to hand off many operational duties to him. I have a very varied life.

I'm really only about half time at CMS. The other half is divided between a few other responsibilities, in the Department of Anesthesia, Critical Care and Pain Medicine (www.mgh.harvard.edu/anesthesia), the Center for Integration of Medicine and Innovative Technology (www.cimit.org) and the MGH Learning Laboratory and Simulation Center .

I can best describe myself as a "boundary spanner". I'm a connector. I love getting people to work with each other, creating new projects, processes and relationships. I love mentoring people, especially students, but also anyone I come in contact with whom I can help in some way. I mostly advise people, help them solve problems, teach them when they need that, try to inspire them at every opportunity and most of all, to have fun.

For me, if work isn't fun, it's not worth doing. We have a great team. Passionate, dedicated, sharing, supportive, open and playful. What more can you ask for?

Acknowledgements

Thank you to my friends and colleagues who helped generate some of the questions for this interview.

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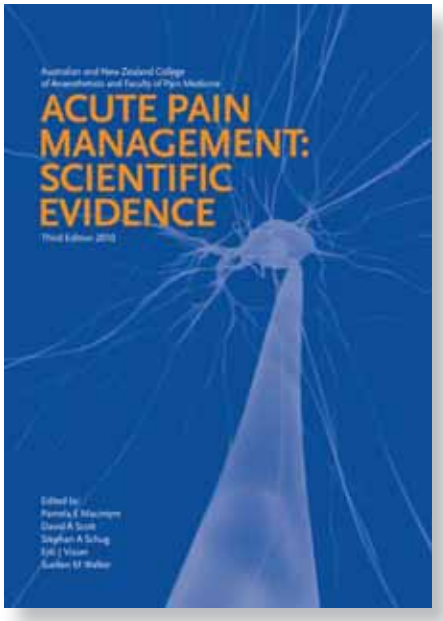
Launch of Acute Pain Management: Scientific Evidence



Recently ANZCA and the Faculty of Pain Medicine published the third edition of *Acute Pain Management: Scientific Evidence*. The 490-page text covers a wide range of clinical topics and aims to summarise the considerable evidence which is available for the management of acute pain. The landmark publication represents the work of 87 people including the working party, contributors, editors, and members of the multidisciplinary consultative committee. In his foreword, Professor Michael Cousins, Director of the Pain Management Research Institute, University of Sydney and Royal North Shore Hospital notes: "The consistently high standards of *Acute Pain Management: Scientific Evidence* have established it as the foremost English-language resource of its type worldwide. Changes between successive editions reflect not simply accumulation of clinical evidence in this dynamic field, but also advancing sophistication in methods of evidence synthesis and decision support".

Acute Pain Management: Scientific Evidence includes chapters on physiology and psychology of pain, assessment and measurement of pain and its treatment, provision of safe and effective acute pain management, analgesic drugs, PCA, regional and local analgesia techniques, non-pharmacological techniques, specific clinical situations, paediatric and other patient groups. These are preceded by an excellent 30-page summary with key messages.

Chaired by Associate Professor Pam Macintyre, the working party included Professor Stephan Schug, Associate Professor David Scott, Dr Eric Visser, Dr Suellen Walker as well as Dr Douglas Justins, Dean of the Faculty of Pain Medicine, Royal College of Anaesthetists in the United Kingdom and Professor Karen Grimmer-Somers from the University of South Australia. They were assisted by a large panel of contributors and a multidisciplinary committee.

"This is a truly outstanding publication," said ANZCA President Professor Kate Leslie. The working party, committee, editorial team and numerous contributors are to be congratulated for their hard work, dedication and commitment. They have set a new benchmark in summarising the scientific evidence for acute pain management with contemporary clinical and expert practice. *Acute Pain Management: Scientific Evidence* not only breaks new ground but ensures Australia and New Zealand remain at the forefront of worldwide efforts to address and alleviate pain and suffering.

The Working Party, contributors and members of the Multidisciplinary Consultative Committee

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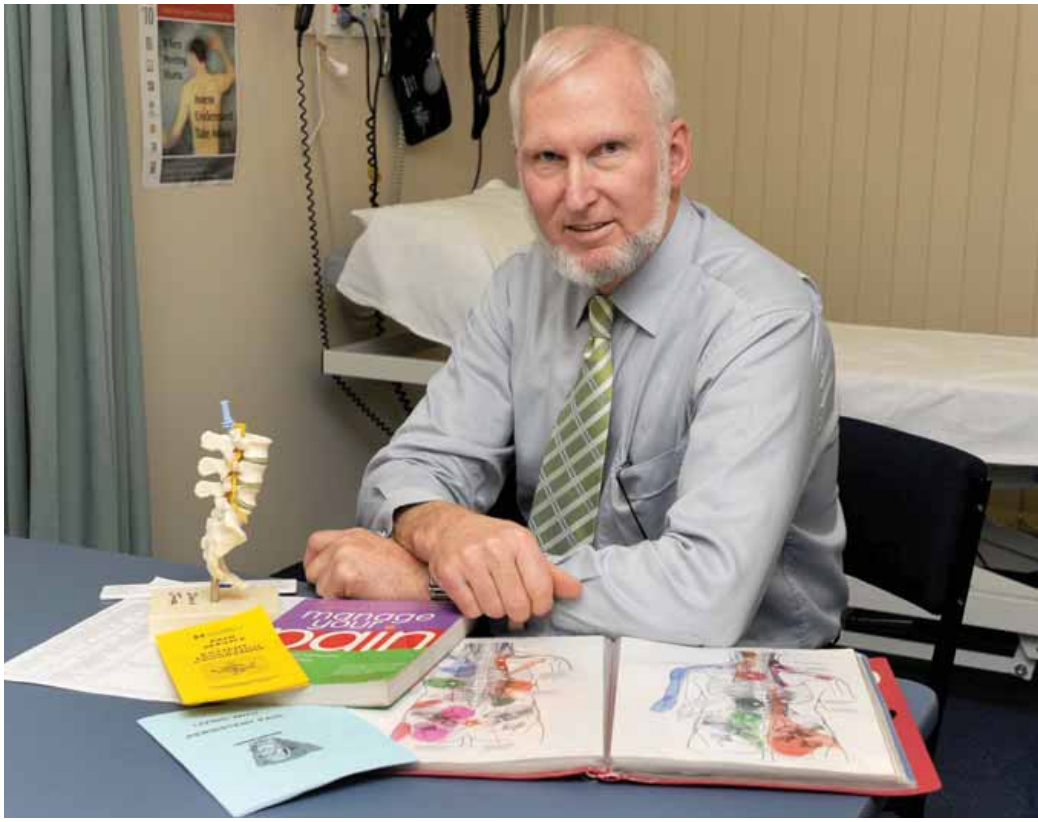
Elizabeth Hall, Jenny Ramson.

Multidisciplinary consultative committee

Professor Paul Rolan, Judith Deane-Freeman, Louise Quinn, Dr John E Greenwood AM, Dr Dale Ashby, Dr Keith Charlton, Associate Professor Philip S Bolton, Dr Michelle Thomas, Helen Maxwell Wright, Dr Caroline Smith, Dr Matt Gaughwin, Professor Nicholas Glasgow, Professor Dorothy MK Keefe, Professor Nigel Jones, Associate Professor Leigh Atkinson, Fran Bermingham, Julie Lanzendorfer, Professor Wayne Gillett, Dr Owen Williamson, Dr Nick Penny, Professor Maree Smith, Stephanie Wiltshire, Professor Tony Wright, Dr Faiz Noore, Dr Carolyn Arnold, Associate Professor Milton Cohen, Dr John Hadok, Professor Paul Myles, Mr Craig Jurisevic.

Pain medicine: The challenges ahead

Dunedin-based pain medicine specialist, Dr David Jones, is the new Dean of the Faculty of Pain Medicine. He spoke to Clea Hincks about his plans for the specialty in Australia and New Zealand.



Giving pain medicine a bigger presence on the health map is one of the main aims of Dr David Jones, the new Dean of the Faculty of Pain Medicine.

He wants to see increased knowledge about pain introduced to the training of medical students and anaesthesia trainees as well as improved relationships with relevant organisations not already part of the Faculty.

"I think we want to strengthen our relationship with some other bodies – for example, GPs at the primary care level, and RANZCOG where it is recognised a large amount of the practice can be dealing with conditions such as chronic pelvic pain," Dr Jones said.

"I think we need to help these practitioners be better equipped so that we can reverse the trend where they ask us what to do, to a point where they know what to do, especially early on."

An estimated one in five people have chronic pain – persistent daily pain for three months or more. In Australia, just 20% have their pain effectively treated while people suffering acute pain and cancer pain are effectively treated in just half of the cases.

The statistics for New Zealand may be worse, given that there are fewer pain clinics and pain specialists per head of population.

Dr Jones said his personal approach now in teaching medical students was to highlight these statistics from the Access Economics report in 2007 *The high price of pain: the economic impact of persistent pain in Australia* that estimates that chronic pain costs the Australian economy $34 billion annually and is the third most expensive health condition. Previously there was scant recognition of the magnitude of the problem.

"We need to start feeding this information out – medical schools are one place, but the community at large also needs to know," he said.

"The public needs to understand better how much pain there is, and what to do - or not do - when they have it by having better factual knowledge.

"So the specialty needs to interface better with the rest of the healthcare community and the public so that they know things can be done and there can be a life with pain, better managed."

The multidisciplinary approach to pain treatment – using teams of healthcare professionals that can include psychiatrists/psychologists, physiotherapists and rehabilitation specialists - was gathering momentum although is by no means new.

Australia is slightly ahead of New Zealand, in that pain medicine has been recognised as a specialty since 2005. The New Zealand Medical Council is now assessing the first stage of an application for similar recognition.

One of the big issues confronting the Faculty is the safe use of opioids in the treatment of pain.

"One of my particular interests is the constructive use of opioids in pain management," Dr Jones said.

"It's a highly emotive field and many people believe there are too many risks associated with opioids. There are risks, but we can learn to identify and manage the risks and get some benefits for the small section of pain sufferers who do well by meeting defined goals with opioids," Dr Jones said.

"There is good evidence that short term use of opioids to get people functioning again as part of a bigger plan can help people with chronic pain. A lot of people have an attitude never to use them but I think we should be willing to go there carefully and see what the outcome is like for an individual without better solutions."

In addition to establishing better guidelines for opioid use, the Faculty was also grappling with the increasingly popular pain treatment, neuromodulation.

"One treatment (opioids) is very cheap but with serious consequences if it isn't managed carefully, the other (neuromodulation) is very expensive, glamourous to the public but there are also many ways it can go wrong and waste a lot of resources in the process.

"People within the Faculty are working on ways to define best practice for both of these treatments, with evidence-based guidelines."

Dr Jones is a born and bred Kiwi. He was part of the original intake of students at the Auckland Medical School in 1968 who has now settled in Dunedin - the original university city of New Zealand.

"It's a nice compact city hospital with everything under one roof – and close to mountains, lakes, rivers and skiing, which also appeals to me," said Dr Jones.

Dr Jones said he was initially attracted to pain medicine through two anaesthesia mentors – Professor Robert Boas, who influenced Dr Jones as a trainee intern, and Drs Michael Roberts and Steuart Henderson, with whom he worked in the Dunedin pain clinic. Another key influence was the opportunity given by Professor Barry Baker who offered him the responsibility to lead the clinic when Dr Roberts moved on in 1984. He has never regretted taking that on.

Dr Jones said he still enjoyed the technical and communication skills required in anaesthesia and still does three sessions a week. The opportunity to spend more time communicating with patients on an ongoing basis with continuity of care (he has been seeing one patient at annual review for 24 years) is, however, a big pain medicine attraction.

"It's amazing how often you can make a difference to a person with pain problems by just spending time identifying, acknowledging and explaining the reasons why they have pain, validating that there is a real basis for it (i.e. it is not imagined) and helping them understand themselves," Dr Jones said.

"It takes time, but that can sometimes make more of a difference than dangerous drugs and procedures."

"I think we want to strengthen our relationship with some other bodies – for example, GPs at the primary care level, and RANZCOG where it is recognised a large amount of the practice can be dealing with conditions such as chronic pelvic pain."

Left: The new Dean of the Faculty of Pain Medicine, Dr David Jones, at work.

ANZCA support for anaesthesia in Papua New Guinea

ANZCA continues to be involved in a number of initiatives aimed at building clinical and educational capability amongst anaesthetists in Papua New Guinea. The current initiatives build on the excellent work done by Professor Garry Phillips when he was Visiting Professor of Anaesthesia from 1995 to 2005.

PNG is Australia's closest neighbour and has one of the fastest population growths in the world. The population is 6.5 million and this is expected to double in the next twenty years. Half the population is under 16 and 85% live in rural village settings. Life expectancy is about 58 years, with about 10% of children dying before the age of five years.

Maternal mortality has deteriorated recently – one in 25 women now die in childbirth. This is on par with sub-Saharan Africa and Afghanistan.

Annual health expenditure in Papua New Guinea is only 3.8% of GDP, or $US50 per capita – in comparison, Australia spends almost forty times this amount per capita. In recent years, basic health services in PNG have deteriorated with the closure of almost one-third of village aid posts. There are severe staff shortages - PNG and Timor Leste have the least number of doctors per capita in the Pacific.

There are nine consultant anaesthetists for the entire country. Five are in the capital, Port Moresby, and the other four are in smaller towns. The University of Papua New Guinea offers a one-year Diploma in Anaesthesia (DA) and a four-year Masters in Medicine (MMed). For a variety of reasons, there have been no MMed graduates for the last four years. Pleasingly, this year there are two Masters candidates with another six junior registrars in training.

Due to the small number of medical anaesthetists, most anaesthesia in PNG is provided by Anaesthetic Scientific Officers (ASOs). These are non-physician anaesthetists who have completed a one-year diploma course offered by the University of Papua New Guinea. This course, instigated by Professor Garry Phillips, has replaced the ATO (Anaesthetic Technical Officer) apprenticeship. During the last seven years, many new ASOs have been trained and nearly all existing ATOs have been upgraded to the new qualification. There are now over 80 ASOs throughout the country.

Intensive care really only exists on a small scale in Port Moresby, with just a few patients being ventilated for short periods in other centres. Acute pain is poorly managed by our standards and treatment options for chronic pain (including cancer pain) are very limited; for example, oral immediate-release morphine is currently unavailable.

There are major problems with infrastructure, equipment and monitoring. Operating theatre and intensive care monitoring is poor, there is a severe lack of equipment maintenance, disposables are often unavailable, and drugs supplies are adequate only 50% of the time. There is a strong reliance on disposables left behind by visiting surgical teams.

Many anaesthetists are providing excellent clinical work and teaching through the HECS Project (Health Education and Clinical Services Project, funded by AusAID), Operation Open Heart and other projects.

ANZCA is also making a vital contribution to the development of anaesthesia in PNG and the region, through a number of initiatives. These include:

- Two visits each year to support ASO training (Diploma of Anaesthetic Science) and anaesthetic registrar training (DA and MMed).
- The development of the Essential Pain Management course. Pilot courses were held in Lae and Port Moresby in April by Drs Roger Goucke and Wayne Morriss.
- Purchase of airway and resuscitation mannequins for undergraduate and postgraduate teaching.
- Formation of the ANZCA Overseas Aid Committee at the ASM.
- Representation on the Overseas Development and Education Committee of the ASA.
- Award of a book prize to the best candidate in the MMed Anaesthesia examination in PNG and Fiji.
- Award of a book prize to the best medical student during their undergraduate anaesthesia attachment in PNG and Fiji.
- The ANZCA International Scholarship for junior consultants to work in Australia or New Zealand for six to 12 months and attend the ASM and Younger Fellows conferences. This year, the College supported Dr Harry Aigeeleng, lecturer in Anaesthesia at UPNG, to attend the ASM in Christchurch.

Anaesthetic doctors and Anaesthetic Scientific Officers in PNG face many difficulties and challenges but continue to strive to improve anaesthetic training and service delivery. It is essential that bodies like ANZCA and AusAID continue to support their efforts. ANZCA Council has made a commitment to this by including aid for educational activities in neighbouring countries in its 2010-12 strategy.

Dr Michael Cooper
Children's Hospital at Westmead,
New South Wales

Dr Wayne Morriss
Christchurch, New Zealand

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Marun G. Developing anaesthesia – intensive care services in Papua New Guinea. Abstract, 68th NSC of the ASA. September 8th, 2009.
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"There are major problems with infrastructure, equipment and monitoring. Operating theatre and intensive care monitoring is poor, there is a severe lack of equipment maintenance, disposables are often unavailable, and drugs supplies are adequate only 50% of the time."

Top left: Airway workshop using the College donated mannequin with Anaesthetic Scientific Officer trainees, Port Moresby General Hospital, School of Medicine and Health Sciences, UPNG;
Above: Presentation of airway mannequins from Dr Michael Cooper (fourth from left) to Dr Harry Aigeeleng, senior lecturer in Anaesthesia, UPNG and Port Moresby General Hospital.

New Fellows Conference 2010 – Hanmer, New Zealand

On April 28, three days prior to the start of the 2010 Annual Scientific Meeting, 27 delegates from New Zealand, Australia, Singapore and Hong Kong met for the 2010 New Fellows Conference.

The 2010 Conference was held in Hanmer, a 90-minute bus ride from Christchurch. Hanmer is a small tourist town made famous by its outdoor thermal hot pools, stunning natural beauty and numerous outdoor activities on offer. It is also home to Mark Inglis who was our guest speaker for the conference.

Mark is a famous New Zealander who in 1982 became trapped for 13 days close to the summit of New Zealand's highest mountain, Mount Cook. After being rescued both Mark and his climbing partner had their legs amputated below the knee because of severe frostbite.

Not content with being labelled disabled and letting the amputation impact on his love of mountaineering and adventure, Mark has gone on to record a number of incredible accomplishments, such as being the first double amputee to summit Mount Everest.

The theme of the 2010 conference was "Anaesthesia and Adventure", which was apt given our surroundings and guest speaker. We were joined at the meeting by three representatives from College Council, Nicole Phillips (previously New Fellows Representative and now ASM Officer on Council), Kerry Brandis and Leona Wilson (in one of her last official roles before handing over the presidency to Kate Leslie).

After checking into the Heritage Hotel in Hanmer, the first afternoon was spent discussing issues regarding "Choices and Challenges of New Fellows" that focused on achieving that elusive goal of an appropriate work-life balance. After an intensive afternoon we had two hours of free time prior to dinner. For most people this meant a trip across the road to the glorious hot pools for some rest and relaxation!

Dinner that evening was held at a local restaurant and was accompanied by a presentation from Lyn McMorran from Westpac NZ on issues in relation to financial planning and security.

The following day was the most intensive of the meeting and involved a number of small group discussions and presentations. Mark Inglis ran a very challenging workshop entitled "The Choice" where in small groups we had to plan the equipment we would take on an expedition to the top of Mount Cook, the major challenge being that we had a specified weight limit that we could carry, so some sacrifices, which may impact on our chances of surviving, would have to be made.

The afternoon was set aside for a unique team building challenge in the Hanmer surrounds. The participants were split into four teams and had to complete a large number of physical and mental challenges, gaining clues to a puzzle along the way. It was a very tight finish with three teams being neck at neck at the very end. It was a fantastic fun-filled afternoon and the groups came away with a huge sense of achievement, especially given that they had slashed 17 minutes off the previous quickest time to finish in one hour and 49 minutes.

Following the Hanmer challenge there was time for another quick dip in the hot pools before the formal dinner. At dinner, Mark Inglis provided a personal account of his time stuck on Mount Cook, his recovery and subsequent successes.

Friday morning was spent discussing ways in which we can "give back" to the anaesthetic community. Nicole Phillips provided an overview of her experiences

to date as the New Fellows Representative on the College Council. Leona Wilson spoke on the wider role of the College and the myriad of functions that it performs and how we can potentially contribute.

Kerry Brandis outlined the structure of the College and the large number of roles available to Fellows starting at the departmental level and progressing through to the state/regional and finally national/council level. It was a unique insight and demonstrated how there are a number of potential ways in which we can be more involved with College affairs and it also emphasised how important it is that we contribute to the College, as much of the function of the College depends on the good will of Fellows.

Interspersed at various points during the conference were presentations by the participants. Each participant was required to present briefly on their own adventures in relation to anaesthesia. Every story was unique and emphasised the immense pleasure, as well as pain, that we gain from a career in anaesthesia.

Stories ranged from highlights of work in retrieval and remote/Third World areas, adventures during fellowship years, travelling and training with children to amazing stories of accomplishment at just completing training during difficult life circumstances.

