

# ANZCA BULLETIN

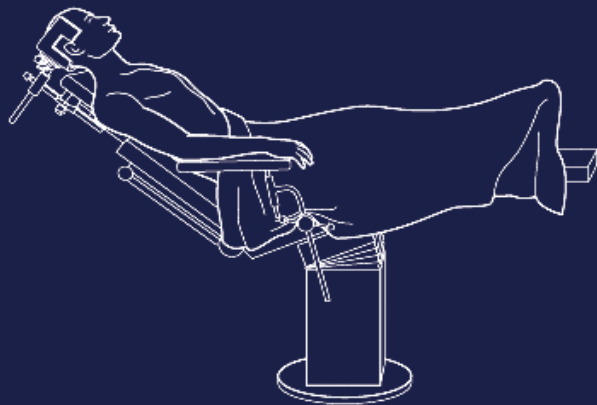
**ANZCA research:  
How we have  
distributed  
\$1.2 million**

**Talking workforce:  
What ANZCA is doing**

**Advancing CPD:  
A first look at the new  
portfolio system**

**National Anaesthesia Day:  
Strongly embraced**





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## 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 specialist pain medicine physicians. ANZCA comprises about 5000 Fellows and 2000 trainees across Australia and New Zealand and serves the community by upholding the highest standards of patient safety.

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# President's message



It's been an extremely busy year for the College, its Fellows, trainees and dedicated staff. My article this quarter highlights 2013 activities and projects planned for 2014 in accordance with our goal of improving the quality and safety of anaesthesia, perioperative medicine and pain medicine. Our focus is on high quality services, both directly to support your day to day practice, and also to address wider health system issues affecting our patients and professions.

I acknowledge the work of many Fellows, trainees and staff who have contributed to the College this year and welcome your feedback at [president@anzca.edu.au](mailto:president@anzca.edu.au). I wish you and your families a restful holiday season and the very best for 2014.

## Pressing issues

### Workforce

To recognise significant workforce issues, the College's workforce action plan focuses on three key areas:

- Ensuring the College has an effective voice in decisions by policy makers.
- Collecting high quality data to inform workforce planning.
- Communicating with Fellows and trainees to understand their views and discuss the College's workforce activities.

The College conducted its first graduate outcome survey on the work situation for new Fellows in 2013. We recognise that the large number of different stakeholders requires a collaborative approach and many meetings are being held with workforce decision makers – Health Workforce Australia, Health Workforce New Zealand, Australian state and territory health departments, and the New Zealand health ministry. For more information, see page 18.

### Revalidation, the ANZCA CPD standard and program

The 2012-2013 Australian Health Practitioner Regulation Authority (AHPRA) annual report *Regulating Health Practitioners in the Public Interest* makes it clear that the Medical Board of Australia is considering revalidation closely and will be informed by international developments (for example, the UK and north American revalidation programs).

It wants to work with the professions, including the Colleges, and the community on this issue. At the same time, the Medical Council of New Zealand has indicated its interest in strengthening systems for identifying and dealing with poorly performing doctors and questioned what the role of medical colleges might be in this. Professor Ron Patterson has been an influential voice in New Zealand and Australia, and his book *The Good Doctor: What Patients Want* elaborates on community expectations of doctors, especially that we remain up-to-date. We have already seen RACS implement compulsory audit; in some respects anaesthesia has some catching up to do and the new ANZCA continuing professional development (CPD) standard starts to address this.

The introduction of revalidation in some form seems inevitable, although the timeframe is unclear. There also seems clear benefit in being actively engaged in the development of a revalidation framework. Overseas, we have witnessed regulatory authorities take the lead with recertification processes. Our professions have an opportunity, and a challenge, to ensure that anaesthetists and pain specialists remain actively involved in any future changes, ensuring that they remain relevant to our clinical practice. It may be that strengthening CPD programs will be sufficient to meet regulatory and community expectations. See the ANZCA website for more information on the revised

ANZCA CPD standard which applies to all anaesthetists and pain specialists in Australia and New Zealand, and page 9 about the new electronic portfolio. Compliance with the new ANZCA CPD Program automatically meets the standard.

### College activities in 2013

Advancing standards (ANZCA strategic priority no. 1)

- Successful launch of the new ANZCA curriculum at more than 170 training sites, the biggest College project ever undertaken – thanks to all involved for your hard work!
- Our first electronic training portfolio system (TPS), progressively enhanced throughout the year in response to your feedback.
- The new integrated primary examination and upgraded examination management system.
- Workplace-based assessment (WBA) rollout supported by WBA champions.
- More podcasts and webinars (see [www.anzca.edu.au/resources/learning](http://www.anzca.edu.au/resources/learning)).
- The handbook and regulation for training in Hong Kong, Malaysia and Singapore.
- Ongoing work on the FPM Curriculum Redesign.
- Successful events: the Melbourne ASM, attracting more than 2000 delegates and widespread media coverage (increasing the profile of anaesthesia and pain medicine); 17 regional combined ANZCA/Australian Society of Anaesthetists continuing medical education meetings in Australia; New Zealand Anaesthesia ASM, Dunedin; six special interest group meetings and the FPM spring meeting.
- Nearly \$A1.2 million for research (see page 24).
- The Electronic Persistent Pain Outcomes Collaboration pilot.
- *Australasian Anaesthesia 2013* (the "Blue Book", page 7).
- Quality and safety: New and revised professional documents, safety alerts, *Bulletin* articles, and support for WebAIRS.

Building engagement, ownership and unity (strategic priority no. 2): Supporting Fellows and trainees

- The inaugural graduate outcome survey on the work situation for new Fellows to guide further action.

- Introduction of the web-based My ANZCA portal that includes simple-to-use online event registration and payment.
- Customer service training and charters for staff to improve service to Fellows and trainees.
- Fourteen hospital visits by Linda Sorrell, CEO and regional/national committee chairs.
- The ANZCA CPD survey, seeking your views on CPD.
- The online library project, improving library services for Fellows and trainees.
- Online “flipbook” style access to the *ANZCA Bulletin*, and the College Conversations CD.
- A New Zealand Anaesthesia Education Committee (NZAEC) website, NZAEC visiting lectureship visits to smaller centres and the BWT Ritchie Scholarships.
- FFPMANZCA logo for Fellows’ professional use on business cards, letterhead and other material.
- New *Bulletin* article series – “Making a difference” about ANZCA-funded research (page 23) and “Your ANZCA” about what ANZCA committees do (see page 8 about the CPD Committee).
- FPM New Zealand National Committee established.
- The Geoffrey Kaye Symposium of Anaesthetic history, History and Heritage Expert Reference Panel and three more web-based “Anaesthesia Stories” ([www.anzca.edu.au/about-anzca/anaesthesia-stories](http://www.anzca.edu.au/about-anzca/anaesthesia-stories)).

#### Stronger external relationships (strategic priority no. 3)

- New Zealand function attended by health leaders, including the Minister of Health.
- Relaunch of National Anaesthesia Day with an eye-catching poster, strong support from many Fellows and hospitals, and very positive news stories (see report on page 12).
- A community survey highlighting the need for more public education about anaesthesia and anaesthetists.
- Widespread media publicity through hundreds of reports reaching a combined audience of millions (see ANZCA in the news on page 11).

- Professional document *PS59 Statement on roles in anaesthesia and perioperative medicine* developed ([www.anzca.edu.au/resources/professional-documents](http://www.anzca.edu.au/resources/professional-documents)).
- Continued expansion of the essential pain management (EPM) program, now in 15 countries globally – a web presence, EPM Subcommittee, newsletter and successful funding of \$150,000 over three years from Perpetual Trustees (see page 58).
- Initiatives to “close the gap” for indigenous communities, including nine podcasts and medical student mentoring (see September 2013 *Bulletin*).
- Collaboration with the Royal Australasian College of Surgeons (RACS) Rural Health Continuing Education (RHCE) indigenous health portal project.
- Support for the National Pain Strategy and the International Association for the Study of Pain (IASP) Global Year Against Pain.
- Patient information sheets developed.
- More than 60 submissions to Australian and New Zealand governments and other authorities.

#### Ensuring ANZCA is sustainable (strategic priority no. 4): Wise use of our resources

- A framework for recognising Fellow and trainee contributions.
- Prudent stewardship of resources to ensure maximum value in supporting Fellows and trainees in providing the highest standards of anaesthesia and pain medicine.
- Improved business processes to ensure efficiency and effectiveness – project management, financial reporting to ANZCA Council, performance appraisal processes, Lean Six Sigma managerial training, information management/information technology roadmap, greater trans-Tasman collaboration, Work Health Safety management and the re-establishment of the Green Committee.
- A staff recognition program, with 29 staff acknowledged for services to the College of between five and 21 years.
- Revised educational governance structure with new educational committees for the new curriculum, including evaluation for evolution (not intermittent “revolution”).
- Restructure of the Anaesthesia and Pain Medicine Foundation, recruitment to the Board of Governors for more effective fundraising and launch of a TV commercial to raise research funds.

#### Key services and projects for 2014

In addition to existing services, new initiatives include:

- A workforce action plan (see page 18).
- The revised CPD standard and program, with streamlined entry on mobile devices, automatically linked to online conference registration (My ANZCA Portal) and the training portfolio system (TPS) to provide automatic recording, supporting handbook with templates and tools, and seamless transition for existing CPD participants (see page 9) and the website.
- A new learning management system (LMS) with better facilities for online education and collaboration for Fellows and trainees (for example, podcasts, webinars, document sharing and editing, committee meetings).
- A fellowship satisfaction survey to ensure the College is on the right track with services for Fellows.
- The “mega” Singapore ASM with RACS.
- Further enhancement of the TPS to support supervisors and trainees.
- Continued implementation of service charters across ANZCA for improved focus on Fellow and trainee needs.
- Finalisation of the FPM curriculum for delivery in 2015.
- Orientation resources for trainees, supervisors of training, rotational supervisors and education officers.
- An online training accreditation system (advancing accreditation).
- Expanded fundraising for research by further recruitment to the Anaesthesia and Pain Medicine Foundation Board of Governors.
- The online FPM education program for allied health practitioners, funded by the Australian Medical Local Alliance (AMLA).
- Investigation of a pain device implant registry.
- Development of a cultural hub in Ulimarua, including relocation of the Geoffrey Kaye Museum of Anaesthetic History.
- Expansion of the EPM program, supporting global health.

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**Dr Lindy Roberts**  
President, ANZCA

# Chief executive officer's message



ANZCA and FPM Fellows and trainees continue to make good use of College library services as part of their membership, and have particularly utilised the expert searching skills of library staff.

The number of literature searches increased in 2013 with almost 100 requests fulfilled. Library staff searched on topics to provide information for clinical evidence, training and study, research, and quality and safety. Fellows and trainees also continue to do their own searches in the variety of medical databases available through the library, with over 110,000 search terms recorded.

While the ANZCA Library still receives regular visitors to head office, the main traffic to the library is online. There were more than 200,000 visits to the library website in 2013, a big increase on 2012.

Earlier this year the library team demonstrated services first-hand at this year's annual scientific meeting in Melbourne. It was a great opportunity to receive feedback from Fellows and trainees.

Library resources will be further enhanced in 2014 with direct and seamless access to material such as articles and books from "apps" and other programs. The library website will be refreshed and library staff are already working with others in the

College including continuing professional development (CPD) and training staff as well as with a number of special interest groups to investigate the collation and linkage of relevant journals, books, videos and other educational material from the website.

The number of online textbooks in the library continues to grow and the usage from Fellows and trainees has increased exponentially. There is now a selection of Oxford handbooks and ClinicalKey. There were over 150,000 downloads from the online book collection this year – close to doubling the number of downloads recorded for 2012. While online textbooks have increased, the loans from the print library collection continues to grow with more than 700 books lent to Fellows and trainees around Australia and New Zealand.

The library provided additional online access to two journals this year – the *Medical Journal of Australia* and *Anaesthesia and Intensive Care*. The large selection of specialised online journals is still a popular resource for Fellows and trainees with ongoing high usage recorded. More Fellows and trainees are becoming aware that the library can obtain articles not available to them personally. Library staff have sourced about 2000 articles for Fellows and trainees from networks, other libraries, and publishers.

Fellows and trainees are also continuing to utilise College learning resources as part of their membership, particularly the podcast resources that cover broader areas of the curriculum.

This year has seen the introduction of podcasts to support key areas of the newly-defined introductory training period. Overall, 20 new podcasts have been published. Fifteen webinars were also held throughout the year, led by Fellows with expertise in specific areas of anaesthesia and pain medicine.

The number of trainees in webinars can be up to 100 and typically 50 per cent of those that register actually attend. The average number of registrations per webinar in 2013 has been 25, so the size is smaller compared to previous years.

Evaluations and interactions with the Trainee Committee confirm that weekday evening work pressures when webinars are scheduled have an impact on attendance. The newly formed Education, Training and Assessment Development Committee is exploring alternative means to capture the interactions between trainees, such as the publication of key discussion points from webinars for those trainees that cannot attend.

ANZCA and FPM Fellows continue to evaluate the ANZCA Foundation Teacher Course as highly valuable in improving their teaching ability. In 2013, four full face-to-face courses and two abridged face-to-face courses were held, with demand exceeding the number of places available.

One Online Foundation Teacher Course has run throughout the year as the content for each module has been finalised. The Clinical Teacher Development Working Group (CTDWG) has reviewed the face-to-face and online courses this year in light of the introduction of the revised curriculum.

Recommendations for the new Teaching and Learning Subcommittee relate to the introduction of a "training the trainer" model for a wider roll out of the course to reach the demand.

Throughout the year, the Education Unit has scoped the requirements for ANZCA's new learning and collaboration management system. The system will be introduced in 2014.

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**Ms Linda Sorrell**  
Chief Executive Officer, ANZCA

# Your ANZCA:

Continuing Professional Development (CPD) Committee

## Setting the standard for professional development



**MANY FELLOWS ARE UNAWARE OF THE WORK THAT GOES ON BEHIND THE SCENES AT ANZCA. THIS ARTICLE ABOUT THE CPD COMMITTEE IS THE SECOND IN A SERIES ABOUT THE ACTIVITIES UNDERTAKEN BY ANZCA'S COMMITTEES.**

Though it's one of the smallest committees, ANZCA's Continuing Professional Development (CPD) Committee influences the professional working life of every specialist.

As such, unlike some committees, the members are not there for their geographical representation (except for the obvious need for both Australian and New Zealand representatives). Rather, they bring the perspective of all types of practice (public, private, urban, and remote/rural) as well as all types of practitioners (clinical, non-clinical, interventionists, non-interventionists, anaesthesia and pain medicine) to the table.

The primary roles of this committee are to oversee our College's CPD standard and our College's CPD program. This means we must ensure that our standard and program are up to date with international developments and research, and importantly make sure that the CPD program complies with the jurisdictional requirements. This must all be balanced against the absolute requirement to ensure that the program is acceptable to all and "doable" by everybody. Business as usual for the committee is usually able to be covered in three teleconferences a year and one face-to-face meeting around the time of the annual scientific meeting.

CPD unit staff at ANZCA keep track of and report to the committee issues raised by Fellows (and others), monitor the audit process and outcomes and have specific knowledge of the complexities of the program, and regulatory requirements, when questions and difficulties arise. They field at least half a dozen queries per week from hospitals and the medical board authorities enquiring about individual Fellows' compliance with CPD. They also are available to Fellows for advice about their individual situations, passing questions to a Fellow on the committee if necessary.

Our major work over the past 18 months or so has been the revision of the CPD standard and program. We are fortunate to have high quality education experts advising us, as well as the Policy unit, who help prepare for meetings with, and documentation for, the Medical Board of Australia and the Medical Council of New Zealand, and issues such as qualified privilege for the program in Australia or protected quality assurance activities in New Zealand.

The committee members are Dr Vanessa Beavis (NZ, chair and councillor), Dr Rod Mitchell (SA, chair Fellowship Affairs Committee and councillor), Dr Sarah Green (NSW), Dr Kerry Gunn (NZ, and chair of the online advisory group), Dr Penny Briscoe (SA, pain medicine), Dr Peter Roessler (Vic, director of professional affairs), Dr Lindy Roberts (WA ex-officio) and Dr Mick Vagg (Vic, CPD chair pain medicine and co-opted for the project).

Many Fellows have spent hours developing or piloting resources for the new program, working on electronic interface and generally being available to bounce ideas off. Despite the tight deadlines, differing views and strongly held opinions, this has been achieved with a degree of humour and collegiality at which one can only marvel.

Fellows who would like to help with this committee would be very welcome. If you wish to put your hand up, please contact [cpd@anzca.edu.au](mailto:cpd@anzca.edu.au).

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**Dr Vanessa Beavis**  
Chair, CPD Committee

Further information about ANZCA committees, including their terms of reference, can be found at [www.anzca.edu.au/about-anzca/Committees](http://www.anzca.edu.au/about-anzca/Committees).

# New CPD system will simplify recording process

Launching  
January 20, 2014

**Continuing Professional Development**

Dashboard | Activities | CPD Plan | Triennial evaluation | Events | Statements and certificates | Contact | CPD Handbook

**Dashboard**

You have 2 activities pending confirmation [View pending activities >](#)

**Triennium progress** PERIOD 01/01/2013 - 31/12/2015 FINAL SUBMISSION DATE 31/12/2015

Year 1

**Practice evaluation** 82% REMAINING  
82 / 100

**Knowledge and skills** 51.2% REMAINING  
39 / 80

**Emergency responses** 8 ACTIVITIES REMAINING

- CICO
- Cardiac arrest
- Anaphylaxis
- Major haemorrhage

**Annual progress**

Credit count for 2013

121 / 30

[Add activity](#)

**Milestones**

- Statement of participant 2013
- Statement of participant 2014
- Statement of participant 2015
- Write Plan
- Write Evaluation
- Certificate of membership

**Your CPD Status**

Membership Status ANZCA Fellow  
Practice Type Clinical

**Resources**

- Google search
- Training portfolio system
- ANZCA website

The countdown is on towards next month's launch of our 2014 CPD program, with the new smart, intuitive electronic portfolio system in its final testing stages.

Accessible on any computer or mobile device, the new system can be used online and offline, ensuring a much more streamlined process for recording activities.

"We did a poll of all Fellows earlier this year and one of the key messages was the eagerness by the fellowship for mobility in entering data if they were away from their desk," said Dr Kerry Gunn, a member of the CPD Committee and the Fellow responsible for co-ordinating the online advisory group.

"There was a strong embracement of information technology through mobile devices."

This means Fellows are able to enter data online or offline at the end of a hospital session or on the plane after an overseas conference, he said.

"These enhancements mean your CPD portfolio lives in ANZCA House but it follows you around the world in your pocket," Dr Gunn said.

Another key feature of the system is how it links to ANZCA's new online events registration system.

When Fellows register online for an ANZCA-run event via the ANZCA website, credits will automatically upload to an individual's portfolio for confirmation and/or editing.

"This makes keeping up easier so there's not that horrible time at the end of a triennium where you're rushing around trying to remember what you did two years earlier," Dr Gunn said.

Similarly, assessments undertaken via the training portfolio system (TPS) will automatically upload to an individual's portfolio for confirmation or editing.

Provisional fellows can also select activities submitted in TPS within the CPD portfolio system quickly and easily to avoid the need to enter activities in both systems.

The system can also be used via desktop computers, which is necessary for some activities that require working in a larger format, for example, with optimised forms. The new CPD portfolio can still be accessed via the ANZCA website using the College ID number and password.

"The challenge has been to deliver on all devices – to try and make it 'platform agnostic'," Dr Gunn said.

"These enhancements mean your CPD portfolio lives in ANZCA House but it follows you around the world in your pocket."

Another key feature of the system is the ability to upload evidence for activities, such as images and documents.

Like the previous system, users will still need to enter a plan at the beginning of the CPD triennium and evaluation will occur at the end of each triennium.

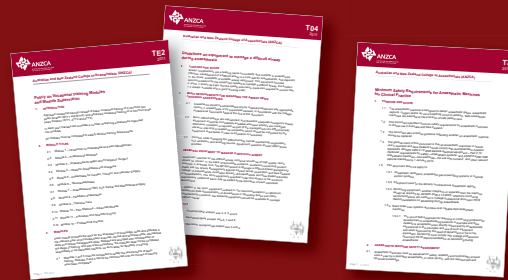
Resources, tools and helpful information are all embedded in the interface and the dashboard enables users to clearly keep track of how they are progressing in each of the CPD categories throughout your triennium.

All previously completed ANZCA CPD trienniums, including plans, evaluations and previously earned certificates, will be available through the new system.

Further enhancements to the CPD portfolio system are planned for the future.



# What would you do?



**ANZCA's professional documents aim to assist Fellows and trainees to provide a high standard of care to their patients. This is part of a series of articles that explain aspects of ANZCA's professional documents in practical terms.**

## Should you advise smokers to quit?

You are in pre-anaesthetic clinic (PAC) and have one more patient to assess before you go home for a well-earned rest (or more realistically to catch up with your paper work).

It is a 62-year-old male presenting three days prior to an elective total knee replacement. During the assessment you inquire about his smoking having noticed nicotine stains on his fingers. He tells you that he has recently cut down. Good you think, and then you ask him when he cut down, to which he responds "last night"!

He admits to cutting down to 10 cigarettes per day having smoked 20 cigarettes per day since age 16. Besides arthritis, he is on treatment for hypertension and mild/moderate chronic obstructive pulmonary disease, but otherwise appears to be in a reasonable physical state. You discuss the anaesthesia plan (likely spinal block) and address the issue of informed consent.

The operation is in a few days and it is assumed that his GP and surgeon have probably addressed the smoking issue, so do you advise him to stop?

### What would you do?

Obviously you would refer to *PS12 Guidelines on Smoking as Related to the Perioperative Period* for assistance.

There is considerable evidence that smoking significantly worsens perioperative outcomes, particularly pulmonary complications and wound infection. In one large study, smokers were 53 per cent more likely to develop postoperative pneumonia and 41 per cent more likely to develop infection.

Randomised controlled trials in this patient group showed six-weeks abstinence significantly reduced these risks and in other types of surgery, three to four weeks reduced wound infection.

Whether patients such as this should be deferred until they stop smoking is the subject of some debate in the medical and wider community. Some may consider it unethical to discriminate against nicotine-addicted patients using a legal product, particularly given that most hospitals do not offer intensive cessation support in the preoperative setting. Others may consider it a waste of time and money doing surgery when patients are not optimised for surgery.

While a few days quitting before surgery is unlikely to reduce risks, current evidence is that it does no harm either. Health advocacy is one of the ANZCA roles, and for smokers who don't quit, one in two will eventually die of a tobacco-related disease. The spontaneous quit rate among smokers in the generally community is about 2 per cent per annum, but it is much higher in those having surgery, particularly major surgery.

The perioperative period may be a "teachable moment" when even inveterate smokers may be interested in having a quit attempt, particularly when presented with the benefits in the perioperative period.

*PS12* recommends always asking about smoking status and advising smokers to quit (as long as possible before surgery). Referral to another service for quit support is likely to increase effectiveness; either the telephone Quitline, GP, pharmacist or other local services.

Assumptions that GPs or surgeons have addressed the smoking issue are flawed and surveys of perioperative patients have shown this is infrequently done.

Addressing smoking as a perioperative issue aligns with ANZCA's wider mission to improve the overall health of the community. Given that surgery is a "teachable moment" when positive behaviour change may occur, it would be a tragedy if our skills and knowledge were used to help the patient just through this knee operation, only to see him again in a few years time on a cardiac or thoracic list with a terminal illness.

---

**Dr Peter Roessler**, ANZCA's Director of Professional Affairs (Professional Documents)

and

**Dr Ashley Webb**, co-author of *PS12 Guidelines on Smoking as Related to the Perioperative Period*

# ANZCA and FPM in the news



National Anaesthesia Day, launched on October 16 after months of planning and preparation by the Communications unit, was a highly anticipated highlight of the third quarter of ANZCA media activity for 2013. The day had great support from hospitals and clinics across Australia and New Zealand.

The combined cumulative audience for ANZCA and FPM media reports since the September *ANZCA Bulletin* exceeds three million. The launch of National Anaesthesia Day on October 16 added significantly to this coverage, with rural and regional audiences hearing about the importance of the practice of anaesthesia and the role of anaesthetists. ANZCA President Dr Lindy Roberts was heard throughout many outback and regional radio stations, as was deputy president Genevieve Goulding. Professor Daryl Williams, a Royal Melbourne Hospital-based Fellow, gave a live-to-air five-minute interview on ABC TV's *News Breakfast*, reaching an audience across the nation that exceeded 300,000. For more on National Anaesthesia Day 2013 see page 12.

The Faculty of Pain Medicine Spring Meeting at the Byron at Byron Resort in Byron Bay also attracted significant media attention. Dr Mark Hutchinson gave an important presentation on recent research highlighting women are more likely to suffer from chronic pain than men, and that their experience of pain is more severe than the male experience. This research has implications for pain treatments, he said, with scope to tailor medications specifically to men and to women.

Since September, ANZCA has generated more than 100 media reports (excluding significant syndicated coverage). They include:

- 26 print stories.
- More than 33 online reports.
- More than 38 radio reports.
- Three television stories.

## Media releases distributed by the ANZCA media team since September:

- Dr William Russ Pugh: A remarkable character comes to life (October 29)
- Childhood pain not make-believe, expert says (October 27)
- The pain of endometriosis a “mystery” to women who suffer (October 25)
- Women’s chronic pain “more complex and more severe” (October 24)
- Unsung heroes of the operating theatre have their day (October 16)
- Enhancing recovery after surgery (October 10)
- National Anaesthesia Day (October 9)
- New ways take the guesswork out of pain relief in surgery, conference hears (September 13)

**Ebru Yaman**  
Media Manager, ANZCA

## Professional documents – update



The professional documents of ANZCA and FPM are an important resource for promoting the quality and safety of patient care for those undergoing anaesthesia for surgical and other procedures, and for patients with pain. They provide guidance to trainees and Fellows on standards of anaesthetic and pain medicine practice, define policies, and serve other purposes that the College deems appropriate. Professional documents are also referred to by government and other bodies, particularly with regard to accreditation of healthcare facilities.

Professional documents are subject to regular review and are amended in accordance with changes in knowledge, practice and technology.

A newly developed professional document, *PS59 Statement on Roles in Anaesthesia and Perioperative Care*, is now being piloted. Revised versions of *PS12 Guidelines on Smoking as Related to the Perioperative Period* and *PS28 Guidelines on Infection Control in Anaesthesia* are also being piloted. The definitive version of *PS53 Statement on the Handover Responsibilities of the*

*Anaesthetist* is now available, following a close of pilot review.

Queries or feedback regarding professional documents can be directed to [profdocs@anzca.edu.au](mailto:profdocs@anzca.edu.au).

The complete range of ANZCA professional documents is available via the ANZCA website, [www.anzca.edu.au/resources/professional-documents](http://www.anzca.edu.au/resources/professional-documents).

Faculty of Pain Medicine professional documents can be accessed via the FPM website, [www.fpm.anzca.edu.au/resources/professional-documents](http://www.fpm.anzca.edu.au/resources/professional-documents).

# Celebrating one of the greatest discoveries of modern medicine – anaesthesia



From Auckland to Perth, 2013 National Anaesthesia Day on October 16 was enthusiastically embraced by a large number of Fellows and hospitals which undertook a range of activities to improve the public's understanding of anaesthesia and what anaesthetists do.

Some simply displayed the College-designed National Anaesthesia Day poster and balloons while others held staffed displays and demonstrations in hospital foyers and answered questions from the public.

The College also ran a media campaign on the day and received a strong response, the day starting with a lengthy live TV interview that ran nationally in Australia. Radio and print stories followed.

The 2013 Community Attitudes Survey commissioned by ANZCA and held in the first half of the year provided the impetus for National Anaesthesia Day. It showed that despite 96 per cent of people reporting experience of a general anaesthetic (personally or through a close family member), nearly one in 10 thought anaesthetists were not doctors and another 49 per cent were unsure.

The survey also showed 30 per cent reported TV medical shows as a source of information (others reported personal experience – 72 per cent; family and friends – 50 per cent; the internet – 17 per cent). And four in 10 perceived going under anaesthesia/sedation as a moderate to high-risk procedure (six in 10 low/almost no risk). A full report on the survey appeared in the September 2013 edition of the *ANZCA Bulletin*.

Above from left: A public demonstration at Auckland City Hospital by anaesthetic technician Jennifer Spencer, Dr David Heather and Dr Marty Minehan. Photo courtesy of Fairfax Media; Dr Philippa Lane and Jonathan Hopkinson at the Women's and Children's Hospital, Adelaide; Registrars Faraz Sayed and Verna Aykenat with Goulbourn Valley Health Clinical Director, Dr Arnold Beeton.

October 16 was chosen as the day to celebrate National Anaesthesia Day because it is the anniversary of the day in 1846 that ether anaesthetic was first demonstrated publicly in Boston, Massachusetts.

