
ANZCA BULLETIN

beyondblue study:
Mental health
concerns for
anaesthetists

IMGS contributions:
Benefiting from
overseas-trained
doctors

Continuing education:
Our successful 2014
ANZCA CPD Program
launch



FPM
FACULTY OF PAIN MEDICINE
ANZCA



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Feedback has been generally positive since the launch of the 2014 ANZCA CPD Program and new CPD portfolio system.



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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We encourage the submission of letters, news and feature stories. Please contact *ANZCA Bulletin* Editor, Clea Hincks at chincks@anzca.edu.au if you would like to contribute. Letters should be no more than 300 words and must contain your full name, address and a daytime telephone number. They may be edited for clarity and length.

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claim Kiwi lives

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President's message



This is my last *Bulletin* message as ANZCA president, focusing on some of the key issues facing our professions. Being president has been an enormous privilege and, of course, a challenge given all that is happening in the broader medico-political environment. It's been a busy couple of years!

I trust that you welcome improved avenues for feedback from Fellows and trainees – to major projects and services such as the College and Faculty strategic plans 2013- 2017, CEO hospital visits, ANZCA/FPM CPD program, training programs, training portfolio system (TPS), and important issues such as workforce, revalidation and raising the profile of our professions. As always, I invite your feedback at president@anzca.edu.au.

Acknowledgements

I acknowledge the support of many dedicated Fellows, trainees, chief executive officer Linda Sorrell, and the hardworking College staff; it has been truly inspirational to be witness to and part of that work. I couldn't have undertaken this role without your efforts and the support of my family. I plan to serve the remainder of my elected term on the ANZCA Council until May 2016.

I am delighted to announce that Dr Genevieve Goulding (FANZCA, FAICD) from Queensland is the president-elect. Genevieve will take over at the Singapore annual scientific meeting (ASM), and has been involved in important College initiatives, with a particularly strong record in governance, quality and safety, education and welfare. I wish her well for her new role leading our College. My thanks to Associate Professor Brendan Moore for his leadership of the Faculty of Pain Medicine over the past two years. I acknowledge also other outgoing ANZCA councillors – Professor Kate Leslie (former president), Dr Kerry Brandis, Dr Michelle Mulligan and Dr Gabriel Snyder (new Fellow councillor).

Workforce

Anaesthesia workforce issues remains at the forefront of ANZCA Council deliberations and College activities. Several articles appear in this *Bulletin* – the graduate outcome survey (page 20), frequently asked questions about anaesthesia workforce (page 23), and ANZCA and Government (page 16). The College's Workforce Action Plan 2014 focuses on collecting high-quality data, ensuring the College has an effective voice in decisions by policy-makers, and communication with Fellows and trainees. I look forward to meeting with Fellows and trainees at the Singapore ASM workforce forum at lunchtime on Tuesday May 6.

The large number of workforce stakeholders requires a collaborative approach. Many meetings are being held with workforce decision-makers – Health Workforce Australia (HWA), Health Workforce New Zealand, Australian state and territory health departments, and the New Zealand Ministry. The College supports the HWA National Medical Training Advisory Network (NMTAN), an ambitious proposal that aims to bring together all the major stakeholders to ensure national co-ordination of Australian medical workforce planning. We are also keeping abreast of broader developments, including the approaches of other bodies¹.

Many Fellows and trainees have raised concerns about industrial issues in Queensland. While the College does not get involved in industrial matters (which is the role of the Australian Medical Association and the Australian Society of Anaesthetists), we are monitoring the situation closely.

I have contributed to a joint statement by all college presidents (<http://cpmc.edu.au/about-us/policy-statements>) which has been sent to the health minister.

We will act if there is evidence that training and supervision, and specialist continuing professional development, are compromised, in the interests of the health of the broader community.

Revalidation

This remains topical in Australia and New Zealand, particularly given developments in countries such as the UK, Canada and the US. Professor Ron Patterson, a former New Zealand Health and Disability commissioner, has been an influential voice in both countries, especially about community expectations that all doctors remain up to date². The chair of the Medical Board of Australia (MBA) has written an article in this edition of the *Bulletin* (page 10). A recent article in the *Medical Journal of Australia* raises important questions that must be addressed in this debate³.

The introduction of revalidation in some form seems inevitable, although the timeframe is unclear. The College is committed to active discussions with the MBA and the Medical Council of New Zealand (MCNZ), especially since we have seen some overseas colleges sidelined. Our professions have an opportunity, and a challenge, to ensure that anaesthetists and pain medicine specialists remain actively involved in any future developments, ensuring that changes remain relevant to *our* clinical practice and are not overly bureaucratic or onerous. I've been asked to present ANZCA's approach at a forum on revalidation in March 2014, which will also be an opportunity to hear from the regulatory bodies and other colleges.

The ANZCA Continuing Professional Development Standard and program

The new ANZCA/FPM Continuing Professional Development (CPD) Standard applies to all anaesthetists and specialist pain medicine physicians in Australia and New Zealand. Compliance with the ANZCA CPD Program (see article on page 8) automatically meets the standard. The new online portfolio should make compliance easier – allowing uploading of attendance certificates and automatic recording of ANZCA/FPM conferences and training activities.

The transitional arrangements mean that there are no compulsory category 1 and 3 activities for 2014; so this gives plenty of time to carefully plan your activities for the next triennium. I'm impressed that some private groups and departments are already working together to assist their members to meet the new requirements.

The feedback I have received so far is that Fellows support the need for regular education in emergency responses (new category 3) – given that we are the acknowledged airway and resuscitation experts – but are concerned about access to relevant courses, especially for those who work only in private practice. ANZCA recently published the criteria that such courses must meet – they can be held locally and there is no need to attend a particular course. The College is making sure that regional/national continuing medical education committees and special interest groups are aware of the new requirements to build the capacity to meet demand.

New category 1 is focused on evaluating your own practice and requires more work than the previous standard and program. Questions I have been asked indicate that some Fellows have not yet accessed the resources provided on the College website, including templates and guidelines on how to undertake each activity. ANZCA has benchmarked itself against other colleges and the requirements are very similar to those of our surgical colleagues who have been undertaking compulsory practice audit for more than 10 years. Some private anaesthesia groups are discussing innovative ways to meet requirements and I welcome feedback and examples of what is working well.

A number of CPD presentations are planned or have already occurred – in NSW, Queensland, Tasmania, Victoria, Western Australia and South Australia. There is lots of information on the College website (including tools, templates and several podcasts) to assist you. Please contact cpd@anzca.edu.au with any questions, or to arrange a presentation to your private group or department.

A call to action in the interests of our professions and the community

You can help by responding to College surveys to ensure representative, meaningful results; by treating every patient interaction as an opportunity to improve understanding of our professions and professionalism; by acting where you can locally to influence health workforce planning; and by ensuring you report any cutbacks that may impact on training to your ANZCA regional or national committee to ensure training quality is maintained.

There are many challenges and threats facing our professions. United, we can make sure that we meet those challenges in ways that ensure the highest standards of professional practice in the interests of Fellows and trainees, and the communities we serve.

Dr Lindy Roberts
President, ANZCA

References:

1. AMA Position Statement (2013). Medical Workforce and Training. Available at <https://ama.com.au/policy/positionstatements>. Accessed March 2, 2014.
2. Patterson R. The Good Doctor: What Patients Want. Auckland University Press, June 2012.
3. Breen KJ. Revalidation – what is the problem and what are the possible solutions? *Med J Australia* 2014;200(3):153-56.

Chief executive officer's message



Recently we held the first meeting of our new History and Heritage Panel – an insightful exercise that gives me great confidence that the management of our College treasures is in good hands.

ANZCA has a large collection of portraits, paintings, furniture, silver, antiques, anaesthetic equipment and paraphernalia, books, archives, documents and oral histories, most of which require specialised care and storage.

The panel was established following a conversation I had with Margaret Birtley, the Executive Manager, Heritage of the Melbourne Cricket Club, who explained the benefits of establishing a panel of experts for advice.

ANZCA's History and Heritage Panel includes five Fellows. Dr Christine Ball is ANZCA's honorary curator and has a keen interest in preserving and promoting the College's historical archives and ensuring they are available as a resource to Fellows and the public. Dr John Paull is ANZCA's honorary archivist and recently published a biography of Dr William Russ Pugh, the first doctor in Australia to demonstrate surgical anaesthesia.

Dr David Jones is the immediate past dean of the Faculty of Pain Medicine and is interested in the history of pain medicine. Professor Barry Baker is ANZCA's dean of education and the executive director of professional affairs at ANZCA. He has written books and articles relating to anaesthetic history and was instrumental in developing the ANZCA's coat of arms when the College formed in 1992. Dr John Williamson also has a keen interest in history. He is a retired anaesthetist who has worked in Townsville and Adelaide.