Friday afternoon consisted of a leisurely bus trip back to Christchurch with a stopover at the Pegasus Bay Winery for lunch and some wine tasting. We arrived in Christchurch just in time for the start of the welcome drinks for the ASM. New friends had been made, ideas had been shared and common problems discussed.

We all left the conference with a greater appreciation of the role of the College and the important part that we all play in its future. A special thanks to Karen Ryan and Ashley Padayachee for all their work in convening the conference and making it such a success.

Next year's New Fellows Conference will be held just prior to the ANZCA ASM in Hong Kong and promises to be another exciting and challenging event. If you are interested in attending, applications will be available through your local regional office later this year.

Dr Nolan McDonnell BHB MBChB FANZCA
Staff Specialist
Department of Anaesthesia and Pain Medicine, King Edward Memorial Hospital for Women

"We all left the conference with a greater appreciation of the role of the College and the important part that we all play in its future."

Frop top left: The delegates celebrating at the end of the "Hanmer Challenge"; the conference venue, the Heritage Hotel in Hanmer; delegates enjoying some pre-dinner drinks at the conference dinner, Drs Ashley Padayachee, David Bramley, Nolan McDonnell, Terry Pan Ling-Te and Simon Zidar; teams receiving a briefing prior to the start of the "Hanmer Challenge".

Successful candidates

Primary Fellowship Examination

The written section of the examination was held in all capital cities in Australia, and in Cairns, Launceston, Newcastle, Townsville, Auckland, Christchurch, Dunedin, Hamilton, Hong Kong, Kuala Lumpur, Singapore and Wellington in early May.

The viva examinations were held at the Sebel Hotel in Melbourne.

A total of 61 candidates successfully completed the Primary Fellowship Examination at this presentation and are listed below.

Perumbuli Achchige Menaka Subhashini	NSW
Andrew Gene Allenby	NSW
Cameron Mahon Anderson	NZ
Ritu Arora	QLD
Raman Azad	NSW
Kirsten Alice Bakyew	VIC
Julia Catherine Lesley Birch	NSW
Stuart Blain	NT
Nellie Bollendorff	QLD
Anders John Bown	TAS
Kelly Victoria Bucca	VIC
Thomas David Righton Burrows	NZ
Jacqueline Anne Cade	VIC
Jing Xuan Ivy Chang	NSW
Rachel Susan Chapman	VIC
Chiu Suet Wai	HKG
Aimee Marie Clark	NZ
Gareth David Collins	NZ
Richard Paul Collins	NZ
Dale Anthony Currigan	VIC
Adel De Lange	QLD
Chrysanthus Marlin De Silva	NZ
Lakmini Kamithri De Silva	VIC
Shekhar Dhanvijay	ACT
Danelle Dower	WA
Miles Earl	WA
Sabry Eissa	NSW
Conrad Engelbrecht	NZ
Dyani Evans	QLD
Kate Elizabeth Fitzsimons	NSW
Adeline Siu Yin Fong	SA
Sara Foroughi	WA
Rahul Garg	NSW
Anthony David Hade	QLD
Oliver Robert Heybourn Hambidge	NSW
Simon Hendel	VIC
David William Hoppe	WA
Hsing-I Gina Hsu	QLD
Erin Elizabeth Innes	NZ
Joseph Isac	VIC
Julie Anne Isaksson	VIC
Jae-Heon Kim	NSW

Final Examination Court of Examiners

Marlene Louise Johnson	WA
Benjamin Philip Jones	VIC
Jin Hyuk Kang	NZ
Nicole Rani Khangure	WA
David Andrew Kingsbury	WA
Petrus Johannes Kotze	QLD
Peter David Koudos	QLD
Natalie Joanne Kruit	NSW
Lai Wing Yee Winnie	HKG
Cassandra Jane McLeod Lang	VIC
Lau Yie Hui	SGP
Nam Van Le	VIC
Lee Sau Man	HKG
Anthony George Justus Lentz	QLD
Daniel Hsin-Kai Liu	VIC
Sheng Jia Low	VIC
Darren John Lowen	VIC
Stuart Michael Luckie	QLD
Michelle Yian Fern Lye	NSW
Brendon Neil Manikkam	NZ
Gregg Ross Masterson	QLD
Mok Yue Hong Louis	HKG
Josephine Agnes Morrison	VIC
Mitchell Morse	QLD
Jeffrey Mott	QLD
Jennifer Anne Myers	ACT
Karthik Nagarajan	NSW
Janice Hyeon-A Nam	VIC
Ragu Nathan	NSW
Nayden Tsvetkov Naydenov	NSW
Vivian Vy Nguyen	VIC
Paul Robert Nicholas	QLD
Jaime Leigh O'Loughlin	NZ
Bjorn Pederson	SA
Vanessa Greta Percival	WA
Vesselin Naoumov Petkov	QLD
Colm James Quinn	VIC
Michael John Rattray	VIC
Francesca Lee Rawlins	QLD
Jeffrey Ian Reddy	NZ
Byrne Erik Redgrave	WA
Matthew Garry Richardson	VIC
Simon William Patrick Roberts	SA
Jon Havard Salicath	NSW
Melinda Kelly Same	WA
Seong Chien Wei	SA
Grace Mei Ling Seow	VIC
Sham Katie Pui Ting	HKG
Bradley John Smith	QLD
Satnam Solanki	WA
Stacey Swinkels	QLD
Agnieszka Paulina Szremska	SA
Lick Wei Tan	NSW
Tan Hon Liang	SGP
Timothy Zien Tay	VIC
Jonathan Colin Kersley Taylor	NZ
Michael Tetley	QLD
Dinesh Harkishin Thadani	NSW
Siji Thalekal	ACT
Han Tuan Truong	NZ
Tsui Pui Yee	HKG
Tsui Tsz Kin	HKG
Ida Fong Ukor	VIC
Nandanan Varatharajan	NSW
Torben Neal Wentrup	QLD
Amanda Patricia Willis	VIC
Rachael Barbara Wright	QLD
Ching Wan Wu	NZ
Nicole Enid Wylie	SA
Emily Ching-Ying Yeoh	NSW
Alexandra Elizabeth Zanker	SA

Renton Prize

Dr. Vivian V. Nguyen	VIC

Merit Certificates

Dr. Anders Bown	QLD
Dr. Anthony Hade	QLD
Dr. Benjamin Jones	VIC
Dr. Gregg Masterson	QLD
Dr. Simon Roberts	SA
Dr. Torben Wentrup	QLD

Final Fellowship Examination

The medical clinical and written sections of the examination were held in Adelaide, Brisbane, Melbourne, Perth, Sydney, Auckland and Hong Kong in late May.

The anaesthesia vivas were held in Melbourne at Caulfield Racecourse.

166 candidates presented for the medical clinical and written sections of the examination of which 157 were invited to the anaesthesia vivas. A total of 130 successfully completed the Final Fellowship Examination.

Fayavar Alireza Ajvadi	QLD
Megan Lise Allen	VIC
Walid Mohammed Abdel Aly	QLD
Ju Pin Ang	VIC
Negar Asadi	NSW
Au Siu Wah Sylvia	HK
Jennifer Elizabeth Benedict	QLD
Timothy John Benny	SA
Yogi Bipinchandra	VIC
Jennifer Gay Blackshaw	QLD
Andrea Jane Bowyer	VIC
Mathew John Brbich	WA
Silke Brinkmann	WA
Vitali Broyda	NSW
Matthew Burke	NSW
Heather Maree Butler	VIC
Jun Keat Chan	VIC
Christine Shona Charlton	SA
Cheah Keen Hoe	MAL
Alex Kuanyu Chen	WA
Chiang Chi Sum James	HK
Matthew Wan Chiew	NSW
Chiu Ching Pik Candy	HK
Craig John Coghlan	QLD
Louisa Jane Crowther	QLD
Yvette Noellynn D'Oliveiro	VIC
Christopher Bruce D'Souza	NZ
Rohone D'Souza	NSW
James Dalby-Ball	NZ
Timothy Patrick Dalton	QLD
Chenqu Darcey	TAS
Faustina Mary DeVeer	NZ
Michael Jeremy Dick	NZ
Paul Egan	NSW
Julianne Marie Evans	SA
Alex Jui-Chia Fang	NSW
Thomas Mark Antony Fernandez	NZ
Yvette Gainey	WA
Oksana Gorlanchuk	SA
Martin William Arthur Graves	NSW
Neville Howard Green	SA
Vanessa Elizabeth Greig	QLD
Nathan James Harper	NSW
Kevin Hartley	WA
Navid David Hasheminia	WA
Nicholas Hogan	QLD
Matthew Hope	NSW
Jane Hosking	NSW
Seumas William Munro Hyslop	NSW
Nathan Clifford James	WA
Bryne John	NSW
Balvindar Kaur	VIC
Joseph Ming Kwan Koh	NZ
Antigoni Koutantos	NSW
Indra Sujeewa Kumarasena	VIC
Ann-Lynn Kuok	WA
Daniel Kwok	NSW
Lai Man Ling	HK
Paul Francis Lambert	SA
Jean Kyung Lee	NSW
John Lee	NSW
Lee Meng Li	MAL
Monn Yee Lee	VIC
Igor Lemech	VIC
Samantha Weng-Yan Leung	VIC
Loh Pui San	WA
Jason Ma	VIC
Swaroop Pandurang Margale	QLD
Simon Roger Keith Martel	NSW
Thomas John Martin	NSW
Rachelle Jenny Mason	NZ
Kirsten Naomi Matheson	NZ
Brent Dean May	VIC
Michael John McArtney	NSW
Symon McCallum	QLD
Allannah Maree McKay	NZ
Aidin Mohajeri	VIC
Cameron James Morgan	VIC
Behin Moser	QLD
Gurunath M S Murthy	SA
Subhashini Nadarajah	NZ
Ashutosh Nath	VIC
Alan Nazha	NSW
Angus John Neal	NSW
Anna Caroline Negus	NZ
Adam Romney Nettleton	VIC
Ng Kwun Tung	HK
Peter Palm	SA
Matthew Prentice	NSW
Leah Chemaron Purcell	QLD
Mohammad Ali Rahmati	VIC
Vaughan Raleigh	VIC
Stephen Allan Richards	NSW
Martin John Robinson	NZ
Twain Russell	WA
Anthony Edward Ryan	NSW
Simon James Samoilenko	QLD
Timothy John Sampson	QLD
Jason John Scott	QLD
Kalmin Thaminda Senaratne	QLD
Timothy James Shakespeare	VIC
Paul Hilton Sherwin	QLD
Navdeep Singh Sidhu	NZ
Shane Barry Smith	NSW
Michael Soares	WA
Jaclyn Cheng Lee Soo	VIC
Margaret Brigida Soroka	QLD
Melanie Louise Speer	NZ
Michelle Julie Spencer	VIC
Arpit Srivastava	NSW
Amber Kate Stenson	VIC
Daniel Kalman Stiglitz	VIC
Brent Aaron Studd	QLD
John Christian SVENDSEN	WA
Abhijeet Bhalchandra Tandel	NSW
Alexandra Taylor	VIC
Andrew Deane Taylor	QLD
Nathan Charles Taylor	NSW
Tey Wan Yee	MAL
Bronwyn Jayne Thomas	QLD
Sarah Thomas	VIC
Minh Hai Tran	NSW
Andrew John Travis	WA
Jonathan Ying Tang Trinh	NSW
Alan Kwan Ho Tse	VIC
Maartje Johanna Tulp	NZ
Tarin Lorna Ward	VIC
Fiona Kim Wilde	VIC
Hui Yi Ernest Wong	NSW
Terence Jen Keat Wong	WA

Cecil Gray Prize

Dr Abhijett Tandel	NSW

Merit Certificates

Dr Angus Neal	NSW
Dr Igor Lemech	VIC
Dr Adam Nettleton	VIC
Dr Annlynn Kuok	WA
Dr Matthew Chiew	NSW
Dr Thomas Fernandez	NZ

12 candidates presented for the International Medical Graduate Specialist Performance Assessment held in March/May 2010 and the following three candidates were successful:

Dr Neville H. Green	SA
Dr Vanessa Elizabeth Greig	QLD
Dr Swaroop Margale	QLD

15 IMGS candidates presented for the Final Fellowship Examination held in March/May 2010 and the following five candidates were successful:

Dr Yogi B. Bhatt	VIC
Dr Faustina DeVeer	NZ
Dr Indra Kumarasena	VIC
Dr Gurunath M. Murthy	SA
Dr Peter Palm	SA

ANZCA Trials Group

The ANZCA Annual Scientific Meeting is a core activity for the ANZCA Trials Group. In Christchurch this year, the Trials Group conducted a concurrent session on Saturday followed by the annual Trials Group lunchtime meeting.

The Chair of the Trials Group, Associate Professor David Story led the session with the much-anticipated REASON Audit results, followed by Trials Group Coordinator Stephanie Poustie presenting a paper on research governance. The session ended with Associate Professor Andrew Davidson speaking on the trials and tribulations of doing international multi-centre research.

The REASON Audit is an observational study of 4158 consecutive patients from 23 hospitals in Australia and New Zealand. In this group of patients 68% had pre-existing co-morbidity. The 30-day mortality was 5% and 20% suffered complications; 9.4% of patients were admitted to intensive care, 5% planned, 4.4% unplanned.

Patient factors associated with mortality included increasing age, worsening ASA status and low preoperative albumin. Non-scheduled surgery and thoracic surgery were associated with increased mortality.

Complications associated with mortality included acute renal impairment, unplanned ICU admission and systemic inflammation.

In conclusion, elderly surgical patients place considerable demands on critical care services and strategies are needed to reduce complications and mortality.

Stephanie Poustie's paper looked at whether the components of research governance, as outlined in the NHMRC guiding documents for research conduct in Australia, have been implemented in research institutions across Australia. Her examination of the institutional web sites of the Melbourne and Metropolitan Health Services, the Australian and New Zealand medical colleges and the "Group of 8 Universities" revealed patchy implementation with poor compliance, particularly among the medical colleges and Group of 8 Universities.

Andrew Davidson revealed some of the difficulties of international multicentre research. These difficulties included ethics and the regulatory environment in differing countries, maintaining a high standard during the research process including the translation of data across English-speaking countries, data ownership and authorship. However the benefits for researchers doing large multicentre trials means there are well-structured steering groups and data safety committees, along with opportunities for external funding that can help augment research departments.

The Annual Trials Group ASM lunch is an important meeting for the Trials Group Executive and the wider Trials Group community of local investigators and their research nurses associated with ATACAS, ENIGMA-II and the REASON Audit. It was a great opportunity for people to put a "face to a name", while discussion allowed participants to make suggestions on improving Trials Group activities.

This year there were 22 participants from Hong Kong, New Zealand and Australia. Subjects discussed included: two Trials Group sessions planned for the Hong Kong CSM in 2011 could include topics on research methodology; the current poor response by Fellows and trainees to electronic survey research, and that a survey research session could be included at the next CSM; the second annual Research Directions Workshop will be held on Friday, October 1 at ANZCA House Melbourne; the lead investigator for The Balance Study, Associate Professor Tim Short, has been awarded a 2010 ANZCA Pilot Grant and subsequently secured another New Zealand research grant to roll this study out as a Trials Group multicentre study involving sites in Australasia; updates on the ENIGMA-II and ATACAS trials from Professor Paul Myles and news of the POISE-2 Study from Professor Kate Leslie who is the Australian and New Zealand Coordinator for this Canadian-led research.

Strategic Directions Research Workshop

Keep your diaries free! New and emerging researchers with ideas for multicentre research are encouraged to attend.

Friday October 1, 9am to 5pm
ANZCA House, St Kilda Road, Melbourne

Further details contact:
trialsgroup@anzca.edu.au

Community-based studies of anaesthetic mortality

The Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) is an expert ministerial committee, whose chief role is to undertake peer review of anaesthesia related deaths in NSW and feed recommendations on safe practice back to individual anaesthetists and the broader anaesthesia community.

This year SCIDUA is celebrating its 50th anniversary. In 2010 SCIDUA will also be under the spotlight as it leads education for anaesthetists in respect to changes in procedural requirements for mandatory reporting of anaesthesia-related deaths.

This is subsequent to recent amendments in the Public Health Act 1991 and Public Health (General) Regulation 2002 in which such deaths are reclassified as a 'Category 1 Scheduled Medical Condition'; no longer incorporated with coronial reporting.

In this article ***Professor Ross Holland***, the inaugural secretary for SCIDUA traces the history of mortality reporting and reflects on the work of SCIDUA.

Attempts to document mortality from anaesthesia have an extensive and mostly honourable history. John Snow himself was aware of the dangers of anaesthesia (in other people's hands – he never had a death himself).

Joseph Clover likewise was concerned about this issue, and he had the advantage of living longer than Snow. Papers exist in the literature documenting his interest in data collection.

The various Chloroform Commissions discussed deaths from this agent throughout the UK, but their deliberations were distorted due to political dissension, largely the result of Scottish obduracy.

As can be seen from the above, no proper scientific framework for the study of anaesthetic mortality existed well into the 20th century. Notwithstanding this, several Australian pioneers approached the subject meticulously, and amongst these were Gilbert Brown, Geoffrey Kaye and Gilbert Troup, the last of whom compiled an excellent study of mortality from anaesthesia in children. Disappointingly, none of the above investigators used community-based data. This omission weakening the results of their work. Some quite large institutional studies were also methodologically unsound, notoriously that of Beecher et al, which reached a negative conclusion in the case of muscle relaxants. Others concentrated on a single agent, such as the Pearl Harbour Thiopentone report which recognised the limitations of that agent, and a Portuguese study on halothane.

The first genuine investigation of anaesthetic mortality across an entire social and geographic entity was that carried out by Professor O.V.S. Kok in the Transvaal. He was assisted in that work by his colleagues Arthur Bull and (later) Gaisford Harrison.

Kok's original paper was published in an obscure journal in the Afrikaans language, since he was a very staunch Afrikaner patriot. Fortunately an English translation does exist, which was used by Harrison in his MD thesis, but that work was not published commercially.

The next significant enterprise which sought to gather information from an area rather than a hospital or group of hospitals was the Association of Anaesthetists of Great Britain & Ireland study of 1956, documented by Edwards, Morton et al., which devised a number of ground-breaking methodologies, notably the eight-category classification still in use today.

The AAGBI work suffered from a serious flaw, in that notification to the working group was entirely voluntary, and indeed largely restricted to members of the association. Nevertheless, it did manage to identify a number of basic errors of management or complications inherent in the abolition of consciousness.

Which more or less brings us to the New South Wales Special Committee Investigating Deaths Under Anaesthesia (SCIDUA).

How did it start?

Post World War II, the great majority of anaesthetics in NSW were administered by general practitioners in private and by junior doctors in public hospitals. Specialist anaesthetists were few in

number and had to compete against the formidable opposition of GPs who jealously guarded their right to anaesthetise the patients whom they had referred to specialist surgeons, as well as those being operated on by their GP colleagues.

As was inevitable in those circumstances, mistakes were made, and despite the legal requirement to report deaths occurring "under" anaesthesia to the coroner, inquests when they were held did little or nothing to identify ways in which these deaths could have been avoided. The coronial findings tended to be formulaic, ending with findings such as: "and when fatal symptoms manifested themselves, every effort was made to restore animation".

There was a belief in both the medical and lay communities that anaesthesia was potentially hazardous and some patients did not "take the anaesthetic well". Nevertheless with the gradual increase in numbers of specialists in anaesthesia, there was a growing understanding that the outcome had a lot to do with the training, experience and competence of the anaesthetist.

Nowhere was this more obvious than in the public hospital system, where junior doctors with scant experience were responsible for administering anaesthesia, including to children, unsupervised by any qualified specialist. As late as 1958, deaths at the hands of these tyros were described as "the cost of teaching".

That attitude appalled me, and led to formulation of a means whereby all anaesthetic deaths in NSW could be analysed by a group of experts. Fortunately, a provision of the NSW Coroners Act forbade the writing of a death certificate concerning any patient who died under anaesthesia. In fact, in 1964 the Act was amended to cover deaths occurring within 24 hours of an anaesthetic.

However, having read the above-mentioned paper by Edwards et al, I submitted a proposal to the Department of Public Health (as it then was) to appoint a committee that would use coronial notifications as a means of approaching the anaesthetists concerned with a request for clinical data.