In the lead-up to National Anaesthesia Day, ANZCA's Communications team contacted hospitals and private practices throughout Australia and New Zealand three times to encourage them to get involved. The day was also promoted in the *Bulletin*, *ANZCA E-Newsletter*, *Gasbag* (our New Zealand e-newsletter), via Twitter and on the ANZCA website (the homepage and on a new web page).

Copies of our eye-catching poster "What is an anaesthetist? (an-ees-the-tist)" developed by the ANZCA Communications team were distributed in late September with National Anaesthesia Day balloons, designed to help draw attention to the posters. Hospitals were also sent a guide on how to get involved and links to web-based patient information sheets ([www.anzca.edu.au/patients/information-sheets](http://www.anzca.edu.au/patients/information-sheets)) specially developed for use on the day.

ANZCA offices in Australia and New Zealand held morning teas and displayed the National Anaesthesia Day poster and balloons.

## Fellows' involvement

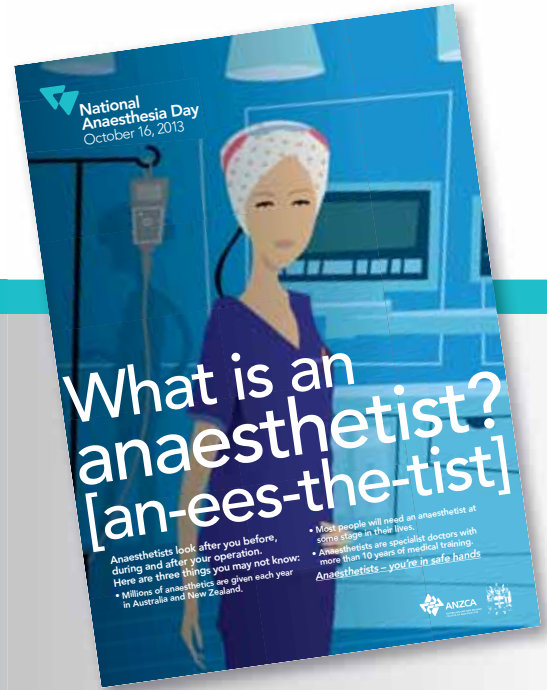
National Anaesthesia Day was celebrated by many hospitals and practices across Australia and New Zealand.

Staffed booths were set up in several hospitals. In New Zealand, Dr Marty Minehan ran a series of demonstrations of anaesthesia techniques at Auckland City Hospital and Dr Jane Torrie ran one at the Greenlane Clinical Centre, with help from



# National Anaesthesia Day

October 16, 2013



Dr David Heather who organised equipment and mannequins and ran the simulations. The demonstrations attracted strong crowds and resulted in good media coverage, with one newspaper videoing the demonstration for its website.

Dubbo Base Hospital in NSW put on a display and held a cake stall fundraiser to buy toys for its paediatric recovery area supported by the local bakery.

Other hospitals that organised displays were the Women's and Children's Hospital in South Australia (two displays), Royal North Shore Hospital, Gosford hospital, Port Macquarie Base Hospital, Tamworth Hospital and John Hunter Hospital in NSW, and Goulbourn and Bendigo hospitals in Victoria.

The College also heard from Wagga Wagga Base Hospital and Ramsay Health Care in NSW, St John of God Murdoch Private Hospital, Royal Perth Hospital and Princess Margaret Hospital in WA, Monash Health and Nepean Hospital in Victoria and Pindara Private Hospital in Queensland, which posted electronic images of the poster in their waiting rooms.

## Media response

More than 170 media reports mentioned ANZCA, reaching a potential cumulative audience/circulation of more than 500,000, according to ANZCA's media monitoring service iSentia.

A media alert distributed a week before National Anaesthesia Day reminded the public that "most people will need the care of an anaesthetist at some stage in their lives".

On October 16, the media release titled "Unsung heroes of the operating theatre have their day" focused on the result of the survey. Background information about anaesthesia, anaesthetists and the history was also supplied to the media.

(continued next page)

## National Anaesthesia Day – some key messages

- Most people will need the care of an anaesthetist at some stage in their lives – for pain relief during the birth of a baby, for a routine day-stay procedure or for a major operation.
- Many of today's operations, especially for the very young, very old or very ill would not be possible without modern anaesthesia.
- Anaesthesia is one of the greatest discoveries of modern medicine.
- 50 per cent of people don't realise their anaesthetist is a highly trained specialist just like their surgeon.
- Anaesthetists are highly skilled doctors who have more than 10 years' medical training.
- Millions of anaesthetics are given each year in Australia and New Zealand yet awareness about anaesthesia and what anaesthetists do remains very low.
- Anaesthetists in Australia and New Zealand provide care and professionalism that is among the best in the world.
- Your anaesthetist makes sure you keep breathing during your surgery, that you're pain-free for your operation and stays with you for the whole of that operation as well as helping take care of you when your operation is finished.

# Celebrating one of the greatest discoveries of modern medicine – anaesthesia (continued)



The day started with an excellent live, national interview with Royal Melbourne Hospital's Professor Daryl Williams on ABC TV which reached an audience of 174,000. He was also interviewed later by Queensland radio.

ANZCA President Dr Lindy Roberts was quoted on several radio stations throughout Australia and ANZCA Vice-President, Dr Genevieve Goulding, was interviewed on Sydney radio. Tasmanian Regional Committee Chair, Dr Nico Terblanche, was interviewed for 10 minutes live on ABC radio in Hobart and Dr Brian Pezzutti was interviewed on ABC North Coast for 10 minutes.

Dr Marty Minehan was interviewed by the *Central Leader* in Auckland (the story also appeared in *Western Leader* and the *Auckland City Harbour News* – the three having a circulation of more than 154,000), Dr Arnold Beeting was quoted in the *Shepparton News*, the *Geraldton Guardian* ran the ANZCA media release in full, as did *NZ Doctor*.

A very good article written by Bendigo Fellow, Dr Eric Knauf, appeared on the Bendigo Health intranet and was published in the *Bendigo Weekly* which has a circulation of 37,000. ANZCA and National Anaesthesia Day was mentioned on New Zealand websites scoop.co.nz, the *Healthed* and *HIIRC*.

ANZCA's tweet of the NAD poster was retweeted 10 times and received two "favourites" and the Royal Children's Hospital in Melbourne tweeting a picture of themselves "Celebrating the @RCHAnaesthesia & Pain Management team today on @ANZCA National #Anaesthesia Day!"

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**Clea Hincks**  
General Manager, Communications  
ANZCA

Clockwise from top left: At Dubbo Base Hospital are Dr Namrata Singh and colleagues; Dr Claire Armstrong at Tamworth Rural Referral Hospital; Dr Eric Knauf and colleagues at Bendigo Health; Celebrating National Anaesthesia Day with cake.

# A new federal government

## Australia

Australia has had a change of federal government and of political direction, following the election of the Abbott Coalition government. While health has not been under the immediate spotlight, the new National Commission of Audit, appointed by Treasurer Joe Hockey, will undoubtedly reveal areas for cost savings and minimisation of waste.

Phase 1, due to report by January 31, will examine:

- The current scope of government and split of roles/responsibilities between national/state and territory governments, including areas of duplication.
- The efficiency and effectiveness of government expenditure.
- The state of the Commonwealth's finances and medium-term risks to the integrity of the budget position.
- Adequacy of existing budget controls and disciplines.

Phase 2, due by March 31, will examine:

- Commonwealth infrastructure.
- Public sector performance and accountability.

### Cap scrapped – reform to deductions for education expenses

Treasurer Joe Hockey has announced the repeal of the former government's proposed reform tax deductions for education expenses. The deductions had proposed a \$A2000 cap on self-education expenses and were widely opposed by health practitioners and

many other professional organisations. ANZCA provided a detailed submission to the government in June outlining the College's role and opposition to the proposed measures.

### Workforce issues

Please refer to the separate feature article in this edition of the *ANZCA Bulletin* on page 18.

### Submissions

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

- National Blood Authority on the Single Unit Transfusion Guideline.
- Health Workforce Australia workforce data for the Medical Training Review Panel.
- National Health and Medical Research Council on Complementary and Alternative Medicine Resource for Clinicians.
- Australian Commission on Safety and Quality in Health Care on shared decision-making.
- Australian Medical Council review of the accreditation standards for specialist medical education and continuing professional development programs.
- Australian Capital Territory Health on options for controlled medicine prescribing in the ACT.

- National Blood Authority consultation on consensus statements on clinical indications for platelets and consensus statements on clinical indications for CMV seronegative blood components to inform development of the National Blood Supply Contingency Plan.

ANZCA's past submissions, including the College's accreditation submission to the Australian Medical Council and significant submissions developed by the New Zealand National Committee, can be accessed via: [www.anzca.edu.au/communications/submissions](http://www.anzca.edu.au/communications/submissions).

### Australian Government grants Specialist Training Program

All successful sites from the 2014 Specialist Training Program (STP) application round have been informed and have begun contract negotiations with the College.

The evaluation of the STP has moved into the consultation and analysis phase. Surveys were sent out in November to all trainees, supervisors and hospital administrators involved in the program to assess the degree to which it is meeting program outcomes. The analysis of this data, as well as data from support projects, will be conducted in December 2013.

The last round of regional stakeholder visits was completed last month with a trip to STP-funded sites in Townsville. Throughout 2013, 19 hospitals have been visited as part of the program, most of them in rural locations.



## New Zealand

### Rural Engagement Project

Following feedback from the Rural Engagement Working Group and chairs of all regional trainee committees, surveys will be sent to a random sample of rural ANZCA trainees and supervisors in November. Feedback from these surveys will be consolidated into a strategy to better engage with trainees and Fellows in rural areas.

### Training More Specialist Doctors in Tasmania

The Training More Specialist Doctors in Tasmania (TMSDT) funding is being finalised with Tasmanian hospitals. All funds will be directed to support approved specialist fellowship training, undertaken and completed in Tasmania, and to support the training and retention of specialist doctors in the Tasmanian public health system.

Inquiries relating to STP, including the above Tasmanian initiative, can be directed to Donna Fahie (Manager, STP) on +61 3 9093 4953 or [stp@anzca.edu.au](mailto:stp@anzca.edu.au).

### Professional documents

Seven revised professional documents have been released this year, including *PS12 Guidelines on Smoking as Related to the Perioperative Period* and *PS28 Guidelines on Infection Control in Anaesthesia*.

Two new professional documents, *PS59 Statement on Roles in Anaesthesia and Perioperative Care* and *Ao2 Policy on Endorsement of Externally Developed Guidelines*, are being piloted.

The College is grateful to all Fellows and trainees for their involvement in the document development groups and consultations and for their valuable contributions.

In recent months the College's interactions with government agencies have been focused on roles, responsibilities and accountabilities. PHARMAC continues to prepare for the extension of its role into medical devices, the Ministry of Health is considering the outcomes of the recent OECD surgical outcomes surveys, and there is discussion about the education and qualification pathways for nurses who work as assistants to the anaesthetist.

Of particular note is the Medical Council of New Zealand's (MCNZ) presentation of a draft model for increased College involvement in the assessment of physicians' competence. This was discussed at length at the August meeting of the Council of Medical Colleges, the annual MCNZ and College meeting in September, and at the International Physician Assessment Coalition conference in Queenstown in October.

The Health Quality and Safety Commission has been continuing the roll-out of its "Open for Better Care" campaign, including a focus on improving surgical safety and medication safety, alongside the work of the mortality committees. Professor Alan Merry (HQSC Chair) and Dr Leona Wilson (Chair, Perioperative Mortality Committee) are among a number of Fellows active within the HQSC, providing a direct link and excellent representation for anaesthesia in these very important initiatives.

Health Workforce New Zealand has recently confirmed its funding model for specialist training, a model which includes a guaranteeing 70 per cent of funding to district health boards, and making the remaining 30 per cent available depending on district health board performance. Three-year contracts will begin in January 2014. HWNZ's focus is on the expected shortage in the nursing workforce in the next few years, and on an unexpected increase in the number of PGY1 students. It will be interesting to track the impact of this larger than expected cohort as they enter specialist training in 2015-16.

The New Zealand National Committee has made submissions to the Ministry of Health, PHARMAC, the Medical Council of New Zealand, and the Perioperative Nurses College of New Zealand.

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**John Biviano,**  
General Manager, Policy, ANZCA



# Talking workforce

## Workforce: a high priority for the College

The ANZCA Council is committed to ensuring the College contributes to effective solutions for workforce concerns. "Talking workforce" highlights the complex interplay of factors impacting on specialist supply, as well as the demand for health services which, in the public sector, is very dependent upon health department budgets. In particular, this article addresses why the College accredits departments and not posts, an issue often raised when I speak with Fellows and trainees.

The College has been very active in ensuring we are involved effectively in the workforce situation. Our current approach is in three areas:

- Ensuring we have high quality data about what is happening – both by collecting our own data (for example, the recent graduate outcome survey and the New Zealand workforce study) and also contributing data to workforce modeling by other organisations, such as health departments and health workforce agencies in both countries.
- Working with regional committees to have an effective voice at a state and territory level, as well as in New Zealand and Australia at a nationwide level. For the latter, we are actively involved in work on the National Medical Training Advisory Network (NMTAN), approved by Australian health ministers and looking at a nationwide approach to workforce.
- Communicating with our Fellows and trainees, both listening to the issues you are facing and illustrating ANZCA's responses and actions. I particularly encourage you to respond to surveys that allow us to better monitor the situation and the effectiveness of what is being done to address it. My plan is to ensure regular updates to you – I welcome your feedback and questions.

Dr Lindy Roberts  
ANZCA President  
president@anzca.edu.au

In line with our mission "to serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine," in 2013, ANZCA engaged in multiple discussions with Fellows and trainees concerning the present state and future of Australia and New Zealand's workforce.

This was influenced by the changing external environment for both trainees and, in particular, new Fellows, who are experiencing concerns about gaining full employment especially in metropolitan teaching hospitals.

From this perspective it is the College's goal to educate specialists to meet the needs of the Australian and New Zealand communities as well as to advocate for meaningful work for its graduates. Determining the appropriate number of trainees is a complex process involving many stakeholders including health jurisdictions, employers, as well as the medical colleges. In Australia, despite community demand, healthcare funding is usually manipulated by governments at both the federal and state level. This obviously has an immediate impact at the local level on hospital budgets with a resultant negative effect on workforce capacity.

The Australian and New Zealand workforce situations are different at this point in time. New Zealand also has a maldistribution of anaesthetists; however does not currently have the same problem of perceived oversupply of graduates in some metropolitan centres. Health Workforce New Zealand (HWNZ) has recently signalled that its major policy challenges are to do with nursing rather than specialist medical workforce.





HWNZ is monitoring the flow of New Zealand-born, Australian trained doctors back to New Zealand in response to employment issues in Australia. As a result, this article focuses primarily on the Australian situation. The issues covered in this paper and Council's subsequent decisions will be relevant should any similar issues arise in New Zealand, and will be of interest to Fellows and trainees in New Zealand. Additionally, any decisions about the training program apply to both countries.

We understand the Fellows' and trainees' concerns regarding future employment and ANZCA has been actively listening to our members and gathering further information to increase our advocacy in this area. Many often ask about why we accredit departments for training and not positions, in contrast to some, but not all, of the other colleges. A brief history is provided below.

### ANZCA's approach to current workforce issues

ANZCA is working on three fronts to advocate for the profession:

- Improved advocacy with the health jurisdictions and government.
- Enhanced communication to members.
- Better data and information on Fellows and trainees.

The College has been working with a number of state jurisdictions including Tasmania, Victoria, Western Australia and New South Wales health departments responding to data requests and providing input into from the College's perspective on the ANZCA training program and the anaesthesia workforce. In New Zealand, our key contacts are HWNZ, the central government, and the Medical Council.

### Ensuring ANZCA has an effective voice

The College has always worked with Australian federal and state governments and other health agencies to ensure input from anaesthetists is considered in areas including workforce, quality and safety, and medical education. These interactions are highlighted as part of the College's strategic plan 2013-2017 under the priorities in table 1.

**Table 1:**

<b>ANZCA strategic priority:</b>	<b>2.</b>	<b>Build ownership, engagement and unity</b>
<b>Objectives:</b>	2.2	Promote and demonstrate the value of ANZCA/FPM
	2.3	Strengthen connections within and between all parts of the college structure
<b>ANZCA strategic priority:</b>	<b>3.</b>	<b>Develop and maintain strong external relationships</b>
<b>Objectives:</b>	3.1.	Develop productive collaborative relationships
	3.2.	Engage and influence government and other key stakeholders
	3.3.	Raise the profile of anaesthesia, perioperative medicine and pain medicine

The College is developing a workforce agenda which includes the range of interactions the College undertakes, including meetings of the regional and national committees, Specialist Training Program, College communications, ANZCA Trainee Committee, Council, President and CEO, co-ordinated by the Policy Unit. This engagement plan is intended to streamline the many levels of the College's external interactions to ensure a consistent message to government, the community and others.

The plan also includes improved communication back to Fellows and trainees to ensure accurate information is available. Information on workforce such as numbers of Fellows and where they work is also being collected via the recent graduate outcomes survey and the fellowship survey in 2014. Better information on our Fellows and trainees will assist with understanding of the issues involved and contribute to improved decision making by authorities.

### Why does ANZCA accredit departments and not posts?

The decision on accrediting hospitals rather than posts was taken in early 2003, based on committee discussions in 2002. In February 2003 Council determined that this approach would start from the 2004 training year which also happened to coincide with the introduction of the "new FANZCA" curriculum.

A new document describing the desirable characteristics of "Training Program Seeking College Approval for Vocational Training in Anaesthesia" (TE10) was developed and approved by ANZCA Council. The Council discussion centered on availability of subspecialty training, especially paediatric anaesthesia, the potential of a bottle neck between basic and advanced training, Joint Faculty of Intensive Care Medicine (JFICM)' approval of hospitals not training positions and a warning about the potential to have to two levels of trainees: rotational and non-rotational.

The following issues were noted:

- As there was a workforce shortage, it was important that the College was not seen to be maintaining bottlenecks, and there was excess available clinical material not currently being used for training purposes.
- There was no wish to control training numbers.
- NSW had established training programs (to ensure trainee access to subspecialty experience).

Prior to the above decision, hospital inspections determined the numbers of accredited posts for each hospital, and these were based on the specialist workforce available for supervision in that hospital. The total number of trainees for the country was not taken into account. (continued next page)

# Talking workforce (continued)

Figure 1: Australian Fellows and new Fellows 2004-2012

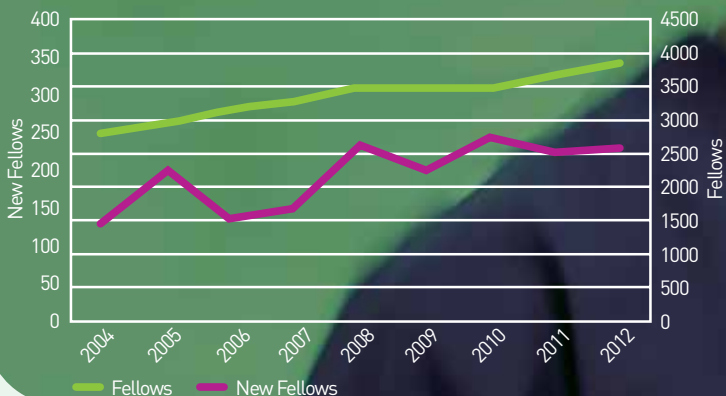
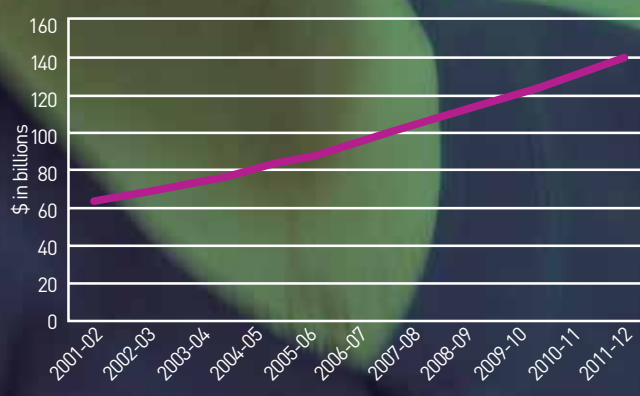


Figure 2: Australian healthcare spending in \$ billions



Key factors in Australia affecting the decision to move to accreditation of hospital departments included:

- The Australian Competition and Consumer Commission (ACCC) was taking a deep interest in medical colleges' so-called "restrictive practices", as were politicians, and removing the College's power to effectively control numbers was a great political lobbying advantage with governments.
- The Australian federal government wanted the state and territory jurisdictions to plan workforce numbers in medicine and the colleges to keep to training and standards.
- The Australian government pressured the colleges to "de-restrict" trainee numbers.
- The Australian Medical Workforce Advisory Committee (AMWAC) identified an anaesthetist shortage in their 2001 report.
- Legal advice at the time was in support of hospital and department accreditation.

## Australian Competition and Consumer Commission

In 2003, ACCC considered the public benefit and competition issues arising from the role of the Royal Australasian College of Surgeons (RACS) in the health sector. This was a result of complaints against RACS that included a restriction on the number of training places and therefore restricted access to MBS payments.

The outcome of the investigation was that the ACCC authorised RACS's role in selecting trainees, accrediting training facilities, assessing trainees and overseas trained surgeons. This authorisation was subject to improved transparency and accountability, procedural fairness, stakeholder participation and clear processes for accreditation of training sites and overseas doctors, and provided temporary immunity from the then Trade Practices Act (now the Competition and Consumer Act). In 2006 RACS developed the Surgical Education and Training (SET) process for selection of surgical trainees. The ACCC judged the SET process constituted a significant change to the College's selection model and revoked the College's immunity.

The ACCC conducted a joint review with the Australian Health Workforce Officials' Committee (AHWOC) in 2005 on the selection, training, assessment and accreditation arrangements of all

specialist medical colleges. Whilst ACCC was primarily concerned with competition issues, AHWOC was concerned with the supply of specialists. The review was done in the context of significant workforce shortages in some medical specialties and continued complaints from junior doctors encountering difficulty entering training programs, or overseas doctors seeking recognition of their specialist qualifications.

In relation to workforce planning, it was recommended that colleges and jurisdictions have an effective mechanism for collaborating on the number of trainees. Jurisdictions should be responsible for delivering optimal workforce numbers to the community while the colleges are responsible for setting standards and curriculum.

## The New Zealand Commerce Commission

Specialist doctors' practice has been scrutinised in New Zealand in recent years, most notably in a high profile case involving a group of ophthalmologists. In its statement of intent for 2013-16, the New Zealand Commerce Commission said:

"We will also continue to work in the health area to improve compliance with competition and consumer laws among health professionals. In New Zealand the health sector is shifting to more integrated models of care, with greater collaboration

Figure 3: IMGS applications per year

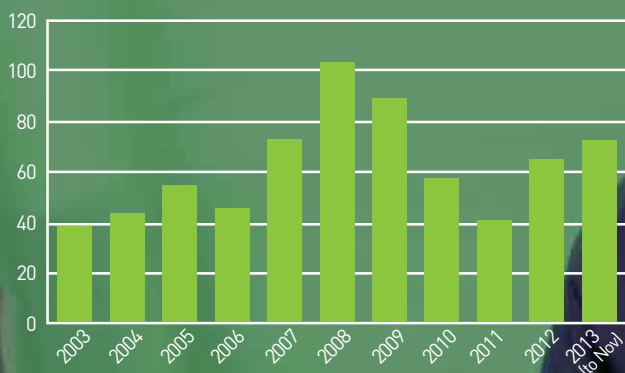
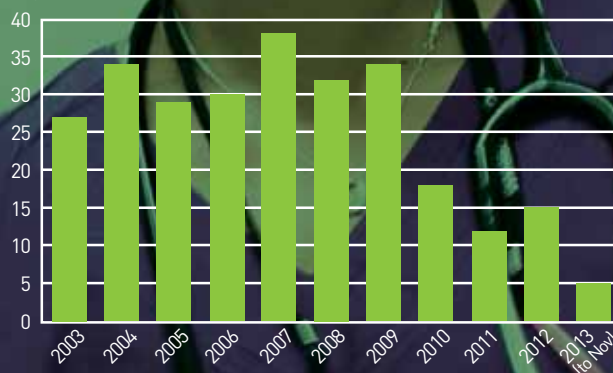


Figure 4: Area of Need 2003-2013



between different health professional groups. This can bring with it risks under the Commerce Act.”

While this statement refers to awareness among individual doctors, it is a signal that any anti-competitive practice in the sector would be of interest to the commission.

In light of these considerations and others, ANZCA Council recently affirmed its approach to the accreditation of departments and not posts. The College recognises the role of health departments and employers in determining training numbers and is working with them to ensure a balance of supply and demand.

This is particularly important given the recent expansion of medical student numbers in both countries, and the need to ensure that these graduates are directed into the areas where they are needed. It is highly likely that the current situation in Australia will lead to pressure to upgrade so called non-training posts to provide training for the rising tide of medical graduates<sup>7</sup>.

#### Data on ANZCA Fellows and trainees

ANZCA routinely provides data on Fellows and trainees on an annual basis to the Medical Training Review Panel (Australian government department of health) in collaboration with Health Workforce Australia (HWA). ANZCA, along with other medical colleges and relevant

parties, is also represented on the MTRP Advisory Committee which meets twice a year. In New Zealand, HWNZ collects data from the district health boards (DHBs), and the Medical Council. HWNZ also commissioned a series of health workforce reviews around 2010-2011, and contacts the contributing colleges and societies for updates on an annual basis.

Figure 1 shows an overall 38 per cent increase in Fellows, including international medical graduate specialists (IMGSs) over nine years; this is comparable to the corresponding increase in overall health expenditure in the same time period (figure 2). Numbers of new Fellows are starting to stabilise at about 220 per annum.

Australia now has about 1200 trainees, with a declining number of first-year trainees now evident. This may be due to many factors including the change to the 2013 curriculum. We will monitor this closely over the next two to three years to see if this trend continues.

The IMGS situation shows volatility in IMGS applications to the College over a number of years with a decline from the peak in 2008 and numbers steady in 2012 and 2013. There has been a dramatic reduction in area of need (AON) applications.

#### New graduate outcomes survey and Fellows survey

A new graduate outcomes survey was developed and was conducted from August to October with first data collected in November.

This will provide ongoing information on the employment patterns of new Fellows including, valuable demographic details. This will be supplemented by information from the Fellows survey scheduled to be undertaken in 2014. Having accurate information will enable ANZCA to respond in an informed and professional way.

The survey results will go to the next ANZCA Council meeting and then be released to the wider fellowship.

#### Health Workforce Australia and the National Medical Training Advisory Network

Health Workforce Australia (HWA) has been driving the bulk of the Australian workforce agenda for the past few years. ANZCA has worked with HWA to provide data on training, fellowship and IMGSs for its 2025 projections. ANZCA shares concerns about the veracity of the projections, and has offered to have further input to remodeling of the data now under way.

(continued next page)

# Talking workforce (continued)

Additionally, the College regularly provides detailed submissions about key workforce proposals and debates including:

- The National Medical Training Advisory Network (NMTAN).
- Workforce innovation and reform (noting we now have a professional document, the *Statement on Roles in Anaesthesia and Perioperative Care* outlining our position on the provision of anaesthesia: [www.anzca.edu.au/resources/professional-documents/pdfs/ps59-2013-statement-on-roles-in-anaesthesia-and-perioperative-care.pdf](http://www.anzca.edu.au/resources/professional-documents/pdfs/ps59-2013-statement-on-roles-in-anaesthesia-and-perioperative-care.pdf)).
- Clinical supervisor support.
- Expand prescribing through the Health Professionals Prescribing Pathway.
- IMGS orientation and supervision.
- Rural Medical Generalist draft framework.

The College has committed to engaging with HWA through the NMTAN, an ambitious proposal that aims to bring

together all the major stakeholders in an attempt to provide a strategic approach to medical workforce planning. Similar efforts will be applied in a timely fashion when appropriate in New Zealand, via Health Workforce New Zealand.

## Challenges

In the future, the key challenge for ANZCA (and other medical colleges), in trying to achieve high quality training as well as optimal workforce outcomes, is the complexity of the stakeholder relationships.

Health services and education providers need to respond symbiotically in a way that addresses community needs by co-ordinating workforce supply and demand. The wider health workforce environment is also influenced by global economic, policy and social trends, and advances in medical technologies and pharmaceuticals. Many of the variables are beyond ANZCA's scope of influence; however the College needs to be able to anticipate and respond to emerging trends.

Part of the relationship challenge for ANZCA is communicating its approach to its Fellows and trainees, assisting them to understand the complexities of the issues as well as the roles and responsibilities of the various stakeholders.

The work currently being undertaken by NMTAN and AHMAC will influence the future direction that ANZCA will take in tackling these issues.