Also bringing a wealth of experience to the panel are Ms Nola Anderson, who is a consultant and provides advice to museums, galleries and cultural institutions; Mr Peter Haynes, a lecturer at several universities who has held positions such as curator of the Parliament House art collection, the director/curator of the Nolan Gallery and art curator at the University of Canberra; and Dr Peter Featherstone, from the UK who has been a member of the History of Anaesthesia Society since 2009.

More detailed profiles on each panel member are on page 13.

At our first meeting in February, which was attended by ANZCA President Dr Lindy Roberts, we discussed the Geoffrey Kaye Museum of Anaesthetic History and its relocation to the historic Ulimaroa building in front of ANZCA House, Melbourne, where it will be the centrepiece of the College's new cultural hub.

An application for the Geoffrey Kaye Museum to join the Museums Accreditation Program was also discussed. To become accredited, museums spend up to three years developing procedures, policies and practice to meet recognised museum standards. Training, advice and information is available to assist museums in meeting these standards. The submission date for the final application is August 31.

The panel was asked for input into how the collection might be displayed for museum tours and enhanced through audiovisual means, so the museum experience can be shared beyond Melbourne.

The group also discussed the web-based oral histories program for 2014 and 2015 to add to the six "anaesthesia stories" already on the website – Dr Patricia Mackay, Professor Ross Holland, Professor Bill Runciman, Dr Nerida Dilworth, Professor Tess Cramond and Dr Duncan Campbell.

How the College's history and heritage should be promoted was also discussed. The panel considered potential articles for the *ANZCA Bulletin* and how the website might be enhanced to improve accessibility for all.

The meeting also discussed ANZCA's archiving system, which was recently reviewed, College policies relating to history and heritage, and ideas for celebrating the 100th anniversary of ANZAC next year.

I feel confident that more Fellows and trainees will be able to experience all the College has to offer from a history and heritage perspective.

Finally, I'd like to mention the enormous amount of work going into this year's Singapore annual scientific meeting from Monday May 5 to Friday May 9, which will be preceded by FPM's popular Refresher Course Day on Sunday May 4.

The Singapore ASM is proving very popular among Fellows, with registrations exceeding expectations. The meeting, themed "Working together for our patients", is a joint exercise with the Royal Australasian College of Surgeons.

For the first time, the two colleges will be sharing scientific sessions and many parts of the social program. And in another break with tradition, the first Monday of the meeting has been set aside for workshops only. FPM will also hold a series of pain-related topical discussion sessions and workshops on the Monday.

If you haven't yet booked for the Singapore ASM, I encourage you not to leave it too late!

Ms Linda Sorrell
Chief Executive Officer, ANZCA

2014 Australia Day Honours

Professor Michael John Cousins, AO, AM, FANZCA, FFPMANZCA

Appointed as an Officer of the Order of Australia (AO) in the General Division

For distinguished service to medicine through specialised tertiary curriculum development, as a researcher and advocate for reform and human rights in the field of pain, and as an author and mentor.

Professor John Herbert Overton, AM, OAM, RFD, FANZCA, FCICM

Appointed as a Member of the Order of Australia (AM) in the General Division

For significant service to medicine, particularly in the area of anaesthesia, through clinical, administration and advisory roles, and to professional organisations.

Dr Peter David Livingstone, OAM, FANZCA

Awarded a medal of the Order of Australia (OAM) in the General Division

For service to medicine as an anaesthetist.

Letter to the editor



Desflurane – far from ideal

How timely and relevant it was to read the article “Greening your gases” (*ANZCA Bulletin*, December 2013). As a trainee I learnt the properties, then considered to be those of an ideal anaesthetic agent. What are the properties of today’s ideal agent? According to the doctrine *primum non nocere* the first property of an ideal

anaesthetic agent should be to do no harm; to the patient, the practitioner, other people or the environment. The poor environmental credentials of nitrous oxide are well known and have contributed heavily to its decline in use. Less well known are the poor environmental properties of desflurane. Desflurane is a potent atmospheric pollutant with approximately 25 times the global warming potential of sevoflurane^{1,2,3}. If we are to accept the doctrine of first do no harm and recognise that minimal environmental impact is a key property of an ideal anaesthetic agent, then desflurane is far from ideal. Any marginal clinical benefit of desflurane is far outweighed by its environmental harm. Climate change is the greatest health challenge facing us in the 21st century⁴. Anaesthetists have a responsibility to do no harm to the

patient and the environment. Given there are effective less harmful alternatives desflurane should cease to be used in clinical practice and along with nitrous retired on the grounds of being far from ideal.

Dr Catherine Hellier, FANZCA

References:

1. Sherman J, Le C, Lamers V, Eckelman M. Life cycle greenhouse gas emissions of anesthetic drugs. *Anesth Analg*. 2012 ; 114(5): 1086-1090.
2. Huncke T.K, Ryan S, Hopf H. W. et al. Greening the Operating Room. *American Society of Anesthesiologists*. April 2012.
3. Anderson S, Nielsen O. J. et al. Medical intelligence article: assessing the impact on global climate from general anesthetic gases. *Anesth Analg*. 2012; 114(5) 1081-1085.
4. Costello A, Abbas M, Allen A et al. Managing the health effects of climate change. *The Lancet*. 2009 Vol 373, issue 9676, 1693-1733.

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, *Ao2 Policy on Endorsement of Externally Developed Guidelines*, is now being piloted, as is a revised version of *PS27 Guidelines for Major Extracorporeal Perfusion*. Both documents are accompanied by background papers. The definitive version of *PS37 Guidelines for Health Practitioners Administering Local Anaesthesia* is also now available.

Queries or feedback regarding professional documents can be directed to profdocs@anzca.edu.au.

The complete range of ANZCA professional documents is available via the ANZCA website, 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.

CPD Program launches successfully



In January the College successfully launched the revised ANZCA Continuing Professional Development (CPD) Program and accompanying CPD portfolio system after several months of work and careful review.

As expected, there has been a higher than usual volume of queries and feedback in relation to the 2014 ANZCA CPD Program, with most issues resolved immediately.

Overwhelmingly, the feedback has been positive, with Fellows appreciating the features and ease-of-use of the CPD portfolio system.

The queries and feedback have all been logged and will be considered by the CPD Committee. There have been some really clever suggestions and these will inform upgrades to the CPD portfolio system and become part of our web-based frequently asked questions and answers.

Common queries include:

- Problems with older internet browsers. The new CPD portfolio system has been tested on Internet Explorer 10, Firefox 25 and 24, Chrome 31 and 30, Safari 7, 6 and 5 and Opera 18. Fellows using older browsers should upgrade to ensure the system works optimally.
- Advice on where, within the new categories, participants should claim certain activities they are undertaking. Some queries are forwarded onto the members of the CPD Committee for advice or are added to a list of activities that will be considered for inclusion within the CPD program by the CPD Committee in the coming months.



- How to complete the 2011-13 triennium. Participants who have not yet finished their 2011-13 triennium need to do so in the old CPD portfolio system, which can be accessed via the ANZCA website until the end of March. Once requirements have been met, a certificate of completion can be generated. This will notify the College that it can begin transferring CPD information into the new portfolio system and set up access for the participant, which takes a few days.

The new CPD portfolio system has many features, including:

- A dashboard highlighting triennial and annual requirements. Helpful information, resources and tools are embedded on the screens for Fellows' convenience.



- Automatic recognition of ANZCA events. When a participant registers online for an ANZCA or FPM-run event via the ANZCA or FPM websites, credits are automatically entered into the Fellow's portfolio for confirmation and editing.
- The ability to upload and store supporting evidence within in the CPD portfolio system. Participants also can undertake a number of processes without an internet or mobile network connection and their portfolio will automatically update when they are next online.
- A direct link to the ANZCA training portfolio system (TPS). When Fellows complete assessments for trainees and log these into the TPS, credits will be automatically entered into the CPD portfolio for confirmation and editing.
- An integrated experience for provisional Fellows to record their CPD online. Provisional Fellows can select activities submitted in the TPS within the CPD portfolio system quickly and easily, avoiding the need to enter activities twice.

For further information about the 2014 ANZCA CPD Program and to log into individual CPD portfolios, go to www.anzca.edu.au/fellows/continuing-professional-development.

The ANZCA CPD unit continues to value Fellows' feedback. Please contact us on +61 3 9510 6299 or cpd@anzca.edu.au.