The Minister of the day, The Hon W.F. Sheahan was a decisive and powerful politician who had no hesitation in approving the proposal and authorised the appointment of nominees from relevant professional bodies, including the Faculty of Anaesthetists, the Australian Society of Anaesthetists and the clinical departments of surgery and anaesthesia of the then existing medical schools (Sydney and NSW). The College of GPs and the RCOG were also invited to nominate.

The Department of Public Health provided the chairman, in the person of its current director, Dr Cyril Cummins, who had advised the minister to create the committee. It also seconded myself, its recently and first qualified specialist anaesthetist, to act as medical secretary to the committee.

It was then given its full and rather grandiose name that survives to the present. It was given the status of a Ministerial Committee, which under the rules of the day could (and did) claim confidentiality on the basis that it enjoyed the same privilege as cabinet documents.

Community-based studies of anaesthetic mortality

continued

Obviously this was an extremely important condition, enabling the Medical Secretary to approach anaesthetists with a guarantee of confidentiality that lasted for over 20 years. Subsequent developments rendered the old-fashioned ruse of "cabinet privilege" unreliable, leading to parliamentary action in the case of the Health Administration Act, which survives to this day.

Unfortunately, while that bill was being drafted and introduced to the Parliament, the committee was obliged to suspend its activities, leading to a loss of data for most of the years 1980-82. Since that time there has been no threat to the status of SCIDUA's proceedings, documents and correspondence. Its confidentiality remains secure, and there has never been a breach in the 50 years of its operations.

The success of the NSW committee led to its emulation in other states, although these committees were rather differently constituted and administered. In Victoria, the committee chose to study morbidity as well as mortality, but its machinery was entirely voluntary. Likewise in Queensland, notification was not compulsory, but in Western Australia reporting of the occurrence of a death was, and is, mandatory.

In South Australia, formation and operations of a committee was delayed and frustrated by the obstinate attitude of the Medical Indemnity Society of that state. Although this was eventually overcome, the infant committee was weak and did not survive into adolescence. Its resurrection is being organised as we speak.

Tasmanian anaesthetists felt that with its small population it would be difficult to maintain a committee and for a time it reported deaths to SCIDUA in New South Wales. It is now in the process of setting up its own committee.

Across the Tasman, the business of reporting and analysing mortality from anaesthesia has been bedevilled by the legal framework that existed in that country. Under laws that had apparently been inherited from South Africa in colonial times, deaths occurring unexpectedly from anaesthesia were grounds for charging the anaesthetist with manslaughter. That legal situation has now been reformed but the bruises remain.

Even so, under the determined enterprise of Professor Alan Merry, it is hoped that a New Zealand committee to investigate anaesthetic mortality will emerge in 2010.

Internationally, a considerable time after the AAGBI study was terminated, a much more powerful mechanism was set up in the Confidential Enquiry into Peri-operative Deaths (CEPOD), chaired by John Lunn. It published two reports and the outcomes were substantial. Although it did not happen until some years after NSW had abolished unsupervised anaesthesia by junior hospital doctors, that serious source of mortality (and morbidity) came to an end.

However, CEPOD was not permanent and was subject to budgetary control insofar as funding was for a limited period. When that ran out, it was not immediately renewed. I understand that CEPOD Mark II has been revived, but its remit is no longer specifically for perioperative deaths, and its current pre-occupation is with mortality amongst the mentally ill.

In the United States it has not been possible to set up a confidential inquiry. This is surprising in that such a body existed in Massachusetts for many years, investigating maternal mortality and published its results in the *New England Journal of Medicine*. I understand that it did not do well after the demise of John Figgis Jewett, its distinguished founder. Interestingly, that committee ensured confidentiality by having an Act passed by the Parliament of Massachusetts which made it an offence for any member of the committee to divulge information to a third party, thus creating a situation of "double jeopardy" which members could (and did) shelter under.

In a typical example of Yankee ingenuity, the American society has instituted several Closed Claims Studies which take advantage of court proceedings which are in the public domain, and more recently of data from the medical indemnity organisations (MDO's) which provide de-identified details of those cases in which settlement was reached without litigation.

In 50 years of operation, SCIDUA has seen remarkable changes in the incidence, variety and demography of mortality from anaesthesia. This will be the subject of talks and interactive sessions at the upcoming NSWACE meeting.

Professor Ross Holland
Inaugural Secretary for SCIDUA

To mark this event the NSW Anaesthesia Continuing Education Committee and the Clinical Excellence Commission will co-host an education seminar "Death Under Anaesthesia" on Saturday August 14, 2010 at the Hilton Hotel, Sydney. The event will include talks and interactive sessions on the topic of anaesthesia-related mortality. For event details see above right and **www.nsw.anzca.edu.au/events**

This year the Clinical Excellence Commission (CEC) will present Professor Holland with a 'CEC Lifetime Achievement Award' for his substantial contribution over 50 years to the SCIDUA and work in anaesthesia mortality reporting. Professor Clifford Hughes, CEO of the CEC will present the award at the upcoming NSWACE seminar on August 14, 2010.

Quality & safety

Quality and Safety Committee member profile

I am a lawyer and have been a member of this committee since 2007, partly because of my interest in health matters, but partly also to maintain a consumer point of view on the committee.

The committee is involved in some cutting-edge issues, including addressing the perennial problem of error from a perspective which is at the top of the cliff, rather than the bottom of the cliff, which is where complaints and other medico-legal processes tend to focus. It is very refreshing to be involved in initiatives that are aimed at lifting the game, particularly the ANZTDAC project which involves an interesting mix of IT issues, ethical issues and a proper understanding of the legal context within which the project should operate.

I have long been involved in medico-legal issues in New Zealand. A particular project on which I worked closely with New Zealand anaesthetists, led by (then) Associate Professor Alan Merry in the early 1990s, related to a successful campaign to obtain an amendment to the laws of medical manslaughter; New Zealand had hitherto been out of step with many other jurisdictions as to the threshold for a medical manslaughter conviction. In 1997 after several years of hard work, the Government of the day was persuaded to enact an amendment to the Crimes Act, lifting the threshold so that a conviction could only be obtained where the omission or neglect involved was a "major departure from the standard of care expected of a reasonable person". For those and other reasons, I have always enjoyed a constructive relationship with anaesthetists – and other specialists as well. A document that has pride of place on my chambers' wall is a Certificate of Honorary Membership awarded by the New Zealand Society of Anaesthetists "in recognition of service to anaesthesia". As I have often said to anyone who will listen, I have been putting people to sleep for years, and I now have formal recognition of that fact!

Other areas of my practice involve a wide range of regulatory work in a number of sectors, personal injury work, employment law and trust/relationship property litigation.

From that broad range of interests, I find my membership of the Quality and Safety Committee quite different from many of my other activities, and one where I enjoy the collegiality of well-motivated colleagues and the constructive discussion of innovative ideas.

Bruce Corkill QC
Wellington

ECRI Alerts

The ECRI Institute (www.ecri.org/Pages/default.aspx) has issued the following warnings:

A14021 Spacelabs-Model 91220 Vital Sign Monitors: May Not Power On with Alternating Current Power and May Not Be Able to Charge Batteries

A medical device correction letter has been posted by the UK Medicine and Healthcare Products Agency which has received reports of incidents in which the above patient monitors did not power on with alternating current power and were not able to charge the batteries. This problem may result in a loss of patient monitoring. Spacelabs states that if the monitor powers on it is unlikely to fail. If the charging circuit fails while the monitor is in use, the monitor will continue to run on battery power until this is depleted when the low battery alarm will continue to work normally.

A14009 GE-Various Datex-Ohmeda Anaesthesia Machines: O2 Flush Button May Stick Open, Potentially Diluting Anaesthetic Agent

Machines manufactured between January 1, 2007 and December 31, 2009. The oxygen flush button may be readily impeded by the anaesthesia work surface and stick in the open or partially open position with the potential to dilute the anaesthetic agent or to cause barotrauma.

The alert applies to the Datex Aspire 100/7100, Aspire 7900, Aspire View, Advance, Amigo and ADS 180.

To view ECRI's alerts in full, please contact the ANZCA library at **library@anzca.edu.au**

Revised safety guidelines for the management of severe local anaesthetic toxicity endorsed by ANZCA

It is rare for a completely new therapy to come along in anaesthetic practice. In 1998 Professor Guy Weinberg of Chicago, acting on a well-educated guess, demonstrated lipid infusion may reduce local anaesthetic cardiotoxicity. Using a rat model, he demonstrated that the dose-response curve for asystole caused by racemic bupivacaine was shifted to the right by 50% in the presence of intralipid[1]. Further research followed and he made the suggestion that it may be effective in treating local anaesthetic toxicity in humans[2]. By 2006 several case reports of apparently successful resuscitation had appeared in the anaesthetic literature, editorial comment was made, and the therapy was established[3-5].

The following year in 2007 the Association of Anaesthetists of Great Britain and Ireland (AAGBI) produced a guideline for use of intralipid that was widely promulgated[6]. Numerous case reports have since been published[7-11]. Last year an international committee was convened by AAGBI to update the guidelines and make them an international consensus document. I represented ANZCA on this committee. The objectives were to review the literature in view of the numerous case reports, mostly successful, and to update the original guideline.

The guideline which we produced has been endorsed by both AAGBI and ANZCA, and is available on the ANZCA website (www.anzca.edu.au/resources/endorsed/). It is suitable for laminating and putting in your emergency trolley. The main changes from the 2007 AAGBI guidelines are: lipid is now given greater precedence over cardiopulmonary bypass, lipid therapy should be considered before cardiac arrest occurs, and there is a recommendation to give lipid therapy if cardiac arrest attributed to local anaesthetic toxicity occurs. The total recommended dose for unresponsive cardiac arrest has also been increased. There is still a great deal we do not know. There is a lack of information on which to base recommendations for vasopressor use[12] and a relative lack of negative reports indicates there may be publication bias in the literature.

Notably, there are as yet no recommendations on which facilities should have intralipid available for immediate use. My personal view is that it should be on the emergency trolley in all locations where doses of local anaesthetics are being injected into patients that would be neurotoxic should unexpectedly rapid absorption or accidental intravascular injection occur.

Severe adverse reactions are hard to study systematically due to their rarity and there is a need to rely on case reports to find out what works. With this is mind a registry has been set up with the objective of gathering more information on the incidence of adverse reactions and the effectiveness of lipid rescue treatment, both for local anaesthetic toxicity and also experimental use in other poisonings with lipophyllic drugs[13-15]. The website is www.lipidregistry.org and is maintained by Martyn Harvey and Grant Cave who are New Zealand emergency physicians. I encourage those that have the occasion to use lipid rescue treatment to submit cases to the registry so that we can all gain a better idea of the effectiveness or otherwise of this novel therapy, and to help further refine our guidelines.

For those of you who want to know more about the subject, Professor Weinberg also maintains an excellent website including a bibliography at www.lipidrescue.org.

Dr Timothy Short
Auckland City Hospital

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AAGBI Safety Guideline

Management of Severe Local Anaesthetic Toxicity

1 Recognition

Signs of severe toxicity:

- Sudden alteration in mental status, severe agitation or loss of consciousness, with or without tonic-clonic convulsions
- Cardiovascular collapse: sinus bradycardia, conduction blocks, asystole and ventricular tachyarrhythmias may all occur
- Local anaesthetic (LA) toxicity may occur some time after an initial injection

2 Immediate management

- Stop injecting the LA
- Call for help
- Maintain the airway and, if necessary, secure it with a tracheal tube
- Give 100% oxygen and ensure adequate lung ventilation (hyperventilation may help by increasing plasma pH in the presence of metabolic acidosis)
- Confirm or establish intravenous access
- Control seizures: give a benzodiazepine, thiopental or propofol in small incremental doses
- Assess cardiovascular status throughout
- Consider drawing blood for analysis, but do not delay definitive treatment to do this

3 Treatment

IN CIRCULATORY ARREST

- Start cardiopulmonary resuscitation (CPR) using standard protocols
- Manage arrhythmias using the same protocols, recognising that arrhythmias may be very refractory to treatment
- Consider the use of cardiopulmonary bypass if available

GIVE INTRAVENOUS LIPID EMULSION
(following the regimen overleaf)

- Continue CPR throughout treatment with lipid emulsion
- Recovery from LA-induced cardiac arrest may take >1 h
- Propofol is not a suitable substitute for lipid emulsion
- Lidocaine should not be used as an anti-arrhythmic therapy

WITHOUT CIRCULATORY ARREST
Use conventional therapies to treat:

- hypotension,
- bradycardia,
- tachyarrhythmia

CONSIDER INTRAVENOUS LIPID EMULSION
(following the regimen overleaf)

- Propofol is not a suitable substitute for lipid emulsion
- Lidocaine should not be used as an anti-arrhythmic therapy

4 Follow-up

- Arrange safe transfer to a clinical area with appropriate equipment and suitable staff until sustained recovery is achieved
- Exclude pancreatitis by regular clinical review, including daily amylase or lipase assays for two days
- Report cases as follows:
  in the United Kingdom to the National Patient Safety Agency (via **www.npsa.nhs.uk**)
  in the Republic of Ireland to the Irish Medicines Board (via **www.imb.ie**)

If Lipid has been given, please also report its use to the international registry at **www.lipidregistry.org**. Details may also be posted at **www.lipidrescue.org**

Your nearest bag of Lipid Emulsion is kept .....

This guideline is not a standard of medical care. The ultimate judgement with regard to a particular clinical procedure or treatment plan must be made by the clinician in the light of the clinical data presented and the diagnostic and treatment options available.

IMMEDIATELY

Give an initial intravenous bolus injection of 20% lipid emulsion

1.5 ml.kg^{-1} over 1 min

AND

Start an intravenous infusion of 20% lipid emulsion at **15 ml.kg^{-1}.h^{-1}**

AFTER 5 MIN

Give **a maximum of two** repeat boluses (same dose) if:

- cardiovascular stability has not been restored **or**
- an adequate circulation deteriorates

Leave **5 min** between boluses

A maximum of **three** boluses can be given (including the initial bolus)

AND

Continue infusion at same rate, but:

Double the rate to **30 ml.kg^{-1}.h^{-1}** at any time after 5 min, if:

- cardiovascular stability has not been restored or
- an adequate circulation deteriorates

Continue infusion until stable and adequate circulation restored or maximum dose of lipid emulsion given

Do not exceed a maximum cumulative dose of 12 ml.kg^{-1}

An approximate dose regimen for a 70-kg patient would be as follows:

IMMEDIATELY

Give an initial intravenous bolus injection of 20% lipid emulsion 100 ml over 1 min

AND

Start an intravenous infusion of 20% lipid emulsion at 1000 ml.h^{-1}

AFTER 5 MIN

Give a **maximum of two** repeat boluses of 100 ml

AND

Continue infusion at same rate but **double** rate to 2000 ml.h^{-1} if indicated at any time

Do not exceed a maximum cumulative dose of 840 ml

This AAGBI Safety Guideline was produced by a Working Party that comprised:
Grant Cave, Will Harrop-Griffiths (Chair), Martyn Harvey, Tim Meek, John Picard, Tim Short and Guy Weinberg.

This Safety Guideline is endorsed by the Australian and New Zealand College of Anaesthetists (ANZCA).

AAGBI Safety Guideline

Management of Severe Local Anaesthetic Toxicity

ACCOMPANYING NOTES

1 Recognition	Local anaesthetic intoxication can present in many different ways, making it very difficult to recognise. After injection of a bolus of local anaesthetic, toxicity may develop at any time in the following hour. Techniques involving infusion of local anaesthetic through a catheter allow intoxication to develop at any time.
2 Immediate management	Some hospital laboratories have encountered difficulty analysing blood drawn during lipid emulsion therapy. If clinical circumstances allow, it may be prudent to draw blood for later analysis before lipid emulsion therapy begins.
3 Treatment	1000 ml of 20% lipid emulsion should be immediately available to all patients receiving potentially cardiotoxic doses of local anaesthetic. 20% lipid emulsion is readily available from most hospital pharmacies, which may also be able to help departments with timely replacement of bags nearing expiry. Intralipid® 20% emulsion has been used in the majority of reported uses of lipid emulsion as an antidote. Alternative preparations have also been used in successful resuscitations. Although some propofol preparations are provided in Intralipid®, e.g. Diprivan®, these are not a suitable alternative due to the significant cardiovascular depression caused by the propofol. This does not preclude the use of small, incremental doses of propofol to treat convulsions. In extremely obese patients, doses of lipid emulsions should ideally be based on an estimate of lean body weight. The interaction between lipid emulsion treatment and other cardioactive drugs used in resuscitation is unclear. Some evidence suggests high doses of vasopressors are harmful in resuscitation in local anaesthetic intoxication. Conversely, some evidence suggests lipid emulsion therapy may be harmful in asphyxial cardiac arrest.
4 Follow-up	The immediate management of severe intoxication by LA is extremely demanding. In the aftermath, completion of forms on websites may seem unattractive. However, every case can help prevent another and improve treatment of the condition. Thus, reports to relevant registries are extremely important. Pancreatitis has occasionally been associated with acute lipidaemia, and therefore should be excluded.
5 Education	Educational material and up-to-date lists of relevant publications are available at **www.lipidrescue.org** This guideline will be updated regularly; the latest version can be found on **www.aagbi.org**

Training team skills for anaesthetists

From acute emergency surgery to chronic pain management, most of the care delivered by anaesthetists and pain specialists is delivered as part of a team effort. In recent years there has been an increasing interest in the effectiveness and training of teams in delivering care. This interest has been driven by the realisation that effective teams have lower rates of adverse events, higher satisfaction levels of the team members and a suggestion of improved patient outcomes [1].

Recent work by industrial psychologists, educators and clinicians has begun the task of understanding what highly functioning teams look like, how to train them and how to assess their effectiveness. This article reviews methods that are available to train effective teams. Not all of these methods are commonly used or evaluated within healthcare at the moment but provide exciting opportunities for future developments.

Two distinct approaches have typically been used to improve team functioning; *education and standardisation*. The more commonly used method is team training, which ideally involves all members of the regular clinical team. The standardisation approach may be seen as complementary to training. This method entails rigidly determining the roles of each team member and ensuring the tasks and responsibilities of each of these roles is detailed. These lengthy procedures are often presented in the form of checklists or flowcharts.

One such example is the set of task management cards developed by Malignant Hyperthermia Australia and New Zealand (MHANZ) [2] that outlines a list of tasks for each team member during a malignant hyperthermia crisis. Unfortunately these cognitive aids are rarely used as intended due to a lack of familiarity or knowledge about the potential benefits of such a method [3].

Team training strategy	Focus	Common modes of delivery
Crisis Resource Management (CRM) or Team Coordination Training (TCT)	Underlying processes of team coordination	Lecture Video critique Immersive simulation
Cross-training	An understanding of the other aspects of the team's work	Lecture Role Modeling Immersive simulation
Team self-correction training	Strategies for monitoring their own and others' behaviours	Role play Immersive simulation
Assertiveness training	Assertive behaviors, especially in junior staff members	Role play Video critique
Perceptual contrast training	Underlying concepts of teamwork and how they are applied	Video critique
Scenario-based training	Specific behavioural objectives embedded in common situations	Screen-based simulation Immersive simulation
Guided error training	Experience and react to common errors to transfer knowledge to real work	Immersive simulation
Stress exposure training	Knowledge of sources and effects of stress in the work environment	Lecture Video critique Immersive simulation
Metacognition training	Process of decision making and potential for error – "thinking about thinking"	Lecture Screen-based simulation Immersive simulation
Team leadership training	Specific skills required to lead a team in a given situation	Lecture Video critique Immersive simulation

Table 1. Methods of team training in common use and their modes of delivery [after Salas et al. and Wilson et al. 7, 8]

Research on team training in health contexts is limited. However, a large body of evidence for the effectiveness of specific methods and modes of team training exists in other domains. In particular, military and transport fields have developed and evaluated many methods of training teams to work in high-risk areas. In a recent meta-analysis by Salas *et al* of 45 primary studies comprising 2650 teams, only 80 of these teams were from healthcare [4]. Although there are clear differences between the work contexts and team dynamics between health and military domains, there are important lessons that can be learnt from this existing research.

The original team training program in anaesthesia was developed by Gaba, Fish and Howard at the Veterans Affairs hospital in Stanford in the late 1980s [5]. The content for their course was derived from perceived gaps in the training of anaesthetists by observation of decision making and performance in a simulated setting. The aviation method of training, termed Crew Resource Management (CRM, earlier termed Cockpit Resource Management) was taken as a starting point as there were clear similarities between decision making in cockpits and in operating theatres. Crisis Resource Management, also termed Team Coordination Training uses didactic teaching, video observation and participation and debriefing of

simulation scenarios to demonstrate key team-working behaviours such as assisting other team members in times of high stress. Additionally, other forms of team training are available and have been extensively evaluated in other settings (Table 1).