Feedback and information is welcomed at [policy@anzca.edu.au](mailto:policy@anzca.edu.au).

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**John Biviano**, General Manager, Policy

## References:

1. The Joint Faculty of Intensive Care Medicine (JFICM) was formerly a faculty of ANZCA and the RACP. There is now a separate college, the College of Intensive Care Medicine of Australia and New Zealand (CICM).
2. Unaccredited registrar positions in Australian public hospitals: is it time for a rethink? Mitchell R, Milford WJ, Bonning M, Markwell A, Roberts-Thomson R. *Australian Health Review* 2013;37:409-11.

ANZCA has a long history of supporting ground-breaking research that has had a major impact on patients' lives. This is the second in a series of articles on some of the projects ANZCA has helped fund.

## Pain relief medication and breast milk – is it safe for babies?

In 2004, Professor Michael Paech and his team received an \$A37,128 ANZCA Project Grant to investigate tramadol and in 2007 a \$A45,549 grant to investigate parecoxib, two commonly used analgesics, and their breast milk transfer to nursing infants following caesarean birth. They found breast-feeding mothers could rest assured that there are many suitable pain relief options following a caesarean.

The transfer of drugs in breast milk is determined by many factors related to drug characteristics, feeding patterns and volumes, but important considerations are the extent of transfer in milk; the infant's age and exposure (oral bioavailability, maturity of metabolic pathways and duration of exposure); and the drug toxicity or likelihood of harm.

As anaesthetists, we are generally dealing with women facing short-term analgesic exposure during the earliest stages of breast milk production. The literature often contains little information (no data, animal data only, single-dose exposure in humans) because the pharmaceutical industry is not interested (and the product information unhelpful, more legal than medical advice) and studies of more than a few cases are difficult to conduct. ANZCA has a strong history of support for studies of drugs in human milk.

The pharmacokinetic parameters used are relative infant dose in breast milk (RID), that is estimated absolute infant dose (drug concentration in milk in  $\mu\text{g/L}$  x estimated volume of milk ingested in 24 hours in L/kg/day) divided by the

maternal dose in  $\mu\text{g/kg}$  and expressed as a percentage; and infant exposure (concentration in infant plasma as a percentage of that in maternal plasma). A relative infant dose of < 10 per cent of a drug that is largely free of serious side effects is arbitrarily considered acceptable.

Fortunately we have a number of analgesics that are considered unlikely to be of harm. Paracetamol has low transfer (RID 1.5 per cent); an excellent record (an absence of incident reports or cases of hepatotoxicity in breast-fed infants); and is endorsed by authorities such as the American Academy of Pediatrics and major texts (Briggs GG, Freeman RK, Yaffe SJ. *Drugs in Pregnancy and Lactation*. 7th ed. Philadelphia: Lippincott Williams and Wilkins, 2007). Most non-steroidal anti-inflammatory drugs (including single dose parecoxib and celecoxib) are considered acceptable, due to low transfer (RIDs 0.5-3 per cent) and good side effect profiles in infants (lack of incident reports). Similarly, short-term use of tramadol (RID 3 per cent and no apparent neurobehavioural changes in exposed infants) and local anaesthetic (highly protein bound, RID 0.5-1 per cent) is suitable.

The opioids are interesting, with some of low apparent risk, such as intravenous morphine (RID 9 per cent but poor oral bioavailability); intravenous fentanyl (low colostrum concentrations and low oral bioavailability) and epidural pethidine (RID 1-2 per cent, exposure 2 per cent). Oral oxycodone is a popular post-caesarean analgesic that may accumulate in ultra-rapid metabolisers and concentrates in milk, leading to possible infant exposure > 10 per cent. I personally limit dosing to 90 mg/day after caesarean on the basis that detectable plasma concentrations in infants are very uncommon after 72 hours of such exposure. Codeine has low

transfer but because of case reports of serious incidents in infants (especially of mothers and infants that are ultra-rapid or extensive metabolisers, converting codeine to higher concentrations of morphine) it is recommended that exposure is limited to two to three days. Despite some reports of infant toxicity, the benefits of continued maternal oral methadone maintenance (RID 2-3.5 per cent) are considered to outweigh the problems from withdrawal.

Analgesics to be avoided are intravenous pethidine, which accumulates rapidly in the infant with repeat exposure due to the long elimination half-lives of pethidine and norpethidine, resulting in poorer neurobehavioural scores after patient-controlled administration; and high-dose aspirin (RID 4-8 per cent but potential antiplatelet effects, metabolic acidosis and Reye's syndrome), although low-dose aspirin may be considered.

There is insufficient information about the gabapentinoids, although gabapentin (RID 2-3 per cent and exposure 3 per cent) has no reported effect. There are no human data for pregabalin and it is not known if the animal research showing impairment of synaptogenesis, as also occurs with several anaesthetic drugs, is clinically relevant.

Overall, we can reassure these lactating mothers that there are many suitable analgesic options to manage their postoperative pain – and that the College is supporting research to further increase our knowledge base.

**Professor Mike Paech, FANZCA**  
King Edward Memorial Hospital for Women, WA

Above from left: Professor Mike Paech, Dr Maartje Tulp (2013 Research Fellow), Dr Nolan McDonnell, Dr Roger Browning and Mrs Desiree Cavill (research midwife/nurse and trials coordinator).



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# ANZCA awards \$A1.2 million for research to improve patient care



The ANZCA Research Committee has awarded funding of \$A1,195,618 through the Anaesthesia and Pain Medicine Foundation for research projects in 2014. The funding supports one academic enhancement grant, 17 project grants, four continuing project grants; one simulation/education grant and the pilot grant scheme. These important research initiatives will be carried out in leading hospitals and universities in Australia, New Zealand and Hong Kong and will continue to advance and maintain a high international standing in safety and quality patient care in anaesthesia, intensive care, perioperative medicine and pain medicine.

## Research awards

The Faculty of Anaesthetists, Royal Australasian College of Surgeons established the Harry Daly Research Fellowship in 1981. The Harry Daly Research Award may be made in any of the categories of research awards made by the College provided the project is judged to be of sufficient merit. The award is made each year to the highest ranked grant assessed by the ANZCA research grant process.

The John Boyd Craig Research Award was established following generous donations from the late Dr John Boyd Craig to the Anaesthesia and Pain Medicine Foundation to support pain-related research by Fellows and particularly by Western Australians.

Mundipharma and Pfizer are major sponsors of the Anaesthesia and Pain Medicine Foundation. For each of these companies, an ANZCA Research Award was established to be awarded to top-ranked project grants. The Mundipharma ANZCA Research Award is awarded to an application related to any speciality and the Pfizer ANZCA Research Award is awarded to pain medicine. The following were awarded for 2014:

The **Harry Daly Research Award** was awarded to **Professor Matthew Chan** for his project “Epigenetic: regulation of chronic postsurgical pain with nitrous oxide”.

The **John Boyd Craig Research Award** was awarded to **Clinical Associate Professor Nolan McDonnell** for his project “A study of the transfer of gabapentin and pregabalin into breast milk”.

The **Mundipharma ANZCA Research Award** was awarded to **Associate Professor Alicia Dennis** for her project “Haemodynamics and myocardial tissue characteristics in women with preeclampsia”.

The **Pfizer ANZCA Research Award** was awarded to **Dr David Sturgess** for his project “Perioperative opioids and tumour growth and metastasis”.

## Academic Enhancement Grant

### Neurobiological, psychological and existential contributors to pain: an integrated approach.

Professor Philip Siddall, Greenwich Hospital, HammondCare and University of Sydney, NSW.

**\$A89,900**

### Assessing and treating pain: an integrated approach

Although persistent pain is highly prevalent and disabling, our ability to treat it effectively is limited with many people experiencing unrelieved chronic pain. One reason for this is that pain is multifactorial with a wide range of biological, psychological, spiritual and social contributors.

This Academic Enhancement Grant will support the development of the research program in the newly created Department of Pain Management at Greenwich Hospital. The broad aim of the departmental research program is to address different, but interrelated questions across a spectrum of biological, psychological and existential/spiritual issues.

Specific research projects that will be supported directly by this grant are: a) to investigate the biological and psychological contributors to irritable bowel syndrome, and b) to investigate the role of existential and spiritual factors in chronic pain.

It is widely recognised that in persistent pain states, pain is due to a complex interaction between various biological, psychological, spiritual and social factors. The contribution and relative mix of these factors is crucial in understanding a person's presentation and appropriate treatment. These projects will help to understand further the nature and relative contribution of central factors in the presentation of a poorly understood condition and the importance and relevance of spiritual and existential issues to people with chronic pain, an area which is underexplored in this context.

## Simulation/Education Grant

### The reliability of the mini-CEX and its impact on supervisors and trainees in the revised ANZCA training program.

Associate Professor Jennifer Weller, Dr Damian Castinelli, Dr Matthew Boyd University of Auckland, NZ.

**\$A35,136**

### How do workplace-based assessments affect trainee supervision and learning?

In 2013, ANZCA introduced compulsory workplace-based assessments for anaesthesia trainees. The assessment will be done by consultant anaesthetists who observe trainees managing actual cases in the workplace. Following the observation, both trainee and supervisor review the trainee's performance and together complete a scoring sheet, the "mini-CEX".

Evidence from our 2009 study found while the mini-CEX assessment improved the quality of supervision and feedback, there were concerns about assessor leniency and the poor reliability of the assessments. A follow-on study on volunteers in three large teaching hospitals, using a system where consultants based their scores on the amount of supervision the trainee needed with the case, showed much higher reliability, and ability to identify underperforming trainees.

In this study, the investigators will explore the reliability of the mini-CEX in anaesthesia training with this new scoring system, when used as a compulsory assessment on a large population of anaesthesia trainees and the effect of the mini-CEX on trainee learning and supervisory practices through the use of interviews and questionnaires.

It is crucial that the workplace-based assessment, now a compulsory component of the ANZCA training program, is reliable and valid, can identify struggling trainees to facilitate timely remediation, and has a positive effect on trainee supervision and learning.

## Project grants

### Nitrous oxide and pain.

Professor Matthew Chan, The Chinese University of Hong Kong, Prince of Wales Hospital, China.

**\$A60,000**

### Genetic mechanisms of nitrous oxide to prevent chronic pain after surgery

Chronic pain for months or years is a well-recognised complication after major surgery, but may also affect patients undergoing minor procedures such as hernia repair. It is estimated that 5-10 per cent of patients may be disabled by this problem after surgery.

This project aims to improve understandings of the role of nitrous oxide (N<sub>2</sub>O) in preventing chronic pain after surgery. It will test the hypothesis that N<sub>2</sub>O regulates downstream expression of pain-related genes, and prevents the development of chronic post-surgical pain.

The research team will investigate how N<sub>2</sub>O modifies the expression of genes and proteins that are important in chronic pain after surgery, without changing the underlying DNA sequence – a process known as epigenetics.

The investigators expect the findings will define the epigenetic mechanisms of N<sub>2</sub>O in producing preventive analgesia. The results will lead to further studies that address the biology of chronic postsurgical pain, help to identify potential drug targets, and motivate clinical studies of established and novel drug therapies.

In addition, the findings of this study will inform researchers about the potential biological mechanisms of chronic postsurgical pain. This could ultimately locate possible targets for developing future therapies to prevent and to treat chronic pain after surgery.

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# ANZCA awards \$A1.2 million for research to improve patient care (continued)

**To assess whether a preoperative 6MWT is predictive of quality of recovery at 30 days, and disability-free survival at 12 months, following elective major noncardiac surgery.**

Professor Paul Myles, Dr Mark Shulman, Ms Sophie Wallace, The Alfred, Vic, Associate Professor Duminda Wijeyesundara, St Michael's Hospital, Canada, Professor Brian Cuthbertson, Sunnybrook Hospital, Canada, Dr Rupert Pearse, Royal London Hospital, UK.

**\$A59,776**

**Using the six-minute walk test to predict quality of recovery and disability-free survival following major non-cardiac surgery**

Despite the advances in modern perioperative medicine, patients continue to experience complications, delayed recovery, long-term disability or death following anaesthesia and major surgery.

It remains a significant challenge to predict which patients are at risk of such outcomes after major surgery. Previous research has shown that poor cardiovascular fitness as measured by formal exercise testing is one indicator of risk, yet this evidence is inconclusive, and formal exercise testing is expensive and time consuming.

The six-minute walk test (6MWT) is a simple, non-invasive, inexpensive and easy-to-administer test. This project aims to assess whether cardiovascular fitness as measured by the 6MWT can predict the quality of recovery and the likelihood of developing long-term disability after major surgery.

Once validated as a predictor of patient outcome following major surgery, the 6MWT will be able to be used as a perioperative tool to stratify risk and guide surgical and perioperative medical treatment planning. In particular, the 6MWT may be used to determine the level of intensity of perioperative care required by the patient.

**Haemodynamics and myocardial tissue characteristics in women with preeclampsia.**

Associate Professor Alicia Dennis, The Royal Women's Hospital, Vic.

**\$A59,245**

**Heart function and structure in women with preeclampsia**

Preeclampsia is a life-threatening disease affecting 5 to 8 per cent of pregnant women. This project investigates the cardiovascular system in women with preeclampsia using transthoracic echocardiography (TTE), vascular ultrasound and cardiovascular magnetic resonance in order to increase understanding of the effects of this disease on the heart and blood vessels.

Recent work by the investigators has demonstrated that women with preeclampsia have increased cardiac output, increased inotropy and diastolic impairment and increased left ventricular (LV) mass. The novel finding of increased inotropy combined with an increase in cardiac output suggests that the hypertension in women with preeclampsia is partly due to an increase in cardiac output and that blood flow may be increased more generally in regional vascular beds. There are no studies investigating the component of myocardial tissue leading to the increased LV mass.

This project therefore aims to determine haemodynamics and regional blood flow in the cerebral, renal and uterine circulations using TTE and vascular ultrasound in women with preeclampsia, and to determine the myocardial tissue characteristics in women with preeclampsia antenatally using cardiovascular magnetic resonance.

It is hoped this research will lead to further exploration of the local vascular mechanisms and investigation of factors influencing tissue perfusion and organ damage in women with preeclampsia. It is also hoped this will contribute significantly to our understanding of the mechanisms of diastolic dysfunction in women with preeclampsia and lead to the consideration of alternative therapeutic agents to treat the disease in the acute phase.

**Osteoarthritis pain; mechanisms and mediators. The roles of NGF and IL-1.**

Professor Stephan Schug, Professor David Joyce, University of Western Australia, WA.

**\$A59,480**

**Mechanisms and mediators of osteoarthritis**

Osteoarthritis is the most common degenerative disease of the joints, affecting at least 50 per cent of people over 65 years of age. Even with current analgesics, the quality of life for the majority of patients with osteoarthritis is significantly impaired by severe, often intractable, pain.

Pain control drugs are often ineffective or have severe side-effects, so there is an overwhelming need for the development of better therapies for this condition.

Cytokines, such as Interleukin 1 (IL-1) and nerve growth factor (NGF) are thought to play a role in osteoarthritis pain, leading to clinical trials blocking these agents. Blockade of IL-1 has had mixed effectiveness, whilst blockade of NGF appears highly effective, but may lead to a more rapid progression of disease.

The aim of this study is to characterise the interplay between NGF and IL-1 in a mouse model of osteoarthritis as blockade of these two cytokines show the most promise for therapeutic development. The study will help to predict and understand side effects that may occur with these therapies and may also identify and develop more specific targets that have less potential side effects and offer effective pain relief.



**The impact of preoperative goal-focused transthoracic echocardiography on outcome after hip fracture surgery (ECHONOF).**

Dr David Canty, University of Melbourne, Professor John Faris, Sir Charles Gairdner Hospital, WA, Professor David Kilpatrick, University of Tasmania, Tas, Associate Professor Andrew Bucknill, The Royal Melbourne Hospital, Vic.

**\$A59,600**

**Does cardiac ultrasound improve patient recovery after hip fracture surgery?**

Surgery for fractured hip has one of the highest rates of postoperative death and disability of all surgery, with heart disease the most common, potentially avoidable cause. Recovery following surgery is often slow and places a large burden on the healthcare system.

Transthoracic echocardiography, a form of non-invasive cardiac ultrasound, increases the speed and accuracy of cardiac assessment leading to improved medical care, which may improve patient outcome. Recent preliminary research by the investigators has demonstrated a high degree of cardiac disease in hip fracture patients by the use of echocardiography, which led to important changes in patient care during and after surgery. There was also a major reduction in mortality 12 months after surgery compared to patients with very similar risk factors who did not receive preoperative echocardiography.

Based on these preliminary studies, the investigators will conduct a randomised, controlled, multi-centre study to determine whether routine preoperative echocardiography by the anaesthetist improves the quality of recovery in patients requiring hip fracture surgery. Pilot analysis of whether the intervention may reduce mortality, morbidity and healthcare costs at three months and 12 months will also be conducted.

**A study of the transfer of gabapentin and pregabalin into breast milk.**

Clinical Associate Professor Nolan McDonnell, King Edward Memorial Hospital for Women, Professor Michael Paech, Dr Sam Salman, University of Western Australia, WA.

**\$A45,401**

**Transfer of gabapentin and pregabalin into breast milk**

Gabapentin and pregabalin are commonly used in the management of both acute and chronic pain and offer a potentially useful analgesic adjunct to women in the post-partum period. However, data on the breast milk transfer of gabapentin is limited and there is currently a single report on one patient for pregabalin, which has led to the recommendation to avoid or limit their use in breast-feeding women.

The investigators will test the hypothesis that gabapentin and pregabalin are transferred into breast milk and that the infant dose received in breast milk from lactating women, who are administered a single dose of either agent, will be an acceptable percentage of the weight-adjusted maternal dose, and insufficient to cause concern about adverse effects in the neonate. Study results will contribute to the development of a novel local assay for drug measurement in biological fluids.

This study will provide information on the potential safety of these agents in breast feeding women and will assist with decision making in those working in the fields of anaesthesia and pain medicine.

**Identify the mechanisms within the body that are activated when pain is experienced.**

Professor Paul Myles, Dr Nicholas Christelis, The Alfred, Professor Nigel Bunnnett, Monash University, Vic.

**\$A56,626**

**Proteolytic mechanisms of chronic pain: research translation**

Chronic pain and disability are common after major surgery and many kinds of trauma, including burns and spinal injury.

Recently it has been recognised that tissue injury and inflammation may activate the nervous system in a way that eventually leads to heightened sensitivity to pain. There is enormous amplification of these processes, offering novel opportunities for preventive treatments and new drug discoveries.

This study will enrol patients with chronic pain states, such as major burns, road trauma and workplace injuries, heart and lung transplantation, and other types of major surgery.

By analysing tissues collected from these patients, the study will identify key mediators and mechanisms of chronic pain that may be targets for more effective and selective treatments.

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# ANZCA awards \$A1.2 million for research to improve patient care (continued)

## Validation of a behaviourally anchored rating scale to assess the use of the WHO surgical checklist: the WHO BARS study (Phase 2).

Professor Alan Merry, Associate Professor Jennifer Weller, Associate Professor Simon Mitchell, University of Auckland, NZ.

**\$A59,328**

## Checking the World Health Organization's checklist

Although modern anaesthesia and surgery are very safe, too many patients are still harmed by the very procedures intended to cure them. Interventions involving checklists, the promotion of teamwork, briefing and debriefing and education to promote changes in culture related to patient safety have been shown to improve the safety of surgery. The WHO Safe Surgery Checklist has been widely implemented internationally, but it is not known which of the above elements is critical to achieving its potential to save lives and reduce harm.

The investigators have developed a tool to evaluate the elements of implementing the checklist. The tool is a behaviourally anchored rating scale (BARS) that allows observers to assess the behaviours and performance of health professionals when using the checklist. However, instead of focusing on detail, the BARS assesses five behavioural domains identified as important for effective implementation of the checklist. These domains were identified by agreement of an international panel of experts who were involved in developing the checklist.

For the BARS to be effective as a research tool, it is important that it has been appropriately tested and shown to be an easy to use, reliable and valid measure. To investigate this, observers trained using videos of simulated cases will use the BARS in operating theatres to assess checklist procedures.

Once the BARS has been shown to be a valid measure that can be used practically and reliably in the clinical environment, it will be suitable for wide implementation to improve the use of the checklist in hospitals around the world, ensuring that the full potential of the checklist to reduce harm to patients and save lives is achieved.

## Perioperative opioids and tumour growth and metastasis.

Dr David Sturgess, Mater Adult Hospital, Mater Health Services, South Brisbane, Dr Marie-Odile Parat, Dr Peter Cabot, Professor Paul Shaw, School of Pharmacy, University of Queensland, Qld.

**\$A60,000**

## Can surgical pain relief influence cancer growth and spread?

Breast cancer is the most common cancer in women and second leading cause of cancer death. Treatment focuses upon definitive surgical removal of the primary tumour. However, there is growing interest in the possibility that effective analgesia, such as provided by local anaesthetic block or higher-dose opioids, can significantly reduce the risk of local or metastatic recurrence.

The investigators' preliminary *in vitro* and *in vivo* data indicate that morphine modulates the pro-invasive interplay between tumours and surrounding cells, resulting in altered extracellular matrix proteolytic profile of tumours. This study seeks to elucidate mechanisms by which perioperative analgesia may protect against tumour recurrence.

The investigators hypothesise that opioids in the perioperative period in cancer surgery patients regulate cancer cell invasiveness via opioid receptor mediated and opioid receptor independent mechanisms. The following specific aims will be used to test the hypothesis: quantification of potentially onco-active opioid metabolites *in vivo*; assessment of the effect of opioid administration on relevant cellular signalling *ex vivo* and determination of the effect of opioid administration in a functional bioassay.

This project may characterise a novel mechanism by which perioperative pain management reduces the risk of breast cancer recurrence and metastasis. This additional approach to cancer therapy might facilitate a change in the clinical practice that is safe, inexpensive, and easy to implement.

## Reduction of chronic post-surgical pain with ketamine – a pilot study.

Associate Professor Philip Peyton, Austin Health, Vic.

**\$A47,618**

## Preventing long-term pain after surgery

Major advances in the management of acute post-operative pain have been made over recent decades. In contrast, chronic post-surgical pain has, until recently, received little attention, which is concerning as increasing evidence shows chronic post-surgical pain is a major source of morbidity in the community.

Ketamine is a well known anaesthetic that acts on the N-methyl-D-aspartate (NMDA) receptor with powerful pain alleviating properties and which is commonly used to manage difficult to treat acute pain after surgery. However, there is little investigation for its potential effect on the development of chronic post-surgical pain.

A pilot study for a large multicentre double-blind randomised controlled trial will be conducted to investigate the effect of intravenous ketamine given prior to and for up to 24 hours following surgical incisions on the prevalence and severity of chronic post-surgical pain at six months postoperatively. The pilot will test the practicality of the protocol design, logistic estimates of research personnel and time, and the need for pharmacy involvement in the study drug preparation and blinding. The pilot will be conducted at three centres, which will provide the leadership base for the subsequent large multicentre outcome study.

If it is shown that ketamine is effective, it will have a major impact on the way anaesthesia is routinely managed and the burden of chronic pain in the community.

### Hyperbaric oxygen therapy in diabetic ulcers on the foot (HOTFUD).

Dr Susannah Sherlock, Dr Diane Smith, Ms Kerrie Coleman, Royal Brisbane and Women's Hospital, Qld.

**\$A20,000**

#### Hyperbaric oxygen therapy for foot ulcers in diabetes

The aim of this prospective, randomised, controlled trial is to determine if hyperbaric oxygen therapy can improve ulcer healing if used in conjunction with standard wound therapy. The investigators propose to conduct the trial in diabetic patients with chronic wounds resistant to conventional best wound care using adjunctive hyperbaric oxygen therapy.

The significance of this trial is that it addresses the lack of evidence for hyperbaric oxygen therapy in the treatment of diabetic foot ulcer in the long term. Diabetes and its consequences are a growing socioeconomic burden to society. This therapy offers the hope of a successful treatment strategy to aid earlier healing and reduce amputation rates.

### A life cycle assessment of morphine.

Dr Forbes McGain, Western Health, Professor David Story, University of Melbourne, Associate Professor Karen Hapgood, Monash University, Vic.

**\$A17,000**

#### The environmental effects of morphine

Life cycle assessment (LCA) is a scientific method that models the financial and environmental costs of a product over its whole life cycle. Few LCAs have been performed in medicine and most of these are of devices, not pharmaceuticals. In the setting of fiscal constraints and climate change, however, there is growing interest in the financial and environmental costs of healthcare among clinicians and governments. The carbon footprint of drug production alone contributes as much to healthcare carbon dioxide emissions as all of the direct energy consumption of all healthcare institutions combined.

Morphine is a common, well-known drug used world-wide for pain in a variety of settings and for this reason its production is likely to have significant environmental effects which will be of interest to doctors from multiple specialities, government bodies and pharmaceutical companies. The environmental costs of morphine production will be determined from opium poppy growing to manufacture of the base compound morphine sulphate, including energy, CO<sub>2</sub> equivalent emissions, water use, petrochemicals and other resources, production of carcinogens and pollution.

Knowledge of the environmental effects of morphine will be of interest to anaesthetists and other doctors. Incremental improvements in the efficiency of morphine production may stem from LCA research. Ultimately, the investigators envisage a series of life cycles of anaesthetic equipment, drugs and processes to develop a scientific foundation to a more sustainable anaesthetic practice.

### Development of the International Registry of Regional Anaesthesia (IRORA).

Dr Michael Barrington, St Vincent's Hospital, Vic.

**\$A59,112**

#### International Registry of Regional Anaesthesia

This study will further develop an existing project formerly known as the Australian and New Zealand Registry of Regional Anaesthesia (AURORA). This project is now known as the International Registry of Regional Anaesthesia (IRORA) and is being developed due to an increasing demand from hospitals in Australia and overseas to participate in quality-improvement projects.

The objective of IRORA is to monitor and report on the quality and safety of peripheral nerve blockade, a commonly performed regional anaesthesia procedure.

IRORA will allow departments and anaesthetic groups to document and benchmark their outcomes using an online data-entry interface. This is important for obtaining meaningful incidence data on infrequent events critical for informed consent and a true assessment of the safety and effectiveness of these techniques in current practice.

Within the IRORA project, collaborators will be able to generate their own reports, which will allow departments to compare their results with other groups. The registry also will have embedded tools used to assess trainee competency as they perform regional anaesthesia procedures, which is an important component of the new ANZCA curriculum. The upgrade of the registry will use new technology that will allow the project investigator to modify these assessment tools with no further information technology costs.

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# ANZCA awards \$A1.2 million for research to improve patient care (continued)

## Predictors of persistent postsurgical pain following total knee joint arthroplasty.

Dr Michal Kluger, North Shore Hospital, Auckland, NZ, Professor Peter McNair, Dr David Rice, Dr Gwyn Lewis, Health and Rehabilitation Research Institute, University of Auckland, NZ, Professor Andrew Somogyi, University of Adelaide, SA.

**\$A41,793**

## What are the factors that predict who will have ongoing pain six months after knee joint replacement surgery?

Knee joint replacement is a common surgery, often performed in people with chronic arthritis. While knee joint replacement is an effective procedure in most people, as many as one in three people have ongoing pain lasting months or years after the surgery.

The primary aim of this prospective, observational study is to identify preoperative, perioperative and early postoperative predictors of persistent postsurgical pain six months after total knee joint arthroplasty. Prior to, and immediately following surgery, measures will be taken of key clinical, psychological, neurophysiological and genetic factors that may influence the development of ongoing postsurgical pain. Knee replacement patients involved in this study will be followed up for six months to see how many still have pain at this time and which of the previously measured factors are significant and independent predictors of ongoing surgical pain.

Determining key factors that predict persistent postsurgical pain will assist in the identification of at-risk patients who may benefit from targeted preoperative interventions, alternative anaesthetic or surgical protocols or more aggressive, individualised postoperative pain management protocols.

## Does varying the chloride content of intravenous fluid alter the risk of acute kidney injury after cardiac surgery?

Dr David McIlroy, Associate Professor Silvana Marasco, The Alfred, Vic.

**\$A60,000**

## Does the composition of IV fluid alter the risk of kidney injury after cardiac surgery?

Acute kidney injury is one of the most frequent complications following cardiac surgery. With an estimated incidence around 25 per cent, acute kidney injury following cardiac surgery is a major problem, contributing to increased morbidity, mortality and healthcare costs. Intravenous fluid therapy is an essential component of perioperative management in all patients undergoing this surgery and yet there is a remarkable lack of evidence to guide selection of fluid composition.

The primary objective of this study therefore is to test whether a strategy to limit the perioperative chloride concentration of intravenous fluid therapy can reduce the occurrence of acute kidney injury after cardiac surgery. The choice of intravenous fluid for administration will be systemised for all patients undergoing cardiac surgery, using sequential variation in fluid type according to predetermined time-intervals over a two-year period. This will allow investigators to determine whether variations in chloride content of intravenous fluid administration can reduce kidney injury in patients undergoing cardiac surgery.