Dr Vanessa Beavis
Chair, CPD Committee

NZ general registrants and ANZCA CPD

ANZCA's Continuing Professional Development (CPD) Program will continue to provide for its current general registrant participants, the ANZCA Council decided at its February meeting.

General registrants are doctors registered with the Medical Council of New Zealand (MCNZ) in the general scope rather than in a vocational (specialist) scope. While all vocationally registered anaesthetists have to undertake ANZCA's CPD program, around 20 doctors registered in the general scope and undertaking some anaesthesia work were also participating in the program when the MCNZ changed its CPD requirements for general scope registrants two years ago.

ANZCA now will seek written confirmation from the MCNZ that its 2014 CPD program meets the requirements for general registrants, and that those participating in it may continue to do so.

It will also seek formal confirmation from general registrants that they wish to continue and provide them with information about their CPD obligations, their transition into the 2014 program and links to required resources.

Susan Ewart,
Communications Manager,
New Zealand, ANZCA

Safety the top concern as regulator ponders revalidation for doctors

Patient safety and good medical practice are at the heart of discussions on revalidation, writes Medical Board of Australia Chair, Dr Joanna Flynn.

The Medical Board of Australia has started a conversation with the medical profession and the community about revalidation for medical practitioners in Australia. The International Association of Medical Regulatory Authorities defines revalidation as “the process by which doctors have to regularly show that they are up to date, and fit to practise medicine”.

In the UK, New Zealand, Canada and the US, medical regulators are discussing how to ensure that doctors in active practice are competent and professional. In some jurisdictions the focus is on enhancing continuing professional development (CPD) frameworks, in others on additional requirements for performance evaluation and feedback. Programs vary between those that target doctors known to be at higher risk and those that take a population wide approach. The UK introduced revalidation for all practising doctors from late 2012. New Zealand has introduced a recertification program for all doctors with a general scope of practice, that is those who are not specialists, and requires all doctors to undertake a structured audit of their practice as part of their CPD. Some Canadian provinces target doctors who practise in isolation or those who are over the age of 70.

The core purpose in all of these programs is to support patient safety and ensure good medical practice. Medical regulators have public protection as their primary consideration. Their role is to regulate standards of practice in the public interest. There is a solid body of international research, which demonstrates that a significant proportion of practising doctors underperform. This comes as no surprise to any practising doctor, as almost all of us can identify colleagues about whom we would have some concerns.

Revalidation is not a tool to weed out bad apples. Its purpose is not to identify a Shipman or a Patel. Doctors who are practising in ways that are in serious breach of accepted standards are identified in other ways and are dealt with through other processes involving employers, the Australian Health Practitioner Regulation Agency and the Medical Board of Australia and sometimes through courts and tribunals. Rather, revalidation is a process to identify and improve the performance of those who are at the lower end of the bell-shaped curve and to move the whole curve to the right.

So is there a place for revalidation in Australia? Who would need to be involved? What would they have to do? How often? What would it cost? And most importantly, what value would it add?

What does the medical board have in place now to ensure appropriate standards of medical practice? As well as responding to notifications, the board sets registration standards, publishes codes and guidelines and approves accreditation standards developed by the Australian Medical Council (AMC) for basic and



specialist education. The board has set registration standards for CPD and for recency of practice and has published *Good Medical Practice*, the code of conduct for doctors in Australia.

In the registration standard for CPD, the board has mandated specialist colleges as the appropriate bodies to set CPD requirements for those in their specialty. In turn, within the accreditation of specialist colleges by the AMC, one focus is the college’s approach to CPD. Each year, when doctors renew their medical registration they are required to make a number of declarations, including that they are meeting the CPD requirements. This year the board will start to undertake random audits to ensure that practitioners are meeting the registration standards.

The board recognises that in Australia there are many other patient safety and quality assurance mechanisms. Clinical governance and performance appraisal are key to good health service management and delivery. But not all doctors participate.

The board ask the profession and the community whether these processes are enough, whether the combination of CPD and clinical governance process are sufficient to allow the board to assure the public that all doctors on the register are competent and fit to practise. And if they are not, what needs to happen? Can or should CPD programs be redesigned? Should the board be targeting groups of doctors known to be at higher risk?

The way forward in Australia is not yet clear. The board needs to consult widely, gather evidence about where the gaps are and about what is effective, watch what is being learned from international experience, consider what may be feasible and test some proposals.

The ultimate question is what will provide a sufficient level of assurance that the trust that the community places in the medical profession is soundly based?

Dr Joanna Flynn
Chair, Medical Board of Australia

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.

Consider the following scenario:

You have been working at a satellite training hospital with a BTY2 trainee (in second year of training) having finished your last emergency case, a ruptured AAA at 10pm. You finally get to "hit the hay" at 11pm aware that you have a private ENT list the next morning. You drift off to sleep feeling reasonably comfortable with your relatively early night.

Suddenly you are awoken from a deep sleep by a phone call from your obstetric colleague with whom you regularly do two private sessions weekly and have done so for the past eight years. He informs you of an urgent caesarian section that he needs to do and wants your help. You look at the clock and notice that it is 1.30am. Even though you are only 10-15 minutes away from the hospital you know that at best, 'knife to skin' won't be before 2am. The obstetrician is quick and surgery should only take about 40 minutes. By the time handover is completed it will be at least 3am and then by the time you get back to bed it will be 3.30am leaving a little over two hours before you have to get up for your morning ENT list.

So far articles in this series have addressed patient-care issues. With the start of the new year, I thought I would raise an equally important issue that is closely related to patient care, and that is our own health and wellbeing. Specifically, I want to raise a concern that flies under the radar to some extent.

Fatigue. (Yawwwwwnnn!)

A lack of rest and sleep is known to adversely affect vigilance and decision-making and consequently impact on patient care. However, a regular pattern of sleep deprivation and chronic fatigue over a period of time can also be detrimental to

the practitioner's health, quite apart from the extra risk of error. (See editorial in *Anaesthesia* 2014 69, 1-13.)

While the issue of fatigue may be well handled by rostering and availability of cover in major teaching hospitals, it may not be adequately resolved in smaller regional centres and in private practice.

It is interesting to contemplate the following:

- How would you really handle this scenario?
- In mentoring a trainee, what advice would you give them if faced with this situation?

The College provides Fellows and trainees with guidance and advice through its professional documents and associated special interest groups (SIGs).

Available resources include:

- ANZCA's professional document PS43: *Statement on Fatigue and the Anaesthetist*.
- The Welfare of Anaesthetists Special Interest Group's resource document 01: *Personal Health Strategies*.
- The SIG's resource document 03: *Depression and Anxiety*.

These very thoughtful documents highlight the problems and the principles underlying them, and offer insight into fatigue and its associated problems. The resources are very good in general terms and are valuable when mentoring trainees or younger Fellows. However, there is a lack of specific advice as to how to deal with this unfortunately not uncommon scenario.

Currently, we tend to respond in numerous ways, ranging from failing to recognise fatigue, dismissing fatigue, attempting to rationalise (rational lies) circumstances, or just accepting it's just the way it is.

Clearly, when this type of scenario arises infrequently, it has implications for patients on the following morning list (or worse still, the afternoon patients). However, a regular and frequent pattern such as this eventually impacts on our own health and practice. Although the presentation of any individual emergency situation is unpredictable, there is an element of predictability in the longer-term pattern of one's practice. Consequently, having a backup within a group of colleagues where feasible, even in solo private practice, could be considered. Obviously, planning on-call so that after-hours commitments do not precede committed morning lists is another option.

As professionals, we all have a responsibility to manage fatigue in ourselves, and our colleagues. Ignoring it won't make it go away!

Basically, fatigue boils down to time management. Failure in the short-term results in tiredness and decreased performance, but in the long term can progress to behavioural changes, physical issues and mental health issues. As a mentor, your role is to support and empower the people you are mentoring and to have their interests at heart. It is worth considering becoming your own best mentor!

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

Acknowledgement:

The Welfare of Anaesthetists Special Interest Group has supported this article. The SIG is an excellent resource for Fellows and offers valuable assistance for a range of issues. Each state has representatives, locally and at executive level, and contact details and further information can be found on the ANZCA website under "Fellows/Special interest groups".

Expert advice for College treasures



The newly-established History and Heritage Expert Reference Panel will provide advice on the history and heritage of the College including the Faculty of Pain Medicine.

This new panel fulfils the College interest in the best care, collection, display – and extension – of the wonderful collection ANZCA enjoys.

ANZCA has a collection of portraits, paintings, furniture, silver and antiques, as well as anaesthetic equipment and other material including books, archives, documents and oral histories. Most of these require specialised care and storage.