Salas *et al*'s meta-analysis [4] examined the effects of using different strategies of team training, and found that other methods in addition to CRM training were highly effective. In particular, cross-training, where team members practice in roles they would not usually undertake, was valuable in helping team members develop skills to back up their team mates. Meta-cognition (critical thinking) training was valuable in appreciating how errors in decision-making and judgement could occur in crises, and how to minimise these. It should be noted that these methods utilise modalities of training differently, from didactic instruction to observation, discussion and participation. Team training has traditionally evolved through simulation in anaesthesia but this modality is not essential to teach teamwork skills. If the material is matched to the mode of presentation, the effectiveness of the session need not be affected.

Simulation training allows presentation of carefully scripted, realistic scenarios to teams to elicit team behaviours that reflect what would happen in a real clinical situation. The benefit of simulation is not solely in the management of the crisis in real-time. Most learning seems to occur after the event during the structured review by the participants on what actually happened, and how they might modify their behaviours in the future to form more effective teams. Immersive (so called high fidelity) simulation has been shown to be powerful in changing behaviours, but is expensive and not easily accessible to all. As a result, other forms of training may be warranted to replace or augment simulation as a modality.

Despite substantial evidence of the effectiveness of team training programs, it should be stressed that most of the research into the training of teams outside academic settings has been performed in military and transport domains. These teams differ from health settings, as

they are often less complex in terms of number and variety of specialist roles, and the team members are usually the same individuals with the same or similar roles each time. This lack of stability and complexity of healthcare teams means that the focus of training must also be different. In military settings, teams are usually trained together, as they will commonly be working together as the same unit. In anaesthesia and surgery the team often comes together at the time of the emergency, commonly with little prior knowledge of each other's skills, or abilities. Consequently, it is impractical in most circumstances to train operating theatre teams, as they may never work together as the same team again. A more logical approach is to focus the training on each individual's abilities to work as an effective team member in whichever team they may find themselves. Transfer of training techniques from other settings should therefore be undertaken with care. The objectives of the training need to be clearly defined and matched to the strategy and mode of training. Ideally the participants should also be observed to ensure the objectives of the training are met.

A further consideration is the focus of content. CRM training typically focuses on the coordination aspects and team working behaviours. There is evidence from obstetric settings however, that concentrating on the performance of the tasks in a timely manner can help the participants understand how to coordinate their activities more effectively. Draycott *et al* [6] showed that a scenario-based approach concentrating on task work required for obstetric emergencies reduced both neonatal mortality and hypoxic ischaemic encephalopathy by 50% following training.

In conclusion, the importance of training teamwork in anaesthesia is becoming more apparent and widespread. At present, only a small number of methods of team training are being employed in health, but evidence from other domains suggests additional techniques may be valuable. Care needs to be taken in translating these methods to anaesthesia because of the different contexts of work and team structures. Evaluation of team training programs is essential to ensure the training objectives are being met.

It is now clear that effective teams have lower rates of adverse events and that this may, in turn, lead to improved patient outcomes. This should be sufficient to ensure that we make team training an educational priority within anaesthesia.

Training team skills for anaesthetists

continued

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Work-life balance: Challenges for the anaesthesia workforce

On a perfect autumn Sunday afternoon in late March a group of female anaesthetists from Westmead Hospital met for lunch at a restaurant on the Jones Bay Wharf in Pyrmont.

The seed for the gathering was sown during a conversation that had taken place weeks earlier in the corridor outside the anaesthetic department. We were lamenting the ongoing stressors involved in maintaining professional standards as consultant anaesthetists and providing a happy and stable home environment for our families. This conflict may sound all too familiar and is likely to be an ongoing issue as the number of female registrars gradually increases.

In 2008, 33% of all ANZCA Fellows were female. The recent anaesthesia workforce document predicts that 40% of anaesthetists will be female by 2028 (1). At Westmead Hospital there are 60 consultant anaesthetists, 15 of whom are female. All of these women work part-time. Nine have children under 10, five have grown up families and one is yet to start her family. Eight of these women are new consultants who have become specialists in the last five years.

The anaesthetic training program doesn't discriminate along gender lines. It's hard work no matter who you are and individual hospitals are variably accommodating of options other than full-time training. The module system and the timing of the exams ensure that, for the most part, registrars acquire knowledge and skills at similar rates. However, for many women the transition from registrar to consultant is not without significant challenges. Reduced working hours may mean more time to enjoy young families but the reality of keeping up to date, maintaining skills and having confidence in both ability and decision making can be incredibly daunting. Watching male colleagues progress in their careers while also enjoying the benefits of family life can be quite disheartening. Wouldn't it be fantastic to have a wife rather than to be the wife?

The reality is that women continue to do the bulk of the housework and child rearing no matter what their work pattern. Juggling on-call commitments, the demands of a partners' career, the needs of growing children and home maintenance is hard work. When the wheels fall off, as they inevitably do from time to time, the conflict between work and family can be difficult to reconcile.

How on earth did the previous generation of female anaesthetists get through their training and manage to forge successful and fulfilling careers? Dr Jane McDonald, the author of *The gender revolution we had to have* describes the reaction of her boss at the news of her pregnancy during her anaesthetic Fellow year. He was clearly annoyed and told her that she should not have taken the job and should have told him that she might get pregnant (2). Thankfully this situation would certainly not be tolerated today.

The desire to learn from our predecessors was one of the primary reasons for the lunch. We invited all female consultant anaesthetists in the department in the hope that we might be able to talk through some of the issues that concern a great many of us in our day-to-day lives. Only two women were unable to attend. While no real answers became immediately apparent, it was wonderful to be able to talk openly to a group of people who, by and large, have faced or are facing similar work-life conflicts. It is fair to say that the younger women in the group came away with a great deal of admiration for those who came before us, in a time when fewer women specialised, there were limited opportunities for maternity leave and little empathy or support for working mothers. There was also a certain element of demystifying the more senior women on staff which in turn has lead to an increased camaraderie and better relations between the female anaesthetists. It also helped to put things into perspective for many of us present. Perhaps not surprisingly there is a fairly universal feeling of being torn between the needs of our families and the desire to have rewarding careers.

For better or worse we have taken on the name "WAGS" – Westmead Anaesthetic Girls Society – and we hope to build on the concept in the future. We are not unique and Gretel Davidson from The Sydney Children's Hospital in Randwick was the driving force behind the regular CME dinners held around the eastern suburbs for female anaesthetists from the Prince of Wales/Sydney Children's hospitals. We have a lot to be grateful for as working mothers in 2010 but any forum that provides support to those of us who might feel a bit overwhelmed at times has got to be something worth continuing.

Dr Moira Rush
Dr Lissa Buenaventura
Staff specialist anaesthetists,
Westmead Hospital, New South Wales

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Above from left to right: Dr Freda Vosdoganis, Dr Sheila Stewart, Dr Elizabeth Darbar, Dr Jane Brown, Dr Jane McDonald, Dr Nicole Phillips, Dr Kathy Bock (standing), Dr Helen Currow, Dr Emily Wilcox (obscured), Dr Moira Rush, Dr Susan Voss, Dr Robyn Alleyn, Dr Lissa Buenaventura.

New Zealand news

New Zealand National Committee

The New Zealand National Committee (NZNC) will meet on July 23-24. ANZCA President, Professor Kate Leslie, will attend the meeting which will hear from Professor Des Gorman, Chair of the Health Workforce New Zealand (HWNZ). HWNZ (the Clinical Training Agency Board) was set up in late 2009 to provide national leadership on the development of the country's health and disability workforce. HWNZ advises the Minister of Health on all aspects of health workforce planning, within the wider program of reform of the health system. Its aim is to work in collaboration with training providers, professional bodies and employers, to build on existing networks and to create new opportunities to involve clinicians and health care providers in planning our future workforce. Numerous initiatives are being driven by HWNZ and they have potential to impact on anaesthesia training and practice (see below).

Health Workforce New Zealand

Health Workforce New Zealand's first annual plan gives a high level outline of its work program for 2010/11. http://www.healthworkforce.govt.nz/sites/all/files/annual-plan-2010-2011.pdf

Two areas that will particularly involve the anaesthesia workforce are outlined in sections 2.2.5 (Anaesthesia review program scoped) and 3.3.1 (Demonstration sites established for physician assistant, nurse endoscopy and surgical assistant (RN)).

NZNC will be engaging with HWNZ to ensure that the anaesthesia workforce in New Zealand continues to provide quality and safe patient care. A HWNZ clinical leadership forum will be held in Wellington on the June 29. Two NZNC representatives will attend. Committee members have been considering the issues arising out of the HWNZ Counties Manukau DHB's physician assistants' pilot. More information about this will be included in the next edition of the *ANZCA Bulletin*.

NZNC elections

Three members of NZNC, Brian Lewer, Arthur Rudman and Paul Smeele did not seek re-election in the recent NZNC elections. The College thanks them for their dedication and work over a number of years. We will miss their expertise, especially in the areas of training, formal projects, CPD, Fellowship affairs, IMG assessments, hospital inspections, quality and safety issues and input into the wide variety of meetings, consultations and submissions that the NZNC participates in.

For the 2010/2012 term, the three new committee members are Kerry Gunn (Auckland), Indu Kapoor (Wellington) and Amber Chisholm (Auckland). Three committee members who had been co-opted during the last term were elected as full members of the committee: Gary Hopgood (Waikato), Nigel Robertson (Auckland) and Jennifer Woods (Christchurch). Vaughan Laurenson, Geoff Long, Gerard McHugh, Joe Sherriff, Malcolm Stuart and Vanessa Beavis were re-elected.

ANZCA 2010 Annual Scientific Meeting

The ANZCA ASM was held in Christchurch from May 1-5. The ASM Regional Organizing Committee led by Associate Professor Ross Kennedy (Convenor), Dr Richard French (Deputy Convenor) and Dr Mark Waddington (Scientific Convenor), College staff and the professional conference organisers, Conference Innovators, are to be congratulated on running a stimulating and enjoyable conference. This edition of the *ANZCA Bulletin* and the College website provides a comprehensive update on the event www.anzca.edu.au/events/asm/asm2010

At the closing ceremony, the President, Dr Leona Wilson reflected on her two years as ANZCA President. It was fitting that her term concluded in the city where she grew up and completed her early years in medicine. The NZNC congratulates Leona on her successful time as the first New Zealand and first female president of the College.

Annual General Business Meeting of New Zealand ANZCA Fellows

The Annual General Business Meeting of New Zealand ANZCA Fellows was held during the ASM. Ian Collens, ANZCA Director of Strategy and Operations, presented some of the findings of the New Zealand workforce survey and analysis of the supply side data. Ian Collens has been working on the demand data and has met with Ministry and DHB officials who are involved in workforce data collection. A methodology for identifying the demand for anaesthesia services has been developed.

Acute care in provincial hospitals

Members of the NZNC have been participating in the Ministry of Health project that is looking at how to strengthen the clinical and financial sustainability of acute services for the populations served by provincial hospitals.

Disaster response

ANZCA wrote to the Minister of Health, Tony Ryall, in March regarding the involvement of anaesthetists in a disaster response plan for New Zealand. A meeting with the ministry will occur on the July 22. Attendees will include the Acting Director of Emergency Management, Charles Blanch and Gillian Bohm, Principal Advisor Quality Improvement from the Ministry and Dr Vanessa Beavis and Dr Maurice Lee. Dr George Merridew, the Chair of the ANZCA Disaster Response Executive from Australia has been invited to join the meeting by teleconference.

The training of anaesthetists to work in disaster situations and the development of a national register of anaesthetists who are willing and able to respond at short notice will be discussed. Please contact Heather Ann Moodie at the ANZCA New Zealand office if you are interested in being involved.

Perioperative Mortality Review Committee

Dr Leona Wilson was recently appointed by the Minister of Health to the Perioperative Mortality Review Committee following the Government's decision to re-establish this mortality review committee. At its first meeting in May, Dr Wilson was appointed the Deputy Chair.

ANZCA New Zealand Trainee Committee

The ANZCA NZ Trainee Committee has prepared a guidebook, *Anaesthesia Training in New Zealand Made Easy*. This has been well received by trainees and is an excellent resource. The Chair of the New Zealand Trainee Committee, Dr Kathryn Hagen, has been elected to be the Chair of the main ANZCA Trainee Committee.

Actioning Medicines New Zealand

The action plan of Medicines New Zealand has sections of particular interest to anaesthesia:

- The proposal to explore amending the Medicines Act 1981 and the Medicines Regulations 1984 to give nurse practitioners and optometrists the same prescribing rights as those available to medical practitioners, dentists and midwives.
- The proposal to amend the Medicines Act to create a new class of prescriber called a "collaborative prescriber".
- The intention to explore an expanded role for PHARMAC in the prioritisation and procurement of hospital medicines, vaccines, and some medical devices.

The New Zealand National Committee has recently received two consultation documents that propose changes to prescribing of medicines:

- Pharmacy Council – Proposed Pharmacist Prescriber Scope of Practice http://www.pharmacycouncil.org.nz
- PHARMAC - Proposal to amend definitions of prescriber types www.pharmac.govt.nz

Consultation documents

The New Zealand National Committee has considered a wide variety of consultation documents over the last few months, including:

Ministry of Health

- How do we determine if statutory regulation is the most appropriate way to regulate health professions?
- Health Quality and Safety Commission Board nominations.
- Proposed amendments to medical regulations under the Medicines Act.
- Definition of "day surgery" under the proposed amendments to the Health and Disability Services (Safety) Act 2001.
- Possible expansion of PHARMAC's role.
- Health Workforce New Zealand (HWNZ) Project: Survey of Health & Disability Activity.
- Paper on NZREX Preparation Placement Programme for IMGs.
- National Health IT Board Clinical Leadership Group - High Level Requirements for the transfer of care between health practitioners, focusing on the transfer of care from secondary to primary health practitioners (discharge summaries).
- The development of a Natural Health Products Bill.

Minister of Health

- Legislative barriers to workforce innovation.
- Public Health and Disability Amendment Bill.

Medical Council

- UK Council for Healthcare Regulatory Excellence – Performance Review of MCNZ.
- Draft statement on "What to do when you have concerns about a colleague".
- Changing recertification requirements for doctors registered in a general scope of practice.
- Revision of statement on non-treating doctors performing medical assessments of patients for third parties.

PHARMAC

- Proposal to widen access to fentanyl patches.
- Draft Consumer Advisory Committee Terms of Reference.
- Proposal to widen funded access to octreotide for patients with malignant bowel obstruction or acromegaly.
- Proposal to fully fund domperidone for all patients without a requirement for Special Authority application.
- Proposal to amend definitions of prescriber types.

Regions

Queensland

A pilot residential program for the primary vivas, specifically aimed at the regional trainees was held on the Sunshine Coast in preparation for the first viva session of 2010. The convenor was Dr Rob Thomas, who put in an enormous amount of work to make the weekend a success. Fellows who dedicated their weekend to providing viva practice to registrants were: David Dolan, Helen Davies, Alex Donaldson, Stephen Mitchell, Kim Fuller, Ben Lloyd, Richard Scolaro, Tania Morris.

Thanks to all of these Fellows for the donation of their valuable time to this pilot.

The course also included the use of a qualified professional to assist trainees with their non-content based approach to these exams along with video-taping of selected vivas for review of such actions as body language, eye contact and nervous habits. The course was extraordinarily well received by trainees with 16 participants attending for the weekend.

Recently, there have been both the primary and final practice viva evenings. Dr Taryn Naggs was the Convenor of the primary practice vivas that were held on Wednesday evenings, April 28 and May 5 and attended by 34 and 30 candidates attended respectively. Thanks to the following Fellows and advanced trainees who attended as examiners over the two weeks: Rhonda Boyle, Michael Cleary, Paul Martin, Petra Millar, Scott Smith, Carolyn Wills, Brooke Vickerman, David Fung, Kate Ferris, Richard Galluzzo, Bruce Hammonds, Jim McLean, Taryn Naggs, Rebecca Ruberry, Gamini Wijerathne and Diana Webster.

Final practice vivas were held on May 12 and 19. There were 21 candidates attending on both nights. Thanks to the following Fellows who gave up their time to attend as examiners: Steve Bianchi, Peter Cook, Chris Jackson, Martin Heck, Tania Lee, Rob Swan, Stefan Ziege, Petra Millar, Ben Lloyd, Kim Vidhani, Jim McLean, Cameron McAndrew, David Dolan, Bridget Effeney, Craig French, Richard Galuzzo, Bruce Hammonds, Gamini Wijerathne, Kerstin Wyssusek, John Wilson, Martin Wakefield.

The short course for both the primary and final exams are scheduled for June–July 2010 and are again fully subscribed with waiting lists.

The annual ANZCA/ASA Continuing Medical Education day is being held on July 10, 2010. Registrations are open and filling. The topic for 2010 is "Acute Pain – the ongoing challenge". The convenor is Dr Richard Pendleton with a number of speakers in the morning sessions and a workshop and PBLDs in the afternoon.

FPM

Mark Tadros was the Convenor of the Faculty of Pain Medicine's CME dinner held on Tuesday, May 25 at the ANZCA regional office. The topic of the event was "Patients with legal claims". About 30 Fellows and external consultants attended the event. The speakers, Margaret Brain from Slater & Gordon lawyers and Rachel Miller from Quinlan-Miller & Treston lawyers gave an engaging presentation using examples from real life compensation claims where they illustrated the case from the perspective of the claimant, the insurers and the lawyers who are involved in requesting medico-legal examinations.

Thanks to the sponsors of the event Medfin Finance, Investec Experien and MDA National.

13th Queensland Registrars Meeting

On Saturday, April 24 the 13th Queensland registrars meeting was held in the ANZCA Queensland regional office.

There were 47 registered delegates, a mix of registrars and Fellows, both active and retired. Eight formal projects were presented on the day. These were:

Dr Louise Munro – Logan Hospital
"An audit of blood transfusion practices in primary electrive hip arthroplasty at Logan Hospital for the 2008 calendar year".

Dr Petra Millar – Gold Coast Hospital
"Anaesthesia for Caesarean Section in achondroplasia: A case series".

Dr Willem Basson – Redcliffe Hospital
"Anaesthetic and analgesix techniques for total knee replacements, a decade apart: Audit".

Dr Scott Smith – Royal Brisbane & Women's Hospital

"Central venous line insertion and needlestick injury – an education and preventative perspective".

Dr Freya Aaskov – Towsnville Hospital
"Pheochromocytoma in pregnancy".

Dr Anton Booth – Mater Hospital

"The prevalence and impact of morbid obesity in a regional Australian obstetric population".

Dr Bridget Effeney – Princess Alexandra Hospital

"Massive transfusion protocol: A review of the first 12 months of implementation at the Princess Alexandra Hospital".

Dr Joshua Tooth - Ipswich Hospital
"A combined approach to management of post-tonsilectomy pain in children".

The Formal Projects officer, Dr Joe Power, was assisted on the day by Dr Peter Moran and Dr Rhonda Boyle as adjudicators, with the ASA Chairman represented by Dr David MacCormack and the timekeeper Dr Whybrew. They were joined by guests Professor Tess Cramond, Mrs Walter (Beverley) Biggs and Leigh Winston (AXXON Health) for the presentation of awards to the following:

Professor Tess Cramond Prize: Dr Anton Booth

Dr Walter Biggs Prize, sponsored by Axxon Health: Dr Willem Basson

ASA "Chairman's Choice" Prize: Dr Louise Munro

Supporting hospital of the Tess Cramond Prize winner: Rockhampton

The event was sponsored by AXXON Health, Investec, MDA, Avant, Pfizer and CSL.

South Australia/ Northern Territory

The South Australia and Northern Territory combined ASA/ANZCA Continuing Medical Education Committee meeting was held in late March at the Women's and Children's Hospital in North Adelaide. ANZCA Fellows from Alice Springs and Royal Darwin hospitals joined in via video conference. Associate Professor Susan Neuhaus gave a presentation "From the heat of battle to the freezer: The role of frozen blood products on military operations".

The South Australia/Northern Territory Regional Committee recently held the Royal Adelaide Hospital Primary Sciences Course with 13 attendees. This popular course was facilitated by Dr Mark Finnis with a program including basic science, structure and content of the primary examination, fellowship training and examination in intensive care. Trainees found the predominantly interactive tutorials very beneficial. The next primary sciences course is due to be held the week of August 9-13 at the South Australia/ Northern Territory Regional Committee office in North Adelaide.