If this intervention is proven effective, it would represent a cheap and easily implemented strategy with the potential for enormous benefit to individual patients and the healthcare system.

## Do ARDS patients with different subtypes behave differently – A PHARLAP (permissive hypercapnia, alveolar recruitment and low airway pressure) sub study.

Dr Shay McGuinness, Auckland City Hospital, NZ, ANZICS Research Centre, Monash University, Vic, Dr Shailesh Bihari, Professor Andrew Bersten, Flinders Medical Centre, Adelaide, SA, Dr Carol Hodgson, Professor Alistair Nichol, The Alfred, Vic.

**\$A34,950**

## Do patients with lung injury have different responses to mechanical ventilation?

Acute respiratory distress syndrome (ARDS) is an inflammatory condition of the lungs that develops in many critically ill patients. ARDS is associated with high morbidity and mortality as it can lead to injury in other organs of the body.

Patients with ARDS are admitted to the intensive care unit and are connected to a ventilator to assist with their breathing. However, over the past few years various studies have compared different levels of breathing machine pressures in the management of patients with ARDS. Emerging data suggests that ARDS may have different subtypes of the disease which may respond differently with different levels of back pressure.

This study aims to explore the hypothesis that chest X-ray findings can be used clinically to identify which patients with ARDS will respond best to different ventilation strategies, in particular PEEP and alveolar recruitment manoeuvres. This can be readily done in parallel with the existing PHARLAP study and is a unique opportunity to study the effects of different back pressure on different subtypes of ARDS.

### Cultural influence of postoperative pain.

Dr Alex Konstantatos, The Alfred, Melbourne, Vic, Professor Matthew Chan, the Chinese University of Hong Kong, Prince of Wales Hospital, China.

**\$A52,079**

### Cultural influence of pain after surgery

The aim of this cohort study is to compare the pain perception and opioid consumption in Chinese patients living in two distinct cultures: Hong Kong, heavily westernised, and Hangzhou, which has remained a traditional Chinese society.

The investigators hypothesise that Chinese patients of similar race (biological features), but different ethnicity (differing sociocultural background) will have significantly different opioid requirements after major abdominal surgery, and that cultural differences within the same race, such as educational level, anxiety, beliefs and attitudes regarding postoperative analgesia, and pain threshold are more influential than biologic factors.

The investigators hope to prove that cultural/environmental factors related to ethnicity are significant enough to strongly influence opioid requirement through pain-related behaviours. With this knowledge, pain physicians will be in a position to modify elements of culture/environment as is possible to bring about better pain management.

## Grant review process

Thank you to all those listed below who reviewed a grant, and in some cases two, for your invaluable contribution to the grant process. The ANZCA Research Committee is extremely grateful for your assistance.

Each year ANZCA Research Committee members read the grants, select two to three reviewers for each grant on the basis of their expertise and relevance to the project, read the reviews, collate the information and act as overall spokesperson for each grant and make the final recommendations.

The grant review process is rigorous and transparent. Conflicts of interest are recorded and members of the committee are excluded from consideration of any grants for which they have a conflict. The presence of Dr Angela Watt, our community representative, adds an extra safeguard in this regard.

### Research Committee members are:

Professor Alan Merry, Chair; Associate Professor David Scott, Deputy Chair; Professor Matthew Chan; Dr Christopher Hayes; Professor Kate Leslie; Associate Professor Simon Mitchell; Professor Paul Myles; Professor Michael Paech; Professor Tony Quail; Professor Britta Regli-Von Ungern-Sternberg; Professor Stephan Schug; Associate Professor Tim Short; Professor Philip Siddall; Professor David Story; Professor Bala Venkatesh; Dr Angela Watt (community representative); Associate Professor Jennifer Weller; Dr Dan Wheeler.

### Grant reviewers for the 2014 grant round:

Dr Megan Allen; Dr David Andrews; Associate Professor Carolyn Arnold; Associate Professor Steve Bolsin; Associate Professor Robert Boots; Professor Thomas Bruessel; Professor Nigel Bunnett; Dr Mary Cardosa; Professor Matthew Chan; Professor Vincent Chan; Professor Milton Cohen; Clinical Professor Tomas Corcoran\*; Dr David Daly; Associate Professor Andrew Davidson; Dr David Elliott; Associate Professor Brendan Flanagan; Professor Tong Gan; Dr Neville Gibbs; Associate Professor Roger Goucke\*; Dr Genevieve Goulding; Dr Keith Greenland; Dr Richard Halliwell\*; Dr Christopher Hayes; Dr Elizabeth Hessian; Dr Malcolm Hogg\*; Dr Phillipa Hore; Dr Richard Horton; Dr CT Hung; Associate Professor Ross Kennedy; Associate Professor Peter Klineberg; Dr Alex Konstantatos\*; Dr Peter Kruger; Dr Geoff Long; Professor Guy Ludbrook\*; Dr Andrew MacCormick; Associate Professor Ross MacPherson; Professor Guy Maddern; Dr Peter McCall; Dr David McIlroy; Dr Christopher Mitchell; Professor Paul Myles; Dr Irene Ng; Clinical Associate Professor Michael O'Leary; Dr Ruari Orme; Associate Professor Philip Peyton; Dr Mark Reeves; Associate Professor Adrian Regli; Associate Professor Bernhard Riedel; Professor Paul Rolan; Professor Colin Royse; Dr Ian Seppelt; Associate Professor Tim Short; Dr Mark Shulman; Dr David Sidebotham; Associate Professor Brendan Silbert; Professor Jamie Sleight; Professor Maree Smith; Dr Natalie Smith; Professor Andrew Somogyi; Dr Christopher Vaughan; Dr Alain Vuylsteke; Dr Margaret Walker; Dr Tony Walton; Associate Professor Leonie Watterson; Dr William Weightman; Dr Owen Williamson.

\*Reviewed more than one grant

# Thank you to all foundation donors

The Anaesthesia and Pain Medicine Foundation would like to thank and pay a special tribute to its generous corporate and individual donors.

These supporters play an important role in helping to improve patient care and outcomes through research, education and the development of the science and practice of anaesthesia and pain medicine.

Research is a mission-critical commitment for the College and it contributes the largest proportion of the funds distributed in the research grant funding program. However, the quantum that comes from donors and sponsors is steadily increasing.

This additional funding means more research projects can be funded, providing greater opportunities for success and increasing the potential to deliver better outcomes to patients.

The foundation committee deeply appreciates the contributions made by donors, and understands donors almost always give on top of other financial commitments.

This provides greater impetus to the foundation's search for new donors to spread the net wider in our quest to significantly improve recovery prospects, especially for high-risk surgical patients and sufferers of persistent pain.

Next year these efforts will be redoubled. The new board of governors is compiling a list of prospective supporters in the philanthropic, corporate and public arenas. The new year will bring greater networking, and new influential members will join the board.

We are seeking new sponsorship funding and partnerships not only from the traditional healthcare sector, but also from parts of the corporate world with connections to health and wellbeing. Support is continually being sought among philanthropic trusts and foundations.

The foundation's 2014 communications will feature the stories behind research projects funded through the foundation. Each project involves a research team seeking to answer an important question; a team with an idea, a hypothesis and a vision of what might be possible in helping patients experience better recoveries.

These are exciting stories. We believe telling them to more people will increase the family of supporters and the resources available to save and improve lives, leveraging the wonderful support that you, our committed donors, already provide.

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**Robert Packer**

General Manager,  
Anaesthesia and Pain Medicine Foundation  
ANZCA

To donate, or for more information on supporting the foundation, please contact Robert Packer, General Manager, Anaesthesia and Pain Medicine Foundation on +61 3 8517 5306 or email [rpacker@anzca.edu.au](mailto:rpacker@anzca.edu.au).

# Busy year for trials group



2013 has been busy for the ANZCA Trials Group with two large, international, multicentre trials commencing and two nearing completion. We have also seen many Fellows and trainees involved in survey research facilitated by the trials group on behalf of ANZCA.

Four pilot grants have been awarded and a record number of attendees joined us in Palm Cove for the annual strategic research workshop. In addition, a significant number of investigators are applying to the trials group for endorsement of their projects, in accordance with the recently introduced endorsement guidelines.

We are especially thrilled to see many sites new to research becoming involved across Australia and New Zealand and we encourage anyone who is interested in finding out more about clinical research to contact the trials group.

## Multicentre trials

**Enigma II: Nitrous oxide anaesthesia and cardiac morbidity after major surgery – a randomised controlled trial** reached its recruitment target of 7107 patients in September. Fifty sites are involved in this study worldwide, to date the largest trial conducted to ascertain the benefits and risks of removing nitrous oxide from the gas mixture in anaesthesia. We are eagerly awaiting the results as they will have important implications for the clinical care of many millions of patients undergoing surgery every year.

**POISE 2 (Perioperative Ischemic Evaluation-2): A large, international, placebo-controlled, factorial trial to assess the impact of low-dose clonidine and low-dose acetyl-salicylic acid (ASA) in patients undergoing noncardiac surgery who are at risk of a perioperative cardiovascular event** reached its worldwide recruitment target of 10,000 patients around the first week of December this year, with 12 months of patient follow up due to finish next year. Sixteen sites in Australia and New Zealand have recruited over 500 patients, representing an impressive 5 per cent of all study participants. POISE 2 recruitment proved challenging as many surgeons have strong ideas about whether or not to withhold aspirin. Special mention goes to Dr Tom Painter and his research team at Royal Adelaide Hospital for recruiting 143 participants (at time of printing). Other sites to be commended include Dr Nico Terblanche and team at Royal Hobart Hospital (54 participants), Dr Cameron Osborne and team at

Geelong Hospital (51 participants) and Dr Julian Mahood, Frankston Hospital (43 participants). Thank you to all those who persevered and contributed to this important study. The first results are expected to be released at the American College of Cardiology annual meeting in Washington DC at the end of March. PJ Devereaux, the principal investigator, is one of the keynote speakers at the ASM in Singapore in May.

Nearly 2200 participants have been recruited into **ATACAS: Aspirin and tranexamic acid for coronary artery surgery – a randomised controlled trial** at 11 Australian and three international sites. ATACAS is due for completion in 2016.

Both the **BALANCED Anaesthesia Study: The influence of anaesthetic depth on patient outcome after major surgery – a randomised controlled trial** and the **RELIEF Trial: Restrictive versus liberal fluid therapy in major abdominal surgery** have recruited their first patients. Many sites are in the process of seeking ethics and governance approval.

## ANZCA ASM 2014 trials group activities

The ANZCA Trials Group will again host two sessions at the annual scientific meeting, as well as the annual lunchtime meeting for investigators and research co-ordinators on Tuesday May 6. PJ Devereaux and Professor Paul Myles will present results from POISE-2 and ENIGMA II respectively in our first session. The second session will focus on research around outcomes.



This year ANZCA Trials Group Co-ordinator Sofia Sidiropoulos conducted a successful workshop designed to assist investigators in navigating research ethics and governance. In Singapore, the trials group will conduct two workshops: one providing an update regarding the ever evolving world of ethics and governance and another entitled “Getting started in research” for those new to multicentre research and unsure of how to begin. Please look out for these sessions in the program as numbers are limited.

## Annual strategic research workshop

Palm Cove was busy this year with 81 delegates attending the ANZCA Trials Group Annual Strategic Research Workshop, an increase of 30 per cent from last year. Fifteen project updates and 13 new projects were presented. The delegates voted overwhelming for a return to Palm Cove for the 6th Annual Workshop. Registration details will be available in the new year.

## Pilot grants awarded

Congratulations to the four recipients of pilot grants in 2013. We wish them and their co-researchers well in their research and look forward to hearing reports regarding progress next year.

**The TALLIS Study: The tranexamic acid in lower limb arthroplasty study**  
Dr Thomas Painter (SA)

**Reduction of chronic post-surgical pain with ketamine – a pilot study**  
Associate Professor Philip Peyton (Vic)

**Association between maternal size and outcomes for caesarean section; a multicentre prospective observational study (The MUM SIZE Study)**

– a pilot study  
Professor David Story (Vic)

**Waist circumference as a predictor of major postoperative adverse outcomes following elective non-cardiac surgeries: A feasibility study**  
Dr Usha Gurnathan (Qld)

The pilot grant scheme policy was refined this year to allow for grants of up to \$A10,000 (rather than \$A5000) to be awarded. Applications for two-year grants also will be accepted. Set time points for submitting applications have been introduced to ensure a competitive and transparent review process.

## Projects endorsed

A number of investigators have applied for trials group endorsement of their multicentre outcomes research proposals. Three projects have been endorsed this year and further applications are under review. The purpose of trials group endorsement is to ensure a consistently high standard of study design, conduct, analysis and dissemination of results.

**Measurement of exercise tolerance for surgery (METS) study**

Dr Mark Shulman  
(Principal investigator – Australasia)

**NeuroVISION Study: Neurological impact of vascular events in noncardiac surgery patients cohort evaluation study**

Dr Doug Campbell  
(Principal investigator – Australasia)

**A perioperative model of care**  
Professor Guy Ludbrook

(Principal investigator)

**International Surgical Outcomes Study (ISOS)**

Dr Richard Halliwell  
(Principal investigator – Australia)

Dr Vanessa Beavis  
(Principal investigator – New Zealand)

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Anna Parker,  
ANZCA Trials Group Co-ordinator  
Tim Short,  
ANZCA Trials Group Chair

### Publications:

Chen Y, Liu X, Cheng CH, Gin T, Leslie K, Myles P, Chan MT. Leukocyte DNA damage and wound infection after nitrous oxide administration: A randomized controlled trial. *Anesthesiology* 2013; 118(6):1322-31.

Gin T, Chen Y, Liu X, Cheng C, Chan M. DNA damage and wound infection after use of nitrous oxide in anesthesia for major surgery, *European Journal of Anaesthesiology (EJA)*. 2013;30:144-144.

Leslie K, Myles P, Devereaux P, Forbes A, Rao-Melancini P, Williamson E, Xu S, Foex P, Pogue J, Arrieta M, Bryson G, Paul J, Paech M, Merchant R, Choi P, Badner N, Peyton P, J. Sear J, H. Yang H. Nitrous oxide and serious morbidity and mortality in the POISE Trial. *Anesth Analg* 2013 May;116(5):1034-40.

Leslie K, Myles P, Devereaux P, Williamson E, Rao-Melancini P, Forbes A, Xu S, Foex P, Pogue J, Arrieta M, Bryson G, Paul J, Paech M, Merchant R, Choi P, Badner N, Peyton P, J. Sear J, H. Yang H. Neuraxial blockade, death and serious cardiovascular morbidity in the POISE Trial. *Br J Anaesth* 2013, 111(3): 382-390.

Myles PS. Trial registration for anaesthesia studies. *Br J Anaesth* 2013; 110(1):2-3.

Myles PS. Stopping trials early. *Br J Anaesth* 2013; 111(2):133-135.

Opposite page from left: Professor Kate Leslie, Associate Professor Tim Short, Professor Alan Merry; Dr Stuart Walker, Dr Pal Sivalingam; Professor Guy Ludbrook, Dr Ed O’Loughlin, Associate Professor Tomas Corcoran.

This page from left: Dr Anja Beilharz, Ms Pauline Coutts, Professor Michael Paech; Dr David Elliot, Professor David Story; Dr Megan Allen, Dr Jonathan Hiller.



# Provisional fellowship training and the 2013 curriculum

Provisional fellowship training (PFT), as the final training stage in the ANZCA Training Program, is intended to enable trainees to transition from registrar to consultant anaesthetist.

By the end of this stage, trainees should be functioning at the same standard of professional and independent practice as consultant anaesthetists.

This stage of the program enables trainees a higher level of choice and responsibility over their own training than previous stages, in that it enables them to select and follow alternative career paths.

Trainees should use this period to either consolidate their clinical experience on a broad basis or to focus on one or more of the following paths; ANZCA Roles in Practice, clinical fundamental, specialised study units.

Trainees may choose a study plan that has been pre-approved by the College, or alternatively they may choose an individualised plan. Both options require approval from the Provisional Fellowship Training Sub-Committee prior to the commencement of PFT.

The Provisional Fellowship Program Sub-Committee is a newly formed sub-committee under the educational governance review whose purpose is to report to the Education, Training and Assessment Management Committee on the suitability of proposed provisional fellowship programs (either individual or preapproved) in accordance with regulation 37.

Processes are being developed to follow up on approved programs to determine if they are meeting the overall aim of transition to consultant practice.



Hospitals may apply to have PFT positions pre-approved by the Provisional Fellowship Training Sub-Committee. All forms relating to this process are available on the ANZCA website under Training/2013 training program/provisional fellowship training.

Participation in the ANZCA Continuing Professional Development (CPD) Program has been incorporated into provisional fellowship training, assisting trainees to move more seamlessly into consultant practice. The pro-rata CPD requirement is 60 CPD credits, with additional credits required for time spent in extended training. Trainees are encouraged to enrol in the CPD program as soon as they progress to PFT.

Provisional Fellows should be involved in the teaching and supervision of more junior trainees, where clinically appropriate, and for this purpose, all provisional fellowship trainees are given the role of workplace-based assessment assessors within the training portfolio system.

In contrast to other training periods, which conclude with a core unit review, provisional fellowship concludes with a provisional fellowship review, where the provisional fellowship supervisor or supervisor of training confirms that all training requirements have been met, as per the agreed prospective approval of their chosen training area.

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**Dr Patrick Farrell**, Chair, Provisional Fellowship Program Sub-Committee

# ANZCA Curriculum 2013 shapes up well on the international stage



In September and October, I was privileged to present “ANZCA Curriculum 2013” at two meetings in North America. This was a terrific opportunity to benchmark informally our new training program against international developments. I believe we can all feel proud of what we have done so far.

The International Conference on Residency Education in Calgary, Canada, provided a chance to hear about the CanMEDS 2015 project, which will revise the CanMEDS framework on which the ANZCA Roles in Practice are based. The Royal College of Physicians and Surgeons of Canada also has introduced a purely competency-based specialist training program in orthopaedics – that is with no minimum timeframe. This will be expanded to include anaesthesia training in 2015.

At the Society for Education (US), a satellite of the American Society of Anesthesiologists meeting in San Francisco, I was part of a panel that delivered presentations about anaesthesia training in Australia, New Zealand, Canada and the UK, to an audience primarily from the US.

In reflecting on anaesthesia training and broader developments in medical education, the new ANZCA curriculum measures up very well internationally. First, there are clearly defined outcomes at each training stage, from introductory through to provisional fellowship training. This brings an expectation that our trainees manage progressively more complex cases with increasingly distant supervision as they progress towards independent specialist practice. (This does not, of course, imply we stop learning at that point, or don't need to seek advice as specialists).

There was particular interest in how the College has anchored the workplace-based assessments (WBA) to supervision requirements, with a scale from the “trainee needs the assessor in the theatre suite” to the “trainee could manage this case independently and does not require direct supervision”. (See [www.anzca.edu.au/training/2013-training-program/assessment](http://www.anzca.edu.au/training/2013-training-program/assessment) for more information). This is more meaningful than “satisfactory/unsatisfactory”, leading to use of the whole range of the assessment scale, while encouraging feedback to trainees about what they must do to become more independent.

There also was interest in the use of the WBA champions model to roll out training across our geographically dispersed training sites; and in the new training portfolio system (TPS), especially the traffic-light system, which monitors progress against requirements. I was able to acknowledge the enthusiasm and work of many ANZCA Fellows, trainees and staff in getting the new curriculum up and running.

The College will continue monitoring developments internationally to ensure our curriculum remains contemporary in content as well as in its teaching and learning methods. Everyone involved should feel positive about the quality of the new ANZCA training program, and be reassured it is well regarded internationally. Well done to all who have contributed.

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**Dr Lindy Roberts,**  
ANZCA President

# Helping others “just part of the job”

“People helped me during my training so I feel it’s my duty to give back to other trainees; it is part of what our job as a doctor should be and it is just what I do.”

This is how the 2013 winner of the Ray Hader Award for Pastoral Care, Dr Catherine Purdy, explains her commitment to trainee welfare.

The Ray Hader Award is made to an ANZCA Fellow or trainee who has made a significant contribution to the welfare of one or more ANZCA trainees. This may have been directly, in the form of personal support and encouragement or indirectly, through educational support or other means. The award was established to promote a compassionate approach to the welfare of anaesthetists; to other colleagues, to patients and to the broader community.

Dr Purdy, of Auckland City Hospital, was selected by the ANZCA Council for this important award for her contribution to the welfare and well-being of ANZCA trainees.

As well as leading the work to establish a trainee welfare and mentoring scheme in New Zealand Dr Purdy, who will complete her ANZCA training within the next two months, has been assisting trainees for most of the last four years. Her own experience of cancer and the “excellent support” she received from Auckland City Hospital colleagues, she explains, highlighted to her just how important it was to have good support systems.

“I was too sick to work full-time but in between chemotherapy sessions I was bored and I had enough energy to help with Part One viva practice at Middlemore Hospital,” she explains.

Dr Purdy has now been in remission for three years and has continued to assist trainees with Part One, and now Part Two, viva practice – often in the evenings or weekends. She has also been a support person for trainees going through the trainees experiencing difficulty process (TDP).

Aware of the importance of confidential support, Dr Purdy researched and produced a pamphlet for new trainees that lists GPs who are comfortable with having doctors as patients and who can take new patients, as well as psychologist contact details so trainees have people to turn to. The pamphlet also reminds trainees of hospital benefits such as cheap gym membership, to encourage a good work/life balance. Auckland City Hospital has been distributing the pamphlet to new trainees and Middlemore Hospital is also soon to start using the resource.

“I got into ‘doctors needing to be patients’, and looking after ourselves, which we do very poorly,” she said.

Dr Purdy was a member of the NZ Trainee Committee (NZTC) in 2012 when she introduced the concept of establishing a trainee welfare system in New Zealand, similar to that in South Australia. ANZCA’s New Zealand National Committee endorsed that move and a working group was established to develop the idea. Dr Purdy was co-opted to remain on the NZTC and now continues leading that work and is also the New Zealand representative on the Executive Committee of the Welfare of Anaesthetists Special Interest Group.

At the ANZCA Annual Scientific Meeting in Melbourne this year, she presented a poster session on the results of a New Zealand survey into what support mechanisms already exist in hospitals for trainees.

Dr Purdy has undertaken all her anaesthesia training at Middlemore and Auckland City hospitals. In November she was completing a fellowship year at



Auckland and went on to eight weeks of training at Middlemore to complete her ANZCA training by the end of January 2014. She plans to then spend a further fellowship year at St Vincent’s Hospital in Melbourne, extending her interest in regional anaesthesia, before returning to a consultant position at Middlemore in 2015.

The award is named after Dr Ray Hader, a Victorian ANZCA trainee who died of an accidental drug overdose in 1998 after a long struggle with addiction. It was established in his memory by Dr Hader’s friend, Dr Brandon Carp.

The winner receives \$A2000 to be used for training or educational purposes and a certificate. Dr Purdy was presented with these in Melbourne on November 15 at the ANZCA President’s function.

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**Susan Ewart**  
Communications Manager, NZ  
ANZCA

# Successful candidates



## Primary examination September/November 2013

Ninety three candidates successfully completed the Primary Fellowship Examination at this presentation and are listed below:

### AUSTRALIA

#### New South Wales

Julian Baldwin  
Jason Charles Bendall  
Robyn Louise Billing  
Steven Ciwen Cai  
John-Paul Favero  
Jacqueline Mary McCallum  
Michael Galvin Mould  
James Robert Tester  
Linda Trang  
Sanjeev Vijayan

#### Queensland

Anthony James Baird  
Conor Dowdall  
Dilruk Lyndon Fernando  
Louis Frederick Guy  
Thusira Karunaratne  
Sarah Naomi Kilvert  
Alexander Kippin  
Andrew John Lonergan  
Jodie McCoy  
Nathan William McCubbery

Edward James Pilling  
Hanna Pyeon  
Hannah Victoria Reynolds  
Shaun James Roberts  
Shervin Hedayat Tosif

#### South Australia

Brigid Jane Sturgeon Brown  
Miad Habibi  
Christiaan Hattingh  
Greg John Houghton  
Cristianne Lorimer Read  
Mei Quinn Tan

#### Tasmania

Sarah Louise Madden  
Samuel James Walker

#### Victoria

Catherine Margaret Algie  
Babak Amin  
Kate Emma Barrett  
Erin Kate Bourke  
Elizabeth Anne Cawson  
Colleen Chew  
Christopher Raoul Clemens  
Michael Itiel Cukierman  
Robert William James  
Melissa Li-Ping Lim  
Fung Nien Lim  
Mark Simon Lycett  
Steven McGuigan  
Ilonka Meyer  
Christopher Jensen O'Loughlin  
Francis James Parker  
Christopher Neale Rees  
Gloria Jieyu Seah  
Hannah Shoemaker  
Lucinda Johnson Verco

Tzu-Yen Wang  
Robert Matthias Wengritzky  
Suran Wickramaarachchi  
Elliot Ariel Wollner  
Hamish Donald John Woonton

#### Western Australia

Andrew Peter Challen  
Yael Katinka Fiebelkorn  
Catherine Elizabeth Goddard  
Anna Karen Hayward  
Jennifer Margaret Howie  
Rebecca Anne Kelly  
Dennis William Millard

#### NEW ZEALAND

Damien Archbold  
Caroline Mary Ariaens  
Alexander James Bates  
Michael David Booth  
Oliver Francis Brett  
Owen Davies  
Carolyn Xiaoxia Deng  
Kaveh Djamali Dogaheh  
Morgan Cavalle Edwards  
Setareh Ghahreman  
Kathryn Margaret Goldstone  
Nicholas Patrick Hingley  
Brendan Paul Little  
Henry Cecil Milne  
Kate Alexandra Elizabeth Romeril  
Mitali Roy  
Claire Francis Smith  
Kelly Maree Tarrant

#### HONG KONG

Chan Chor San Alfred  
Chan Wai Kit Jacky  
Chun Man Wai  
Hung Ching Yue Janice  
Lam Chi Cheong  
Ng Siu Pan  
Ng Wai Tsan  
Wong Hang Pui

#### MAYLAISIA

Chong Howe Yee

#### SINGAPORE

Ju In Jason Chan

#### Merit certificates

Merit certificates were awarded to:

Catherine Elizabeth Goddard, WA  
Jennifer Margaret Howie, WA

# Successful candidates (continued)



## Final examination August/October 2013

One hundred and twenty-six candidates successfully completed the Final Fellowship Examination at this presentation and are listed below:

### AUSTRALIA

#### Australian Capital Territory

Adam Travor Eslick  
Candida Francesca Marane  
Nathan Mark Oates

#### New South Wales

Willian Breton Bestic  
Andrew John Chapman  
Antony Douglas Clyde  
Rahul Garg  
Kate Elizabeth Fitzsimons  
Matthew Liang Ho  
Jeff Jaeheon Kim  
Alexander Leslie Kroll  
Natalie Joanne Kruit  
Jennifer Lee  
Yin-Yin Leow  
Nicholas Peter Maytom  
Jacqueline Anne McPhee  
Callum Hsing Ming Moi  
Janice Hyeon-A Nam  
Xuan-Phuong Nguyen  
Benjamin John Piper  
Craig Alan Plambeck  
Chetan Reddy  
Akshat Sehgal  
Nanki Singh  
Catherine Eileen Traill  
Hawn Trinh  
Nicola Ellen Woollard  
Karen Wong

#### Northern Territory

Kirstie Juliana Morandell

#### Queensland

Catherine Ann Abi-Fares  
Ohnmar Kyawt Kyawt Aung  
Stuart Blain  
Joanna Burton  
Nicola Vincenzo Giorgio Cannizzaro  
John Paul Cotter  
Stephen Richard Daglish  
David Bruce Goldsmith  
Andrew James Jorgensen  
Peter Iu  
Heydon Kufakwame  
Daniele Lazzari  
Jonathan Hui-Hwong Lau  
Diwakara Krishnappa Madina  
Josephine Maria  
Stephen John Schreiber  
Kristopher Jon Skeggs  
Carradene Taylor  
Nigel Patrick Woodall

#### South Australia

Adam David Badenoch  
Ann-Maree Barnes  
Ravindra Vincent Cooray  
Nicole Robyn Dyson  
Irina Beatrice Hollington  
Stuart Anthony Keynes  
Jackson Tsai-Sheng Lee  
Swati Sethi  
Fiona Joan Taverner  
Claudia Elsie Tom  
Teoh Chee Yeow

#### Tasmania

David Robert Alcock  
Alan Choon Kiang Ch'ng  
Joel Michael Scott  
Michael Charles Lumsden-Steel

#### Victoria

David James Brewster  
Rachel Susan Chapman  
Damien Elsworth  
Darren John Lowen  
Vina Meliana  
Melinda Neroli Miles  
Jacquelyn Peta Nash  
Iraj Nikpey  
Michael Patrick Patterson  
Jade Radnor  
Zoe Wake

#### Western Australia

Paul Anthony Cosentino  
Scott Glen Douglas  
William Henry Fellingham  
Jan David Janmaat  
Mumtaz Anwar Khan  
Anthony John Klobas  
Heong-Chong Kwah  
Andrew Ross Beyer Lamb  
Kendrick Yeao Kwong Ling  
Rohan David Mahendran  
Jaya Raj s/o V.K. Manoharan  
Cameron Paul Prosser  
Paul Matthew Ricciardo

### NEW ZEALAND

Jalal Sadiq Alsaad  
Jennifer Margaret Best  
Thomas David Righton Burrows  
Richard Grant Cooper  
Yuan-Hsuan Chang  
Roana Donohue  
Julia Margaret Foley  
Kushlin Rachel Higgie  
Nicola Jane Hill  
Nicola Gail Hooper  
Thomas Alexander Knobloch  
Sathish Krishnan  
Brendon Neil Manikkam  
Loretta Clare Muller  
Titaina Danielle Palacz  
Anne Margaret Rainey

Shaun Michael Ryan  
John Paul Scarlett  
Clare Louise Smith  
Era Soukhin  
Michael Richard Guan Seng Tan  
Kathryn Jane Tietjens  
Ross Dominic Scott-Weekly  
Christopher Aaron Hau Gwun Wong

## HONG KONG

Pak-Wai Lau  
Steffie Pui Yew Lee  
Chan Albert Kam Ming  
Ying-Fung Shiu  
Fung-Ping Wong  
Man-Kin Wong  
Stanley Sau-Ching Wong

## MALAYSIA

Sukcharanjit Singh Chahil  
Fan Yin Kwok

## SINGAPORE

Stella Lin Ang  
Desmond Yu Mun Ho  
Ng Xiang Long Louis  
Priscilla Phoon  
Jerry Keng-Tiong Tan  
Ing Hua Tiong

## IMGS examination

Twelve candidates successfully completed the International Medical Graduate Specialist Exam at this presentation and are listed below:

### AUSTRALIA

#### Australian Capital Territory

Manasi Rai  
Ashwini Ashokrao Tambe

#### Northern Territory

Joseph Elengikal Domini

#### Queensland

Emad Makram Boules Atia  
Christopher John Brasher  
Jo-Anne Mileham  
Anna-Louis Reyneke  
Raman Deep Singh

#### South Australia

Bipphy Kath  
Arpudaswamy Kumar

#### Western Australia

Kahalawala Chandrasena

## NEW ZEALAND

Nitin Vishnu Gidgil

## Cecil Gray Prize

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 30 December 2013, be awarded to:

Matthew Liang Ho, NSW

## Merit certificates

Merit certificates were awarded to:

Andrew John Chapman, NSW

Rahul Garg, NSW

Cameron Paul Prosser, WA

Kathryn Jane Tietjens, NZ

# Surgery in the “beach chair” position

In August 2011 a 50-year-old former rugby player died as a result of a stroke, which occurred during arthroscopic shoulder surgery in the “beach chair” position. The NSW Deputy State Coroner found this was the result of cerebral hypoperfusion “caused by a failure to estimate and maintain an appropriate level of mean arterial pressure in the blood supply of the brain”.