The panel's terms of reference are to advise on:

- The management of tangible and intangible assets of the College and Faculty that have heritage or historical value.
- Aspects of history and practice relating to anaesthesia and pain medicine.
- Topical issues suitable for exhibitions, *ANZCA Bulletin* articles, oral histories and other tangible demonstrations of history.

- Appropriate and relevant promotional activities regarding the history and heritage of the College.
- Current, new and emerging trends in the area of collections, museum and archives practice.

The panel comprises a group of people all dedicated to the preservation and development of historical items, which, they believe, are all relevant to the future of medical and scientific advance.

"The preservation and the expansion of the Geoffrey Kaye museum, its artefacts and archives, is very important to the College," said Dr Christine Ball, ANZCA's honorary curator.

"We see it as both a living and historical gift to anaesthetists and pain medicine physicians – retired, practicing and in training, as well as to the medical and broader community in general.

"The history of anaesthesia and pain medicine is rich, fascinating and constantly evolving. Museums are not dusty places left for future generations but contain items which are of great relevance to us now.

ANZCA CEO, Ms Linda Sorrell, who chairs the panel, said: "Our aim is to ensure ANZCA collections are vibrant, well-utilised and recognises the important work of medical specialists from the past, the present and the future."

Ms Nola Anderson is one who admits a passion for making sure exhibitions are available and understood by the community.

"These items have an important place in our history and I look forward to working with the panel to ensure their value is accessible to all," Ms Anderson said.

Dr Peter Featherstone is another panel member who believes museums and collections are relevant to people of all ages and all walks of life.

"There is more to the history of anaesthesia and pain medicine than the technical or the equipment itself," Dr Featherstone said.

"I'm interested in making the very many and varied personal stories known. There are fascinating characters behind our medical advances."

Dr John Williamson believes that developing the ANZCA collection and working with the panel will help raise the profile of anaesthesia and its important place in medicine.

"History is important no matter what the field and anaesthesia needs a higher profile – it always has," Dr Williamson said.

"But we are standing on the shoulders of our forebears. This is my way of thanking those pioneers."

Ebru Yaman
Media Manager, ANZCA

History and Heritage Expert Reference Panel



Ms Nola Anderson BA Arts, Dip Education (Art), has been appointed to a number of boards and committees including the International Council of Museums (Australia) and Canberra Glassworks. She attended the Getty Museum Leadership Program in the US in 2005 and was awarded the Smithsonian Institution International Fellowship in Museum Studies, Washington US, in 1998. She recently published a book titled *Australian War Memorial: Treasures from a Century of Collecting*, Murdoch Books, 2012.



Mr Peter Haynes, BA (Hons) Archaeology, BA (Hons) Fine Arts, MA English Literature has held many positions including being a lecturer at several universities, Curator, Parliament House Art Collection, Director/Curator Nolan Gallery and University Art Curator at the University of Canberra. He has held numerous board and committee positions and has published a large number of papers.



Dr John Williamson AM, FANZCA, is a retired anaesthetist who has worked in Townsville and Adelaide and was a consultant anaesthetist for the Australian Patient Safety Foundation for eight years. He has a keen interest in history.



Professor Barry Baker FANZCA, FCICM, is ANZCA's Dean of Education and Executive Director of Professional Affairs at ANZCA. He was formerly the Nuffield Professor of Anaesthetics, University of Sydney and chairman, Department of Anaesthetics, Royal Prince Alfred Hospital, Camperdown, Sydney. He has a long standing interest in history and has been involved in College activities for many years.



Ms Linda Sorrell MHA, BHSM, ANZCA's Chief Executive Officer, chairs the new History and Heritage Reference Panel. Ms Sorrell has nearly 20 years' experience in high-level management positions in the healthcare sector in Victoria and NSW and was the 2007 Telstra Victorian Business Woman of the Year.



Dr Christine Ball FANZCA, is an anaesthetist, a Monash University lecturer and the Honorary Curator of the Geoffrey Kaye Museum of Anaesthetic History. Dr Ball has a keen interest in preserving and promoting the College historical collections and ensuring they are available as a resource to all in the profession of anaesthesia and pain medicine, as well as the general public.



Dr John Paull FANZCA, was recently appointed as ANZCA's Honorary Archivist. He has been interested in the history of anaesthesia in Australia for the past 10 years and recently released a biography of Dr William Russ Pugh, who is famous for being the first doctor in Australia to demonstrate surgical anaesthesia. Dr Paull understands how archival systems are organised and the care and attention to detail required in successful archival activities.



Dr David Jones FANZCA, FFPANZCA, is an immediate past dean of the Faculty of Pain Medicine. He is an anaesthetist and clinical senior lecturer at Dunedin Hospital and University of Otago, also clinical leader for the pain service there. Major interests include neurogenic pain, best practice opioid treatment, chronic pelvic pain and post surgical pain conditions. He is interested in history especially of intravenous anaesthesia, and pain medicine.



Dr Peter Featherstone FRCA, FFCM is in Australia and working at the Alfred Hospital with Dr Chris Ball, ANZCA's Honorary Curator. Dr Featherstone will return to the UK in the middle of 2014. He has been an active member of the History of Anaesthesia Society in the UK since 2009. He continues to serve as the society's webmaster with a particular interest in increasing public engagement in the history of anaesthesia through social media.

Your ANZCA:

Overseas Aid Committee

Supporting anaesthesia education around the globe



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

ANZCA has a long history of providing educational support in our region. The Overseas Aid Committee assists the College to deliver its commitment to overseas aid in line with its strategic objective to advocate for community development with a focus on indigenous health and overseas aid.

The committee's vision is "to improve education and training capacity in anaesthesia and pain medicine in response to the needs expressed by low and middle income countries" through:

- Supporting training and education in Papua New Guinea.
- Supporting training and education opportunities for anaesthetists and pain medicine specialists from low and middle income countries.
- Supporting the donation of educational equipment and safety initiatives for low and middle income countries.
- Engagement and advocacy.

The College has a long relationship assisting the development of anaesthesia in Papua New Guinea. The committee funds and organises external instructors to support the anaesthesia diploma and masters courses in PNG and supports an external examiner. This work is done in conjunction with the Health Education and Clinical Services (HECS) program organised by the Australian Government. A consistent theme arising from the 2013 evaluation of the HECS program was how much the PNG medical community values the support provided by Australasian colleges over the past 20 years.

The committee offers a number of scholarships to promote education and leadership by anaesthetists. The ANZCA International Scholarship is awarded annually to foster leadership in anaesthesia and pain medicine, by giving a recently qualified specialist the chance to pursue



Dr Chris Acott running an oxygen therapy workshop for Anaesthetic Scientific Officers in PNG.

additional training in Australia or New Zealand for up to 12 months. This year's award, to Kenyan anaesthetist Dr Timothy Muriithi Mwitii, marks the scholarship's 11th anniversary.

The Overseas Aid Trainee Scholarship, now in its third year, funds a short-term clinical or educational visit in the Asia-Pacific region to foster interest in overseas aid among trainees and provisional Fellows. The scholarship is gaining in popularity each year.

In 2013, the committee awarded the inaugural Anaesthetic Services Group Victoria Scholarship to give an anaesthetist from a developing country the chance to attend an anaesthesia scientific meeting in Australia or New Zealand. This scholarship is fully supported by Anaesthetic Services Group Victoria through the ANZCA Foundation and provides exposure for qualified anaesthetists to international forums, colleagues and learning opportunities.

The committee has also provided material support for anaesthetists in the region, including an airway mannequin, textbooks through the Real World Anaesthesia Library initiative and identifying, organising and providing training for Lifebox pulse oximeters. More information on these initiatives can be found online at www.anzca.edu.au/fellows/overseas-aid.

In 2013, the committee established the Essential Pain Management Sub-Committee to support the development of the Essential Pain Management (EPM) program, which has been run in over 30 countries since being piloted in 2010. Further information is available from www.essentialpainmanagement.org.

Many ANZCA Fellows and trainees have an interest in volunteering and assisting foreign doctors to further their training in Australia and New Zealand. The Overseas Aid Committee is developing information sheets to assist those interested in volunteering and/or navigating the registration process to support training opportunities for overseas doctors. These will be available soon through the ANZCA website. The committee welcomes queries from trainees and Fellows and is happy to provide advice and support where possible. Please contact us on overseasaid@anzca.edu.au.

Dr Michael Cooper, Chair, ANZCA Overseas Aid Committee

Further information about ANZCA committees, including their terms of reference, can be found at www.anzca.edu.au/about-anzca/Committees.

Reforms to Medicare on the agenda

Australia

The Abbott Coalition government has signalled reforms to Medicare as part of its health agenda.