Australian Capital Territory

The ACT Regional Committee met on June 1. The new office bearers are:

Chair: Carmel McInerney

Deputy Chair: Caroline Fahey

REO: Simon Robertson

Formal Projects Officer: Don Lu

Secretary/Treasurer/New Fellow: Ross Peake

Quality and Safety Officer: Stephen Brazenor

Trainee Representative: Zain Upton.

Welcome to the new members and farewell and many thanks for years of service to Thomas Bruessel, Grant Devine and Cliff Peady.

The ANZCA/ASA combined scientific meeting, "The art of anaesthesia", has been scheduled for May 5-6, 2011.

It is proposed that an intensive one-day workshop entitled "Simple but not easy: Anaesthetic management of acute trauma" be held on Saturday, September 11. This will be a great way to round off the CPD triennium. The ACT Trainee Committee held its second meeting including the representative from Albury via Skype. Planning is under way for a registrars workshop with a focus on obstetrics.

Finally, the ACT Regional Committee would like to congratulate Dr Louise Ellard who was awarded the Cecil Gray Prize at the ASM in Christchurch.

Opposite page: Fellows and trainees at the primary practice vivas residential pilot program.

This page, top left: Professor Tess Cramond presents the Tess Cramond Prize to Dr Anton Booth.

This page, bottom left: Associate Professor Susan Neuhaus giving a presentation on "From the heat of battle to the freezer: The role of frozen blood products on military operations".

Western Australia

ANZCA\ASA Combined WA Winter Scientific Meeting

On Saturday, July 31 Western Australia will be holding its annual winter scientific meeting at the Perth Convention and Exhibition Centre. The title of the meeting is "Current challenges in anaesthesia". Dr Eric Visser will give the Dr Ian McGlew Lecture and will present on the peri-operative management of patients on methadone and buprenorphine. Other sessions include an update on the management of diabetes, and the optimal management of patients undergoing colorectal and joint replacement surgery. There will be a workshop on "Dealing with an impaired colleague", a panel discussion and several PBLD's. The academic program will be followed by a sundowner.

WA Faculty of Pain Medicine Education Meeting

On Wednesday, June 23 the WA FPM will be hold an education meeting at the University Club of WA. Topics on the agenda are "Opioid contracts" and "Ketamine lozenges use and contracts". The education meeting will be followed by WA FPM Regional Committee meeting.

WA trainees movie night

A movie night was organised by GASACT for the WA anaesthetic trainees on the evening of June 1. The trainees were treated to pizza, sushi and a few liquid refreshments followed by a screening of the new Robin Hood movie. Some trainees had just returned from the anaesthetic vivas in Melbourne so this was a chance for them to catch up and relax outside the work and study environment.

Above: Trainees enjoy a movie night in early June. Some of the trainees had just returned from the anaesthetic vivas in Melbourne.

New South Wales

In May this year the NSWACE Committee hosted the Annual Scientific Meeting's "Regional lecture series" in which one of the ASM's international keynote speakers delivered a series of talks locally in one state or region. Following his success at the ASM, Utah-based Professor of Anaesthesiology, Talmage Egan, delivered the keynote lectures for these events, focusing on intravenous anaesthesia, a topic on which Professor Egan is an internationally recognised expert. The first lecture hosted by Westmead Hospital on May 11 and entitled "Pharmacodynamic drug interactions: hypnotics and opioids", was attended by 39 anaesthetists and trainees. The second lecture was presented on Wednesday, May 12 as part of the NSWACE Committee's first evening seminar series. The seminar commenced with a keynote talk by Professor Egan entitled "Advances in propofol formulation and delivery: a review of new propofol formulations, propofol delivery devices and new sedative-hypnotic agents". Following the session, Professor Egan and Royal North Shore based anaesthetists Drs Paul Sinclair and Adam Rehak presented a series of interactive group learning sessions, each addressing different aspects of TIVA. As testimony to the steely nerve and adaptive planning of the ANZCA staff and presenters, the 48 delegates were blissfully unaware of the prolonged power failure to the venue in the two hours immediately preceding the event. The NSWACE Committee's "Evening seminar series" is being piloted with a second planned for early 2011. Many thanks to Nicole Phillips for convening and hosting the Westmead evening, Adam Rehak and David Elliott for hosting the Royal North Shore evening, the presenters and ANZCA staff.

For the diary

On Saturday, August 14 the NSWACE will co-host its winter seminar with the Clinical Excellence Commission (CEC). The seminar entitled "Death Under Anaesthesia – 50 years of the Special Committee Investigating Death Under Anaesthesia (SCIDUA)" will celebrate SCIDUA's anniversary with a series of talks, group leaning sessions and workshops on the topic of anaesthesia-related mortality. SCIDUA's work is featured in an article authored by Professor Ross Holland on page 66. NSWACE's summer regional meeting is scheduled to be held in Port Macquarie on the weekend of November 20-21, 2010.

Tasmania

After a very successful and well attended ANZCA/ASA CME meeting entitled "A disaster of a conference" in February, the committee has commenced planning for the 2011 meeting to be held at the Hobart Function and Conference Centre from February 18-20, 2011.

A registrar's workshop is being organised for November 6 in Launceston and a Part 3 Course will also be held in Launceston mid-year.

An ANZCA Teacher Course – Advanced Level is also scheduled to take place in Launceston on Friday, August 13.

Victoria

The ANZCA Part Zero course, held at Lorne on Victoria's Surf Coast from March 20-21, was aimed at assisting those trainees new to the specialty of anaesthesia in adapting to this exciting and challenging career. It was an opportunity for new trainees to meet each other and the course facilitators who have a special interest in teaching new trainees. The program was interactive and practical, and was enjoyed by the 46 participants. The success of this course has encouraged the Regional Education Officer to consider running it again in 2011.

The primary full-time pre-Fellowship course is run for trainees prior to the primary written examination. This year it was held from May 31 to June 11 with 36 attendees. The course convenor for the primary full-time course is Dr Adam Skinner who attracted 35 lecturers for this course from the major teaching hospitals. Their time and effort are greatly appreciated and we thank them for their valuable contribution.

Above: NSWACE Committee member Dr David Elliott and Professor Talmage Egan at Westmead Hospital.

Right: ANZCA Part Zero Course participants at the Cumberland Resort in Lorne.

Dean's Message

As this is my first Dean's message, I would like to make some introductory comments. First to express appreciation to those who entrusted to me the opportunity to serve on the Faculty board and now the responsibility of Dean. I was privileged to have *ab initio* presence on the Board, from November 1998 and, before that, the predecessor Pain Management Advisory Committee of ANZCA from 1994. I have worked with excellent role models and seen hard acts to follow. I will work hard to ensure good things from before continue, and on new issues that will enhance what we do. I soon learned that much hard work goes on behind the scenes by each board member on a *pro bono* basis, and by executive staff, whom I know work beyond usual office hours as necessary – ultimately to benefit our patients and community through improved training, standards and practice. Thanks to you all.

Dr Penny Briscoe, Immediate Past Dean gave much thought, energy and time to the Faculty's development, commencing long before deanship. Penny was inaugural Chair, and developer of the Faculty's examination. This took considerable effort, has been viewed and commented on favourably by outside observers and is a strong pillar of the credibility of our qualification. Penny also took great interest in case reports – and our profession is about cases and what we can do to help them. Penny has only stepped sideways from her role as Chair, continuing with important roles not limited to Chair, Fellowship Affairs Portfolio, and nominee to the National Pain Strategy as it continues working towards implementation.

The topic of Penny Briscoe's last Dean's message was opioids. I could not disagree with advice contained therein. A paradox from the week following our very successful Faculty and College ASMs in Christchurch must be mentioned. *The Press*, a local newspaper there, featured in large lettered headlines "Opioid abuse on rise" and "Police, doctors in bid to block illicit use". These articles arose from sessions at another congress in Auckland (RANZCP), during the same week as ours. For information, the RANZCP also is one of the partner Colleges to our Faculty! The first of the articles[1] declared "PHARMAC (NZ equivalent of the PBS) figures show an opioid called oxycodone hydrochloride had gone from no prescriptions in 2005 to more than 100,000 in 2009". What this failed to say, in its attempt to put the prescribing in its worst light, was that before 2005 this medication was not funded in NZ, therefore hardly anyone prescribed it because of (a) very few knowing of its existence and (b) most patients rejected paying for medications (at least in NZ). So funding it in 2005 was obviously the major factor in the number of prescriptions being written subsequent to that.

Similarly "Another opioid, fentanyl, was prescribed fewer than 1000 times in 2005, but more than 5500 times last year". Clearly this is a meaningless statement even if it were correct, because PCA fentanyl has been used extensively in *hospital* in anaesthesia practice, PACU and a significant proportion of PCAs. What this public news item did not say in explanation was that *transdermal* fentanyl was only approved for funding (after special authority application for each case) in 2005 IF the patient is terminally ill AND is opioid-responsive, AND is unable to take oral medication OR is intolerant to morphine, OR morphine is contraindicated. Note the range of conditional criteria.

The article elsewhere mentions that a cancer patient's family can divert some of their SR morphine supply and still leave the patient with enough. So the comment does not point out that the fentanyl matrix patch may give better pain control and not be so divertible without the patient noticing their supply had gone. Yes, we are aware that opioid supplies to cancer pain patients are just as divertible as to non-cancer patients – but are they suggesting we don't even use opioids in cancer pain management because of this as a *potential* problem?

These emotive twists and turns using half truths and omitting explanations for the statistics is irresponsible, yet moulds much of the opinion, in public and professionals alike. None of these items mentions what the National Pain Strategy brought out – that access to good pain management is woefully limited, despite much that could be safely relieved. And that there is still much unrelieved acute pain, where an early and better intervention attempt is a step towards halting some of acute pain's progression to chronicity. Inevitably judicious use of opioids must feature as part of this effort, appropriately especially when *part* of a multimodal treatment plan.

So the messages at present are mixed, contradictory and confusing. We still have much to do with a treatment class as ancient and time honoured as opioid analgesia, how to guide careful constructive use, and devise harm minimisation measures. We lack tools like ability to access in real time whether our current patient is obtaining opioids from multiple sources. The official baulk is on grounds of privacy and costs, yet at the same time we do have (in NZ for instance) websites that we and pharmacists use with secure access and confidential information exchange, for purposes of managing funding control and restrictions! It is there so they can control the spending on some (not very harmful) pharmaceuticals. But such a system is not fully available[2] for more clinically useful purposes, like supporting control of S8/Controlled Drugs where there is significant onus on prescribers for harm minimisation. This reveals where the priorities of some lie, and the doors we need to keep knocking on, or down. The Faculty is chipping away at this, it is frustratingly slow, and we are aiming for balance.

News

"We still have much to do with a treatment class as ancient and time honoured as opioid analgesia, how to guide careful constructive use, and devise harm minimisation measures. We lack tools like ability to access real time whether our current patient is obtaining opioids from multiple sources."

ANZCA is doing much through its media work to improve the standing of both our anaesthesia and pain medicine specialties. I don't see this as self edification or a personal gain issue, but part of raising the public's confidence in our professionalism.

Defence organisations advise that good communications reduce complaints even when mistakes occur! Each of us has an opportunity every time we engage with patients, their relatives/supporters and the public, to maintain and enhance that picture of professionalism through communicating our care and concern for their issues. Just by doing our job well we build confidence.

For the last part of this message I would like to acknowledge colleagues and others close to me who by their support in many and different ways make it possible to carry out the duties. Colleagues do pick up work tasks when I am absent, and help with continuity of patient care. I take this opportunity to thank them for that.

David Jones
Dean

References

1. Clip Reference: 00069537135 from Media Manager, ANZCA: communication@anzca.edu.au
2. Some information via Australian Prescription Shopping Information Service (1800 631181).

National Pain Strategy

Funding of $39.1 million for persistent pain clinics in Queensland

On June 8, 2010, Queensland's Deputy Premier and Health Minister Mr Paul Lucas announced that Queensland Health would provide $39.1 million to establish and fund persistent pain clinics in four public hospitals — the Gold Coast Hospital, the Princess Alexandra Hospital, the Nambour Hospital and the Townsville General Hospital. Significant improvements for pain services in Queensland can be expected as a result of the Government's 2010-11 Budget.

New models of pain services for Queensland can be expected under the leadership of Professor Julia Fleming at the Royal Brisbane and Women's Hospital Pain Clinic and through the establishment of services in four other major public hospitals.

It is hoped the funding will extend to community and GP educational programs.

For more information please visit our website.

International Pain Summit

Following the success of the National Pain Summit in Canberra on March 11, an International Pain Summit is planned for September 3 in Montreal following the IASP World Congress in that city.

Discussions on the formation of a National Pain Advocacy body to move forward with the main strategic objectives agreed at the Summit are also in progress.

Faculty Board

Dr Penny Briscoe handed over to the new Dean, Dr David Jones, following the AGM on May 2 in Christchurch. Penny's leadership and significant contributions to the Faculty during her time as Dean were acknowledged at the Faculty of Pain Medicine's annual dinner and AGM. Penny will remain on the board and will Chair the Fellowship Affairs Portfolio. David, as Dean, will now Chair the Relationships Portfolio. Dr Brendan Moore (Qld) was elected Dean-Elect at the new board meeting on May 2. Brendan will continue to Chair the Trainee Affairs Portfolio. Associate Professor Leigh Atkinson, as Treasurer, will continue to Chair the Resources Portfolio.

Appointments

The Faculty board is pleased to announce the appointment of Associate Professor Milton Cohen, FRACP (NSW) as its first Director of Professional Affairs. The Director of Professional Affairs FPM is responsible to the Dean and the FPM Board for the provision of professional advice on Faculty matters, particularly on policies as they relate to clinical and professional issues affecting the fellowship.

New Zealand application for specialty recognition

In August 2009, the Faculty of Pain Medicine started the application process for specialist vocational recognition in New Zealand with the Medical Council of New Zealand (MCNZ).

A draft report from the Education Committee of MCNZ was recently provided for comment to the New Zealand National Committee of ANZCA. It was apparent that firm ground had been established for pain medicine being recognised as a separate vocational scope. Concerns raised in the draft report will be addressed in stage II of the process. A response is expected shortly from the MCNZ Education Committee.

Professional Documents

The Board approved two new Professional Documents:

- PM7: "Policy on Supervision of Clinical Experience for Vocational Trainees in Pain Medicine" (designed to compliment PM5).
- PM 8: "Policy on Trainee Illness and Disability".

The following Professional Documents were recently reviewed and updated:

- PM3: "Lumbar Epidural Administration of Corticosteroids".
- PM5: "Policy for Supervisors of Training in Pain Medicine".

PM7 and PM8 are published in full at the end of this section. To view all professional documents please visit our website.

Dean's Prize

The Faculty Free Papers session was held on Sunday, May 2. The Dean's Prize is 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. This year the prize was awarded and presented at the AGM to Dr Rutha Nerlekar, an ANZCA trainee based in South Australia, for her research paper "Placebo vs nocebo questioning for pain evaluation after caesarean section". Dr Nerlekar was awarded a certificate and a grant of $1000 for educational or research purposes.

Above: Dr Rutha Nerlekar is presented with the Dean's Prize by Dr Penny Briscoe. Above right: Dr Phillip Cornish, Dr Pamela Eccles and Dr Tania Morris.

Fellowship training and examination dates for 2010

Examination dates
November 24-26, 2010
Barbara Walker Centre for Pain Management at St Vincent's Hospital, Melbourne.

Closing date for registration
October 8, 2010

Pre-exam short course
October 13-15, 2010
Royal Adelaide Hospital.

Closing date for registration
October 1, 2010

Admission to Fellowship of the Faculty of Pain Medicine

By training and examination:

Dr Philip Cornish	SA
Dr Johann Emmanuel	UK
Dr Zamil Mehboob Karim	VIC
Dr Tania Lea Morris	QLD
Dr Ban Leong Sng	Singapore
Dr Jennifer Anne Stevens	NSW

By examination:

Dr Simon Jude Tame	NSW
Dr Jane Mary Thomas	NZ

By election:

Dr Anthony Thomas Davis	SA
Dr Susan Evans	SA
Dr Thierry Vancaillie	NSW

Honorary:

Professor Andrew Somogyi	SA

FPM trainee lunch

The Faculty invited all pain medicine trainees registered for the ASM to attend a buffet lunch during the ASM with the aim of providing an opportunity for FPM trainees to get together and to meet key people from the Faculty. The Dean (Dr Penny Briscoe), Vice-Dean (Dr David Jones) Assessor (Dr Frank New), Supervisor of SoTs (Dr T Semple), Chair of Examinations (Dr Ray Garrick), Deputy Chair of Examinations (Dr Meredith Craigie) and the Executive Officer (Ms Helen Morris) also attended to respond to questions about the training program. Faculty trainees, Drs Max Sarma (Tas) and Kerry Thompson (Vic) spoke about their Faculty training and examination experiences and provided valuable insights to current trainees.

Fibromyalgia – an update

The history of "fibrositis" syndrome/fibromyalgia (FM) in the modern era began in 1977 (1). A controversial but major step for research, rather than clinical medicine, was the publication of the ACR (American College of Rheumatology) 1990 criteria for the classification of FM (2). Just published are new preliminary diagnostic criteria by the ACR stated to be suitable for use in primary and specialty care, not requiring a tender point examination but providing a severity scale for characteristic FM symptoms (3,4). Controversy is likely to continue. Also recently published is an ACR report on pain management (5).

Since 2000 checking the major national rheumatology journals, Arthritis and Rheumatism (USA), Rheumatology (United Kingdom), Journal of Rheumatology (Canada), for editorials/reviews shows the following, grouped according to journal. Also available is the first book ever published on FM (6) which gives excellent overviews of the history, basic science, clinical observations and management of what is really a generalised nonspecific (i.e. no specific pathology) musculoskeletal pain syndrome. Many rheumatologists prefer to describe FM this way, not using the label of FM. Labelling has good and bad aspects to it.

References:

1. Smythe HA, Moldofsky H. Two contributions to the understanding of the 'fibrositis' syndrome. Bull Rheum Dis 1977;28:928-931
2. Wolfe F et al. The American College of Rheumatology (ACR) 1990 criteria for the classification of FM: report of the Multicenter Criteria Committee. Arth Rheum 1990;33:160-172
3. Wolfe F et al. The ACR preliminary diagnostic criteria for FM and measurement of symptom severity. Arth Care and Res 2010;62:600-610
4. Edit. Wolfe F. New ACR criteria for FM: a twenty-year journey. Arth Care Res 2010;62:583-584
5. ACR Pain Management Task Force. Report of the ACR Pain Management Task Force. Arth Care Res 2010;62:590-599
6. (eds) Wallace DJ, Clauw DJ. FM and other central pain syndromes. Lippincott, Williams and Wilkins, 2005

Arthritis and Rheumatism (since 2000):

Edit. Winfield JB. Does pain in FM reflect somatisation? Arth Rheum 2001;44:751-753;

Edit: Crofford LJ, Clauw DJ. FM: where are we a decade after the ACR classification criteria were developed? Arth Rheum 2002;46:1136-1138;

Review. Fitzcharles M-A, Almahrezi A, Shir Y. Pain: understanding and challenges for the rheumatologist. Arth Rheum 2005;52:3685-3692;

Edit. Clauw DJ, Witter J. Pain and rheumatology: thinking outside the joint. Arth Rheum 2009;60:321-324.

Rheumatology (since 2000):

Review. Hazemeijer I, Rasker JT. FM and the therapeutic domain: a philosophical study on the origins of FM in a specific social setting. Rheumatology 2003; 42:507-515;

Edit. Croft P. Symptoms without pathology: should we try a little tenderness? Rheumatology 2003;42:813-817.