In March 2013, prior to the NSW Coroner’s determination, a committee of surgeons and anaesthetists from Australia and New Zealand was set up by Mr Greg Hoy, the President of the Australian and New Zealand Shoulder and Elbow Society, to examine safety issues surrounding shoulder surgery in the beach chair position. Clinicians on this committee are highly experienced specialists with a particular interest in shoulder surgery and/or safety issues. Members with a range of views were deliberately invited.

Following extensive collaboration, and with the support of ANZCA, suggested guidelines for shoulder surgery in the beach chair position have been developed. This document was prepared by Hugh Pearce, Paul Soeding and Greg Hoy. Contributions were also received from Mark Hayman and Emma Halliday.

## Guidelines for shoulder surgery in the beach chair position

### Background

The beach chair position (BCP) is extensively used as a routine approach for shoulder surgery in Australia, New Zealand and around the world. Beach chair surgery requires appropriate surgical and anaesthetic management to ensure patient safety. Protection of cerebral perfusion is paramount.

### Surgical indications for BCP

Many surgeons consider BCP preferable as it confers certain advantages over the lateral decubitus position, namely:

- Improved access.
- Increased operative arm mobility and ease of examination under anaesthetic.
- Reduced bleeding as a result of improved venous drainage.
- Easier conversion from arthroscopic to open procedures.
- Avoidance of brachial plexus traction injury.

### Risk of cerebral injury with BCP

BCP is commonly associated with a fall in blood pressure, and therefore has a potential risk of cerebral hypoperfusion and cerebral injury. The catastrophic complication of global cerebral ischaemia is rare, and has been reported in the literature. This event is considered to occur as a result of significantly reduced cerebral blood flow during general anaesthesia. Normally when cardiac output and arterial blood pressure decrease, cerebral blood flow is autoregulated to maintain adequate flow. If arterial pressure falls below a certain level, this normal protective physiological mechanism is unable to compensate and prevent cerebral ischaemia.

### Hypotensive bradycardic events (HBE) under anaesthesia

HBE is an idiosyncratic event occurring with BCP characterised by a significant decrease in mean arterial pressure (MAP), pulse rate and cardiac output. These effects may be exaggerated in BCP.

This problem is well understood by the anaesthetic community and surgeons should also be aware of it when proposing to operate on patients in BCP. Surgeons and anaesthetists must be prepared to take the necessary steps to minimise the occurrence of HBEs and reduce any risk of cerebral hypoperfusion.

### Patient selection

It is important to identify patients preoperatively who may be susceptible to the risk of cerebral ischaemia during BCP. Co-morbidities that may increase the risk of cerebral hypoperfusion include:

- Diabetes and autonomic neuropathy.
- Cerebrovascular disease.
- Severe hypertension and generalised vascular disease.
- Cardiac disease.
- History of fainting.
- Febrile conditions.
- Patients considered to be at increased risk should be referred to a specialist physician or anaesthetist for preoperative assessment and work up, and the anaesthetist (if not already involved) should be forewarned.

- Surgeons must be aware that some patients may be clinically unsuitable for BCP by reason of an unacceptable risk to the cerebral circulation. In these cases the surgical approach may need to be reconsidered. A surgeon may have to reduce the angle of elevation of the table or alter their surgical approach with the patient in a supine or lateral decubitus position.

Only specialist anaesthetists who are aware of the potential complexities should provide anaesthesia for these cases.

### Operating table

The operating table used for BCP must be a properly designed device meeting current Australian and New Zealand standards. Specifically, it must be secure in the upright position and easily and rapidly laid flat. Positioning of the head and neck must be anatomical and without focal areas of pressure on parts of the neck to ensure normal vascular flow as well as the general avoidance of injury. The airway is positioned to maintain ventilation and the eyes must be protected.

### Aims of intraoperative management

A primary aim of anaesthetic management is to maintain MAP and to ensure adequate cerebral perfusion. This involves appropriate monitoring, vigilance and intervention when required. The potential adverse effect of BCP on the circulation may be limited by:

- Ensuring that the patient is properly hydrated within normal fasting guidelines.
- Intravenous fluid loading before induction.
- The use of compression stockings.
- Gradual elevation to BCP.
- Pretreatment with vasopressors.
- Choice of anaesthetic technique.
- Avoidance of hyperthermia.
- Avoidance of hypocapnia in ventilated patients.

### Monitoring

Full monitoring as per ANZCA guidelines is required. This includes arterial pressure monitoring, ECG, oxygen saturation [SpO<sub>2</sub>] and other airway gases when general anaesthesia is used.

## New version of National Inpatient Medication Chart

The Australian Commission on Safety and Quality in Health Care has released a new version of the National Inpatient Medication Chart (NIMC) in both paper and electronic formats. It aims to reduce medication errors through standardised prescribing, dispensing, administration and information presentation. Use of the chart is mandatory for hospitals verifying services for accreditation under the new National Safety and Quality Health Service Standards. The chart also incorporates a pre-printed venous thrombo-embolism section. The NIMC document is available from: [www.safetyandquality.gov.au/our-work/medication-safety/medication-chart/](http://www.safetyandquality.gov.au/our-work/medication-safety/medication-chart/)

## Recall of Tec 6 vaporisers

GE has issued a recall of Tec 6 and Tec 6 Plus Desflurane vaporisers manufactured between 2005 and 2012 due to potential degradation of the seal. The low-pressure leak test at 1 per cent may not detect the full range of leaks from the seal with the potential for a fresh gas leak to atmosphere and thus potentially reduced volume, oxygen and anaesthetic gas delivery to the circuit. GE says the low-pressure leak test should be performed with the dial turned to 12 per cent. Vaporisers that fail the test should be removed from use.

An updated list of safety alerts is distributed in the first week of each month in the "Quality and safety" section of the *ANZCA E-Newsletter*. They can also be found on the ANZCA website: [www.anzca.edu.au/fellows/quality-safety/safety-alerts](http://www.anzca.edu.au/fellows/quality-safety/safety-alerts)

Arterial pressure must be monitored frequently and accurately. Arterial pressure may be monitored either non-invasively (NIBP) or with intra-arterial pressure monitoring (IABP) as selected by the anaesthetist. NIBP is measured on the nonsurgical arm, not the leg. IABP has the advantage of being continuous and can provide a measure of arterial pressure at the level of the brain when the transducer is placed at the level of the tragus. When NIBP is used a correction for the height between arm and brain is required, since a difference of up to 15-20 mm Hg exists.

### Blood pressure measurement and management

During BCP surgery, clinicians should aim to keep MAP > 70mm Hg when using NIBP at the arm in healthy patients, and higher in those with hypertension or known cerebrovascular disease, at the discretion of the anaesthetist.

Similarly, deliberate BP reduction below normal levels to control bleeding (controlled hypotension) should be avoided. A blood pressure that is close to normal, for that particular patient, is recommended.

Blood pressure management includes:

- Ensuring an adequate MAP following anaesthetic induction and before BCP.
- Measurement of MAP immediately after BCP.
- Treating a fall in MAP of greater than 25 per cent from resting baseline or a MAP of less than 70mm Hg.
- Aggressive treatment of HBE using intravenous fluids, cardiac stimulants and vasopressors and if non-responsive to these measures, laying the patient supine. HBE lasting for three minutes or more may lead to permanent cerebral damage.

### Choice of anaesthetic technique

Early evidence suggests that anaesthetic technique can influence the frequency and severity of hypotensive events and the need for intervention. It may be inferred that by reducing the incidence of HBE patient safety is increased.

In higher risk patients it may be preferable to use a technique of intravenous sedation with interscalene regional anaesthesia and avoid the use of intermittent positive pressure ventilation (IPPV) with general anaesthesia. Regional anaesthesia with sedation is associated with a lower incidence of HBE compared

to general anaesthesia with IPPV. A possible mechanism is IPPV-induced interference with venous return and therefore cardiac output.

The role of neurological monitoring during BCP, including the use of transcranial Doppler or cerebral oximetry is emerging. These techniques require validation before recommendation as a standard of care can be made.

The authors are of the view that these minimum recommendations need to be adhered to in order to minimise the risk of the unlikely event of catastrophic global hypoxic cerebral damage.

**Dr Hugh Pearce, FANZCA**

**Dr Paul Soeding, FANZCA**

**Dr Greg Hoy, FRACS FRCSF FAOrthA FASMF**

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# webAIRS news

There are currently 61 sites registered with webAIRS and 1957 incidents have been reported as of September 2013. Data from these incidents has been used in a presentation entitled “Lessons from critical incident reporting in anaesthesia” at the Australian Society of Anaesthetists National Scientific Congress in Canberra in September and at the New Zealand Society of Anaesthetists Annual Scientific Meeting in Dunedin, November 2013.

## Mobile app

The Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) and the web-based Anaesthetic Incident Reporting System (webAIRS) have developed a mobile version of webAIRS. This is in the final stages of testing and should be released in early 2014. The original development and programming of the incident reporting page was performed by Dr Pieter Peach, the local webAIRS administrator at Cabrini Hospital, Malvern, Victoria. The web app was then further customised for the webAIRS website to include a mobile login and to save the data in the database.

A screenshot of the application is shown above. The mobile version will be able to be reached at [www.anztadc.net/mobile/mobile.aspx](http://www.anztadc.net/mobile/mobile.aspx) and a demo version can be viewed now at [www.anztadc.net/demo/mobile.aspx](http://www.anztadc.net/demo/mobile.aspx).

Recent updates to the ANZTADC website are:

- Registration links.
- Frequently asked questions.
- Morbidity and mortality reporting tool.

## Recent alerts

- Multiple patients have noted an unusual taste in their mouth following the use of BD PosiFlush prefilled saline syringes. Patients describe a foreign, plastic/vinyl taste shortly after flushing. Reports exist in literature<sup>1</sup> but there appears to be no evidence that there is any clinical significance. However it may be worth warning conscious patients prior to administration and also observe for other untoward effects.
- A report was received of a confirmed anaphylaxis to Patent Blue Dye V in a patient undergoing a mastectomy with sentinel node biopsy. The immunologist suggested that if required, methylene blue could be used in the future as there is no cross reactivity.
- GE Healthcare B20, B30 and B40 patient monitors have been found to have a potential problem with the ECG filter setting. If the monitor starts with impedance respiration set in the “ON” position, instead of the user selected filter, an additional 0.5 Hz high pass filter is automatically used. The additional 0.5 Hz high pass filter causes changes to the ECG waveform morphology and incorrect display of ST values. The ST-elevation measurement can be underestimated in this situation and treatment of the patient can be delayed. Please note that there is no issue when the monitor starts with impedance respiration set in the “OFF” position. GE Healthcare is providing users with the former work around instructions to follow until a software correction is available. A “Recall” software update is expected in the future. There is a company response on the Therapeutic Goods Administration (TGA) website<sup>2</sup>.



**webAIRS**  
Anaesthetic Incident  
Reporting System  
from ANZTADC

webAIRS plans to release more de-identified alerts in future articles. Thank you to the reporters for these interesting alerts. webAIRS will be grateful for more unusual reports to be entered into the incident reporting system and to be flagged as alerts. Reports can be submitted either via webAIRS (preferred method), or directly by email to [ANZTADC@anzca.edu.au](mailto:ANZTADC@anzca.edu.au) if not registered with webAIRS.

**Adjunct Professor Martin Culwick,**  
FANZCA, Medical Director, ANZTADC

Email: [mculwick@bigpond.net.au](mailto:mculwick@bigpond.net.au)

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To register visit [www.anztadc.net](http://www.anztadc.net) and click the registration link on the top right hand side.

Demo at [www.anztadc.net/demo](http://www.anztadc.net/demo)

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# Greening your gases



Anaesthesia and the environment can make happy bedfellows without affecting safety.

The World Health Organization's website carries a quote attributed to leading medical journal *The Lancet* from 2009: climate change, it says, was "the biggest global health threat of the 21st century".

Although it remains a polarising and controversial topic, concern at the phenomenon of climate change – a phenomenon the vast majority of the world's scientists do not dispute – has risen dramatically, even since 2009.

There is some dark irony, then, around the argument that the healthcare industry itself contributes significantly to those emissions and waste creation considered to have harmful environmental effects that will in turn pose a threat to human health.

Dr Forbes McGain, left, is a specialist anaesthetist and intensivist at Western Health in Melbourne and a leading proponent of "greening" the healthcare industry, in particular, operating theatre practices.

"Operating suites are a significant contributor to hospital environmental resource consumption and waste production, generating a great deal of hospital waste," Dr McGain says.

Anaesthetists, he argues, are a constant presence in operating theatres and are especially well placed to improve the environmental effects of their workplaces.

It is estimated 20 per cent of all hospital waste comes from operating theatres and about 75 per cent of material such as operating theatre packs could be recycled.

An operating suite audit at one Melbourne hospital found anaesthetic waste was 25 per cent of total operating suite waste and 60 per cent of general anaesthetic waste was potentially recyclable.

"There is a growing interest in encouraging anaesthetists to consider their current and future practices and instigate changes in their own workplaces so we can move towards environmentally sustainable health care," Dr McGain says.


There is another pressing imperative for greening anaesthesia, Dr McGain argues, and that is the overall financial benefits for the health system.

"It will save money in the longer term," he says.

## Tips for the green anaesthetist:

- **Reduce:** Minimise nitrous oxide use; use low flow anaesthesia.
- **Re-use:** Consider the financial and environmental benefits of re-usable versus disposable equipment.
- **Recycle:** Contact local waste recycling firms about recycling options.
- **Rethink:** Use oral medication rather than intravenous forms if appropriate; encourage the purchasing of more sustainable products.
- **Research:** Encourage life-cycle analysis and costing products in the operating suite; investigate where decreases in energy and water consumption can occur.
- **Advocate:** Become an active member of your operating suite's equipment purchasing committee – advocate for sustainable products.

Source: Australasian Anaesthesia, 2009 – Dr Forbes McGain, Dr Eugenie Kayak, Professor David Story.



“Anything sustainable saves you money – sustainability and cost-saving are two notions that marry well although it certainly needs initial capital investment.”

Dr McGain, who is completing a PhD in hospital sustainability, says eco-friendly practices are often overlooked in hospitals.

“Unless you have a boss who is in [supporting eco-friendly practices] no one is in.”

Dr McGain recently received an award for his efforts at reducing waste and a local newspaper article reported in September:

“[Dr McGain] realised early in his medical career that the health and wellbeing of people is impacted by the health of the environment and that sustainable approaches need to be part of the ethic of healthcare provision.

“In conjunction with the industry, government and academic partners he has developed world-first sustainability initiatives which are now being implemented throughout Australia,” the article states.

This includes the first medical PVC recycling program that recycles waste from hospitals in Victoria, NSW and

Tasmania, as well as his ongoing work on a sustainability program at Western Health.

Part of the recognition Dr McGain receives has been attributed to the work he has achieved at Western Health in Melbourne’s west, where he chairs the sustainability committee he established in 2007.

With this initiative 340 tonnes of waste every year – 27 per cent of all Western Health waste – is now diverted from landfill and there has been a 10 per cent reduction in water consumption.

Improvements can be made to reducing waste and energy by taking a savvy approach to design and engineering, he says.

“Having an intensive care unit that faces west – which happens – gets very hot in summer, which means constant use of air conditioning.

“Design informs sustainability.”

The debate between single-use theatre drug trays, which are the norm, and the notion of reusable ones, is a significant case in point, Dr McGain argues.

There is a chasm, he believes, between the notion of sterility and the reality of it.

“Drug trays – all anaesthetists use them. Life-cycle studies have shown the environmental benefits of recycling and not disposing.

“It is possible without any compromise of patient safety.”

While many hospital staff recycle happily at home the behaviour doesn’t always translate to the workplace. Dr McGain refers to “cognitive dissonance”.

“There can be a “moral offset” mindset – doctors think because they do good that negates the need for environmental sustainability in their work.

“I recycle at home but not at work, that is someone else’s responsibility.”

The greatest motivating factor for the introduction of sustainable hospital practices, he says, is leadership.

“You need a committee, some leadership support and you also need an agitator – someone like me – in each hospital for change. We can do a lot better.”

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**Ebru Yaman**  
ANZCA Media Manager

# Dean's message



The collegiate nature of our fellowship was evident at the recent, very successful spring scientific meeting of the Faculty held in Byron Bay. Congratulations and thanks go to Dr Michael Vagg, Dr Susan Evans and Dr Angela Chia, who put together an interesting and engaging program. The Byron at Byron resort proved a warm and hospitable venue for the event.

The program was consistent with the theme of the Global Year Against Visceral Pain. The title of the meeting, "Internal pain is not eternal pain", and themes including abdominal pain, pelvic pain, adolescent pain and associations with sexual trauma and abuse, were very well received.

The meeting attracted valuable media coverage, which remains so important for keeping the issue of chronic pain management on the agenda in public and government debate.

The social aspects of the meeting were again a significant highlight and ensured the continued tradition of the spring meeting being a special, intimate and fun meeting providing an exceptional opportunity to enjoy the company of our colleagues.

This year the guest dinner speaker was Jim Hearn, researcher, writer and chef, and reformed illicit drug user. He has written five original feature-length screenplays and worked on film scripts including *Chopper* and an adaption of Andrew McGahan's

novel *Last Drinks*. Jim is completing a PhD in the Transforming Cultures Research Centre at the University of Technology, Sydney, and he is a recent winner of the Griffith Review novella prize. He has received high praise for his first novel, *High Season: A memoir of heroin and hospitality*. This novel was the catalyst for inviting Jim to address us in Byron Bay.

In his studies, Jim deals with his own experience and explores the themes of hospitality, addiction and transgression. Jim's address was captivating and gave rare insights into a perspective of drug addiction, prescription opioid misuse and the social pressures and consequences relevant to these issues. Jim spoke of the "absence of pain" as the motivation of many drug users rather than the pursuit of pleasure or euphoria. He described a pain that is vague and indefinable, except by the pleasure and peace achieved by its absence. By drug use whichever way it is available. It is rare for us to have the opportunity for such raw and honest insights from this perspective. I want to acknowledge and thank Jim Hearn for his generous and memorable contribution to this year's spring meeting.

From the many poignant messages in Jim's writings and his address, I have repeated below a quote from his recent novella, *River Street*, which I think is relevant to the desperation experienced by some of our patients:

*"I wonder why I feel the need to make things so hard. It's not enough for me to go to work and earn an honest dollar. I use smack and run a rabbit, push everything to its limits."*

*"Transgression is all about limits. By surviving the extremes of hospitality, and what transgression means, I seek a path to approval."*

*Jim Hearn, River Street. 2013*

As 2013 draws to a close, the Faculty is a year older and continues to grow in strength. The Faculty now has 358 Fellows, 89 trainees and 29 training hospitals across Australia, New Zealand, Hong Kong and Singapore. The ambitious but arduous task of redesigning the Faculty training curriculum continues at a rapid pace and when it is introduced late in 2014, it will both define and secure the quality of our training scheme and hence our fellowship.

I would like to take the opportunity to thank our general manager, Helen Morris, and the staff of the Faculty for their unwavering support and dedication throughout a very busy year. Thank you also to the chief executive officer, president and council of ANZCA and all our own Fellows, who continue to contribute so much. I wish you all a happy and safe Christmas and look forward with energy and optimism to the 2014 new year.

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**Associate Professor Brendan Moore**  
Dean, Faculty of Pain Medicine

## Admission to fellowship of the Faculty of Pain Medicine

By examination:

**Angela Chia**

**Karin Jones**

**David Kibblewhite**

**Palanisamy Vijayanand**

We are pleased to report that this takes the total number of Fellows admitted to 358.

## FPM Undergraduate Prize in Pain Medicine

As part of the Faculty of Pain Medicine's strategic plan to increase education and training in pain medicine, the Faculty offered an undergraduate medical student prize in medical schools across Australia and New Zealand.

All medical schools were offered an opportunity to apply for the award with a prize of \$A500 and a certificate awarded to the best undergraduate student in pain medicine in the last two years of undergraduate training.

The recipients of the 2013 FPM Undergraduate Prize in Pain Medicine include Mr Oscar Horky from the Graduate School of Medicine, University of Wollongong and Ms Catriona Downie from the Undergraduate Medicine (Bachelor of Medicine – Joint Medical Program), The University of Newcastle, and Ms Katherine Stead from the Bachelor of Medicine/Bachelor of Surgery, The University of Notre Dame.



## Faculty of Pain Medicine examination 2013

The 2013 Faculty of Pain Medicine clinical examination was held on November 23-24 at the Geelong Hospital, Victoria. The written examination was held on November 8. Twenty-seven of the 33 candidates were successful.

The significant contributions of retiring examiners Dr Penny Briscoe, Associate Professor Ray Garrick, Dr David Gronow and Dr Frank New were acknowledged.

Clockwise from top left: Court of examiners; Retiring examiners Dr Frank New, Dr David Gronow, Dr Penny Briscoe and Associate Professor Ray Garrick with the Chair of Examinations, Dr Newman Harris; Successful candidates.



# News (continued)

## Faculty of Pain Medicine Spring Meeting

The Faculty of Pain Medicine Spring Meeting “Internal pain is not eternal pain” was held from October 25-27 at the Byron at Byron Resort, NSW. The meeting was very successful with more than 120 delegates registered and strong healthcare industry support. The meeting featured many local speakers, presenting on a range of topics exploring some of the most challenging pain-related diagnoses, including chronic pelvic pain, functional abdominal pain and chronic pancreatic pain.

The meeting also attracted significant media attention. Dr Mark Hutchinson gave a well-received presentation on recent research that highlighted women are more likely to suffer from chronic pain than men. His research also revealed the female experience of pain was more severe than the male experience. This research, he explained, has implications for pain treatments and that there was scope to tailor medications specifically to men and to women. This story was picked up by multiple research outlets and Dr Hutchinson gave radio and print interviews.

Dr Meredith Craigie gave a presentation on adolescent pain and how it can be a sign of severe psychological distress. This was picked up by many print and online outlets, as well as radio. The spring meeting reached a combined cumulative audience of more than 550,000 according to ANZCA media monitoring.

This page from top: Opening session of the 2013 Faculty of Pain Medicine Spring Meeting; Welcome cocktail reception in the healthcare industry area; FPM Dean Associate Professor Brendan Moore with Dr Mark Hutchinson; ANZCA President Dr Lindy Roberts at the meeting.

Opposite page: FPM Dean Associate Professor Brendan Moore with dinner speaker Jim Hearn.





## Pain, pleasure, and drugs

This is an abridged version of an after dinner talk I gave at the recent ANZCA conference in Byron Bay in October 2013. In the transcript of my talk, I discuss pain, pleasure, and drugs from the point of view of being a self-injecting drug user. Many years have passed since I used heroin and other drugs, but nonetheless, I have written extensively about those experiences in my book *High Season: a memoir of heroin and hospitality* (2012), as well

as in my novella *River Street* (2012). I wrote both books while studying for a PhD at the University of Technology, Sydney, and it was a great pleasure for me to discuss my research at the recent ANZCA conference.

*The pain that drives the junkie is often very difficult to define, describe, and diagnose. Like homelessness often has multiple causes, so to does addiction to illicit or prescription drugs. In that way, addiction is not only about the pleasure affects of drugs, even if the junkie is obsessed with those pleasures and cannot point with any certainty to what is causing him or her pain. What the junkie knows for sure, is that the pleasure of using drugs beats the vague, obscure pains that previously constituted what being normal meant. As such, even if junkies are not aware of it, what normal means is often painful.*

*The pain that many addicts feel, the pain that drives them to so easily to fall in love with the pleasure effects of drugs, are difficult to be objective about. There is often a history of complex psychological, sexual, emotional, and transgressive pains that lack a clear logic or definitive diagnosis. What my research has led to an understanding about is that acts of transgression concern discordant power relations between individual subjects. Transgression often infers a loss of*

*innocence in how transgression enacts taboos. In that way, researching how transgression spirals throughout lived experience can lead researchers to not only better understand what transgression means, but also to self-reflexive understandings about how power has played out between individual subjects.*

*Well before most people are able to critically analyse their lived experience of addiction though, what an addict has to come to terms with is that the pleasure affects of their drug of choice bring about so many difficult and complex pains of their own making, that their favoured drug is no longer worth the effort. This is the point where the tragedy of addiction often becomes a comedy whereby a hopeless junkie spends a lot of time looking for something that no longer exists. Such an ending of the pleasure affects of drugs is perhaps the only thing that might pave the way for a person to want spend time gaining greater insights into their subjectivity.*

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**Jim Hearn**, Author  
FPM Spring Meeting dinner speaker

# Faculty celebrates its early years

A letter set in motion a course of events leading to a pain medicine qualification and the birth of ANZCA's Faculty of Pain Medicine.

Healthcare professionals and scientists interested in pain usually join the International Association for the Study of Pain (IASP) or its local chapters.

This account of the “pre-teen” history of the Faculty of Pain Medicine, ANZCA links with the IASP through a May 18, 1988 letter from Professor Michael Cousins, then Chair of the Department of Anaesthesia and Intensive Care, Flinders Medical School, South Australia, and also IASP president, addressed to Professor Barry Baker, the Dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons (RACS).

In this letter, Professor Cousins highlighted recent IASP taskforce publications, especially the “core curriculum for health professionals working in the field of pain”, which described “...appropriate beginnings for Faculty of Anaesthetists to consider the scope of education”. In his opinion “the Faculty cannot afford not to address... knowledge, examinable material...and possibly guidelines”.

Professor Baker copied this letter to Dr Mack Holmes, the Chair of the Faculty's Education Committee. Both these gentlemen then resided in Dunedin, New Zealand. Serendipitously this early core curriculum became a cornerstone for the yet-to-emerge FPM study guide more than a decade later. The reader should note the two different faculties described here.