In late February 2014, the Health Minister, Peter Dutton, flagged major changes to the health system including an increasing role for private health insurance and the private sector, a broad cost-cutting agenda, and a focus on preventable and “lifestyle” diseases.

In the minister’s address to the Committee for Economic Development of Australia (CEDA) conference in February, Dutton made reference to the total health expenditure increasing 122 per cent in the 10 years to 2011-12, when it totalled \$140 billion. He highlighted the need for improved sustainability of the system and is awaiting the results of the Commission of Audit which is looking at minimising waste and inefficiencies and identifying cost savings.

In a welcome move, a further \$133 million in funding has been allocated to boost medical research. The funding will support 153 grants across five National Health and Medical Research Council (NHMRC) schemes.

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:



- Australian Workforce and Productivity Agency Submission on Updates to the Skilled Occupation List 2014.
- National Blood Authority on the Patient Blood Management Guideline Companion.
- Australian and New Zealand Hip Fracture Registry on the ANZ Guideline for Hip Fracture Care.
- National Blood Authority on the Preoperative Anaemia.
- Australian Health Practitioners Regulatory Authority on Criminal History and English Language.
- Health Workforce Australia, via the Committee of Presidents of Medical Colleges, on clinical training reform and simulated learning environments.
- WorkCover WA on the Review of the Worker’s Compensation and Injury Management Act.

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.

Specialist Training Program

All participating hospitals have received their new funding agreements or deeds of variation for 2014 and negotiations are under way. Unlike previous years, there will be no application round this year. Existing funding agreements will continue until 2015 and the College will communicate any new information regarding the direction of the program as it becomes available from the health department. Further information on the Specialist Training Program can be found at www.anzca.edu.au/training/specialist-training-program.

New Zealand

Training More Specialist Doctors in Tasmania

The Training More Specialist Doctors in Tasmania (TMSDT) project is the second element of the Tasmanian Health Assistance Package which is designed to ease immediate pressures across the Tasmanian health system and to fund clinical innovation and system improvement.

This initiative provides \$39.6 million in funding from the Australian government over three years from 2014-16 to support approved medical specialist fellowship training, undertaken and completed in Tasmania, and to support the training and retention of specialist doctors in the in the Royal Hobart Hospital, Launceston General Hospital and North West Regional Hospital. The TMSDT working group met for the first time in February 2014.

The group will provide expert advice to the College and support the commitment at regional and local levels to help achieve successful implementation of the TMSDT. Members are active clinicians in Tasmania who have been appointed on the basis of their skills and expertise to ensure an appropriate profile of knowledge and experience.

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



Ms Linda Sorrell (ANZCA CEO), Dr Nigel Robertson (ANZCA NZ National Committee Chair), Dr Kieran Davis (FPM NZ National Committee Chair) and Ms Heather Ann Moodie (GM NZ) met the Minister of Health on March 6 with discussions covering ANZCA's revision of its continuing professional development program to meet the HPCA Act and the Medical Council of New Zealand's (MCNZ) recertification requirements, colleges' involvement in identifying and dealing with poorly performing doctors, ANZCA's policy on advising patients to quit smoking, the recommendations on the assistant for the anaesthetist document and workforce issues. They also met with Annette King, Labour health spokesperson, later that morning.

Meetings were also held with the CEO of the MCNZ, Philip Pigou, and the Chief Medical Officer at the Ministry of Health, Dr Don Mackie, to discuss the medical colleges' roles and responsibilities regarding competence, compliance and delivery of safe care by Fellows and trainees" and how colleges can work collaboratively with the medical council, the ministry, employers and others to address the issue of "poorly performing doctors".

Dr Davis will discuss the high incidence of chronic pain in New Zealand and the funding requirements to ensure adequate training places for pain medicine specialists.

John Biviano,
General Manager, Policy, ANZCA

ANZCA and FPM in the news



ANZCA is funding research into a simple, non-invasive test that involves walking along a corridor to determine fitness for major surgery and identify patients who could be at risk of serious complications after operations.

Researchers hope the six-minute walk test will be a strong predictor of wellness for major surgery and reduce the risk of complications, including delayed recovery, long-term disability and death, following anaesthesia and a major operation.

Dr Mark Shulman and Professor Paul Myles say the study, which will recruit 500 people, is the first time the simple and inexpensive six-minute walk test has been trialled in this way. If successful, it could be used as a guide to surgical and post-surgical care planning in patients, including transplant recipients and cancer sufferers.

The story received prominent coverage on page three of the *Herald Sun* (circulation 400,000) as well as several other newspapers across Australia, including the *Adelaide Advertiser*, the *Courier Mail* and the *Townville Bulletin*. Dr Shulman and Professor Myles gave follow up radio interviews with ABC radio's national AM program and on radio 3AW.

The Faculty of Pain Medicine's Director of Professional Affairs, Professor Milton Cohen, was interviewed about FPM Fellow Professor Michael Cousins, who was appointed an Officer of the Order of Australia.

Since November last year ANZCA has generated six radio reports, 10 print and nine online stories, reaching an estimated audience of almost one million. These figures do not include syndications.

Ebru Yaman
Media Manager, ANZCA

ANZCA Media Award winner



"Pain, finding perspectives", a cover feature by *New Zealand Doctor* journalist Virginia McMillan, has won the ANZCA Media Award for the best news story or feature about anaesthesia or pain medicine that appeared in the Australian and New Zealand media in 2013.

Ms McMillan's article appeared in the December 4, 2013 edition of *New Zealand Doctor* and examined why chronic pain is so difficult to treat.

"This article was sparked by a comment from an anaesthetist that there is limited understanding of pain management in the wider health community," Ms McMillan said.

"I found this was backed up by anecdotes heard over a number of years ... the indirect message that 'it's all in your head' was often picked up, and a feeling of blame engendered.

"I set out to gather a wide range of experiences of pain, both on the providing and the receiving end of care."

Ms McMillan wrote a compelling piece of long-form journalism and included case studies, extensive interviews with health professionals and recent statistics to illustrate the story, including young, outgoing and active people who live with persistent pain, to shatter the stereotypes of chronic pain sufferers.

The story was one of many entries for the award, spanning pain medicine and anaesthesia across print, radio and television media. It was judged by former ABC journalist, lecturer and media training expert, Doug Weller; anaesthetist and *ANZCA Bulletin* Medical Editor Michelle Mulligan, and former *Age* health editor and Ambulance Victoria media director Tom Noble.

The judges were impressed by the breadth of the entries but found it very difficult to pick the winner from what they described as a "tough field" with some "terrific entries". They particularly commended Ms McMillan's extensive research and concluded:

"'Pain, finding perspectives' took as its subject a challenging and little understood phenomenon – the world of chronic pain. We were impressed with the how thorough the reporting was, and that it included not only case studies and the views of clinicians but some little-understood and often under-reported statistics on the nature and complexity of chronic pain – both its experience and its treatment."

Since November last year ANZCA has generated:

- Six radio reports.
- 10 print stories.
- Nine online stories.

Media releases since November:

- Virginia McMillan wins 2013 ANZCA Media Award for pain story (March 3).
- Six-minute walk before surgery could save lives (December 18).
- Award winner says helping others "just part of the job" (December 11).

Staff rewarded in new recognition program



Three ANZCA staff members and a team were presented with awards as part of ANZCA's new Staff Recognition Program last month.

Hannah Burnell and Rebecca Conning were joint winners of the 2013 Staff Excellence Award for Innovation or Process Improvement, while Eric Kuang won the 2013 Staff Excellence Award for Customer Service. The Policy unit won the 2013 Staff Excellence Team award.

Hannah, who works in ANZCA's Fellowship Affairs unit, was recognised for her work on the online event registration system, which has delivered significant benefits for events staff and Fellows when registering for an event. Rebecca, who works in the Policy unit, was nominated for providing expert guidance and drive to create a new structure and streamlining of the professional documents.

Eric was recognised for his work on training portfolio system upgrades where he demonstrated constant diligence, clear logic, patience and exceptional problem-solving while showing outstanding respect for his co-workers.

The Policy team (John Biviano, Paul Cargill, Rebecca Conning, Brigid Borlase, Donna Fahie and Michaela Lodewyckx) was nominated for consistently achieving high standards in the successful delivery of a wide array of projects and initiatives, which support many ANZCA units, Fellows and trainees, including some outside their normal remit.