Journal of Rheumatology (since 2000):

Edit. Wolfe F. For example is not evidence: FM and the law. J Rheumatol 2000; 27:1115-1116;

Edit. Croft P. Testing for tenderness: what's the point? J Rheumatol 2000;27:2531-2533;

Edit. Wolfe F. 'Stand and deliver, for you are a bold deceiver': faking FM. J Rheumatol 2000;77:2534-2535;

Edit. Smythe HA. FM: can one distinguish it from malingering? More work needed; more tools supplied. J Rheumatol 2000;27:2536-2540;

Edit. Gordon DA. Comment: FM – real or imagined? J Rheumatol 2003;30:1665;

Edit. Ehrlich GE. Pain is real; FM isn't. J Rheumatol 2003;30:1666-1667;

Edit. Hadler NM. 'FM' and the medicalisation of misery. J Rheumatol 2003;30:1668-1770;

Edit. Wolfe F. Stop using the ACR criteria in the clinic. J Rheumatol 2003;30:1671-1672;

Edit. Smythe HA. FM among friends. J Rheumatol 2004;31:627-630;

Edit. Nielson WR, Harth M. FM: beyond the rhetoric. J Rheumatol 2003;31:631;

Edit. Wallace DJ. To FM nihilists: stop pontificating and test your hypothesis. J Rheumatol 2003;31:632;

Edit. Goldenberg DL. FM: to diagnose or not. Is that still the question? J Rheumatol 2003;31:633-635;

Edit. White KP. FM: the answer is blowin' in the wind. J Rheumatol 2003;31:636-639;

Is FM a neuropathic pain syndrome? J Rheumatol 2005;32:Supplement 75 (San Francisco, CA, USA, September 19, 2003);

Edit. Smythe H. The symptom intensity scale, FM, and the meaning of FM-like symptoms. A review. J Rheumatol 2006;33:2113-2114;

Edit. Gracely RH. A pain psychologist's view of tenderness in FM. J Rheumatol 2007;34:912-913;

Edit. Harth M. Nielson WR. The FM tender points: use them or lose them? A brief review of the controversy. J Rheumatol 2007;34:914-922.

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Honorary Fellowship: Professor Andrew Somogyi

PhC (Sydney) 1971; PhD (Sydney) 1978

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. Professor Andrew Somogyi was conferred with Honorary Fellowship of the Faculty of Pain Medicine, ANZCA at the College Ceremony in Christchurch.

Andrew Somogyi graduated as a Pharmacist (PhC) at the then Tasmanian College of Advanced Education in Hobart in 1971. Following a year of traineeship in retail pharmacy, he attended Sydney University and obtained a graduate diploma in hospital pharmacy and a Masters in Science. He then undertook a higher degree research program on the clinical pharmacokinetics and dynamics of the neuromuscular blocking drug pancuronium under the supervision of Professor Ted Triggs (Pharmacy Department, Sydney University) and Dr Colin Shanks (Department of Anaesthetics, Royal Prince Alfred Hospital, Sydney) culminating in the awarding of a PhD degree in science in 1978.

He then spent a three-year period of postdoctoral training in clinical pharmacology in the Department of Medicine at the University of Bonn in Germany where he undertook several clinical pharmacokinetic and dynamic studies on cimetidine and ranitidine prior to their registration onto the market. He also became exposed to the role of genetics factors in drug metabolism, pharmacokinetics and their contribution to interindividual variability in drug response through collaborative research with Professor Michel Eichelbaum, the discoverer of the CYP2D6 genetic polymorphism.

Following a short post-doctoral period in Melbourne, he moved to the University of Adelaide as NHMRC Senior Research Officer. He was subsequently appointed to an academic position in 1992 and over the past 18 years has been progressively promoted, culminating in a personal chair as Professor in Clinical and Experimental Pharmacology in 2002.

Professor Somogyi has spent the past 20 years investigating the clinical pharmacology of opioids, including codeine, morphine, oxycodone, methadone and buprenorphine. These studies have included elucidating the enzymes involved in their metabolism, pharmacokinetics and pharmacodynamics in targeted populations including those with acute and chronic pain and palliative care and the increasing importance of genetic factors in opioid pharmacology. His most important findings relate to his hypothesis of absence of analgesia to codeine in those with the CYP2D6 poor metaboliser geno- and phenotype due to lack of metabolism to morphine; the phenomenon of opioid-induced hyperalgesia in chronic pain patients treated with either morphine or methadone; that the phenomenon is likely to be applicable to all opioids but with varying potency and that the mechanism can be explained by opioid-induced proinflammatory cytokine release involving a new target of opioid action, that of toll-like receptors on glia. He has published more than 200 papers, several highly cited reviews (Pharmacogenetics of opioids, role of active metabolites in the use of opioids), several book chapters and is a regular speaker at national and international conferences. He is senior editor for the *British Journal of Clinical Pharmacology* and is on the editorial boards of the *Journal of Opioid Management*, *Pharmacogenetics and Genomics* and *Pharmacogenomics and Personalised Medicine*.

Professor Somogyi was Associate Dean of Research in the Faculty of Health Sciences at the University of Adelaide from 2004-2009, is a member of the Non Prescription Medicines Advisory Committee of the TGA (Department of Health and Ageing) and for the last three years has been a member of the NHMRC Grant Review Panel for Pharmacology. He is also a member of the Faculty of Pain Medicine Research Committee.

In summary, over the past two decades, Professor Somogyi and his team have undertaken research into the clinical pharmacology of opioids particularly with respect to elucidating the genetic factors that contribute to interpatient variability with the potential for further enhancing a personalised approach to pain therapy. The award of Honorary Fellowship of the Faculty of Pain Medicine is a fitting recognition of the substantial contributions Professor Andrew Somogyi has made to the broad field of our specialty.

Dr Christopher Hayes
Hunter Integrated Pain Service
New South Wales

Standardisation of outcome measures for persistent pain

A National Pain Outcome Initiative has been listed as one of the 12 key priorities of the recently developed National Pain Strategy. This prioritisation is influenced by international recommendation [1] and the benefits to rehabilitation medicine and palliative care respectively of implementation of the Australian Rehabilitation Outcome Centre (AROC) and the Palliative Care Outcome Centre (PCOC). The focus on outcome measurement at this time of healthcare reform also reflects the political importance of being able to clearly demonstrate the impact of pain management interventions. Despite prioritisation in the National Pain Strategy, there is no source of funding available for a large scale national outcome initiative. There is, however, an opportunity to trial smaller scale pilot projects utilising existing resources.

One such pilot is a collaborative outcome project under way at Caulfield Pain Management and Research Centre (CPM&RC) and Hunter Integrated Pain Service (HIPS). The research involves the analysis and benchmarking of quantitative data contained in questionnaires completed by study participants from January 2010 to January 2012. Information to be collected from questionnaires pre- and post- intervention includes:

1. Brief Pain Inventory (BPI) [2]
   - Pain severity subscale as a measure of pain intensity.
   - Pain interference subscale as a measure of physical functioning.
2. Kessler 10 (K10) as a measure of emotional functioning (Kessler and Mroczek,1992, cited in [3]).
3. Coping Strategies Questionnaire Short Form (CSQ-R)[4] as a measure of cognitive processes related to pain.
4. Health service use in the past three months.
5. Current medication use (Medication Quantification Rating Scale [5]).
6. Additional information:
   - demographics (date of referral, date of birth, gender, postcode and compensable status).
   - time from referral to first intervention.
   - number, type (individual/group) and hours of interventions provided.
   - patient status (inpatient or ambulatory).
   - whether the client dropped out of treatment.

There is an opportunity for other interested centres to be involved in the project at either of two levels. At a formal research level, centres may opt to use the shared outcome measurement data set and participate, using their own resources, in the benchmarking process. This level of involvement would require application to their local research ethics committee. Alternatively, centres may simply choose to use the core outcome measures without being part of the formal benchmarking process. At this level of engagement a proposal to a local ethics committee would not be necessary. For those who are interested in either level of involvement further information can be obtained from Meredith Jordan, Clinical Psychologist at Hunter Integrated Pain Service (Meredith.Jordan@hnehealth.nsw.gov.au).

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2. Cleeland C, Ryan K. (2004). Pain assessment: Global use of the Brief Pain Inventory. *Annals of Academic Medicine*, 23, 129-138.
3. Andrews G, Slade T. (2001) Interpreting scores on the Kessler Psychological Distress Scale (K10). *Australian and New Zealand Journal of Public Health*, 25, 494-497.
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5. Harden N, Weinland S, Remble T et al. (2005). Medication quantification scale version III: Update in medication classes and revised detriment weights by survey of American Pain Society Physicians. *The Journal of Pain*, 6(6), 364-371.

Dr Christopher Hayes
Hunter Integrated Pain Service
New South Wales

Dr Carolyn Arnold
Caulfield Pain Management
and Research Centre, Victoria

Policy on illness or disability for trainees and Fellows

PM8 (2010)

1. Introduction

1.1 Trainees have a responsibility to ensure that they are appropriately fit to practise, and that they seek medical advice if they are uncertain about their fitness to practise.

1.2 Those dealing with trainees who are ill or disabled must ensure both that patients are not put at risk, and that the affected trainees receive as comparable educational and training opportunities to other trainees as is feasible.

1.3 Maintenance of confidentiality and protection of privacy are paramount obligations to trainees with illness or disability. These obligations should not be breached except in the case of mandatory reporting requirements to external regulatory authorities, and/or where patient safety is at risk.

1.4 In cases where patient safety may be affected, the Faculty reserves the right to notify Medical Boards/Councils or other appropriate authorities.

1.5 This document is in compliance with the Medical Boards of the various Medical jurisdictions.

2. Training Options in the case of Illness or Disability

2.1 All trainees are entitled to take sick leave under their contractual arrangements. Normal sick leave requirements do not constitute an interruption of training (see Regulation 15 for details of Normal Leave).

2.2 Interruption of training is allowable, but may have implications for training requirements (see Regulation 15).

2.3 Extended parental or sick leave must be notified to the Faculty and advice obtained as to the effect on training time.

2.4 Any trainee may undertake part-time training provided this is prospectively approved by the Assessor and meets the other requirements (see Regulation 15).

2.5 A candidate may withdraw on medical or compassionate grounds from the Examination. A formal application for special consideration or approval for withdrawal will be required by the Faculty, and should be made in writing and addressed to the Head of Examination Committee.

2.6 Application may also be made for special consideration for assistance appropriate to any disability (see definition) that may impair performance in a Faculty Examination, provided that such assistance does not compromise the fairness and reliability of the Examination. Application should be made as in 2.5.

2.7 Some trainees with illness or disability will require the assistance provided under the *College/Faculty's Guidelines for Assisting Trainees with Difficulties*. Where these Guidelines have been applied without resolution of the issue(s), the Trainee Performance Review Process may be implemented. This Process may result in a determination that the trainee is not fit to continue in the training program.

2.8 Some jurisdictions have programs specifically set up to assist doctors with impairment. Where appropriate, these or other doctors' health programs should be accessed to deal with trainee illness or disability.

3. Fitness to Practice

3.1 The College does not determine fitness to practice. This is a matter for the trainee's treating medical practitioner, his/her employer and, where relevant, the supervising Medical Board/Council.

3.2 Reporting requirements in relation to medical practitioner illness or disability vary from one jurisdiction to another and it is important that relevant requirements are met.

3.3 At the end of each Hospital Employment Year, and as part of the Application to present for the Faculty Examinations, trainees are required to make a declaration as follows:
I certify that:
a) I have no illness or disability (including a substance abuse disorder) that would preclude the safe practice of Pain Medicine. I have informed the Faculty of inappropriate use of medications or other substances with the potential to compromise the safe practice. I am receiving appropriate medical care.
b) I undertake to notify the Faculty on the following: - if I develop a substance abuse disorder with recreational prescribed or non-prescribed drugs; if I commence treatment with prescribed drugs with the potential to compromise the safe practice of pain medicine; or if I develop an illness or disability that may preclude the safe practice of pain medicine.
c) Pursuant to 1.3, all communications made by the officers of the Faculty/College, and all answers made are absolutely privileged.
Signature:

3.4 Admission to Fellowship is dependent on compliance with 3.3.
Signature:

3.5 Communication to the Faculty/College pursuant to 2.3 must in writing and directed to the Executive Officer/Chief Executive Officer.

3.6 The College will handle each notification, taking into account all the particular circumstances and the principles set out in 1.2, 1.3 and 1.4.

4. Trainee Selection

4.1 This Faculty's training programme is based on equal opportunity without prejudice. The Faculty has the right to exclude applicants from training if not compliant with 3.3.

4.2 The Faculty is not responsible for employment of Trainees.

5. Seeking Advice

All enquiries, applications and communications regarding this policy must be made in writing and addressed to the Executive Officer, Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists, 630 St Kilda Road, Melbourne, Victoria 3004, Australia.

Notwithstanding any provision in this policy, where there are exceptional circumstances recognised and approved by the Assessor of the Faculty, the Board of the Faculty and the Council of the College may approve an amended Training Program.

Definition of Disability: any restriction or lack (resulting from an impairment or disease) of an ability to perform an activity in a manner or within the range considered normal for a human being (WHO 1980)

References

College Professional Document TE18 *Guidelines for Assisting Trainees with Difficulties*.

College Professional Document EX1 *Policy on Examination Candidates Suffering from Illness, Accident or Disability*.

College Professional Document PS 49 *Guidelines on the Health of Specialists and Trainees*.

Regulation 33, Trainee Performance Review Process.

Regulation 14 Eligibility for Fellowship by Examination.

Regulation 15, Training and Examinations in Anaesthesia.

Guidelines for the Selection of Trainees.

This Professional Document should be interpreted with regard to the following Documents:

PS49 *Guidelines on the Health of Specialists and Trainees*

Policy on supervision of clinical experience for vocational trainees in pain medicine

PM7 (2010)

1. Introduction

Supervision of clinical experience allows Vocational Trainees in Pain Medicine to have a good quality learning experience as they progress towards independent practice. Supervision of clinical work during training is a vital part of developing professional competence, and can guide training. The category and form of supervision provided varies as a trainee gains experience and expertise during the training program.

2. Supervisors

2.1 Supervisors of Training must be appropriately qualified, holding FFPMANZCA or other qualifications approved by the Faculty of Pain Medicine.

2.2 Medical staff other than the Supervisor of Training may provide day-to-day or after hours supervision.

3. Categories of Supervision

The category of supervision will vary for a given trainee. It will be more intensive in the initial period of training. Supervision should be available at all times.

3.1 Category 1: Supervisor working directly and in close proximity with a Trainee.

3.2 Category 2: Supervisor within same location in the hospital, and available for assistance and face-to-face consultation within minutes, and immediately by telephone.

3.3 Category 3: Supervisor present elsewhere in hospital, and available for consultation and assistance within 15 minutes, and immediately by telephone.

3.4 Category 4: Supervisor not in hospital but contactable and, if necessary, available within a reasonable travelling time (less than 60 minutes). This category of supervision applies to out-of-hours cases. Telephone consultation must be available at all times.

4. Supervisors Of Training Time for Trainees

In large pain units with more than two Trainees, an allocation of one session per week to Supervisors of Training is necessary to meet their responsibilities. This session can occur fortnightly in smaller pain units with up to two Trainees.

5. General Principles

Whenever the Trainee is on duty, there must be a clear line of responsibility from the patient, through the junior medical staff to the trainee, and to the consultant responsible for the patient's care. Should the consultant usually responsible for the clinical care of a particular patient not be available, the Trainee should have access to a similarly qualified consultant who is prepared to act in a locum capacity.

During the structured year of training, the Supervisor should focus on knowledge, attitudes and skills required for:

- Interviewing
- Specific Pain History
- Physical Examination
- Mental state examination
- Formulation of Cases
- Presentation
- Interventions
  - clinical
  - procedural
- Case management
- Multidisciplinary team participation and management
- Educating and Training of others
- Correspondence
- Management and review of quality care

6. Interventional Supervision

The Trainee should observe Supervisors conducting diagnostic and therapeutic interventions. It may be appropriate for the Trainee to practice in a simulated environment and a number of closely supervised repeats may be desirable for *some* Trainees and for *some* skills. Supervisors should observe a Trainee conducting similar interventions until such stage, that the Trainee can continue these activities independently, confidently and at a competent level.

7. Feedback

In addition, periods are to be set aside specifically for the purpose of supervision of the training issues that are not directly occupied with providing clinical care. Trainees should be encouraged to discuss their progress on a regular basis (not less than 30 minutes per fortnight) with their Supervisor of Training during these face-to-face sessions.

8. In-Training Assessment

In-training assessments (ITAs) will be carried out at quarterly intervals. The last ITA will be summative.

This Professional Document should be interpreted with regard to the following Documents:

PM5 *Policy for Supervisors of Training in Pain Medicine*

Faculty of Pain Medicine Professional Documents

Substantial revisions have been made to PM3 Lumbar Epidural Administration of Corticosteroids and minor revisions have been made to PM5 Policy for Supervisors of Training in Pain Medicine to reflect the changes of the appointment process of Supervisors of Training. Both documents are available online and can be viewed at http://www.anzca.edu.au/fpm/resources/professional-documents

Report from the Faculty of Pain Medicine Board Meetings held on April 29 and May 2, 2010

Faculty Board

The Faculty Board met on April 29 and the "new" Board met on May 2 for the purpose of appointing office-bearers and Committee Chairs and Membership.

Dr Penny Briscoe stepped down as Dean of the Faculty following her two-year tenure, handing over to the new Dean, Dr David Jones, following the Annual General Meeting. Penny continues her commitment to the ongoing development of the Faculty, and remains on the Board and Executive. Penny's leadership and significant contributions to the Faculty during her time as Dean were recognised at the Board Meeting and AGM.

Dr Brendan Moore was elected Vice-Dean.

Relationships Portfolio

Liaisons with Medical Colleges

ANZCA

The Board was pleased to note that FPM representation continued and, in some cases, has been reinstated on a number of ANZCA Committees. Subsequent to the Board meeting, Dr Lindy Roberts was appointed by ANZCA Council as their Representative to the Board.

RACS

RACS Council has recently approved the development of a Section of Pain Medicine under their Fellowship Services section. This focus group for those interested in the field, will allow the FPM Board to have an identified route for communications. Associate Professor Leigh Atkinson will Chair the group, comprising 12-13 surgeons, which is expected to expand with time. Terms of Reference are currently being developed. Dr Graham Campbell, RACS Chair of Fellowship Services, will be invited to attend a future Board Meeting to further develop opportunities for interaction.

The 2010 RACS ASC on the Gold Coast included a full training session on pain which was acknowledged by the Board as an enormous advance.

Corporate Affairs

National Pain Strategy

Discussions are in progress on the formation of a National Pain Advocacy body. ANZCA has indicated its support of the idea of a national pain body in principle and a detailed financial proposal is awaited for consideration.

An International Pain Summit is planned for September in Montreal following the IASP World Congress in that city.

National Pain Outcome Initiative

The Faculty has recognised that a National Pain Outcome Initiative is an important way ahead for gaining the information needed to make quality improvements in services. This would provide a measurement tool needed in negotiations with government. At first consideration this is within the ambit of the National Pain Strategy and a proposal has been submitted for this much needed initiative.

FPM Director of Professional Affairs

The Faculty Board appointed Associate Professor Milton Cohen, FRACP (NSW) as its first Director of Professional Affairs. The Director of Professional Affairs FPM is responsible to the Dean and the FPM Board for the provision of professional advice on Faculty matters, particularly on policies as they relate to clinical and professional issues affecting the Fellowship.

FPM Regional Committees

Following recent calls for nominations to the Queensland and New South Wales FPM Regional Committees, the Board endorsed the nominees as follows:

FPM QRC	FPM NSWRC
Dr Paul Gray	Dr Charles Brooker
Dr Jason Ray	Dr David Gorman
Dr Richard Pendleton	Dr Lewis Holford
Dr Mark Tadros	Dr Martine Holford
Dr Kathleen Cooke	Dr Kok Khor
Dr Matt Bryant	Dr Marc Russo
(co-opted Member)	Dr Glen Sheh
	Dr Paul Wrigley

Associate Professor Leigh Atkinson and Drs Brendan Moore and Frank New will be *ex-officio* members of the FPM QRC and Drs Guy Bashford, Ray Garrick and Chris Hayes *ex-officio* members of the FPM NSWRC.

Communications

As well as media attention during the Refresher Course and ASM, pain medicine has attracted significant media interest recently, including Dr Penny Briscoe's interview with Radio New Zealand's Nine to Noon program and National Pain Summit news coverage.

The Faculty has been contacted by Good Health Publications with plans to develop a "*Pain Management in General Practice*" publication. As the Faculty has an interest in improving knowledge and practice at Primary Care level, the Faculty's DPA is investigating further including liaising with the GP organisations with regard to their needs before responding.

Fellowship Affairs Portfolio

Fellowship

The following were admitted to Fellowship:

By examination and training:

Zamil Mehboob Karim, FANZCA (Vic)
Tania Lee Morris, FANZCA (Qld)
Jennifer Anne Stevens, FANZCA (NSW)

By examination:

Simon Jude Tame, FANZCA (NSW)
Jane Mary THOMAS, FANZCA (NZ)

By election:

Dr Anthony Thomas Davis, FRANZCP (SA)
Dr Susan Evans, FRANZCOG (SA)
Dr Thierry Vancaillie, FRANZCOG (NSW)

Two applicants for election to Fellowship were offered the Summative Assessment pathway to Fellowship that involves satisfactory completion of examination and case report requirements without further training.