In May 1990, the dean invited the chair of the South Australian Regional Committee, Dr A.J. Crowhurst, to draw on local expertise and draft an “acute post-operative pain relief” document for anaesthetists, with urgency. Ironic that this request was recursive and digressed from the intention of Professor Cousins' earlier letter, which had advocated much wider pain education than just for acute post-operative pain, including management of cancer pain in which anaesthetists played leading roles.

On July 20, 1990, Professor Cousins wrote to Dr Peter Livingstone (the last Dean of the Faculty of Anaesthetists before ANZCA emerged) restating

his original proposal but adding “a more difficult question for longer term consideration by the Board is the potential for development of an additional qualification in ‘pain management’...I make no judgment or recommendation at this stage on the latter”. Another decade passed before this recommendation for training and a qualification eventuated.

Instead, a three-page document on acute postoperative pain emerged from the Education Committee in March 1991, a Joint Faculty of Anaesthetists and RACS statement. The significance of the joint effort will become clearer later.

A working party of Professor Barry Baker and Professor John Gibbs, both in New Zealand, presented a proposal to the Faculty in June 1991 for a multidisciplinary post-fellowship diploma in pain management, describing it as urgent. This proposal noted “if we do not make a move, someone else will”. Faculty Board minutes of September 1991 show a resolution to this effect was passed, but also recommended wider consultation. Mr RL Atkinson, a neurosurgeon and RACS representative on the Faculty Board, strongly supported this cross-specialty collaboration for pain management. By virtue of alphabetical order he received diploma number one for fellowship of the Faculty of Pain Medicine, was its second dean and served the maximum allowable 12-year term on the FPM Board.



**Figure 1:** Professors AB Baker and JM Gibbs as a working party tasked in March 1991 to present a position paper on “diploma in pain management” to Education Committee (Anaesthesia) of Faculty of Anaesthetists, RACS (Chair: Dr CMcK Holmes). Note the NZ domicile of all three. Their report in June 1991 noted the new Objectives of Training of an Anaesthetist included a separate section covering acute, non-cancer and cancer pain, but that a qualification was “urgent”.

**Table 1:** Joint Advisory Committee on Pain Medicine (JACPM 1995-98) reported to ANZCA Council.

Professor John M Gibbs (Chair)	FANZCA
Dr Graham I Rice	FRANZCP
Dr Terry F Little	FANZCA
Professor J E (Ben) Marosszeky	FAFRM, RACP
Professor R Leigh Atkinson	FRACS
Dr Richard Chye	FACHPM, RACP
Dr C Roger Goucke	FANZCA
Dr David Jones	FANZCA

The next seven years saw ANZCA emerge, and the establishment by ANZCA Council of the Pain Management Working Party (1992-94) chaired by Professor Gibbs. Later this widened to include other disciplines as the Joint Advisory Committee on Pain Medicine (JACPM 1995-98, table 1). This body set standards for training units<sup>7</sup>, accredited centres for training, and devised assessment processes for a Certificate in Pain Management. Still there was no *registerable* qualification in pain medicine.

On March 12, 1998, leader representatives of specialist medical colleges – ANZCA, the Royal Australasian College of Physicians, the Royal Australasian College of Surgeons, the Royal Australian and New Zealand College of Psychiatrists and the Australasian Faculty of Rehabilitation Medicine (Royal Australasian College of Physicians) – met at the ANZCA headquarters. At this meeting, chaired by Professor Cousins, agreement was reached that cross-specialty collaboration was the best way forward for training and examination in pain medicine. Note here the shift in language from “pain management” to “pain medicine”.



This agreement was presented to the June 1998 ANZCA Council meeting, which took what was to be a giant leap for it by approving the formation of a new Faculty of Pain Medicine which would have its own qualification. Professor Cousins was tasked by Council to form an interim board to execute the intent of that decision. Induction of foundation Fellows followed soon after, with a plan made for the first examination to be held in November 1999. The Faculty was a world-first as a *multi-collegiate* pain medicine training and standard setting body.

In October 1998, ANZCA Council approved the Faculty regulations, appointed six of its Fellows with substantial experience in pain management (table 2) onto the initial board, with the others to be nominated by their respective Colleges, and Professor John Gibbs as the ANZCA Council representative. From then on, the Faculty of Pain Medicine became a permanent item on ANZCA Council agenda.

The inaugural teleconference of Faculty Board was held on November 23, 1998 and was followed by a meeting of this initial board on February 4, 1999, operating under an ANZCA Council transition regulation which named its 10 appointees as the foundation Fellows of the Faculty. This coincided with the IASP celebrating its 25th anniversary.

On April 8, 1999 as initial censor I received the first application to undergo Faculty training (Dr Eric Parisod of Geneva, at Royal North Shore Hospital in Sydney). A qualification in pain medicine was now possible, although there was still a distance to go until recognition of pain medicine as a separate vocational specialty came to pass. Its curriculum was based on the results of the IASP task force document referred to in the opening paragraph<sup>1</sup>.

Another early task of the interim board was to assess applications for additional foundation Fellows, using ANZCA Council approved and advertised criteria. There were 101 applicants from multiple specialties, of whom 47 met the criteria and were approved.

The first examination process was finalised and the inaugural panel of examiners appointed by September 1999. Further applicants for election to fellowship were considered, followed by election among all Fellows of the inaugural board in February 2000, supported by Ms Margaret Benjamin as its initial executive officer. All five “parent” colleges were represented on this board which took office in May 2000 and elected Professor Michael Cousins as the first Faculty dean.

(continued next page)

**Table 3:** The Inaugural Panel of Examiners appointed by FPM Board September 30, 1999, as they appear in the minutes.

David Jones, NZ	FANZCA
Penny Briscoe, SA,	FANZCA
Richard Chye, NSW,	FRACP
Milton Cohen, NSW	FRACP
John Corry, ACT	FAFRM (RACP)
Tess Cramond, Qld	FANZCA
Bruce Kinloch, Vic	FAFRM (RACP)
George Mendelson, Vic	FRANZCP
Bruce Rounsefell, SA	FANZCA
Peter Reilly, SA	FRACS
<b>Reserves:</b>	
Ray Garrick, NSW	FRACP
John Ditton, NSW	FANZCA
Paul Glare, NSW	FRACP
Roger Goucke, WA	FANZCA
David Gronow, NSW	FANZCA
Terry Little, Vic	FANZCA
Suellen Walker, NSW	FANZCA
Ben Marosszky, NSW	FAFRM (RACP)
Richard Vaughan, WA	FRACS
Robert Large, NZ	FRANZCP
R Leigh Atkinson, Qld	FRACS

**Table 2:** The six Foundation Fellows, and Initial Board of Faculty of Pain Medicine appointed by ANZCA Council in October 1998.

Professor Michael J Cousins	FANZCA	Dean	NSW
Dr C Roger Goucke	FANZCA	Vice-Dean	WA
Dr David Jones	FANZCA	Censor	NZ
Dr Terence F Little	FANZCA		VIC
Dr Pamela Macintyre	FANZCA		SA
Dr Suellen M Walker	FANZCA		NSW
Mr R Leigh Atkinson	FRACS	Honorary treasurer	QLD
Associate Professor Milton L Cohen	FRACP	Chair Education Committee	NSW
Dr Graham I Rice	FRANZCP		QLD
Professor J E (Ben) Marosszky	FAFRM, RACP		NSW
Professor John M Gibbs	FANZCA	ANZCA Council Nominee	NZ

# Faculty celebrates its early years (continued)



**Figure 2:** Dean's badge of office. The five sides represent the contributing collegiate bodies. Inscribed on the reverse is: "Presented to the Faculty of Pain Medicine by the Royal Australasian College of Surgeons 6th May, 2000". The accompanying letter states: "This gift is a token of the close relationship between our two Colleges and of the interest this College has in the Faculty of Pain Medicine".

This brief history describes an approximate 25-year span from the first "flirting pass" by Professor Cousins, until, as a world first multi-collegiate body, the Faculty of Pain Medicine completed its 12 initial ("pre-teen") years. During this time, 159 doctors from all the base specialties passed the examination following training. A further 109 with existing substantial experience in pain medicine were elected to fellowship, and a further 11 high-standing professionals to honorary fellowship.

During those first 12 years, robust governance processes were developed together with a continuing professional development (CPD) program as support for Fellows, strengthening of the relationship with ANZCA and growth of reputation both with stakeholders and internationally. Ms Benjamin was succeeded by Ms Helen Morris first as executive officer then as general manager of the Faculty, supported by three other staff plus many departments of ANZCA. This illustrates the growth of activity which is needed to sustain the specialty.

The particularly noteworthy milestones of recognition of pain medicine as a vocational specialty and the Faculty's accreditation for training and assessment

by both the Australian Medical Council (2005) and the Medical Council of New Zealand (2012), dictated the need for the governance processes mentioned above, CPD and infrastructural support for the specialty. FFPMANZCA is the registerable specialist qualification with these bodies in Australia and New Zealand. A new phase with curriculum realignment to serve future needs in pain medicine is now well under way.

All first six deans had contributed in the specialty long before the Faculty existed. Of the initial board only Professor Atkinson and this author traversed the full pre-teen era of the Faculty. As a welcome sign of maturing, the current Dean Associate Professor Brendan Moore has the role of steering the Faculty through its teen years, and is the first who has graduated from FPM training.

As one who was influenced initially by Professor Tess Cramond (Brisbane), well known for her early major contributions to pain medicine training and services and in our region, this gives us a sense of "regeneration"...

**Dr David Jones**  
Immediate Past Dean, FPM

#### Acknowledgements:

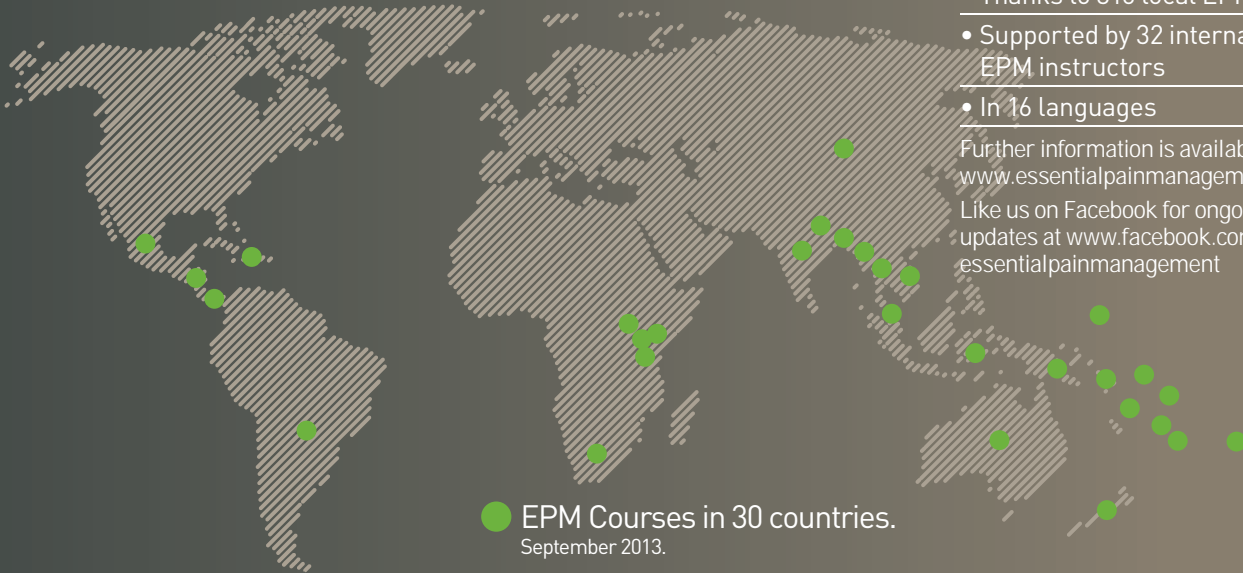
I would like to thank all those who facilitated the formation of the Faculty, and as such gave opportunities which allowed me to be part of this history as well as to record it here. These include but are not limited to Professor Michael Cousins for his tenacity in following through on his vision for better pain knowledge and management, those within the former Faculty of Anaesthetists, RACS and ANZCA who took the hard decisions, ANZCA archivist Fraser Faithfull, Ms Helen Morris for supply of photos and other information and the series of deans and board members with whom I have had the privilege to work.

#### References:

1. Core curriculum for health professionals working in the field of pain. Described in "Pain" (monograph): HL Fields, Macgraw Hill, New York, 1987.
2. P25: Requirements for Multidisciplinary Pain Management Centres Offering the Certificate in Pain Management.

Above: The six Faculty deans during the first 12 years, in order from "birth to teens": Professor Michael J Cousins, AO, Professor R Leigh Atkinson, Associate Professor Milton L Cohen, Dr C Roger Goucke, Dr Penny A Briscoe and Dr David Jones.

# Essential Pain Management continues to grow



Since the inception of Essential Pain Management (EPM) and the first program in Lae, Papua New Guinea, in 2010, 30 countries have hosted EPM programs. More than 1686 local participants have been trained along with 310 local instructors. We now have 32 external instructors helping to deliver the program primarily in Asia and more recently in Africa and South America.

EPM has been enormously fortunate in securing funding from ANZCA, the Australian Society of Anaesthetists, World Federation of Societies of Anaesthesiologists, International Association of the Study of Pain, the Royal Australasian College of Surgeons through the Pacific Islands project, Interplast Australia and New Zealand, and a very generous three-year donation totalling \$A150,000 from the Geoffrey Arnott Foundation, which is being administered through Perpetual Trustees.

EPM is governed by the EPM Sub-Committee, which reports to ANZCA Council through the Overseas Aid Committee. We have drafted a three-to-five-year plan that envisages consolidating EPM in a limited number of countries while offering ongoing delivery of EPM to new countries as requested.

We are very pleased with our developing partnerships with Interplast and the Hoc Mai Foundation, and we hope to work closely with Pain SA (the South African Pain Society), and a number of the anaesthesia and pain societies in central and South America and the UK.

We have launched a fledgling Facebook page, [www.facebook.com/essentialpainmanagement](http://www.facebook.com/essentialpainmanagement), and would welcome Fellows checking out Essential Pain Management and “liking” us. Our website has just been relaunched and can be viewed at [www.essentialpainmanagement.org](http://www.essentialpainmanagement.org). If there are any Fellows who have time and experience in developing apps for iPhones or other smart phones, we would be happy to have some input as this may be a useful tool.

EPM now offers a suite of products. Perhaps the most significant is EPM Lite, a condensed program run over five hours. The program is being developed and piloted by Linda Huggins, at the University of Auckland, and also in a slightly different format by Amada Baric, at the University of Melbourne. We hope this may be useful to other undergraduate medical courses. eEPM, which is currently an intranet-based program, also has been developed in Auckland and may be useful for PGY1 and 2. We plan to place this as an interactive program on our website once established. We also are developing iEPM, which we hope to offer to Aboriginal health workers.

The EPM Sub-Committee is very grateful to Fellows who give their time to help deliver EPM. One of the major issues in aligning Fellows with courses is often the short period between a country arranging the time and venue and the ability of Fellows to arrange leave, transport and visas. EPM has now been delivered throughout the Pacific including Fiji, Papua New Guinea, Solomon Islands, Tonga, Cooks, Micronesia, Vanuatu and Samoa. In Asia, programs have run in Vietnam, Mongolia, Indonesia, Myanmar, Nepal, Bangladesh, India, Thailand and Malaysia. A number of these countries

Since the initial pilots in 2010 EPM has been delivered:

- In 30 countries
- With 1686 EPM participants
- Thanks to 310 local EPM instructors
- Supported by 32 international EPM instructors
- In 16 languages

Further information is available from [www.essentialpainmanagement.org](http://www.essentialpainmanagement.org)

Like us on Facebook for ongoing updates at [www.facebook.com/essentialpainmanagement](http://www.facebook.com/essentialpainmanagement)

are now running their own programs independently. In Africa, programs have run in Tanzania, Kenya, Uganda, Rwanda and South Africa (Pretoria and Cape Town); in Latin America they have run in Honduras, Mexico, Panama, Paraguay; and in the Caribbean they have run in the Dominican Republic.

Without champions in each of these countries we would not get far! We recognise the incredible amount of work the local course organisers and facilitators take on when agreeing to host EPM and their continued commitment to supporting the effective management of pain in their countries.

While EPM focuses on acute postoperative and trauma pain, including burns, it also discusses the use of morphine in cancer. The huge problem of chronic non-cancer pain, including the wide variety of neuropathies, including HIV, diabetic and post-amputation pain, together with ubiquitous low back and neck pain and headaches, is an ongoing challenge and learning experience for both instructors and participants. Fellows who are interested in transcultural and religious belief systems as they relate to pain might find participating in an EPM workshop particularly stimulating.

Fellows interested in finding out more on the Essential Pain Management program can contact Paul Cargill at [overseasaid@anzca.edu.au](mailto:overseasaid@anzca.edu.au).

**Associate Professor Roger Goucke,**  
FANZCA, FPPMANZCA  
Chair, Essential Pain Management  
Subcommittee

# Kenyan anaesthetist settles into scholarship in Sydney



Kenyan specialist Dr Wangari Nyaga is learning a lot during her one-year placement on an ANZCA International Scholarship.

Dr Wangari Nyaga is a Kenyan anaesthetist working at the Children's Hospital at Westmead in Sydney, NSW, on a one-year international scholarship awarded by ANZCA. Her work in Australia is focusing on paediatric pain management and anaesthesia and supervised by Dr Michael Cooper, the chair of the ANZCA Overseas Aid Committee.

First awarded in 2004, the scholarship was not awarded in 2011 or 2012 due to challenges in finding a candidate who could meet all relevant criteria and satisfy the medical board requirements. A 2014 recipient has already been selected; Dr Timothy Murithi Mwitii, a Kenyan anaesthetist who will work at the Sir Charles Gairdner Hospital in Perth under the supervision of Associate Professor Roger Goucke, chair of the Essential Pain Management Sub-Committee. He will focus on pain management.

One of the major obstacles in finding a suitable candidate has been the need to satisfy the language requirements of the Australian Health Practitioner Regulation Agency for short-term training. The College supports these requirements as being important to patient safety, although they do pose an obstacle for people coming to Australia and New Zealand for short-term training.

Dr Nyaga, who arrived on August 23 and will be in Australia for one year, spoke to *the Bulletin* about her experiences and impressions so far:

**How long were you a doctor in Kenya?**  
*I have been a doctor in Kenya for 10 years.*

**What made you interested in visiting and working in Australia?**  
*I heard that the pain program in Australia is very good (from a senior anaesthetist in Kenya). I was also told that Australians are very friendly. This was from people who had visited here. The combination of studying with leading authorities in the field and being in a conducive environment appealed to me.*

*The health and hospital systems would be very different between the two countries – what has struck you the most?*

*The amount of resources available in the public sector!*

**What could Australia learn from the Kenyan health system and vice versa?**

*This is a difficult one. I've only been here for a short while, and only in one hospital so don't know the health system in Australia very well. Also the fact that the priorities of the two health systems are probably different makes it difficult to say what one can learn from the other.*

*One thing that has struck me though is that staff can work part-time. In Kenya, I've not seen this implemented in the public sector, only in the private hospitals. It could be a way of reducing staff shortages if we allow people who are in the private sector to also work part-time in the public hospitals.*

**Where are you living while you're in Australia?**

*At the overseas doctor's quarters at the Children's Hospital, Westmead.*

**Has the scholarship program been a valuable experience so far?**

*Yes, very valuable. I'm learning a lot – such as how an effective pain service is set up, and what it takes to run it (a lot of effort and dedication!). Also the experience doing anaesthetics here has been enlightening.*

ANZCA awards up to one international scholarship annually with the aim of developing leaders in anaesthesia and pain medicine in developing countries. The scholarship is open to a qualified specialist anaesthetist to pursue additional training in Australia or New Zealand and is designed to increase the recipient's capacity to advance anaesthesia and/or pain medicine for the benefit of their community.

The scholarship provides the recipient the ability to join the staff of a major hospital or rotation for up to one year. More information is available at [www.anzca.edu.au/fellows/overseas-aid](http://www.anzca.edu.au/fellows/overseas-aid)

**Ebru Yaman**  
ANZCA Media Manager

# From ANZAC to ANZCA



## A former naval doctor gives up life on the front line to focus on anaesthesia.

Pre-dawn Gallipoli on any day of the year would have been a “deeply moving” experience according to ANZCA trainee and former Royal Australian Navy doctor Lieutenant Commander Peter Smith, but on the eve of the ANZAC Day commemoration in 2011 it held special significance.

“Where I walked, before the crowds arrived, you could see the soldiers’ trenches,” he said. “It was quite an experience, standing there quietly, thinking about the war and what the men went through.”

That ANZAC Day, Dr Smith, an anaesthetic registrar at John Hunter Hospital in NSW, had travelled to Gallipoli in the position of medical officer accompanying the Australian Government delegation to the ANZAC Day commemorations.

It was a big job. About 10,000 people make the pilgrimage every year, many from Australia, to see the dawn service.

Part of his duty was to act as liaison between the Turkish health system and hospitals for people who needed care. Emergency medical issues arise in any large swell of people, but night-long exposure and cold can compromise even the sturdiest constitution.

“There are a lot of people who make this trek and spend a lot of money and time getting there for the dawn service and are determined to see it however they are feeling,” he said.

“It shouldn’t happen but when people travel such a long way they are determined to see the experience through ... then they have to sit out all night when it is freezing and they get sicker.”

In this year’s Queen’s Birthday honours Dr Smith was awarded a Conspicuous Service Cross, a tribute he described as surprising and humbling, for outstanding achievements as the officer-in-charge of the submarine and underwater medical unit at HMAS Penguin in Sydney.

The unit was one of the first of its kind in Australia and advises on standards, safety and regulations of submarine rescue and diver safety and care among the defence and the civilian populations.

It provides expert advice on diving and submarine medicine to the Australian Defence Force; health care for diving personnel, including emergency recompression for diving accident victims; diving-related research, and emergency treatment and advice to civilians suffering from diving illnesses.

“It’s a very busy unit and maintains and leads world-class standards in a niche part of a highly specialised area.”

He remains part of the army reserve but has switched his career full-time to anaesthesia after serving full-time as a navy doctor until 2012. After being seconded to Lismore Base Hospital, he settled at John Hunter in July.

Dr Smith said he was now focused on anaesthesia full-time and diving and underwater medicine part-time so he can finish the ANZCA training he began in 2007.

Although he started his career as a psychologist, the 41-year-old says his real passion is medicine.

“As much as I loved being in the navy full-time it made it very difficult to work through the [anaesthesia] training. Now working in anaesthesia on a full-time basis, I can progress through the final stages of training a bit easier.”

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**Ebru Yaman**  
Media Manager, ANZCA

Above from left: Lieutenant Commander Peter Smith, former Royal Australian Navy doctor at work; Dr Smith after receiving his 2013 Queen’s Birthday honour, with family; Dr Smith at Lismore Base Hospital, NSW.

# Announcing the merger of the Medical Education and the Simulation SIGs



## Juliet:

“What’s in a name? That which we call a rose

By any other name would smell as sweet.”

**Romeo and Juliet**  
**William Shakespeare**

“Medical education” is an umbrella term covering a huge range of topics. It may include teaching of knowledge, skills and non-technical skills. It can be formal, informal, at the bedside, one on one, small group, or large scale, involve faculty development, assessment, research, supervision and feedback, curriculum development, the use and development of different educational technology methodologies – and the list goes on.

Simulation – or the replication of real-world activities in an artificial environment for the purposes of learning – is one educational technology that has grown enormously over the past 10 to 20 years. It is now a highly valued educational tool in medical education and is widely used in hospitals and universities.

The Simulation Special Interest Group (SIG) for anaesthetists was formed in 2000 to support the growth and development of simulation within anaesthesia training and practice. The Medical Education SIG was formed in 1999 with a similar purpose, but for medical education in general. However, following 18 months of discussion, the executive groups of the Simulation SIG and the Medical Education SIG have concluded that simulation is now recognised as a sub-specialty area of education and doesn’t warrant the existence of a separate group.

Other issues considered include:

- The large overlap between the memberships of the two groups; that is, many people are members of both.
- The Simulation SIG is a member of the “Combined SIG” group, which runs the Combined SIG meeting in September every year. Australia’s premier simulation in health meeting is also held in September, is run by an external organisation, and many, if not most, anaesthetists with an interest in simulation attend this meeting, usually as an alternative to the Combined SIG meeting. Therefore, those anaesthetists with an interest in simulation are well covered by existing meetings.

- In a climate of increasing busy-ness for all, the administration of both groups is increasingly difficult to maintain. Willing, enthusiastic members and executive members are hard to find, and it makes sense to concentrate the ones we have.

By the time this article is printed, the merger of the two groups will be complete. The executives have merged into one, the memberships have been informed and chosen to transfer to the new group (or not!), and the paperwork will have been done and dusted. The new group has retained the name Medical Education SIG because this is what it represents. Our plans and activities remain focused in the same direction – on the promotion of medical education in all of its representations throughout the anaesthesia world.

We look forward to welcoming as many anaesthetists as possible to the next Combined SIG meeting, which is co-ordinated by the Medical Education SIG, at Peppers Salt Resort Kingscliff in warm sunny northern NSW next September.

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**Dr Natalie Smith**  
Chair, Medical Education SIG



# Returning to work after extended leave – the CRASH course in anaesthesia



## CRASH course

Critical care, resuscitation, airway skills and high fidelity simulation – a refresher course in critical care  
[www.anaesthesia.mh.org.au/about-crash/w1/i1014955/](http://www.anaesthesia.mh.org.au/about-crash/w1/i1014955/)

### Courses in 2014

January 31, 8-5pm, Melbourne, Vic

September 19, 8-5pm, Venue TBC

To register, please visit the website:  
[www.anaesthesia.mh.org.au/about-crash/w1/i1014955/](http://www.anaesthesia.mh.org.au/about-crash/w1/i1014955/)

The CRASH course is designed to support the many anaesthetists who take long periods of leave from clinical anaesthesia during training or after fellowship. This leave may be in conjunction with other clinical or academic work, such as training in another speciality, or sabbatical leave, but some will not undertake clinical work in that time.

Little research has been done into how time away from the operating theatre affects our craft group. Delivering safe anaesthesia involves a number of technical and psychomotor skills, which are likely to deteriorate with lack of practice, a “use it or lose it” scenario. Currently ANZCA requires a four-week period of retraining if more than 52 consecutive weeks of leave are taken, with an additional four weeks for every 12-month period away. The Australian Health Practitioners Regulation Agency (AHPRA) has requirements for doctors returning to practice after 12 months leave, which vary depending on the length of leave. AHPRA have developed a return to work template which is available on their website ([www.medicalboard.gov.au/Codes-Guidelines-Policies/FAQ.aspx](http://www.medicalboard.gov.au/Codes-Guidelines-Policies/FAQ.aspx)). Continuing professional development is key area of returning to work, as it is a surrogate measure of connection to the workplace during leave.

A complicating factor in managing the needs of a doctor returning from leave is a wide variation in these needs. The reasons for taking leave range from travel or sabbatical, planned leave in the

event of maternity or paternity leave, or unplanned leave for illness. Additionally, a range of activities performed during leave including research, CPD, or clinical work in other areas result in a complex picture of the doctor who hasn't practiced anaesthesia for several months. The AAGBI has identified three groups of doctors returning to anaesthetic practice. Most straightforward is the doctor with no ongoing physical or cognitive impairment, who is expected to return to normal duties quickly. The other groups have more complex needs: doctors who require a period of supervision or assessment following a longer suspension or illness, and doctors who have serious issues surrounding competency where a period of formalised retraining may be necessary.

In addition, the work environment to which the doctor returns is crucial in considering the need for retraining or reorientation. A trainee returning to a familiar department who will be supervised for most lists has different needs to a specialist returning to private practice, particularly if taking a list in a different speciality to his or her usual practice. Fortunately, it is easier to relearn neglected skills than to acquire a new skill, assuming the same level of difficulty. More difficult skills will take longer to learn or refresh than less complex skills, which may be further compounded if a trainee undertakes part-time rather than full-time work.

A survey of trainees in Wessex who had time off work found that 100 per cent of trainees felt a period of direct supervision would be valuable, with 90 per cent of those feeling that one to two weeks would be adequate. The majority of trainees were senior (ST5+ 85 per cent), and had six to 12 months off (68.4 per cent). These figures also are likely to reflect trends in Australia.

In developing the new ANZCA Continuing Development Program (CPD) Program, the College has retained a triennial model, which will be useful for specialists who take less than three years of leave. There has been a simplification of the program, with requirement for regular retraining in “can't intubate, can't oxygenate” scenarios, anaphylaxis, major haemorrhage and cardiac arrest. There also are additional requirements for group and self-directed learning.

Meeting the need for retraining and familiarisation of the anaesthetist who is returning to work is complex and individual, however commonalities exist. A return to work course (GAS Again) has run successfully in the UK for several years, with 100 per cent of participants believing the course was valuable. The CRASH course is designed to meet the needs of ANZCA trainees and Fellows and will run twice in 2014, on January 31 in Melbourne, and in September in conjunction with the Welfare and Medical Education SIG meeting. The course will encompass training in airway management, including emergencies, advanced life support algorithms, problem-based learning discussions and high-fidelity simulation scenarios.