The presentation, attended by ANZCA President Dr Lindy Roberts and councillor Associate Professor David Scott, also recognised staff who reached career milestones during or prior to 2013. Twenty-year milestone certificates were awarded to Carolyn Handley and Cherie Wilkinson; a 15-year certificate was awarded to Helen Morris, 10-year certificates were awarded to Juliette Whittington, Heather Ann Moodie, Jenny Jolley and Annette Strauss, and five-year certificates were awarded to Sue Willmott, Kirsty Robinson, Renee McNamara, Fraser Faithfull, Gert Struve, Daphne Erler, Professor Barry Baker, Karen Gordon-Clarke, Jodie Cottrell, Penny McNair, John Biviano, Professor Martin Culwick, Dr Stuart Henderson, Hannah Burnell, Laura Foley, Anna Kleskovic, Michaela Lodewyckx, Deanie Tang, Liane Reynolds, Kavitha Faruqui, Shilpa Dumasia and Galina Fidler.

The Staff Recognition Award Program was introduced to recognise staff who have demonstrated excellence in service delivery and commitment, and have achieved outstanding results that have made a significant contribution to ANZCA's priorities and objectives and/or had a significant impact on the lives of their work colleagues and other College community members.

The program, which also has a unit-level component that allows managers to individually recognise staff, aligns with ANZCA's strategic priority to ensure ANZCA is a sustainable organisation, and the objective to retain the best people.

Ms Linda Sorrell
Chief Executive Officer, ANZCA

Above from left: Joint winners of the Individual Award for Innovation or Process Improvement, Hannah Burnell and Rebecca Conning; Winner of the Individual Award for Customer Service, Eric Kuang; Winners of the Team Award, the Policy Unit, Michaela Lodewyckx, Donna Fahie, John Biviano, Rebecca Conning and Paul Cargill.

New Fellows snapshot – the ANZCA Graduate Outcomes Survey 2013

In 2013 ANZCA undertook its first Graduate Outcomes Survey. This ongoing annual survey targets new Fellows in each of their first three years of practice, and is designed to identify how ANZCA can assist new Fellows with their practice and professional development.

It will provide a deeper understanding of graduate outcomes that will aid negotiations with government and other groups on important issues such as workforce.

All new Fellows (via the examination and international medical graduate specialist pathways) from Australia, New Zealand, Hong Kong, Singapore, Malaysia and other parts of the world, were invited to participate.

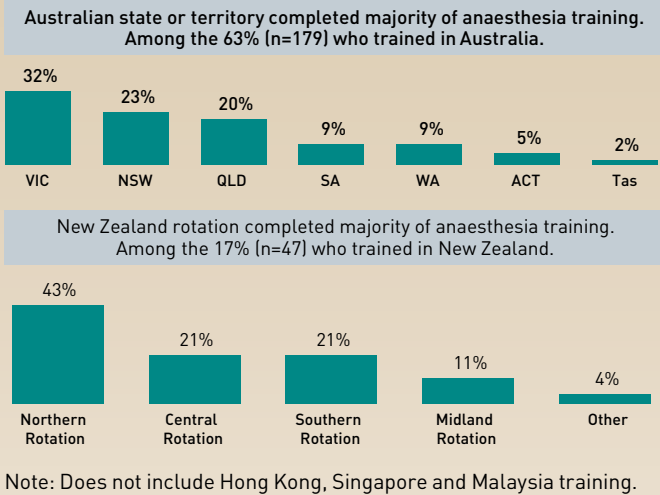
The survey is an important part of ANZCA's effort to increase the quality of its workforce data.

The 2013 survey gives us a single snapshot of our new Fellows' situation regarding these issues, and because it is repeated annually it will allow ANZCA to track the evolution of these issues over time.

It is designed in a way that will allow ANZCA to detect changes within states or regions, within cohorts based on year of fellowship, and also look at changes within an individual.

The survey and analysis was conducted by Acuity Research & Insights, a strategic market research consultancy that has worked with some of Australia's leading corporations, brands, and social organisations. An online survey was conducted between August 14 and October 21 last year, with invitations and survey reminders sent by ANZCA to 601 appropriate ANZCA members. A total of 284 completed the survey, a response rate of 47 per cent. Following is a summary of the key findings.

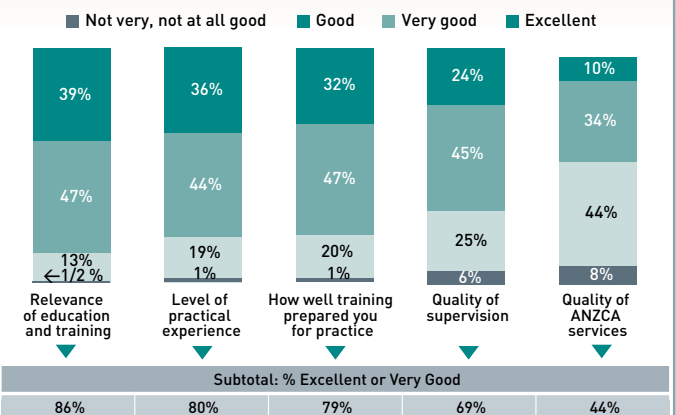
Figure 1. Location in Australia and New Zealand where majority of anaesthesia training was completed



Professional training

- 73 per cent have no other post-graduate qualifications other than their FANZCA.
- 63 per cent completed their anaesthesia training in Australia and 17 per cent in New Zealand. See Figure 1 for breakdown.
- There are positive perceptions overall of key aspects of anaesthesia training. See Figure 2.
- The most frequently used ANZCA services are the website and library, with podcasts, webinars and research grants being used much less frequently.

Figure 2. Rating of key aspects of anaesthesia training



There are positive perceptions of all key aspects of anaesthesia training. However while the majority rate the relevance of their education and training as very good or excellent, satisfaction with the quality of supervision is more moderate.

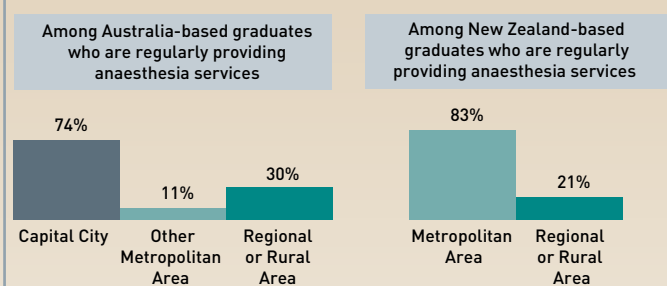
Working and professional status

- 90.5 per cent of respondents had entered the workforce as specialist anaesthetists, with 95 per cent providing anaesthesia services at least once per month.
- The most common reasons for not providing clinical anaesthesia services were personal, such as further training, travel, and maternity and family commitments.
- 24 per cent of respondents are doing work that is either unpaid or paid below the level of a consultant. This is more common among Fellows practising in Australian capital cities, and those who gained their fellowship in 2013 compared with 2012 or 2011.
- 66 per cent of those who provide anaesthesia services on a regular basis are satisfied with their hours; 24 per cent would like more hours and 10 per cent would like fewer. New Fellows in New Zealand and those who completed their training before 2013 were more likely to be satisfied. Males practising in Australian capital cities were most likely to want more hours (31 per cent).
- The average number of hours worked was 38.2 hours per week, and again new Fellows in New Zealand and outside of Australian capital cities were more likely to be working longer hours. See Figure 3.
- On average, 79 per cent of their time was spent working in public hospitals. The 2013 new Fellows are spending more time (24 per cent) in private hospitals compared to 2011 new Fellows (16 per cent).

Practice location and factors in location choice

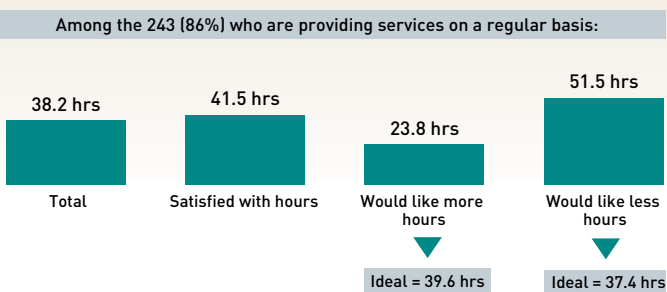
- 30 per cent of Australian and 21 per cent of New Zealand respondents worked in regional or rural areas. See Figure 4.
- Important factors in choosing practice location are family issues, access to quality hospitals, working hours and demand for anaesthesia services.
- Remuneration and costs of living and setting up practice were rated as less important.

Figure 4. Australia and New Zealand: location of practice



Note: Respondents may be working in more than one location.

Figure 3. Average hours of anaesthesia work each week



Those graduates who would like to work more hours are currently working 23.8 hours a week on average – and ideally would like to work 39.6 hours. Those graduates who would like to work fewer hours are currently working 51.5 hours per week on average – and ideally would like to work 37.4 hours.