Professor Andrew Somogyi presented for conferment of Honorary Fellowship in Christchurch.

This takes the number of Fellows to 288. The Board was pleased to note that the Fellowship now includes three O&G Fellows highlighting that people with a demonstrated interest and experience in pain medicine from other specialty groups are able to be accepted into the Faculty. This has reciprocal benefits in collaboration on the training of future generations of specialists, noting here that chronic pelvic pain is a huge chunk of practice in this area, with need for cross-specialty knowledge sharing.

Associate Fellowship

Regulations for Associate Fellowship were finalised. Those who have completed the Training and Examination requirements of the Faculty, but who are not eligible for full Fellowship because they do not hold an approved Australian or New Zealand primary specialty Fellowship, will now be eligible for Associate Fellowship. Associate Fellowship will not be conferred before specialist registration is completed in the country of practice at the time of application. The agreed post-nominals will be AssocFFPMANZCA.

Continuing Education and Quality Assurance

Scientific Meetings

2010 ASM and Refresher Course – Christchurch

The Board noted the success of the Faculty's Refresher Course Day and ASM Programs. More than 110 registrants attended the Refresher Course to hear 12 speakers give presentations on sessions titled "Pain and empathy", "Age, gender and pain", "Regional anaesthesia and acute pain" and "Clinical applications of advances in research". The international speakers, attracted significant media interest with more than a dozen interview requests from print, radio and TV coordinated very effectively by ANZCA's Media Manager, Clea Hincks.

The Faculty's ASM Program was well received with over 300 delegates attending the first 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 AGM to Dr Rutha Nerlekar, an ANZCA trainee based in South Australia, for her research paper "*Placebo vs nocebo questioning for pain evaluation after caesarean section*". Dr Nerlekar was awarded a certificate and a grant of $1000 for educational or research purposes.

Progression in Pain Day

The Faculty, in conjunction with the Royal Australian College of General Practitioners hosted a continuing medical education day "Progression in Pain – From Hospital to Home" at The National Wine Centre of Australia, Adelaide on Saturday, May 29, 2010. Invited speakers Dr Michael Fredrickson (anaesthetist, Auckland) and Dr Malcolm Dobbin (Public Health Physician, Senior Medical Advisor on Alcohol and Drugs to Mental Health and Drugs Division Victorian Department of Health) led the program.

2010 Spring Meeting

Registrations have commenced for the Spring Meeting in Newcastle from October 8-10. Two major sponsors and four HCI exhibitors are confirmed. The theme is "Transitions in Pain" with prominence given to a Models of Care sub-theme. Dr Cathy Price (Southampton, UK) is the International Visitor.

2011 ASM – Hong Kong

The Faculty's ASM Officer and 2011 Deputy Convenor, Associate Professor Pam Macintyre, and Faculty staff, met with the Faculty Convenor, Dr P P Chen during the Christchurch meeting. The meeting venue for the 2011 Refresher Course Day was confirmed as the Hong Kong Convention Centre and the dinner venue was also confirmed. Discussions with the healthcare industry attending the Christchurch meeting were fruitful in securing commitments for sponsorship of the Faculty's program.

2011 Spring Meeting

Drs Geoff Speldewinde and Guy Bashford will convene the 2011 Spring Meeting in Canberra. Dates, venue and meeting theme are yet to be confirmed. There is potential to make this a joint meeting with the musculoskeletal group and Occupational Rehabilitation Special Interest Group of the Australasian Faculty of Rehabilitation Medicine, RACP.

2012 ASM – Perth

The Faculty Board decided to defer selection of its ASM Visitors until after the IASP World Congress in Montreal, where potential speakers might be identified. A decision will be made at the October Board meeting.

Professional

New Zealand Application for Specialty Recognition

A draft report from the Education Committee of the Medical Council of New Zealand (MCNZ) was provided to the New Zealand National Committee of ANZCA during the ASM at Christchurch, for opportunity to comment. Processes have changed once again, however the Faculty has elected to remain with the previous process, as those requirements had been followed exactly in submissions to date. From the response received it was apparent that there had been mostly positive support from those they had consulted and that firm ground had been established for pain medicine being recognised as a separate vocational scope. Concerns raised in the draft report will be addressed in stage II of the process once invited to enter. A response is expected shortly from the MCNZ Education Committee.

Trainee Affairs Portfolio

Education

FPM Supervisors of Training Agreement

The Board approved a Supervisors of Training Agreement that sets out obligations of the Supervisor of Training in connection with FPM training. This document is to be signed upon the Training Unit Accreditation Committee's ratification of the SoT and then forwarded to the Faculty. The Faculty will then return a copy to the SoT for their records.

Professional Documents

The Board approved new Faculty Professional Document, PM8 (2010) *Policy on Illness or Disability for Trainees and Fellows* and PM7 (2010) *Policy on Supervision of Clinical Experience for Vocational Trainees in Pain Medicine*. These documents are published in full in this edition of the *ANZCA Bulletin*.

Revisions of Professional Documents PM3 *Lumbar Epidural Administration of Corticosteroids* and PM5 *Policy for Supervisors of Training in Pain Medicine* were also approved and can be viewed on the Faculty Website at http://www.anzca.edu.au/fpm/resources/professional-documents

Training Unit Accreditation

Following successful reviews, Royal Perth Hospital (WA) and Flinders Medical Centre (SA) were re-accredited for training.

A workshop for the Faculty's Panel of Reviewers, to be facilitated by the Cognitive Institute, will be held at ANZCA House on Saturday, August 7, in conjunction with the August Board Meeting.

Resources Portfolio

Finance

The Faculty continues to track closely to budget for 2010. Timing issues account for the most significant variations in expenses and income.

Report from the Faculty of Pain Medicine Board Meetings held on April 29 and May 2, 2010

continued

Board and Committee appointments

Board Members:
Dean: David Jones
Vice Dean/ Chair Training Unit Accreditation Committee: Brendan Moore
Assessor: Frank New
Assistant Assessor: Penny Briscoe
Chair Education Committee: Ted Shipton
Chair Examination Committee: Ray Garrick
Chair Research Committee: Chris Hayes
Chair Continuing Education & Quality Assurance Committee/CPD Officer: Guy Bashford
Treasurer/Scientific Meeting Officer: Leigh Atkinson
Carolyn Arnold
Max Majedi
Co-opted Member representing ANZCA: Lindy Roberts

Other Officers:
Deputy Scientific Meeting Officer/ASM Officer: Pam Macintyre
Senior Editor Pain Medicine/ FPM Director of Professional Affairs: Milton Cohen

Executive Committee/Portfolio Chairs:
Chair Relationships Portfolio: David Jones
Chair Trainee Affairs Portfolio: Brendan Moore
Chair Fellowship Affairs Portfolio: Penny Briscoe
Chair Resources Portfolio: Leigh Atkinson

Examination Committee:
Chair: Ray Garrick
Deputy Chair: Meredith Craigie
Dean (ex officio): David Jones

Members:
AFRM (RACP): Carolyn Arnold
Mark Tadros
RACS: Leigh Atkinson
RANZCP: George Mendelson
Frank New
ANZCA: Penny Briscoe
Melissa Viney
New Fellow Representative: Martine Holford

Education Committee:
Chair: Ted Shipton
Dean (ex officio): David Jones
Chair Trainee Affairs Portfolio (ex officio): Brendan Moore
Chair Examinations Committee (ex officio): Ray Garrick

Members:
Director of Education, ANZCA, Mary Lawson
Frank New
Faizur Noore
Supervisor, SoTs, Tim Semple
Stephan Schug
Peter Teddy
New Fellow Representative, Clifton Timmins
Jane Trinca
Deputy Supervisor SoTs, Melissa Viney
Owen Williamson
Paul Wrigley

Training Unit Accreditation Committee:
Chair, Brendan Moore
Assessor (ex officio), Frank New

Members:
Carolyn Arnold
Penny Briscoe
Matthew Crawford
David Gronow
Diarmuid McCoy
Deputy SSoT, Melissa Viney
Pauline Waites

Research Committee:
Chair: Chris Hayes
FPM Executive Member (ex officio), Penny Briscoe
Senior Editor Pain Medicine (ex officio), Milton Cohen
Section Editor Pain Medicine, Colin Goodchild

Members:
Carolyn Arnold
Guy Bashford
Julia Fleming
Malcolm Hogg
Tim Pavy
Stephan Schug
Philip Siddall
Maree Smith
Andrew Somogyi

Continuing Education & Quality Assurance Committee:
Chair: Guy Bashford
Scientific Meeting Officer (ex officio): Leigh Atkinson
Deputy Scientific Meeting Officer/ASM Officer: Pam Macintyre
Immediate Past ASM Convenor: Ted Shipton
ASM Convenor: P P Chen
Future ASM Convenor: Max Majedi
Spring Meeting Convenor: Chris Hayes
Future Spring Meeting Convenor: Geoff Speldewinde

Members:
Penny Briscoe
Milton Cohen
Diarmuid McCoy
Peter Rofe
Michael Vagg

Representation on ANZCA Committees:
Examinations Committee: Ray Garrick
Primary Examination Sub-Committee: Ray Garrick
Education and Training Committee: Ted Shipton
Research Committee: Chris Hayes
Fellowship Affairs Committee: Pam Macintyre
IMGS Committee: Frank New
Overseas Aid Committee: Roger Goucke
Quality and Safety Committee: Michal Kluger
Training Accreditation Committee: Brendan Moore
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,Max Majedi
New Zealand National Committee, Kieran Davis
ACT, Geoff Speldewinde

External Committees and organisations:
Australasian Anaesthesia: Robyn Campbell

Faculty Working Parties and Task Forces:

Blueprinting Sub-Committee:
Chair, Owen Williamson

Members:
Wilbur Chan
Frank New
Tim Semple
Jane Trinca

Paediatric Pain Medicine Working Party
Chair: Meredith Craigie

Members: George Chalkiadis
Suellen Walker
Kathleen Cooke

Library update

New titles

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

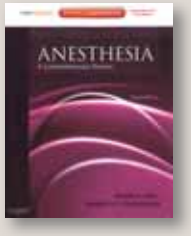
ANZCA members are entitled to borrow a maximum of five books at one time from the College library. Loans are for three weeks and can be renewed on request. Members can also reserve items that are out on loan.

Melbourne-based members are encouraged to visit the ANZCA Library to collect requested books. Items will be sent to other library users within Australia. When requesting an item from the catalogue, please remember to include your name, ID number and postal address to ensure prompt delivery.

A core collection of the anaesthetic syllabus textbooks is available for loan from the New Zealand office of the College. A list of the New Zealand books can be accessed by selecting "New Zealand" from the "Location" drop-down box of the catalogue.

Anaesthesiology: Churchill's ready reference / Mythen, Monty [ed]; Burdett, Edward [ed]; Stephens, Robert C.M. [ed]; Walker, David [ed]. -- 1st ed -- Edinburgh: Churchill Livingstone Elsevier, 2010.

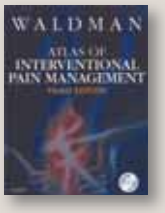
Anesthesia: a comprehensive review / Hall, Brian A. [ed]; Chantigian, Robert C. [ed]. -- 4th ed. -- Philadelphia: Mosby Elsevier, 2010.



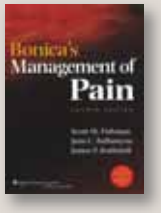
Anesthesia for the high-risk patient: anesthesia and perioperative care / McConachie, Ian [ed]. -- 2nd ed -- Cambridge: Cambridge University Press, 2009.

Anesthesia secrets / Duke, James [ed]. -- 4th ed -- Philadelphia: Mosby Elsevier, 2011.

Atlas of interventional pain management / Waldman, Steven D. -- 3rd ed -- Philadelphia, PA: Saunders/Elsevier, 2009.



Bonica's management of pain / Fishman, Scott M. [ed]; Ballantyne, Jane C. [ed]; Rathmell, James P. [ed]. -- 4th ed -- Baltimore, MD: Lippincott Williams and Wilkins, 2010.



The Checklist manifesto: How to get things right / Gawande, Atul. -- London: Profile Books Ltd, 2010.

Good medical practice: professionalism, ethics and law / Breen, Kerry J.; Cordner, Stephen M.; Thomson, Colin J H.; Plueckhahn, Vernon D. -- New York: Cambridge University Press, 2010.

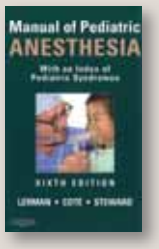
An Infinity of things: How Sir Henry Wellcome collected the world / Larson, Frances. -- Oxford: Oxford University Press, 2009.

Kindly donated to the ANZCA Library by Dr W. John Russell.

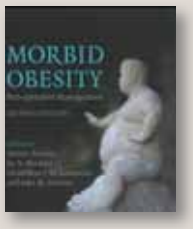
Johns Hopkins anesthesiology handbook / Heitmiller, Eugenie S [ed]; Schwengel, Deborah A [ed]; Johns Hopkins University, School of Medicine. -- 1st ed -- Philadelphia, PA: Mosby/ Elsevier, 2010.

The Jolly dolphin in the school of sharks: an insider's tales about how cleverly Datex made its way to world leader – to ultimately become acquired by GE / Vallikari, Jouko. -- Helsinki, Finland: Finish Healthcare Technology Association; FiHTA, 2009.

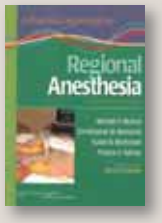
Manual of pediatric anesthesia / Lerman, J; Cote, Charles J; Steward, D J. -- 6th ed -- Philadelphia, PA: Churchill Livingstone/Elsevier, 2010.



Morbid obesity: perioperative management / Alvarez, Adrian [ed]; Brodsky, Jay B [ed]; Lemmens, Hendrikus J M [ed]; Morton, John M [ed]. -- 2nd ed -- Cambridge: Cambridge University Press, 2010.

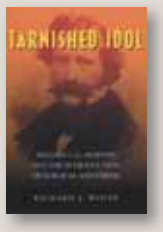


A practical approach to regional anesthesia / Mulroy, Michael, F [ed]; Bernards, Christopher M [ed]; McDonald, Susan B [ed]; Salinas, Francis V [ed]. -- 4th ed -- Philadelphia, PA: Lippincott Williams & Wilkins, 2009.

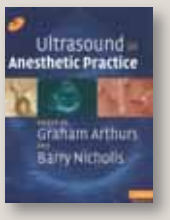


Radiology for anaesthesia and intensive care / Hopkins, Richard [ed]; Peden, Carol [ed]; Gandhi, Sanjay [ed]. -- 2nd ed -- Cambridge: Cambridge University Press, 2010.

Tarnished idol: William T. G. Morton and the introduction of surgical anesthesia: a chronicle of the ether controversy / Wolfe, Richard J. -- San Anselmo, California: Norman Publishing, 2001.



Ultrasound in anesthetic practice / Arthurs, Graham [ed]; Nicholls, Barry [ed]. -- Cambridge: Cambridge University Press, 2009.



Library update
continued

Your library, your say

The ANZCA library is a service available to all Fellows, trainees, and staff of ANZCA and the Faculty of Pain Medicine. The library provides book loans, online journals, database access and searching assistance, interlibrary loans/document delivery and other tools and resources for the information needs of our users.

The library has been involved in two initiatives to ensure that members have their say about the library services and resources.

Survey

During May this year, members were invited to complete a library user survey to determine how the library is being used, why some members are not using it and how it can be improved. More than 1000 responses were received and library staff will collate the results and adapt the services and resources to best suit the information needs of the membership. Thank you to all members who responded to the survey.

Reference group

College representatives will now be able to provide feedback and advice through the new Knowledge Resources Reference Group (KRRG). Liaising with the library, the Geoffrey Kaye Museum of Anaesthetic History and the Archives department, the KRRG membership includes representatives from the Fellowship, FPM, Examinations, and trainees.

The knowledge resource team welcome feedback and can assure College members that issues, comments and suggestions will be considered by a dedicated group.

New additions to the journal collection – pain journals

Two new pain-related journals have been added to the online collection – *Techniques in Regional Anesthesia and Pain Management* and *European Journal of Pain*.

Access is via the journals webpage: http://www.anzca.edu.au/resources/library/online-journals.html

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.

Recent notices include:

Operating Room Risk Management Newsletter, March 2010:

- Computer-aided surgery: A GPS for the OR.
- Patient "burns" not always what they seem.
- Left-handedness associated with increased risk of needlestick injury.
- BCMA reduces medication errors in medical/surgical units.
- Briefing and debriefing tool improves communication in a hospital OR.
- Surgical site infection.
- Tips to increase staff voluntary error reporting.

Health Devices, Vol. 39, No. 2, February 2010, and

Health Devices, Vol. 39, No. 3, March 2010

- Best portable ventilators.
- Monitoring project that won Health Devices Achievement Award is featured in *Anesthesiology*.
- Choosing not to follow recommendations in medical device recalls, notifications, or alerts.

New research in anaesthesia and pain medicine

Log-in to the ANZCA Library website to access these journals articles.

Anesthesia 2.0: Internet-based information resources and Web 2.0 applications in anesthesia education.

Chu, Larry F, et al, *Current Opinion in Anaesthesiology*. 23(2):218-227, 2010.
Although direct practice and observation in the operating room are essential, Web 2.0 technologies hold great promise to innovate anesthesia education and clinical practice such that the resident learner need not be in a classroom for a didactic talk, or even in the operating room to see how an arterial line is properly placed. Thoughtful research to maximize implementation of these technologies should be a priority for development by academic anesthesiology departments. Web 2.0 and advanced informatics resources will be part of physician lifelong learning and clinical practice.

The Effect of Bispectral Index Monitoring on Long-Term Survival in the B-Aware Trial.

Leslie K, Myles PS, Forbes A, Chan MTV. *Anesthesia and Analgesia*. 110: 816–822, 2010

Monitoring with BIS and absence of BIS values <40 for >5 min were associated with improved survival and reduced morbidity in patients enrolled in the B-Aware Trial.

The transversus abdominis plane block: a valuable option for postoperative analgesia? A topical review: a qualitative systematic review

Petersen, PL, et al. *Acta Anaesthesiologica Scandinavica*. 54(5): 529-35. 2010
Post-operative pain treatment with a TAP block is a promising new technique, demonstrating both a substantial reduction in morphine consumption as well as improved pain scores in surgery involving the anterior abdominal wall. Before the TAP block is implemented in routine clinical practice, however, further studies are warranted in order to support the findings of the primary published trials and to establish general recommendations for the use of a TAP block, especially as part of a multimodal post-operative analgesic regimen.

Paracetamol and selective and non-selective non-steroidal anti-inflammatory drugs (NSAIDs) for the reduction of morphine-related side effects after major surgery: a systematic review.

McDaid C, et al. *Health Technology Assessment*.;14(17):1-153, iii-iv, 2010

24-hour morphine consumption decreased by 6.3 mg to 10.9 mg, compared to placebo, when paracetamol, NSAID or COX-2 inhibitors were added to PCA morphine following surgery. Differences in effect between the three drug classes were small and unlikely to be of clinical significance. There does not appear to be a strong case for recommending routine addition of any of the three non-opioids to PCA morphine in the 24 hours immediately after surgery, or for favouring one drug class above the others.

http://www.hta.ac.uk/fullmono/mon1417.pdf

Association between nitrous oxide and the incidence of postoperative nausea and vomiting in adults: a systematic review and meta-analysis.

Fernández-Guisasola J, et al. *Anaesthesia*. 65(4):379-87. 2010

The authors conclude that avoiding nitrous oxide does reduce the risk of postoperative nausea and vomiting, especially in women, but the overall impact is modest.

Obstetric analgesia: a comparison of patient-controlled meperidine, remifentanil, and fentanyl in labour.

Douma MR, et al. *British Journal of Anaesthesia*. 104(2):209-15. 2010

The efficacy of meperidine, fentanyl, and remifentanil PCA for labour analgesia varied from mild to moderate. Remifentanil PCA provided better analgesia than meperidine and fentanyl PCA, but only during the first hour of treatment. In all groups, pain scores returned to pre-treatment values within 3 h after the initiation of treatment.

Complications during rapid sequence induction of general anesthesia in children: a benchmark study.