**Dr Kara Allen, FANZCA**  
Course Co-ordinator

#### Resources:

[www.rcoa.ac.uk/document-store/career-breaks-and-returning-work](http://www.rcoa.ac.uk/document-store/career-breaks-and-returning-work)  
[www.aagbi.org/sites/default/files/Wessex%20Return%20to%20Training%20flowchart.pdf](http://www.aagbi.org/sites/default/files/Wessex%20Return%20to%20Training%20flowchart.pdf)  
[www.fph.org.uk/uploads/RTW\\_REPORT\\_April2012\\_3%2000.pdf](http://www.fph.org.uk/uploads/RTW_REPORT_April2012_3%2000.pdf)

Above from left: Dr Janette Wright and Dr Kara Allen; Dr Janette Wright and Dr Andrea Bowyer.

# New Zealand news



## Great attendance for NZ Anaesthesia ASM

Around 220 registrations ensured a successful NZ Anaesthesia Annual Scientific Meeting (ASM) in Dunedin, November 6-9.

A high number of registrations were from Australia and a smaller number from 10 other countries, with the big majority of attendees from New Zealand.

A full exhibition and the parallel anaesthetic technicians' conference created a lively atmosphere and with a lot of interest in the scientific and social programs.

The conference theme of "Best practice: aiming for excellence" treated anaesthetists to topics on how emerging technologies could affect anaesthesia practice, whether general analgesia could replace anaesthetics in the future, the effects of disruptive behaviour in the operating room, the place of compassion in medical decision-making, medical economics, medical law, new uses for existing drugs, and how to treat athletes without contravening anti-doping regulations. Workshops on ultrasound technology were over-subscribed and there was keen interest in the problem-based learning discussions.

A fully-subscribed healthcare industry exhibition and social events including dinner at the historic Larnach Castle – the whole of which was open to view – gave attendees ample opportunity to mix with peers and colleagues.

ANZCA's New Zealand National Committee (NZNC) thanks the organising committee comprising Dr Champion Read (convener), Dr Hansjoerg Waibel (scientific program), Dr Ulla Reymann (workshops/PBLDs), Dr Andrew Smith, Dr Jason Henwood, Dr Justin Holborow and Dr Robyn Chirnside.

Top row from left: The opening session at the 2013 NZ Anaesthesia Annual Scientific Meeting; The organising committee from Dunedin Hospital at the dinner; ANZCA Vice President Dr Genevieve Goulding and outgoing NZ Society of Anaesthetists' president Dr Rob Carpenter.

Middle row from left: NZNC Chair Dr Nigel Robertson at the opening of the ASM; Dr Annabel Taylor of Auckland, Nikita Kanji and Dr Kishor Kanji, Dr Carolyn Fowler and Dr Alex Garden; Dr Geoff Laney, Dr Andrew Mitchell and Dr Jason Henwood; Professor Mark Warner with Dr Mary Ellen Warner.

Bottom row from left: Dr Robyn Chirnside, Dr Carolyn Fowler, Dr Keat Lee and Dr Malcolm Stuart; Dr Rochelle Barron, Dr Marissa Henderson and anaesthetic technician Tracey Hanna; The dinner setting at Dunedin's historic Larnach Castle.





## Positive feedback for Part 3 Course

The last day of the ASM saw 18 senior trainees gather for the NZ Anaesthesia Part 3 Course. With the theme “Leaving the nest and ... soaring into the future”, senior trainees received an insight into life as a consultant in public, private and rural settings.

The course included a workshop on CVs and interview skills with plenary sessions on topics that included ANZCA and ways to get involved with the College, what it's like in private practice and rural settings, how to work smartly (work/life balance), academia and research, and being an influence for change in your department.

A panel discussion, driven by questions from participants, canvassed issues from surviving that first night on call (when the buck stops with you) through to employment contracts, conferring with colleagues, and seeking the assistance of a financial adviser.

Feedback about the course, and the dinner, has been very positive. ANZCA thanks Dr Annick Depuydt, Dr Julian Dimech (both Middlemore) and Dr Jason Henwood (Dunedin) for their hard work in putting together another successful course.

The 2014 Part 3 course returns to Middlemore's Ko Awatea Centre.



## Robust discussion at NZNC meeting

The NZNC meeting held in Dunedin in conjunction with the ASM saw some vigorous discussion. Hot topics included the hospital accreditation process, training for anaesthetist assistants, ANZCA's revised CPD Program, Medical Council (MCNZ) proposals on competence, and workforce developments in Australia and New Zealand – particularly the potential “bottleneck” at the pre-vocational level.

The committee approved a paper on “New Zealand medical colleges’ roles and responsibilities regarding competence, compliance and delivery of safe care by Fellows and trainees”. This was developed after the MCNZ's recent focus on this topic was well canvassed at a Council of Medical Colleges’ forum in August, the annual MCNZ meeting for colleges in September and the International Physician Assessment Coalition Conference held in Queenstown in early October. These discussions have shown that no one agency has the mandate or the mechanisms to address the issue alone, and partnership and collaboration will be required for any measures to be effective. The paper will go to the ANZCA Council for consideration.

The committee also spent time reviewing 10 high-quality applicants for next year's New Fellows Conference.

## Preventing surgical site infections

The second phase of the Health & Safety Quality Commission's patient safety campaign, “Open for better care”, focuses on reducing the number of surgical site infections (SSIs). International research suggests up to five per cent of surgeries can result in a person suffering from an SSI.

The campaign supports the Surgical Site Infection Improvement Programme (SSIIP), which standardises the collection and reporting of SSIs and encourages hospital healthcare workers to adopt improvements proven to help prevent these infections. The SSIIP was rolled out to all district health boards earlier this year after a successful trial in eight pilot sites.

Actions that can help prevent SSIs include good hand hygiene, giving patients the right antibiotic at the right time and using appropriate skin preparations before surgery.

The national patient safety campaign focuses on four areas where evidence shows it is possible to reduce patient harm – falls, infections, surgery and medication. The SSI focus will run from October 2013 to March 2014 before the campaign moves on to focus on harm caused by perioperative care and, finally, medication.

In October, MercyAscot Hospital in Auckland became the first private provider to sign up to the campaign, which has been running since April and is supported by all 20 district health boards. The campaign is expected to run until at least mid-2015. Further information can be found at [www.open.hqsc.govt.nz](http://www.open.hqsc.govt.nz).

This page:

Part 3 Course from top: Dr Annick Depuydt (left) and Dr Julian Dimech from Middlemore Hospital in Auckland, organisers of the Part 3 Course assisted by Dr Jason Henwood from Dunedin; Participants in the Part 3 Course held in Dunedin on the last day of the ASM.

NZNC meeting: Robust discussion.

## New Zealand news (continued)



### Visiting lectureships for 2014

The NZ Anaesthesia Education Committee has awarded three NZ Anaesthesia Visiting Lectureships for 2014. The lectureships promote the exchange of knowledge and experience between anaesthesia departments and practices. Smaller and provincial departments are supported to hear presentations from big city hospitals.

The 2014 visiting lecturers will be:

- Dr Jane Torrie, a specialist anaesthetist at Auckland City Hospital and a senior clinical lecturer and Director of Simulation Centre for Patient Safety at the Department of Anaesthesiology at Auckland University. She will present in her specialist areas of emergency management of anaesthetic crises, simulation and team work.
- Dr Colin Marsland, a specialist anaesthetist at Wellington Hospital, who will present on his research topics of emergency transtracheal ventilation and bronchoscopic airway management.
- Dr Nav Sidhu, a consultant anaesthetist at North Shore Hospital in Auckland, whose topic is "CICO and the Surgical Airway: a personal account". This presentation uses a case report to highlight issues and discuss evidence surrounding emergency airway management, with a particular focus on cricothyrotomies.

The visiting lecturers will each present their lectures at two regional centres in New Zealand during 2014.

### UK experience has lessons for others

An October workshop run in Wellington (and later in Melbourne) focused on lessons to be learned from the inquiry into the Mid Staffordshire National Health Service Foundation Trust. The inquiry found numerous failings in the quality of care the trust had provided to patients between January 2005 and March 2009.

The 209 recommendations from the inquiry emphasise the importance of creating a culture that respects patients and their families, is open to learning from others, improves internal processes and has strong clinical leadership. Professional accountability is needed by health care practitioners, regulators, directors and managers to address problems with patients' care and patients need to be empowered to raise questions and concerns.

Inquiry chair Robert Francis QC, a leading UK barrister who specialises in medical negligence, was the keynote speaker for the forum. He was brought to New Zealand by a partnership between the Waitemata District Health Board, the Health Quality & Safety Commission and the Australian Commission on Safety and Quality in Health Care.

Following Mr Francis' presentation, discussions were held on how the consumer-centred system needs engagement (involving patients), transparency (disclosure, sharing information, benchmarking of data, peer review and colleges' role in this), seamless service (working in teams and not in isolation), accountability (including district health boards and regulators as well as practitioners), and a culture that embraces all these.

Presentations from the workshop are available on [www.hqsc.govt.nz](http://www.hqsc.govt.nz) under the "events" tab.

### More public input on hospital care

A national patient survey will be rolled out to New Zealand public hospitals from mid-2014 so patients can provide feedback on the care they receive. The survey will provide information for district health boards (DHBs) about what they are doing well and what areas need to be improved.

The survey will look at four key areas – communication, partnership, co-ordination, and physical and emotional needs. This will be the first time such information has been collected and measured in the same way across the whole country. The results will be published regularly. The development is part of the government's drive to improve the quality of health services.

Health professionals will be consulted and the survey will be piloted before it is rolled out nationally.

# Australian news

## Queensland



## Queensland supervisor of training meeting

The Queensland supervisor of training meeting was held on November 1 with a strong showing of our state's representatives at the Brisbane office.

Dr Suzanne Bertrand, from the Mater Hospital, Brisbane, chaired the meeting with input from Queensland Regional Committee (QRC) chair Dr Mark Young.

Townsville-based Dr Clair Furyk, a QRC representative, was invited to speak at the scholar role workshop. Her informative discussion allowed for a lively and interesting debate around the topics presented.

## Weekend primary viva course

The primary viva course was held at the lovely Sheraton Noosa resort. The aim of the course is to offer intensive viva training to those invited to sit the primary exam in November.

Fifteen people travelled to participate and, with the help of a large number of doctors from the Nambour and Sunshine Coast region, participants took part in vivas on Saturday and Sunday.

Above from top: Queensland Regional Committee (QRC) chair Dr Mark Young speaking at the Queensland supervisor of training meeting on November 1; There was a strong showing of Queensland's representatives at the meeting in the Brisbane office.

## South Australia and Northern Territory



## ANZCA/ASA SA and NT Registrars Scientific Meeting

The ANZCA/Australian Society of Anaesthetists South Australia and Northern Territory Registrars Scientific Meeting was held on Wednesday September 25 with three formal projects presented. Dr Michael Schurgott presented "Validity of a new airway manikin in simulating a range of difficult intubation", Dr Rebecca Jeffery presented "A retrospective audit of the prevalence and impact on perioperative anaemia in patients undergoing elective hip or knee arthroplasties" and Dr Adam Badenoch presented "Blood product use in postpartum haemorrhage". Trainee Rebecca Jeffery was the winner of the best formal project presentation for 2013. South Australian scholar role champion Dr Laura Burgoyne gave an overview of the scholar role and how it works. The meeting was well attended by trainees and consultants.

Above clockwise from top: Formal project presenters Dr Michael Schurgott, Dr Rebecca Jeffery, Dr Adam Badenoch; Trainees Dr Nicholas Harrington, Dr Caroline Delaney, Dr Bjorn Pederson; Dr Rebecca Jeffery and Dr Nathan Davis (Chair SA/NT CME Committee).

## Tasmania



### SA and NT CME meeting

The SA and NT CME meeting was held on October 24. International guest speaker, Dr Sibylle Kozek-Langenecker, presented the topic “Perioperative haemostasis management”. Dr Kozek-Langenecker is Chairperson, Department of Anaesthesiology and Intensive Care at the Evangelic Hospital, Vienna and her major research interests are perioperative bleeding management and postoperative pain. The meeting was video conferenced to Royal Darwin, Alice Springs and Mount Gambier hospitals.

### SA FPM CME meeting

The SA FPM CME meeting titled “The complex pain patient in the acute pain setting” was held on November 4. It was presented by Associate Professor Pam Macintyre and Dr Meredith Craigie and focused on approaches to patients with pre-existing high opioid use, buprenorphine use, the presence of other addictions and appropriate patient follow-up.

Above: Dr Bill Wilson and Dr Sibylle Kozek-Langenecker at the SA and NT CME meeting.

Right from top: Dr Andrew Messmer presenting; Practical and hands on in the laboratory; Theory with Dr Nico Terblanche.

### Hands-on spinal anatomy and ultrasonography workshop

An innovative Spinal Ultrasound and Applied Spinal Anatomy Workshop was held at the Menzies Centre, University of Tasmania in Hobart on Saturday October 19. Attendees travelled from Burnie, Launceston as well as Hobart to attend.

This half-day session was jointly facilitated between the University of Tasmania School of Medicine and ANZCA, with anaesthetists Dr Nico Terblanche and Dr Andrew Messmer and anatomy demonstrator Dr Derek Choi-Lundberg providing a practical and hands-on workshop. Dissected cadavers, prosected specimens, skeletons and high-fidelity anatomically correct simulators were used to demonstrate the anatomy. The anatomy was correlated with the sonograms produced by performing spinal ultrasound scanning. Participants also gained practical experience using ultrasound machines on volunteers. The patient with difficult sonoanatomy and real-time procedures also were covered by the course. Feedback was very positive with comments including, “Very well organised and administrated. Good balance of theory and practical”, “Great concept of anatomy and u/sound”, “Great workshop, experienced practitioners/lecturers. Would be happy to start using u/s in practice”.

This was the second ultrasound/anatomy workshop facilitated in 2013, with an upper-limb anatomy workshop being held in January. Course facilitator Dr Nico Terblanche said ANZCA members would have another opportunity to attend these workshops at the upcoming Tasmanian Annual Scientific Meeting to be held in Hobart on March 1 and 2, 2014.

“Ultrasound machines will again be onsite to enable participants to relate ultrasonic images to anatomical structures using fresh cadavers, live models and high fidelity anatomically correct simulator models,” Dr Terblanche said.



“To our knowledge, the applied spinal ultrasound component is a first of its kind and will be facilitated by a pioneer in this field, the respected international obstetric anaesthesia expert, Professor Jose Carvalho, from the University of Toronto.”

Online registrations are available on the ANZCA website, <http://tas.anzca.edu.au/> events, and due to demand and a limit on numbers attending workshops, people are encouraged to register as soon as possible.

# Australian news (continued)

## Western Australia



## Updates in Anaesthesia

The Updates in Anaesthesia meeting was held October 11-13 at the Pullman Resort in Bunker Bay. The meeting, following a theme of “Enhanced recovery after surgery”, was convened by Dr Rupert Ledger, a consultant anaesthetist from Fremantle Hospital.

Dr Monty Mythen presented an overview on “Enhanced recovery after surgery” via video link from London and Dr Ron Collins presented on the “Canadian Colorectal ERAS programme”, via video link from Canada.

Dr Dennis Kerr, from a private practice in Sydney, presented on orthopaedics. He also had copies of his book, *Local Infiltration Analgesia*, available for the delegates. Dr Adrian Hall, a staff specialist at Princess Alexandra Hospital in Brisbane, presented on “New theories on the endothelium and its impact on fluid management”. We thank Dennis and Adrian for taking the time to present at the meeting.

Topics covered at the meeting included preoperative optimisation, emerging science that underpins what anaesthetists perform, important intraoperative themes and particularly the hot topics of fluid management and cardiac and microcirculatory optimisation, optimal analgesia, postoperative care and a successful plan for home.

Dr Mike Ward and team organised a hands-on workshop with 10 haemodynamic and oxygenation monitoring devices, which was very beneficial to the attendees. Feedback from the 107 delegates who attended the conference has been positive. The Continuing Medical Education Committee thanks those who took the time to present and attend and to Dr Rupert Ledger for convening an excellently meeting.

The WA Office has been busy with various committee meetings. The Australian Society of Anaesthetists Committee met on September 24, education officer Dr Jodi Graham met with anaesthesia department heads on October 17. The Western Australia Regional Committee met on September 16, the Faculty of Pain Committee met on October 22 and the Continuing Medical Education Committee met on October 28. The Faculty of Pain Medicine exam was held on November 8.

ANZCA’s Education Training and Development Manager, Maurice Hennessey, ran the Foundation Teacher Course from October 30 to November 1. The 17 attendees enjoyed the course and thank Maurice for his efforts.

The WA conference dates for 2014 are as follows: Autumn Scientific Meeting, March 15 at the University of Western Australia (UWA); Winter Scientific Meeting, 27 July 2014 at UWA; and the Country Meeting, October 17-19 at the Pullman Resort Bunker Bay.

## Victoria



## Victorian Registrars’ Scientific Meeting

More than 40 trainees attended the Victorian Registrars’ Scientific Meeting (VRSM) 2013 on November 22 at ANZCA House, Melbourne. Professor David Story opened the meeting with a short presentation on “Academic anaesthesia”, outlining the importance, significance and process of research and teaching in anaesthesia. He adjudicated the presentations with Dr Elizabeth Hessian (Western Health), Dr Tuong Phan (St Vincent’s Hospital) and Dr Mark Schulman (The Alfred).

The prize for the best presentation in the clinical/scientific research section was Dr Nicholas Lanyon with “Mean perfusion pressure deficit during the initial management of shock”. The audit/miscellaneous prize was awarded to Dr Samantha Biggs with “Local audit of post operative mortality rates in elderly patients at Bendigo Hospital”.

The adjudicators were delighted with the high quality of presentations and an apparent resurgence in enthusiasm for anaesthesia research. Congratulations to both prize recipients and many thanks to the adjudicators and organisers.

**Dr Shiva Malekzadeh**  
Convenor, VRSM 2013

From left: Bunker Bay; The Updates in Anaesthesia meeting was held October 11-13 at the Pullman Resort in Bunker Bay.

## Quality assurance meeting

A very successful Australian Society of Anaesthetists/Victorian Regional Committee Combined Quality Assurance Meeting was held at the College on Saturday October 19 in Melbourne with a record number of 64 participants.

The meeting was convened by Dr Andrew Schneider and Dr Usha Padmanabhan, of the Victorian Section of the Australian Society of Anaesthetists, on Saturday October 19. It began with lectures at 2pm followed by interactive group discussions until 5.30pm. The format for our quality assurance meetings has proven very successful and this meeting was no exception.

We thank our delegates for their part in discussing their own cases, all of which contributed to an interesting and successful meeting. Delegates expressed their appreciation for the opportunity to participate in this type of quality assurance meeting and felt rewarded for their efforts in attending. There was a general request for these meetings to be held more frequently in 2014.

We also thank our lecturers, Dr Miriam Bar, Dr Vangy Malkoutzis, Dr Antonio Grossi and Dr Andrew Schneider, for generously giving their time to help make this meeting so successful. For logistical organisation and planning we thank the Victorian Regional Committee staff, Ms Daphne Erler and Mrs Cathy O'Brien, and College facilities staff member Barry Walker.

Left from top:

All the presenters

Standing from left: Dr Carsten Aase, Dr Timothy Coulson, Dr Justin Nazareth, Dr Nicholas Lanyon, Dr Joshua Szentel, Dr Matthew Lee, Dr Peter Featherstone, Dr Nicholas Gilfillan.

Sitting from left: Dr Samantha Bigg, Dr Tim Howes, Dr John Ozcan.

Judges from left: Professor David Story, Dr Tuong Phan, Dr Mark Shulman, Dr Elizabeth Hessian.

# Australian news (continued)

## New South Wales



## NSW supervisor of training meeting, Friday November 15

More than 40 enthusiastic supervisors of training crowded into the NSW Regional Office on Friday November 15 for our bi-annual meeting, which covered a wide range of topics. We were fortunate to have several ANZCA staff present and several more by telephone, who presented updates on the training portfolio system (TPS) and answered our questions about the TPS and the curriculum. Many thanks to Lee-Anne Pollard for organising.

The rest of the day was filled with presentations and discussions about the trainee with difficulty process, extended training, Trainee Committee issues, state-wide quality assurance activities, state-wide recruitment issues and an excellent interactive session on the scholar role. The group made several recommendations, which will be sent to the NSW Regional Committee and heads of departments.

We did a preliminary review of the initial assessment of anaesthetic competence (IAAC) process in NSW this year; this will be followed up by email to make recommendations for next year.

Thanks to all who helped make the day so beneficial, especially the rest of “team REO”, and our willing and able scholar role guinea pig volunteers.

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**Natalie Smith**  
Education officer, NSW

Left, clockwise from top: New South Wales spring regional conference clockwise from top: Careflight simulation; David Murrell and Simon Gower; Dale Greer and Fiona Shields; Stanley Yu resuscitation workshop; Scott Fortey and Elsbeth Bright.

Above: More than 40 enthusiastic supervisors of training crowded into the NSW Regional Office on Friday November 15.

## NSW Spring Regional Conference

The NSW Spring Regional Conference, “Anaesthesia on the edge”, was held on November 2 and 3 at the Fairmont Resort, Blue Mountains and the bushfires burning around the venue certainly kept us on the edge!

With more than 130 delegates and speakers in attendance, the atmosphere of the conference was electric. More than 30 speakers presented during a comprehensive series of lectures, workshops and problem-based learning discussions and the program was well received by delegates.

A special mention goes to the CareFlight team, who ran a workshop on emergency procedures in the out-of-hospital setting using simulation equipment. This was a highlight of the weekend and generated positive feedback from delegates and the public.

We thank all the speakers for their hard work and dedication to the scientific program.

# Special interest group events

## Perioperative Special Interest Group meeting



The Perioperative Special Interest Group (SIG) held its second annual meeting at the Byron at Byron Resort from September 13-14. The meeting was entitled “Controversies and practical solutions in perioperative medicine” and was again trade free. Most of the 130 delegates were anaesthetists or intensivists although there were some physicians and general practitioners in attendance. In the future we would love to see more nurses and surgeons attending. It was a pleasure to have the new College of Intensive Care Medicine (CICM) Perioperative Medicine SIG in attendance.

The plenary sessions were wide-ranging from the opening lecture on focused transthoracic echo by Dr David Canty to the causes of patients being

“stuck” in intensive care by Dr David Sturgess. The “Yoda” session on pain by Professor O’Sullivan and Robert Schutze was fascinating and challenging for many delegates. Dr Greg Treston’s data on fasting times in the paediatric population in emergency department sparked lively debate. The plenary sessions concluded with an expert panel answering questions from the audience. Prizes were awarded for best question and worst clinical scenario.

The afternoon sessions were filled with problem-based learning discussions as per delegates request from last year. These were well received but could have been more interactive.

Already enthusiasm is building for next year’s meeting about futile surgery

in conjunction with the CICM SIG. We are exploring focused echo workshops by Dr Canty and simulation to occur in parallel with the problem-based learning discussions.

A big thank you to Hannah Burnell and her team, the Perioperative Executive, and all our wonderful speakers who give their time freely to make the event possible.

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**Dr Dick Ongley**  
Convener and Chair of Perioperative Medicine SIG

Above from left: Professor David Story in the “Perioperative Booth” delegates in a panel session; Dr Dick Ongley, Dr Nic Randall and Dr David Wong.



## Combined Special Interest Group meeting



The Welfare of Anaesthetists Special Interest Group (SIG) convened the 2013 Combined SIG meeting in sunny Noosa from September 20 to 22. The theme was “Mindfulness, performance and achievement”.

This conference has grown rapidly and as in previous years we continued to look for experts in fields outside medicine who had not previously presented at anaesthesia meetings. This was well received as evidenced by the 150 delegates who registered. After feedback from previous years, the format was simplified to have fewer concurrent sessions.

Our invited speakers included Dr Patsy Tremayne, a co-ordinator for psychological services at the NSW Institute of Sport. Dr Tremayne works with high performance athletes and has had extensive experience with anaesthesia trainees in difficulty. We were fortunate to have her present on several topics including an insightful plenary session on “Life skills for anaesthetists”. She also presented on practical skills and advice during her lecture, “Mindful training under pressure to perform on demand” and a workshop about communication in exams.

Dr Heather Wellington brought her extensive experience in healthcare administration to her presentation on “Scope of practice-shifting the risk”.

Dr Shirley Prager continued with the theme of her presentation last year on “Peer review groups in anaesthesia practice” with a follow-up master class this year on how to run a peer review group. It was well attended and resulted in the formation of a committee to develop guidelines and promote the adoption of peer-review groups as a continuing professional development activity.

As in previous years, the workshops proved to be very popular. In particular the pre-meeting workshop run by Spiritual Care Programme on the topic of “Mindfulness: Practising compassion for self and others” was heavily oversubscribed. It was new to most participants, who found it challenging and very different from a typical anaesthesia workshop.

The medical education workshop also was popular with Dr Vanessa Beavis presenting on performance appraisal and Dr Natalie Smith on how to use errors to improve performance.

The Management, Medical Education and Welfare sessions included diverse topics including performance management, dealing with the disruptive department member, the science of the mind, and the management of propofol abuse.

The meeting concluded with two panel discussions on the topics of workforce issues and what makes a healthy anaesthetic department versus what makes an excellent anaesthetic department. The panelists came from

large, small, regional and urban centres across Australia and New Zealand. As we learned from the lively discussion, we seem to know when departments aren't working but what constitutes excellent or healthy cultures isn't so clear.

We were very fortunate to have great weather for the social events. The Outrigger resort was a stunning venue and the ocean views from the conference centre lent a particularly relaxed ambience to the conference.

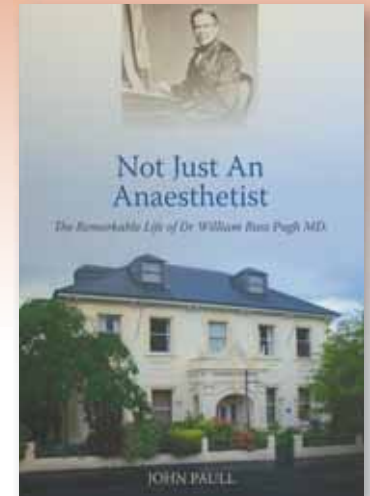
Thanks to my co-convenors Dr Natalie Smith and Professor Thomas Bruessel, the ANZCA staff, all the presenters and the delegates who made the meeting such a success.

The convenors of the 2014 Combined SIG meeting are Dr Tomoko Hara and Dr Neroli Chadderton from the Medical Education SIG. They are pleased to announce next year's meeting will be held September 19-21 at Peppers Resort, Kingscliff, NSW and will include the Communication in Anaesthesia SIG for the first time. We hope to see you there.

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**Dr Prani Shrivastava**  
Convenor

# Dr William Russ Pugh: A remarkable character comes to life



More than 60 people attended the October launch of *Not Just An Anaesthetist: The Remarkable Life of Dr William Russ Pugh, MD*, by retired Fellow, Dr John Paull.

The launch of the book about Dr Pugh, who is famous for being the first doctor in Australia to demonstrate surgical anaesthesia for the first time in 1847, was held in Dr Pugh's former home in Launceston. The launch was attended by ANZCA President, Dr Lindy Roberts, Tasmanian councillor Dr Richard Waldron and Tasmanian Regional Committee Chair, Dr Nico Terblanche, as well as several other Fellows of the College and ANZCA chief executive officer, Ms Linda Sorrell.

Dr Pugh was the first doctor in Australia to demonstrate surgical anaesthesia. This occurred in Launceston when he used ether to remove a growth from the jaw of "Mrs L", just eight months after the world-first public demonstration of ether by William Thomas Green Morton on October 16, 1846 in Boston, US.

Prior to moving to Launceston nearly 15 years ago, Dr Paull said he had never heard of Dr Pugh.

However, Dr Paull soon became fascinated in Dr Pugh's life after being given an envelope of press clippings and other records to write a chapter "The

Coming of Anaesthesia to Launceston" for the book, *Effecting a Cure: Aspects of Health and Medicine in Launceston* edited by Paul AC Richards.

"The further I explored Pugh's life, the more I realised that he was a remarkable man," Dr Paull writes in his book's preface.

"A skilled and innovative surgeon? Yes. An educated and inquisitive natural philosopher? Yes. A compassionate husband? Yes. A community minded supporter of good causes? Yes. Short-tempered and intolerant of fools and poor professional behaviour? Yes. An entrepreneur? Yes. A good manager of money? Probably not. A very interesting character whose interest in anaesthesia peaked over a period of two weeks? Yes.

"I became fascinated by the personality of the man the microfilm was revealing and after finishing my chapter for the book, decided I owed Pugh a more complete story of his life in Launceston. Hence, *Not Just an Anaesthetist*".