New Fellows snapshot – the ANZCA Graduate Outcomes Survey 2013 (continued)

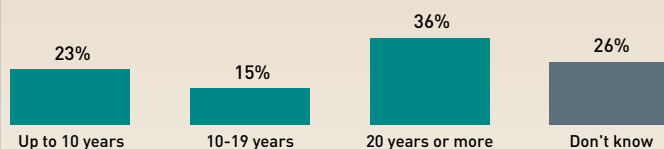
The future

The respondents were asked a series of questions about where and how they saw themselves practising in the future.

- 51 per cent of graduates expect to remain in their current location for more than 10 years; 36 per cent expect to remain for more than 20 years. See Figure 5.
- New Fellows practising in Australia were less confident that there will be enough quality career opportunities in the future, with 56 per cent disagreeing a lot or a little with this statement compared to 27 per cent of those in New Zealand.
- 80 per cent of all respondents agreed a little or a lot with the statement that 10 years ago there were more professional and career opportunities in anaesthesia.
- 74 per cent of all respondents would encourage junior doctors to pursue a career in anaesthesia.

Figure 5. Expected time in current location

Among the 243 (86%) who are providing services on a regular basis:



There is a majority of these graduates (51 percent) who expect to remain in their current location for more than 10 years – with many (36 percent) expecting to remain for more than 20 years.

The survey gave the opportunity for new Fellows to provide feedback in the form of comments on any of the issues that were targeted or any other issues they felt were important. The most commonly cited issue was workforce. Some new Fellows were concerned that there are too many anaesthetists being trained and that new Fellows do not have adequate career or professional opportunities. This survey has helped identify the extent of the actual employment situation.

Limitations of this survey are that we don't have any prior benchmarks with which to compare results. This will change in following years as trends emerge from annual repeat surveys. Additionally, the response rate of 47 per cent means that we don't have any data about the 53 per cent who did not respond.

The results of this survey contribute to an important component of ANZCA's response to the workforce issue – the collection of high quality data to understand the situation. The other two components of ANZCA's action plan focus on ensuring that the College has an effective voice in decisions by policy-makers, and communication with Fellows and trainees. For more information about the College's efforts on workforce, please see the December 2013 edition of the *ANZCA Bulletin* – www.anzca.edu.au/communications/anzca-bulletin.

The survey will also influence decisions relating to the revised curriculum especially the development of resources to assist trainees in their transition to fellowship and independent practice as a specialist. Information about reported usage of services will be used to improve resources provided by the College. Specific points or requests (for example, a suggestion that the library holds a particular journal, or the Records Management unit follow up a specific issue) will be addressed individually.

The Graduate Outcomes Survey will be repeated in 2014 and beyond, and we hope to increase our response rate in future years. The next survey will have new questions exploring the reasons why new Fellows may be doing more than one provisional fellowship year, and whether it is because new Fellows feel they need more overall experience before commencing independent practice or because they are seeking development of specific expertise or for other reasons.

ANZCA welcomes any feedback on this survey (president@anzca.edu.au). I would like to thank all new Fellows for their time spent completing this survey and encourage those eligible, to participate in future surveys.

Dr Gabriel Snyder
New Fellow Councillor

Frequently asked questions about anaesthesia workforce

ANZCA President Dr Lindy Roberts is frequently involved in workforce discussions with Fellows, trainees and external organisations. ANZCA's General Manager Policy, Mr John Biviano, is responsible for the College's workforce action plan, in line with the direction set by the ANZCA Council. He also oversees many external submissions made by the College about workforce issues. Many of their conversations with Fellows and trainees reveal common themes and questions, answered here.

Further information can be found in past issues of the *ANZCA Bulletin*¹⁻³. Please send feedback and questions to policy@anzca.edu.au and president@anzca.edu.au.

1. What are the main workforce issues in Australia and New Zealand? How is the College involved?

Medical workforce issues are part of broader challenges facing governments and health systems internationally, as well as in Australia⁴ and New Zealand⁵. All OECD countries face unsustainable growth in their health budgets relative to gross domestic product (GDP), exacerbated by ageing populations, increasingly complex and expensive diagnostic and treatment modalities, rising public expectations and regulation, and a difficult and uncertain global economic climate. Increasingly, governments and other health planners question how taxpayer funds are spent and what value is created. Common themes in this debate include increased productivity, greater efficiency, new models of care and funding, alternative providers and the need to ensure that every health worker is contributing at the "top of their scope" (that is by doing things that only they can do with their expertise and delegating more routine tasks to others within the healthcare team).

In Australia, medical student numbers have more than doubled in the past 10 years. The findings of the 2013 Australian Commission of Audit will influence the forthcoming Australian budget in May 2014. Similarly in New Zealand, there are concerns about the flow-on effects for New Zealand graduates, with a slowing of migration to Australia. This is being monitored by Health Workforce New Zealand.

The College contributes to workforce and other policy debates through government relations and advocacy (more about this later), regular submissions, development of policy and public statements, media and publications, as well as data collection and sharing. We also liaise and work with other medical colleges. The ANZCA president is on the Committee of Presidents of Medical Colleges (CPMC), Australia, and the chair of the New Zealand National Committee, Dr Nigel Robertson, is a member of the Council of Medical Colleges (CMC), New Zealand. The CPMC is also represented on the executive committee of the National Medical Training Advisory Network (NMTAN), which aims to produce an Australia-wide training plan for 2015.

2. What is the current state of the anaesthesia workforce?

Trainee numbers have stabilised after significant growth over the past 10 years; this growth in anaesthesia workforce is similar to that in other medical specialties. The ANZCA Graduate Outcomes survey (refer to page 20) points to some areas of oversupply in metropolitan locations. Requests for "Area of Need" specialists have declined to almost zero (as, increasingly, local graduates fill vacancies in regional and rural Australia). The College is working with Australian state health departments, through regional committees, to provide data and input to their workforce modelling to ensure there are appropriate numbers of trainees for requirements. In Australia, national co-ordination is required to make sure that the rising tide of medical students ends up in areas of undersupply (such as general practice).

3. What is ANZCA's goal in relation to anaesthesia workforce?

The College supports action to ensure a balance of anaesthesia workforce supply and demand. This goal will maintain safe and high-quality care for the Australian and New Zealand communities, and ensure appropriate access to anaesthesia services. It also supports meaningful work for our Fellows and trainees, maintenance of their skills and appropriately resourced and supervised training of the next generation of anaesthetists.

(continued next page)

Frequently asked questions about anaesthesia workforce (continued)

4. What is ANZCA's responsibility in relation to its Fellows and trainees in the current workforce environment?

Significantly, although the College does not employ any doctors, it has a responsibility to ensure meaningful work for its Fellows and trainees in line with its constitution. ANZCA remains actively involved in workforce issues though its links to health jurisdictions in partnership with regional and national committees.

5. How are the numbers of trainees regulated? What is ANZCA's role? Why doesn't ANZCA just control trainee numbers?

The New Zealand ministry and each of the Australian governments (federal, state and territory health departments) oversee workforce planning for their areas of jurisdiction. This includes workforce modelling based on the data available to them. The key agencies responsible for workforce planning at a national level are Health Workforce Australia (HWA) and Health Workforce New Zealand (HWNZ).

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 these graduates are directed into the areas where they are needed.

A decision was made in early 2003 to accredit hospitals rather than posts based on the recommendations of a report by the Australian Competition and Consumer Commission (ACCC). 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 curricula. A similar situation applies in New Zealand where the New Zealand Commerce Commission takes the same view.

6. What is ANZCA doing about workforce?

ANZCA's activities are focused on three main areas – collecting high-quality data, ensuring we have effective input into jurisdictional workforce planning, and communicating our activities to our Fellows and trainees. The situation is dynamic and the ANZCA Council regularly reviews its approach and seeks new ways it can potentially act to address the workforce situation. This includes responding to the feedback it receives from its Fellows and trainees. The way in which we address workforce may change as new information comes to hand.

7. What is "workforce advocacy" in practical terms?

This is about recognising the key decision-makers in workforce planning, and developing ongoing relationships with them to assist them in their planning and decision-making. Such assistance includes providing up-to-date data, as well as input into their workforce modelling and conclusions.

A concrete example of advocacy is the recent negotiations with the Tasmanian and Australian governments, together with the ANZCA Tasmanian Regional Committee and hospitals on improving specialist-training capacity (Training More Specialist Doctors in Tasmania). This involved targeting jobs where appropriate, resulting in additional specialist jobs (supervisory roles) and training posts in areas where there is a real need (pain medicine and hyperbaric medicine), rather than an unplanned increase in anaesthesia trainees. This is an example of successful advocacy in support of a balanced workforce.