Gencorelli, FJ, Fields, RG and Litman, RS. *Paediatric Anaesthesia*. 20(5): 421-4. 2010

In our cohort of 1070 children who underwent RSI, difficult intubation was encountered in 1.7% and transient oxyhemoglobin desaturation occurred in 3.6%. Severe hypoxemia was more likely in children <20 kg. There were no children who could not be intubated, and there were no long-term or permanent complications.

What effect does low temperature have on cylinders containing a mixture of 50% nitrous oxide and 50% oxygen?

Publisher: Wessex Drug and Medicines Information Centre

If the cylinder temperature is allowed to fall below -6 degrees Celsius, there is a risk that the two gases in the mixture will start to separate. To prevent this, the cylinders should be protected from the cold and stored above 10 degrees Celsius for at least 24 hours before use.

http://www.nelm.nhs.uk/en/NeLM-Area/Evidence/Medicines-Q--A/What-effect-does-low-temperature-have-on-cylinders-containing-a-mixture-of-50-nitrous-oxide-and-50-oxygen/

Contact the library
Librarian: Laura Foley
www.anzca.edu.au/resources/library
Phone: (+613) 8517 5305
Fax: (+613) 8517 5381
E-mail: library@anzca.edu.au

ANZCA in the news

The Annual Scientific Meeting in Christchurch attracted significant media attention as reported on page 26. However, this was not the only coverage ANZCA received.

ANZCA's serious concerns at the lack of consultation with the College in the formation of draft maternity guidelines released for public comment in May prompted a media release that resulted in coverage including in *The Australian* newspaper.

More recently, a media release was issued applauding the Queensland Government for allocating $39.1 million over four years to pain services in the state. Queensland is the first state or territory to address the problem of pain management since the National Pain Summit in March.

Faculty of Pain Medicine board member, Associate Professor Leigh Atkinson, played a key role in attracting the funding.

Lengthy interviews by presenters exploring anaesthesia and pain medicine in depth were done with Westmead Hospital's Dr David Elliott on Clive Robertson's 2UE program and with former Faculty of Pain Medicine Dean, Dr Penelope Briscoe on Radio New Zealand.

Media releases distributed by ANZCA (since mid-October)

"Relief for pain sufferers in Queensland budget" (Tuesday June 8, 2010)

"Maternity guidelines misleading: ANZCA" (Monday May 31, 2010)

"Melbourne anaesthetist new ANZCA president" (Wednesday May 19, 2010)

"Anaesthesia meeting concludes" (Wednesday May 5, 2010)

"The great unsolved mystery: how does anaesthesia work" (Tuesday May 4, 2010)

"Anaesthetists outline dire situation overseas" (Monday May 3, 2010)

"Medical story of Trishna and Krishna a highlight of day two" (Sunday May 2, 2010)

"Obesity, obstetrics and professionals in distress on agenda" (Saturday May 1, 2010)

"Faculty of Pain Medicine Refresher Course Day" (Friday April 30, 2010)

"More than 1000 anaesthetists to attend meeting" (Wednesday 28 April, 2010)

"March Bulletin out now" (NZ media - Wednesday March 31, 2010)

"March Bulletin out now" (Australian media - Tuesday March 30, 2010)

These media releases and other media coverage involving Fellows can be found at **(www.anzca.edu.au/news/announcements)**.

Since mid-March, ANZCA has generated...

34 print and online stories

15 radio interviews

7 radio news stories

3 television reports

Clea Hincks
Media manager, ANZCA

ANZCA's communications unit is always looking for good news or general interest stories that can be promoted in the media. If you have an idea or suggestions, please contact media manager, **Clea Hincks**, at ANZCA via e-mail **chincks@anzca.edu.au** or by phone **+61 3 9510 6299** or **0418 583 276**.

Robin Farquhar Waspe

March 5, 1949 – March 19, 2010

Rob was born on March 5, 1949, in Johannesburg, South Africa, and was educated in the midlands of Natal, initially at the Drakensberg School for Boys in Richmond and, subsequently, at Clifton, Nottingham Road, and Michaelhouse, Balgowan, a prestigious red-bricked college in an idyllic setting in rural Natal and modelled on the best of the British public school traditions. Rob enjoyed the camaraderie of these schools and revelled in the sporting and educational opportunities they presented. After completion of his secondary education, Rob enrolled in pharmacy studies at Rhodes University, Grahamstown, but later changed to engineering studies before settling on his real vocation, the study and practice of medicine. Accordingly, in 1969, Rob commenced medical studies at the University of Cape Town and forged lifelong friendships there.

After graduation, Rob was keen to return to his beloved Natal and took up a residency position at the Addington Hospital on the beachfront in Durban. The life of the residents there involved long shifts at the hospital, honing their medical skills, but quieter moments saw the doctors on call relaxing on the beach nearby, a white sheet draped from the hospital balcony being the sign to return to duty for a waiting patient. Weekends off call were spent on the magically tranquil south coast or up in the dramatically scenic Berg. After residency, Rob spent a delightful six months travelling around southern Africa by 4-wheel drive, fishing along the "wild coast" of the Transkei and camping out with lions and elephants circling nearby. Following this memorable adventure, Rob undertook locums in the rural districts of Natal and the Transkei. Rob recalled that it was being asked to give an anaesthetic for a lawyer's daughter one weekend in the town of Seymour that first got him really thinking of becoming skilled in anaesthesia. He returned to hospital training at Addington before deciding to broaden his horizons and travel to Australia.

After his arrival in Australia in early 1978, Rob worked initially at Toowoomba Base Hospital before embarking on specialist anaesthetic training which he pursued at the Princess Alexandra, Rockhampton Base, Mater and Greenslopes Hospitals. On obtaining his Fellowship in mid-1982, Rob headed north from Brisbane to Bundaberg where he felt at home as the ambience and scenery reminded him of coastal Natal. However, the surgical scene at the time in Bundaberg was a little too sedate for a budding young specialist anaesthetist keen to make his mark so, after a few short months, he relocated further north to the industrial city of Gladstone. The local hospital had just expanded to accommodate the growing population and was very keen to have a specialist anaesthetist on its staff. Rob commenced work there in November 1982.

Rob remained as the only specialist anaesthetist in Gladstone for the next 14 years –an onerous commitment, providing 24/7 cover for the vast majority of time over those years. The emergencies were sporadic and unpredictable but invariably called for his rapid attendance—be it for an epidural in labour, an urgent caesarean section, a case of epiglottitis or a trauma case arriving in casualty. Rob's calm, diligent and systematic approach saw case after case successfully concluded, earning the trust and gratitude of his patients and the respect of his colleagues.

By the mid-1990s, Rob was keen for a change from the rigours of constantly being on-call and undertook locums in Melbourne and the Gold Coast before settling in Shepparton, Victoria in 1997. Rob enjoyed working as part of the anaesthetic group in Shepparton and, more recently, in Bendigo. Rob was due to fly out to South Africa for a holiday in mid-March when he was diagnosed with an aneurysm of the aortic arch, a late complication of the coarctation he had had repaired years earlier in South Africa. Tragically, he did not survive the major surgery undertaken in Melbourne on March 19 to repair this vascular anomaly.

A heartfelt tribute to Rob was held in Bendigo on the afternoon of March 26.

His friends and family recalled with admiration his highly-principled standards—to play by the rules and to be always honest, trustworthy and dutiful. Rob applied himself with diligence and dedication to the care of his patients and his reassuring calmness and methodical approach always allayed their fears. He delighted in the company of those dear to him, in engaging conversations and debate, and in sharing his knowledge in topics as wide-ranging as the financial markets, the history of the British Empire and the finer points of his much-loved rugby.

Rob truly lived by the values imbued in him during his formative years at Michaelhouse, expressed by the school as "to live our lives according to the Christian values of integrity, humility, compassion and courage in service to our community and country". It is hoped that the shining example Rob provided of a life well-lived in dedication and service to his profession will inspire others to excel in their life's work.

Collette Sheridan

Obituary

Professor Konrad Jamrozik

May 2, 1955 – March 24, 2010

Professor Konrad Jamrozik, head of the School of Population Health and Clinical Practice at the University of Adelaide, died on March 24, 2010. He was 54.

Konrad was best known within the anaesthesia community for his many research collaborations, particularly within the Master Trial, The Multicentre Australian Study of Epidural Anaesthesia, published in *The Lancet* in 2002.

During and after the completion of the Master Trial, Konrad collaborated in other projects with anaesthesia colleagues. However, most anaesthetists would not be aware of the extraordinary breadth of Konrad's prodigious research output in diverse areas of epidemiology and public health.

Konrad undertook his basic medical training in Adelaide and Hobart and subsequently completed a doctorate in Oxford where he examined various strategies for the promotion of the cessation of smoking in general practice. He moved to the University of Western Australia in 1984 to take up a research fellowship in the Unit of Clinical Epidemiology and subsequently held lectureships in medicine and public health at the University of Western Australia. He was promoted to Professor of Public Health at UWA in 2000. From December 2000 until September 2004 he held the chair in Primary Care Epidemiology at Imperial College, London, and from November 2004 until June 2007, he was Professor of Evidence-based Health Care at the University of Queensland. From 2007 he was head of the School of Population Health and Clinical Practice at the University of Adelaide.

Konrad had wide research interests in the epidemiology and prevention of vascular disease, in the design and conduct of randomised controlled trials in procedural care and new strategies in health promotion, and in assessing the uptake and impact of the results of clinical trials in day-to-day practice, especially in the area of cancer. He had an international profile in the area of tobacco control and maintained a clinical commitment in medical oncology for more than 20 years.

International appointments included posts at the World Health Organization in Geneva, Harvard Medical School, the Clinical Trial Service Unit in Oxford, the Data Centre for the WHO MONICA Project at the National Public Health Institute in Finland, and at the School of Public Health at the Jagiellonian University in Krakow, Poland.

Among Konrad's many awards were life membership of the Australian Council of Smoking and Health, the inaugural President's Award from the National Heart Foundation of Australia and a special research assistants grant for outstanding teachers from the University of Western Australia.

Over 28 years, Konrad authored or co-authored nearly 300 publications; mostly original research papers, the remainder being book chapters and commissioned reports. This work represents an extraordinary legacy of a great Australian population health scientist, whose life was tragically cut short.

The full story of the origins of Konrad's involvement in, and major commitment to, the Master Trial has never been documented. Given the ongoing impact of the legacy of Konrad Jamrozik on anaesthesia research, it is important to the historical record that the story be told.

Julius Comroe wrote nearly 50 years ago about the importance of serendipity in science. Serendipity he described, in this context, as the combination of chance and the prepared mind; this notion encapsulates the nature of my early encounters with Konrad from 1989.

I was a member of staff of McMaster University Medical School in Ontario, Canada for 10 years in the 1970s. A brilliant young American public health physician, David Sackett, was chairman and head of the Department of Epidemiology and Biostatistics. Later, Sackett achieved international recognition as the founder of the Evidence Based Medicine movement.

"Serendipity" began in 1987 with the publication by Mark Yeager, David Glass and colleagues of a paper "Epidural Anaesthesia Analgesia in High Risk Surgical Patients". They concluded that epidural anaesthesia and analgesia exerted a significant beneficial effect on operative outcome in a group of high risk surgical patients. An accompanying editorial warned against acceptance of these results because of the small sample size.

However, it acknowledged, as Sackett has done many times in the past 40 years, the importance of the randomised controlled trial as the most important design feature of the study, enabling maximum strength of inference. In 1993, Michael Davies, Brendan Silbert and colleagues published a study in *Anaesthesia and Intensive Care* of 100 unselected (not high risk) cases in a randomised trial of epidural anaesthesia, compared with general anaesthesia. They found no difference between the groups. Through various discussions, we all agreed that we needed to study selected high risk cases in a multicentre trial to limit the possibility of Type II error, the probability of finding no difference when in fact there was a true difference.

In 1989, David Sackett visited Australia as the Sims Commonwealth Professor courtesy of Royal Australian College of Physicians. At a social function to welcome him to Perth, I met Konrad for the first time. The conversation began about the idea of multicentre trial of epidural anaesthesia and analgesia. In 1990, I spent three months at the Bowman Gray School of Medicine in North Carolina and wrote a "cook-book" paper, "Does Reginald Block Improve Outcome after Surgery", published in *Anaesthesia and Intensive Care* in 1991. This was essentially a detailed description of "How to do the Master Trial". At this time I also wrote the first draft grant applications and spent a week visiting David Glass and Mark Yeager in New Hampshire and Dave Sackett in Ontario. I still have in my file a July 1991 letter from Sackett, in which he wrote "I think you have made a good case for the Trial".

With this strong collegial support, I visited Konrad on my return to Perth. From that moment, we became a strongly committed team of two, and slowly gained further collegial support across Australia, yet encountered some opposition from unexpected quarters.

Without Konrad's continuing strong commitment and unshakeable faith in both the science and the ethics, we would have not persisted with three successive NHMRC applications which finally resulted in a grant of over $500,000 to give the trial group a real chance of success.

From 1989 to 2002 (the year the Master Trial was published) and beyond, I worked with Konrad and through this association, Konrad met many other anaesthesia research colleagues, most notably Paul Myles, Brendan Silbert and Phil Peyton, with whom he continued to collaborate in various projects.

All who have worked with Konrad in research feel greatly privileged to have had this opportunity.

We remember Konrad with great affection. We were inspired by his passion for science, his integrity, availability to collaborate, enormous intellect, droll sense of humour and his unswerving commitment to both the scientific and social components of research collaboration. We had a lot of fun on the journey.

Konrad Jamrozik was a great Australian public health intellectual, a scholar who made an extraordinary contribution to anaesthesia research over more than 20 years. A great life has ended but his legacy, of total commitment to meaningful research for the better health of all, continues. Vale Konrad.

Associate Professor John Rigg, FANZCA
Cottesloe, Western Australia

ANZCA Council meeting report

April 2010

Report following the Council meeting of the Australian and New Zealand College of Anaesthetists held on April 17, 2010

Council election

Dr Patrick Farrell, Dr Mark Reeves and Dr Rodney Mitchell have been elected to Council and Dr Genevieve Goulding and Dr Lindy Roberts have been successful in their re-election to Council. The results are to be ratified at the Annual General Meeting in Christchurch, New Zealand.

Death of Fellow and trainees

Council noted with regret the deaths of the following Fellows:

- Dr Robin Waspe (VIC) FFARACS 1982, FANZCA 1992
- Dr Ingrid Ellen Dzendolet (NSW) FFARACS 1972, FANZCA 1992
- Dr William Sheldon Rehfisch (VIC) FFARACS 1979, FANZCA 1992

Although not a Fellow of the College, the death of Prof Konrad Jamrozik was recorded by Council. Dr Jamrozik was a great supporter of the College's research and pivotal in the Master Trial.

Education and Training Committee

Recommendations for the Curriculum Review

Council approved the recommendations for the Curriculum Review which will be launched at the May 2010 ASM in Christchurch, New Zealand.

Finance

Payment of subscriptions for past Faculty Deans

Council has agreed that former Deans of FPM, FIC and JFICM who are Fellows of ANZCA are to be exempt from payment of the ANZCA annual subscription effective from 2011.

Reinstatement fee

Council has agreed to introduce a reinstatement fee equivalent to the entrance fee for New Fellows (A$786 plus GST in 2010) be introduced effective immediately for former members seeking reinstatement following withdrawal of fellowship for non-payment of subscriptions.

Internal Affairs

Fellowship Survey

The Fellowship Survey was circulated to Fellows in hard copy and was made available online. By the closing date of April 20, 1964 responses had been received. Data analysis was undertaken on April 26 to identify the main issues to be discussed at the focus groups which are to be held at the ASM in Christchurch, New Zealand.

National Pain Summit

The CEO acknowledged the significant amount of work undertaken by the Faculty of Pain Medicine, the Communications department and staff which resulted in a successful and well attended summit.

College of Intensive Care Medicine (CICM)

After a number of delays, CICM moved into their new premises in early April after obtaining their Certificate of Occupancy.

Formation of Overseas Aid Committee

Council has approved the establishment of an Overseas Aid Committee which will report directly to Council. Regulation 2 has been amended accordingly. Membership of the committee includes representatives of the Faculty of Pain Medicine and the Australian and New Zealand societies.

Honorary Archivist

The position of Honorary Archivist has been reinstated.

ANZCA International Scholarship

The 2010 ANZCA International Scholarship has been awarded to Dr Phone Myint from Myanmar. He plans to undertake a three-month training program at the Royal Prince Alfred Hospital from October 2010.

Annual Reports for regional / national committees

From 2011 onwards, the Annual Report prepared by the regional and national committees will cover the calendar year. For 2009 the period from April 2009 to March 2010 will be covered; and 2010 will cover the period from April 2010 to December 2010.

Fellowship Affairs Committee

2012 ASM Perth, Australia – ANZCA ASM Visitor

Dr Ruth Landau has been invited to become the 2012 ANZCA ASM Visitor. Dr Landau is a Faculty Consultant at the Geneva University Hospital and also Director of Obstetric Anaesthesia and Clinical Genetics Research at the University of Washington, Seattle.

Revised Fellowship Affairs Committee (FAC)

The membership structure of FAC has been revised to embed professional oversight of the ASM within FAC, which in turn will improve ASM management, increase corporate knowledge and improve relationships between ROCs and the College. Accordingly regulation 2.10.1 has been amended to reflect the restructure with membership to be determined at the New Council Meeting.

Professional Documents

Position of DPA (Professional Documents)

This position has been advertised in the latest issue of the *Bulletin* and Rebecca Conning has also been appointed to assist with professional documents.

TE6 (2006) – Guidelines on the Duties of an Anaesthetist

With the separation of the Faculty of Intensive Care Medicine from ANZCA, a minor modification has been made to professional document TE6 (2006) – *Guidelines on the Duties of an Anaesthetist* to be more specific about the duties of anaesthetists with respect to the management of intensive care patients, as follows:

> *"2.8 Assistance with the intensive care management of patients, particularly when there is no intensive care medicine specialist available."*

This minor change to TE6 will be noted as an interim review.

TE14 (2007) – *Policy for the In-Training Assessment of Trainees in Anaesthesia*
TE18 (2005) – *Guidelines for Assisting Trainees in Difficulty*
At February Council, it had been agreed to revise the In Training Assessment process to take effect from mid 2010. To facilitate this, revision of TE14 *Policy for the In-Training Assessment of Trainees in Anaesthesia and* TE18 *Guidelines for Assisting Trainees in Difficulty* is now required.

With that in mind, the following draft documents will be circulated to the national/regional committees for consultation and for finalised versions to come back to June Council for approval:

- Draft Professional Document TE14 and draft Background Document; and
- Draft Professional Document TE18 and draft Background Document

TG4 - *Draft Equipment to Manage a Difficult Airway During Anaesthesia*
This document is to be placed on the ANZCA website to be reviewed again in 12 months' time to incorporate any amendments or feedback provided during that period.

Professional Documents Background Paper
This document is also to be placed on the ANZCA website to be reviewed again in 12 months' time to incorporate any amendments or feedback provided during that period.

Trainee Committee

Council approved the membership of the National/Regional Trainee Committee Membership (refer to Appendix 1).

Dr Leona Wilson
President

Professor Kate Leslie
President-Elect

Appendix 1:

Anzca National/Regional 2010 Trainee Committee Membership

Queensland
Brett Segal
Anand Parameswara
Agustina Perez-Smith
Chris Breen
Rob Miskeljin
Mark Gibbs
Anton Loewenthal

Victoria
Mahsa Adabi
Arvinder Grover
Bradley Hindson
Paul McCallum
Raje Rajasekaram
Ravi Ramadas
Kym Saunders

South Australia / Northern Territory
Luke Murtagh
Rowan Ousley
Tim Crichton
Rebecca Lewicki
Sarah Flint
Palash Kar
Andrew Thomas

Western Australia
Emelyn Lee
Kevin Hartley
Ed Debenham
Vanessa Percival
Nigel Hamilton
Yvette Gainey
Melinda Same

New Zealand
Sheila Barnett
James Dalby-Ball
Rachel Dempsey
Kathryn Hagen
Timothy Hall
Sheila Hart
Kim Heus
Thimali Rajapaksa
Sarah Sew-Hoy
Joseph Taylor

New South Wales
Simon Martel
Rachel Ruff
Colleen Bruce
Daniel Michael
Timothy Holliday
Michael Stone
Jennifer Tan
Emily Stimson
Jamie Rickcord

TASMANIA
Christopher Wilde
Shona Bright
Michael Lumsden-Steel
Mark Alcock
Tin Win

Australian Capital Territory
Peter Flynn
Elizabeth Merenda
Zain Upton
David Wright