Dr Paull said Dr Pugh was a great character.

"He was accused of not being medically qualified and of poisoning patients with cyanide but he confounded his critics by gaining an MD from Germany," Dr Paull said.

"He was very outspoken and had a strong social conscience – he believed ending transportation was the only way to end child sexual abuse in Van Diemen's Land."

The chapters of *Not Just An Anaesthetist* are written in different voices. For example, the first chapter is told through the eyes of Captain Riddell of the Derwent, the ship on which Dr Pugh emigrated to Australia. Other chapters are told in Dr Pugh's voice and that of his beloved wife, Cornelia Kerton, who Pugh met aboard the Derwent. He walked from Hobart to Launceston to court Cornelia.

The information for the book was gleaned from a 1934 reprinting of Pugh's lost journal, articles in local newspaper, *The Examiner*, and other historical documents.

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**Clea Hincks**  
General Manager, Communications  
ANZCA

To order a copy of *Not Just an Anaesthetist*, go to [www.jdpaull.com.au](http://www.jdpaull.com.au). Regrettably the stock of 100 hard cover copies was exhausted in the three weeks since the book launch but the soft cover version is still available.

Above from left: Author Dr John Paull with ANZCA President Dr Lindy Roberts; Dr Paull signs a copy of his book at the launch; the cover of *Not Just An Anaesthetist*.

# BULLYING AND HARASSMENT

**ALL WORKPLACES HAVE LEGAL OBLIGATIONS TO PROVIDE A WORKING ENVIRONMENT THAT IS SAFE AND WITHOUT RISKS.**

“Bullying” has been identified as conduct which breaches this obligation and can be summarised as “behaviour that intimidates, offends, degrades, insults or humiliates a person, which includes physical or psychological behaviour”. Bullying is usually repeated and unreasonable behaviour, directed towards a person or a group. Occupational Health & Safety legislation places employers under a clear duty to deal with these issues.

The medical colleges, as workplaces, have an obligation to ensure that bullying does not occur within their own workplace. The colleges, being responsible for the training and supervision of trainees, have a clear right and obligation to raise issues of bullying where they are encountered. In the main, they will be matters for the workplace (hospitals), but could raise issues for the colleges if conducted by their representatives. For example, a supervisor of training who bullied trainees under his or her supervision could accrue liability both to the employer (the hospital) and the college which he or she represents.

**“MANY BULLYING TACTICS ARE NOT AS CLEAR CUT BUT ARE CLEARLY INTENDED TO HAVE THE SAME EFFECT OF OFFENDING, DEGRADING OR HUMILIATING OTHERS.”**

A recent report (Australian Health Review 2012, 36, 197-204) concluded that Australian doctors experienced significant bullying, which had a strong association to poorer health outcomes and affected longevity in the health workforce.

The *Medical Journal of Australia* also recently noted that over 54 per cent of female Australian GPs have experienced sexual harassment from patients.

A study by Griffith University “Safeguarding the Organisation against Violence and Bullying” (McCarthy/Mayhew) estimates that between 350,000 and 1.5 million people are victims of bullying in the Australian workplace. The study sought to quantify the cost of bullying to the Australian economy and estimated:

- National costs from \$6 billion to \$13 billion, including that of hidden and lost opportunity costs, rising to between \$17 billion and \$36 billion per year were calculated.
- Costs to smaller organisations (less than 20 employees) that included direct, hidden and lost opportunity costs, were estimated at between \$17,000 and \$24,000 per annum. Cost estimates for larger corporations (1000 employees) ranged from \$600,000 to \$3.6 million per year.

- The average cost of a bullying case, in lost worker productivity terms, ranged between \$17,000 and \$24,000.

Many would recognise and criticise the more obvious examples of bullying:

- Verbal abuse.
  - Initiation pranks.
  - Displaying written or pictorial material to degrade or offend others.
  - Sexual comments, jokes and innuendo.
- However, many bullying tactics are not as clear cut but are clearly intended to have the same effect of offending, degrading or humiliating others, such as:
- Sarcasm and belittling one’s opinions.
  - Constant criticism or insults.
  - Setting impossible deadlines.



1. Bullies, in general, are often not aware of the nature of their conduct. When confronted with an adverse finding arising from an investigation into their behaviour they cannot appreciate or accept the judgment of the investigator. Quite often they will assert that the investigation process constituted bullying of them and they may well leave the workplace under a stress claim.

**Lesson:** *The intention of the bully in his or her behaviour is irrelevant to whether or not bullying has occurred. Bullies are often motivated by the best of intentions, with the worst of delivery.*

2. Bullying is about abuse of power. Those who bully do so because they can. While there are cases of “upward” bullying, generally bullies pick on those who lack power.

**Lesson:** *Never underestimate the effect of your behaviour on those who have little power. A whisper from you at the top of the tree is heard as a shout by the powerless.*

3. Never assume in your interaction with another that he or she has any degree of robustness or resilience. None of us is bulletproof, and your behaviour may be the straw that broke the camel’s back.

**Lesson:** *The unintended consequences of your behaviour will live with you for the rest of your life.*

4. Many industries in Australia are low-margin enterprises. The profit on a widget may be, and usually is, very small. The difference between success and failure in a competitive marketplace is the quality of your employees.

**Lesson:** *Contented employees are more productive and less likely to change jobs. The bonus is that competitive edge which sees off the opposition.*

5. The Australian Government is moving towards a national occupational health and safety regime. It will be an amalgam of the existing state and territory legislation drawing, one expects, from the strictest aspects of each. The Occupational Health & Safety Act 2004 (Victoria) has significantly increased the personal exposure of officers (directors, board members, senior managers) and employees to fines and imprisonment for breaches of occupational health and safety laws – including bullying.

**Lesson:** *You have personal liability.*

**Michael Gorton AM**  
Principal – Russell Kennedy Solicitors

- Changing work rosters to inconvenience others deliberately.
- Deliberately delaying or withholding information or resources.
- Persistent nit-picking and unjustified criticism.
- Constantly being singled out or targeted for practical jokes or gossip.
- Deliberately being ostracised, isolated or ignored.

Without exploring the various forms of bullying, which appear to be only limited by human ingenuity, it is useful to make some general observations.

## WHAT THE COLLEGE IS DOING

As stated on its website, ANZCA considers bullying, discrimination and harassment unacceptable behaviour that will not be tolerated under any circumstances. Fellows and trainees acting as College representatives are responsible for their behaviour and should ensure an environment free of bullying, discrimination and harassment. The ANZCA Policy on bullying, discrimination and harassment for Fellows and trainees acting on behalf of the College or undertaking College function can be found at [www.anzca.edu.au/resources/corporate-policies](http://www.anzca.edu.au/resources/corporate-policies). There is also an anti-bullying policy for ANZCA staff, who undergo training programs based on this policy. The College has a process for handling bullying complaints and aims to act promptly and effectively when alerted to inappropriate behaviour.

# New online books and new books for loan

## New online books

Online textbooks can be accessed via the ANZCA Library website: [www.anzca.edu.au/resources/library/online-textbooks](http://www.anzca.edu.au/resources/library/online-textbooks)

**Essentials of Anaesthetic Equipment** / Al-Shaikh, Baha; Stacey, Simon. -- 4th ed -- Edinburgh: Churchill Livingstone Elsevier, 2013.

**Ganong's Review of Medical Physiology** / Barrett, Kim E. [ed]; Barman, Susan M. [ed]; Boitano, Scott [ed]; Brooks, Heddwen L. [ed]; Ganong, W. F. -- 24th ed -- New York: McGraw-Hill Medical, 2012.

**Learning the System: In the Words of Overseas Doctors** / Harris, Anna. -- Melbourne: Centre for Health and Safety, Melbourne School of Population Health, University of Melbourne, 2010.

**Perioperative Transesophageal Echocardiography: A Companion to Kaplan's Cardiac Anesthesia** / Reich, David L. [ed]; Fischer, Gregory W. [ed]. -- 1st ed -- Philadelphia: Elsevier Saunders, 2013.

**Quality Management in Anesthesiology, Volume 1: Fundamentals** / Dutton, Richard P. [ed]. -- Hagerstown, MD: Wolters Kluwer/Lippincott Williams & Wilkins, 2013. International Anesthesiology Clinics

## New books for loan

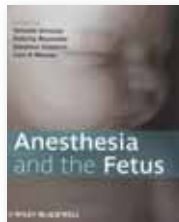
Books can be borrowed via the ANZCA Library catalogue: [www.anzca.edu.au/resources/library/book-catalogue.html](http://www.anzca.edu.au/resources/library/book-catalogue.html)



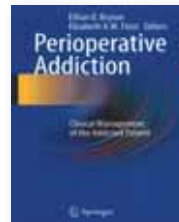
**Anaesthesia and Intensive Care A-Z: an Encyclopaedia of Principles and Practice** / Yentis, Steven M; Hirsch, Nicholas P; Smith, Gary B. -- 5th ed -- Edinburgh: Churchill-Livingstone, 2013.



**Not just an Anaesthetist: The Remarkable Life of Dr William Russ Pugh MD.** / Paull, John. -- Lanena, Tas.: Dr John Paull, 2013.



**Anesthesia and the Fetus** / Ginosar, Yehuda [ed]; Reynolds, Felicity [ed]; Halpern, Stephen [ed]; Weiner, Carl P. [ed]. -- 1st ed -- Chichester, UK: Wiley-Blackwell, 2013.



**Perioperative Addiction: Clinical Management of the Addicted Patient** / Bryson, Ethan O. [ed]; Frost, Elizabeth A.M. [ed]. -- 1st ed -- New York: Springer, 2012.



**Clinical Examination: a Systematic Guide to Physical Diagnosis** / Talley, Nicholas J.; O'Connor, Simon. -- 7th ed -- Sydney: Churchill Livingstone Elsevier, 2014.

## How do you save \$9 for every \$1 spent?

Did you know that by using your hospital or College library you are saving the organisation money, through both time and economic factors. A recent study by SGS Economics demonstrated that for every \$1 spent on a health library, there is a return on investment of \$9!

Libraries save doctors time and money by bulk-buying and collating relevant resources such as journals and textbooks and providing seamless access online, as well as services such as obtaining articles when required and performing expert literature searches to assist clinical, research, and educational needs.

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The ANZCA Library is a free service available to all ANZCA and FPM Fellows, trainees and international medical graduate specialist members. Contact the library, or visit us online or at the head office in Melbourne today.



## New ECRI safety publications

Health Devices, Vol. 42, No. 9, September 2013

- The best in portable ultrasound.
- Failure points in alarm safety: how to minimise the risks.

Health Devices, Vol. 42, No. 10, October 2013

- Physiologic monitoring systems – our judgements on eight systems.

Operating Room Risk Management, October 2013

- Surgical fires.
- Managing obese patients in the healthcare setting.

## Latest anaesthesia and pain medicine research

All articles can be sourced in fulltext from the library's online journal list: [www.anzca.edu.au/resources/library/journals](http://www.anzca.edu.au/resources/library/journals)

Engelbrecht S, Wood EM, Cole-Sinclair MF. Clinical transfusion practice update: Haemovigilance, complications, patient blood management and national standards. *Med J Aust* 2013;199(6):397-401.

Stanton TR, Wand BM, Carr DB, Birklein F, Wasner GL, O'Connell NE. Local anaesthetic sympathetic blockade for complex regional pain syndrome. *Cochrane Database Syst Rev* 2013;8:CD004598.

Haddy S. Anesthesia for structural heart interventions. *Cardiol Clin* 2013 Aug;31(3):455-465.

Euliano T. Effects of general anesthesia during pregnancy on the child's ability to learn. *Anesthesiol Clin* 2013;31(3):595-607.

Ansermino JM. Universal access to essential vital signs monitoring. *Anesth Analg* 2013;117(4):883-890

## Most borrowed books in 2013

Copies of the Australian title *Your Guide to Paediatric Anaesthesia* were borrowed from the ANZCA Library 20 times in the past year.

Over the same period, the online version of *Miller's Anesthesia* was downloaded more than 20,000 times.

The following list is the top 10 most borrowed books from the ANZCA Library over the past 12 months.

1. *Your guide to paediatric anaesthesia* / Sims C; Johnson C, 2011
2. *Dr Podcast scripts for the final FRCA* / Leslie RA [ed]; Johnson EK. [ed]; Thomas, G [ed]; Goodwin, APL [ed], 2011.
3. *Examination anaesthesia: a guide to the final FANZCA examination* / Thomas C; Butler C. -- 2nd ed, 2010.
4. *Basic physics and measurement in anaesthesia* / Davis PD; Kenny GNC. -- 5th ed, 2002.

5. *Dr Podcast scripts for the primary FRCA* / Leslie RA [ed]; Johnson EK [ed]; Goodwin APL [ed]; Thomas G [ed], 2011.
6. *The physics, clinical measurement and equipment of anaesthetic practice: for the FRCA* / Magee P; Tooley M. -- 2nd ed, 2011.
7. *Pharmacology and physiology in anesthetic practice* / Stoelting RK; Hillier SC. -- 4th ed, 2006.
8. *Anatomy for anaesthetists* / Ellis, Harold; Feldman, Stanley. -- 8th ed, 2004.
9. *Handbook of communication in anaesthesia and critical care: a practical guide to exploring the art* / Cyna AM [ed]; Andrew MI [ed]; Tan SGM [ed]; Smith AF [ed], 2011.
10. *Pharmacology for anaesthesia and intensive care* / Peck TE; Hill SA; Williams M. -- 3rd ed, 2008.

### Contact the ANZCA Library

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# Dr Colin Richmond (“Dick”) Climie

## 1923 – 2013



Dick Climie was born on December 16, 1923 in Carterton near Wellington, New Zealand. He died peacefully in Hobart on July 27, 2013. Two sons, a daughter and six grandchildren survive him. Patricia, his wife of 63 years, predeceased him eight months earlier.

Dick was born into a family of talented engineers, most notably his father Harry Climie, and was a skilled craftsman and inventor in his own right. He made his first boat, a 12-foot skiff, with a hull of roofing iron, at the age of 17. He was an exceptionally capable, hard-working young man who endured the difficulties of life during the Great Depression in New Zealand and who, as a medical student at Otago University, worked part-time jobs, including shearing and digging ditches, to pay for board and keep. He continued to engage in manual labour throughout his life, especially building, refitting and maintaining the sailing boats that were one of his life's passions. After his retirement he became a skilled carpenter and keen gardener.

After graduating in 1948, Dick was a resident and an anaesthetics registrar at Wellington Hospital. He then went into general practice for five years, maintaining his interest in anaesthetics.

He met his wife Patricia while they were both studying at Otago, and they married in 1949. They had two sons, Richard in 1951 and Andrew a year later. In 1956 Dick decided to specialise in anaesthetics, so the young family boarded a cargo ship to England.

He gained his FFARCS in 1957 while a registrar at Hammersmith Hospital, three months after the birth of their daughter, Libby. During his tenure, epidural blockade was being advanced as an integral part of obstetric anaesthesia by trailblazers such as Philip Bromage. This opportune exposure had a significant influence on his career path.

In 1958 they sailed back to New Zealand. Dick was appointed as a full-time specialist at the National Women's Hospital in Auckland where he used his recently acquired expertise to pioneer the use of epidural anaesthesia in obstetrics in New Zealand. He gained his FFARCS in 1960.

In 1963 Dick accepted an offer to become the inaugural full-time director of anaesthesia at the Royal Hospital for Women (RHW) in Paddington after it was assigned to Sydney's second medical school at the University of New South Wales. Among his many celebrated achievements in his 21 years at RHW, Dick was responsible for introducing and promoting the use of epidural analgesia for pain relief in labour and, in 1965, established the first 24 hour epidural service in an obstetric hospital in NSW. Developments he instigated resulted in rapid decreases in maternal and infant morbidity and mortality.

Dick was deeply committed to the advancement of anaesthetics, and is fondly remembered by many registrars as an outstanding teacher and mentor with remarkable patience, clarity and tolerance. His approach to technical and procedural details was unfailingly evidence-based and ergonomically sound. In spite of an onerous workload, understaffing and negligible funding for research, he oversaw and engaged in a

wide variety of original research projects and their associated publications. He was recognised as a respected leader in the field and was invited to speak at local and international conferences.

Dick resigned from RHW in 1984, and returned with Patricia to Auckland where he eased into semi-retirement, while continuing to work part time. After a short stint at the National Women's Hospital he moved to the North Shore Hospital where he helped establish the obstetric anaesthesia service, until finally retiring in 1990. In 1998 he and Patricia moved to Tasmania to be closer to their children and grandchildren, and Dick immediately became actively involved in the community, joining the U3A and various social groups. He volunteered at the Australian Medical Association museum and served as the treasurer, secretary and president of the local residents' association. Following Patricia's death at the end of last year, Dick's health deteriorated and he finally succumbed to pneumonia.

Dick was an exceptional person; congenial, extremely conscientious and extraordinarily competent at almost everything he set his mind to. He was the quintessential professional, quietly spoken, modest and self-effacing, dignified, calm in emergencies and noted for his basic goodness, kindness and empathy. He has left a great legacy through his many years of teaching and contributing to the anaesthetic community in particular and the wider society in general, and will be greatly missed by his family, friends and all of those fortunate enough to have known him.

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**Dr Eddie Loong** OAM FANZCA  
Alstonville, NSW

# Dr Ashleigh Alick Bishop

## 1938 – 2013



Ashleigh Bishop was born in Lower Hutt, New Zealand on October 26, 1938, the only male of six children. He died in Brisbane, Queensland on September 12, 2013.

After primary and secondary school education in the Lower Hutt and Wellington area, he graduated in medicine from Otago University, Dunedin in 1962. Ashleigh then returned to the Wellington area to undertake his hospital internship and early anaesthesia training, passing the primary FFARACS examination in 1967. He elected to complete his training in Melbourne, and was appointed to the well known and highly sought after Royal Women's and Royal Children's rotation in 1968, where he came under the influence of the legendary directors Kevin McCaul and John Stocks. He gained the FFARACS diploma that year, and spent a further year in intensive care at the Royal Children's in 1969.

Ashleigh had been offered a position in New Zealand, but elected to accept the position of part-time director of anaesthetics at the Mater Mothers Hospital, Brisbane, arriving in early 1970. He was later appointed to the visiting staff of both the Mater Children's and Royal Children's Hospitals, Brisbane, and also entered private practice. Despite carrying a heavy workload, Ashleigh became an enthusiastic teacher and mentor to younger anaesthetists.

In 1972 Ashleigh was invited to join the private anaesthetic practice now known as Narcosia, where he made major contributions. Being "computer literate" well ahead of most of his colleagues, he laid the foundation of what has become a very sophisticated computer system. He was heavily involved with the organisation of the practice, chairing its executive in 1993-94, handling difficult staffing and other problems with great maturity and wisdom.

Ashleigh found time to become involved in Faculty of Anaesthetists RACS affairs. He was elected to the Queensland Regional Committee, serving in several positions, culminating in chair in 1983-84. He was appointed as examiner to the final fellowship FARACS in 1984, and served his full 12-year term until 1996.

Ashleigh had been diagnosed with retinitis pigmentosa, a familial problem, which gradually diminished his peripheral vision, although his central vision remained amazingly acute. Eventually advancing disease prompted his retirement from practice in 2007.

By any set of values, Ashleigh had an impressive professional career. Although he did not restrict his practice to obstetric and paediatric anaesthesia, they gave him the most interest and commitment. His reputation and stature as a paediatric anaesthetist, in particular, places him as one of the leaders of his era. At a time when monitoring and other techniques were not as advanced as now, his knowledge, dexterity, and innate ability to make complicated problems seem simple made him outstanding. His quiet unassuming approach calmed the anxieties of patients, parents and surgeons alike. He was kept in great demand by the busiest paediatric surgeons in Brisbane, for whom he worked seemingly tirelessly, often out of hours, whether he was supposedly on call or not. His personality made him immensely popular with other staff, and with colleagues who approached him for advice.

In retirement, Ashleigh remained active, despite his inexorably advancing visual problem. His home is a serene, relaxing place, surrounded by a landscaped garden, largely a product of his own efforts. In this environment he was a most gracious host. He was a great lover of music, enthusiastic concert goer, and a highly accomplished pianist in his own right, spending many hours at the keyboard, which gave him great enjoyment. Sadly, he became increasingly frustrated, as failing vision precluded him from seeing his beloved music and the keyboard at the same time. His family have given him much joy and interest. Angela, his wife of nearly 50 years, bore him four children, who in turn have presented them with 12 grandchildren. Angela has been a tower of strength and support, from the early days in private practice when she also acted as secretary, and at the later part of his career, when his visual problem prevented him driving. The grandchildren adored him.

In late 2012 Ashley was diagnosed with urinary tract malignancy that would prove to be terminal. He accepted the diagnosis and its prognosis with the quiet dignity and resignation that typified his strength of character. He remained in good humour, happy to see old friends and have a convivial whisky or coffee almost to the end, despite increasing distress. He died at home in the company of his wife and family.

At his passing we have lost a wonderful friend, colleague and inspirational anaesthetist.

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**Dr David H McConnel** MBBS (Qld)  
FRCA FANZCA OAM  
Narcosia Anaesthetic Group (retired)  
Brisbane



# Dr John Leonard Handsworth

## 1939 – 2013



John was born in Romford, Essex, England on December 24, 1939, to Flo and Leonard Handsworth.

The family decided to immigrate to Australia when John was 17 and they arrived in Adelaide on February 14, 1957. The family settled in Elizabeth and John attended Woodville High School. Had John's parents taken him to another state, this story could have been very different as John wanted to be a vet!

There was no veterinary school in Adelaide so John decided to study medicine instead, helping to fund his studies by working in market gardens around Salisbury. He began his medical studies at the University of Adelaide in 1959 and we graduated together in 1965. As a frustrated vet he enjoyed biology, dissecting rats, frogs and cockroaches, and applied physiology anaesthetising rats and rabbits. He did comment on one occasion after we euthanased the rabbits and sent them to the incinerator that it seemed like a waste of good protein and we should be allowed to take them home and eat them.

In 1966 I went to Papua New Guinea and John went into general practice with Dr Vin Hart in the Salisbury area. Over the next seven years, John gave anaesthetics for his partner Dr Hart, removed tonsils and adenoids, the occasional appendix, set simple fractures and delivered lots of babies.

After seven years in general practice, John was looking for a new challenge. He was looking at psychiatry or anaesthetics. The training post for psychiatry was in Brisbane and because he had two children

in Adelaide, he chose anaesthetics. So in 1973 John and I met up again when we both joined the Anaesthetic Training Scheme at Royal Adelaide Hospital. This began a professional and private friendship that lasted our whole lives.

It was the right choice for John because he loved the science of medicine and had great practical ability. He loved solving problems and was always ready to debate situations with tutors and senior colleagues. Both John and I had a few problems with the primary exam for the anaesthetic fellowship. We decided this was due to the explosion of knowledge in the basic sciences, which had occurred since our undergraduate days. Someone was heard to say, "Well of course John would rather be out sailing than studying!" John loved his yacht and sailing. It was his time out, relaxation away from work and study.

During his life, John was very active and had many hobbies, including scuba diving, fishing, camping, sailing, bushwalking, metal work and woodwork. He built his own 29-foot cruising yacht with his father-in-law. John had a natural musical talent. He played the clarinet, saxophone, harmonica and the bugle. He taught himself the Northumbrian small pipes as well as the didgeridoo. John was always whistling, he just loved music.

John was admitted to the Faculty of Anaesthetists Royal Australasian College of Surgeons on June 6, 1980, and began a 20-year career as a specialist anaesthetist. He did most of his work in the Salisbury, Elizabeth and Gawler, with the occasional visits to the private hospitals in Adelaide, and sometimes travelling as far afield as Karoonda, east of Tailem Bend, Crystal Brook and Port Pirie in the north. He was one of the first anaesthetists to provide an epidural service for the obstetricians at the Lyell McEwin Hospital and was one of the first to be appointed as a visiting consultant anaesthetist to that hospital.

He was instrumental in forming the first and only group of specialist anaesthetists based in the northern suburbs of Adelaide. The group consisted of John, Dr Rupert McArthur, Dr Paul Rainsford, Dr Max Gluyas, Dr Jeyaseelan, myself, and later Dr Harbans Gill. This group provided a good anaesthetic service for several years until Dr McArthur went full time to the Lyell McEwin Hospital, Dr Rainsford went to Whyalla and Dr Jeyaseelan tragically died of leukaemia.

On the June 30, 1992, John was made a Fellow of the Australian and New Zealand College of Anaesthetists. For the last 10 years of his working life, John was the only specialist anaesthetist resident in the north available after hours for the Central Districts Private Hospital and the Gawler Hospital.

John and Rosie had moved to a property on Mount Gawler near Kersbrook in 1984 and it was while living here that we see what John would have considered to be one of his greatest failures and one of his greatest successes.

Firstly the failure... John was great at epidurals. Clinically, Blossom needed one, but it failed to work and the local vet had to be called and rebuked John by telling him he wasn't qualified! Blossom was a cow!

John's greatest achievement was as a gynaecologist to a ewe with a prolapsed uterus. He managed to push the uterus back and keep it back. John had finally achieved his wish to be a vet!

In 2001, John was diagnosed with Alzheimer's disease. He retired and taught himself to play the trumpet and continued to grow vegetables and various berries. Three years ago John lost the ability to sight-read music, which was a sad time for him. Thanks to his wife Rosie, John was able to remain in the home that he loved, surrounded by the gardens that he had tended. John passed away peacefully at home on the June 13, 2013. He is survived by Rosie, four children and nine grand children.

John was an excellent anaesthetist and clinician. He would not want public recognition or thanks for his service to the community, but John stands out as the anaesthetist who made a tremendous contribution to the anaesthetic service in the Salisbury, Elizabeth and Gawler region.

Perhaps the best summary of John comes from his children.

"Dad was an inspirational, intellectual and pragmatic person. He was multi-skilled in art, music, woodwork and metalwork; he was a sailor, cook, gardener: he was experimental, scientific, strict but fun, a teacher, a hard worker and a loving father."

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**Dr John L Foote** MBBS FFARACS FANZCA

# Dr Prem Narain Rastogi

## 1933 – 2012



Dr Prem Narain Rastogi was born in Lucknow, India on January 28, 1933, the eldest son of a businessman and the second of eight children.

From a very early age, Prem aspired to study medicine and in 1956 he graduated from King George Medical College, Lucknow. In 1957, Prem married his soul mate and the love of his life, Ved. Not content with his father's plans for a safe and prestigious general practice in his hometown, Prem soon set sail for England in pursuit of a residency in anaesthesia where he was joined a year later by his young wife.

In 1964, Prem decided to further his career in anaesthesia by accepting a consultancy in the British outpost of Nigeria, and living there for a year with his wife and two young children. It was a bold move but at the time consultant positions in anaesthesia in England were rare.

In 1967, now a Fellow of the Faculty of Anaesthetists of the Royal College of Surgeons (FFARCS), Prem was invited to join the newly founded Anaesthesia and Intensive Care Unit at the Royal Newcastle Hospital in Australia as a consultant. The unit's founder, Dr Ivan Schalit, was to become a colleague, mentor and close friend.

Prem quickly fell in love with the city of Newcastle and he loved working at the Royal Newcastle Hospital. He enjoyed the camaraderie of the new department and devoted his working life to teaching and mentoring registrars in anaesthesia and the young doctors who rotated through the department. He rose through the ranks within the hospital and was often acting head of the department but, preferring clinical work and teaching over administrative duties, never permanently accepted this position.

Often described as a "true gentleman", Prem was known for his quiet, gentle and caring manner and the respect with which he treated his colleagues and staff, as well as his patients. Affectionately known as Razz, Dr Rastogi was a generous and devoted teacher, teaching generations of registrars and residents the virtues of patience and calmness as well as skill and precision.

Prem was a skilled clinician, eager to keep his skills updated with continuing education and to explore new techniques as well as pioneer techniques of his own. The "Rastogi grip" remains a legacy still taught to Newcastle anaesthesia students long after his retirement.

Prem remained at the Royal Newcastle Hospital as a staff specialist until the early 1980s and then as a visiting medical officer till his retirement from the public hospital system in 1988. Prem practiced anaesthesia solely in private hospitals until his retirement in the mid 2000s.

A highlight in Dr Prem Rastogi's career was working for over five years alongside his son and cosmetic surgeon Dr Anoop Rastogi.

Having retired from anaesthesia, Prem discovered new delights in his life. He spent his time with his adored wife and his grandchildren. He could be seen most days walking near his home beachside at Bar Beach, chatting to people and enjoying the view, the fresh air and watching the dolphins and whales.

Dr Prem Rastogi passed away in his home on May 19, 2012 following a stroke two days earlier. His beloved wife, Ved, was by his side and his children and grandchildren surrounded him. Prem is remembered and missed by many.

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**Dr Anjali Rastogi (BDS) (LLB)**  
(daughter)