8. How is the College supporting trainees in the current environment?

In 2014, the first cohort of ANZCA trainees is undertaking the new provisional fellowship training period, which supports their transition to specialist practice. By mid 2014, the College will have a new learning and collaboration management system. This will provide high-quality online learning capability for our trainees and Fellows. Project groups are developing online trainee resources to assist provisional Fellows to prepare for specialist practice. Feedback about what resources are needed is welcomed at president@anzca.edu.au.

9. Why does ANZCA approve international medical graduate specialist (IMGS) applications (isn't this just contributing to greater issues for local new graduates)? Couldn't ANZCA just stop assessing IMGS and this would open up more jobs for locally trained anaesthetists?

ANZCA does not make decisions about employment or immigration and assesses IMGS applications on behalf of the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ). This process promotes patient safety and preserves quality standards for the community. If we did not assess IMGS applications there would be a significant risk to the community – as the specialist medical college that understands anaesthesia standards we are best placed to do these assessments.

Additionally, international medical graduate specialists have contributed to the health of the Australian and New Zealand communities, often in places that could not attract local graduates and in times of workforce shortage. Many have become Fellows of our College and make substantial contributions (see the article on page 30). If our countries reduce their reliance on international immigration to provide anaesthesia services, then applications to the College will decline.

10. Why is ANZCA involved in training GP anaesthetists?

The College and, in the past, the Faculty of Anaesthetists (RACS), has been involved in training GP anaesthetists for nearly 40 years². This is co-ordinated through the Joint Consultative Committee on Anaesthesia (JCCA) with the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine. GP anaesthetists have formed a vital part of anaesthesia services in rural and remote areas in Australia. Many of these areas are unable to sustain a specialist anaesthesia workforce, although it is likely as these areas grow that some will be able to support groups of specialists.

11. Why is ANZCA involved in the Australian Specialist Training Program (STP) program?

The Australian Government has provided funding to support training in so-called “expanded settings” over the past seven years (to 2015) with a small amount of additional funding for educational resources. The primary aim of this program is to increase specialist-training capacity in non-traditional settings, namely private hospitals and rural/regional areas. Half of the ANZCA STP positions are in regional areas and approximately two thirds are in private hospitals. Many of the College-supported posts are in non-anaesthesia areas, including pain medicine, and ANZCA also administers posts for the College of Intensive Care Medicine (CICM).

12. What is the workforce situation for other specialties?

Workforce is a hot topic among all disciplines. The work of many other specialties influences the demand for anaesthesia services. From the Health Workforce 2025 report, Volume 3⁶, specialties perceived to be in shortage include:

- General practice.
- General medicine.
- Medical oncology.
- Psychiatry.
- Radiation oncology.

The following specialties were perceived to be in adequate supply, and are projected to move towards oversupply by 2025, if recent trends in supply and demand continue:

- Cardiology.
- Gastroenterology and hepatology.
- Neurology.
- Surgical specialties.

13. How will the modelling and activity of Health Workforce Australia affect the anaesthesia workforce? What is NMTAN? How is ANZCA involved in this initiative?

ANZCA supports a nationally co-ordinated strategic approach to workforce planning that acknowledges all contributors. The National Medical Training Advisory Network (NMTAN) is up and running and aims to have an Australian national training plan for 2015 (www.hwa.gov.au/work-programs/clinical-training-reform/national-medical-training-advisory-network). ANZCA is represented on NMTAN through the Committee of Presidents of Medical Colleges (CPMC).

14. What can individual anaesthetists and trainees do about workforce?

Individuals can contribute to College activities by providing feedback, individually (policy@anzca.edu.au or president@anzca.edu.au), and by responding to College surveys to ensure robust response rates and meaningful results. Individuals also can advocate and act in their spheres of influence, depending upon their role (for example, as a department director or member).

Dr Lindy Roberts, ANZCA President,
and **Mr John Biviano**, ANZCA General Manager Policy

References:

1. Roberts LJ. Workforce, a hot topic: what is the College doing? ANZCA Bulletin, March 2013; 12-13.
2. Leslie K. A diploma of rural general practice anaesthesia – has its time come? ANZCA Bulletin, September 2013; 42-45.
3. Biviano J. Talking workforce. ANZCA Bulletin, December 2013; 18-22.
4. Australian Medical Association position statement: Medical workforce and training (2013). Available at <https://ama.com.au/policy/positionstatements>, accessed 2 March 2014.
5. New Zealand Medical Association. Principles of health workforce redesign (2013). Available at www.nzma.org.nz/policies/advocacy/position-statements, accessed 2 March 2014.
6. Health Workforce 2025, medical specialties, volume 3 (November 2012). Available at www.hwa.gov.au/health-workforce-2025. Accessed 2 March 2014.

Report triggers concern about doctors' mental health

Anaesthetists have a high risk of developing mental health problems a new study has found. But there are things we can do to reduce the risk.



In October 2013, beyondblue published the results of their *National Mental Health Survey of Doctors and Medical Students* aimed at:

- Understanding issues associated with the mental health of Australian medical students and doctors.
- Increasing awareness across the medical profession and broader community of issues associated with the mental health of medical students and doctors.
- Informing the development of mental health services and supports for the medical profession.

A total of 12,252 doctors and 1811 medical students responded (27 per cent response rate). Demographics of doctor respondents matched those of the broader medical community while too little is known of the medical student population to state whether this was true of that sample. In total, 1433 anaesthetists and anaesthesia trainees responded.

Members of the Welfare of Anaesthetists Special Interest Group (SIG) reviewed the report and summarise the findings here. They propose actions for discussion among the wider anaesthesia community with a view to addressing some of these findings.

Main findings

Doctors have higher rates of anxiety, depression and suicidal thoughts than the general population. Twenty one per cent of doctors have been diagnosed with depression with 6 per cent currently being treated.

A total of 25 per cent of doctors have had suicidal thoughts at some time and 10 per cent have had suicidal thoughts in the last 12 months. Two per cent of doctors have attempted suicide (4.6 per cent of female medical students).

Young doctors (under 30 years) and female doctors had higher levels of mental health problems and greater work stress. Also those working in rural areas and indigenous doctors were more at risk.

A high proportion of doctors seek treatment but concerns regarding privacy, confidentiality and embarrassment are barriers to them seeking treatment.

Doctors are more likely to seek treatment than the general population and many use positive coping strategies to manage some of the negative effects of poor mental health. Jogging and exercise was the most commonly identified coping technique.

Forty per cent of doctors felt that doctors with mental health problems are perceived as being less competent and 48 per cent felt that these doctors are less likely to be appointed than those without mental health problems.

A specific demographic of male doctors who work long hours and specialise in emergency medicine, anaesthesia, oncology and obstetrics and gynaecology were identified as being more likely to employ negative coping strategies. This was associated with greater personal impact, high-risk alcohol use and low professional efficacy.

For anaesthetists:

- 29.5 per cent are highly likely to have a minor psychiatric disorder (behind oncologists, paediatricians and non-patient contact doctors).
- 20 per cent have been diagnosed with depression (sixth).
- 13 per cent have had suicidal thoughts in the past 12 months (second highest behind doctors who have no patient contact, and equal with emergency physicians).
- 3.8 per cent are experiencing very high psychological distress.
- 15 per cent drink at moderate risk levels (third highest behind emergency physicians and surgeons) and 3.4 per cent are drinking alcohol at a high-risk or harmful level (second behind rural/remote and indigenous doctors).

The top sources of stress for doctors were:

• Conflict between study/career and family/personal responsibilities	26.8 per cent
• Too much to do at work	25.0 per cent
• Responsibility at work	20.8 per cent

Barriers to seeking help

While about a third of doctors stated they felt comfortable seeking help for mental health problems, the most commonly cited barriers were:

• Fear of lack of confidentiality/privacy	52.5 per cent
• Embarrassment	37.4 per cent
• Impact on registration and right to practise	33.4 per cent

Only 5.3 per cent stated that a lack of knowledge about mental health services stood in the way of seeking assistance.

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"Doctors have higher rates of anxiety, depression and suicidal thoughts than the general population. Twenty one per cent of doctors have been diagnosed with depression with 6 per cent currently being treated".

Coping strategies

A number of coping strategies used by respondents were identified by the survey:

Positive coping strategies

- Do something enjoyable.
- Try to look on the bright side of things.
- Talk to others.
- Jog or do other exercise.
- Pray.
- Practice mindfulness or another relaxation technique.
- Seek spiritual help.

Negative coping strategies

- Avoiding people.
- Eating more than usual.
- Take yourself to bed.
- Drinking more alcohol than usual.
- Smoking more than usual.
- Taking non-prescribed medication.

Recommendations

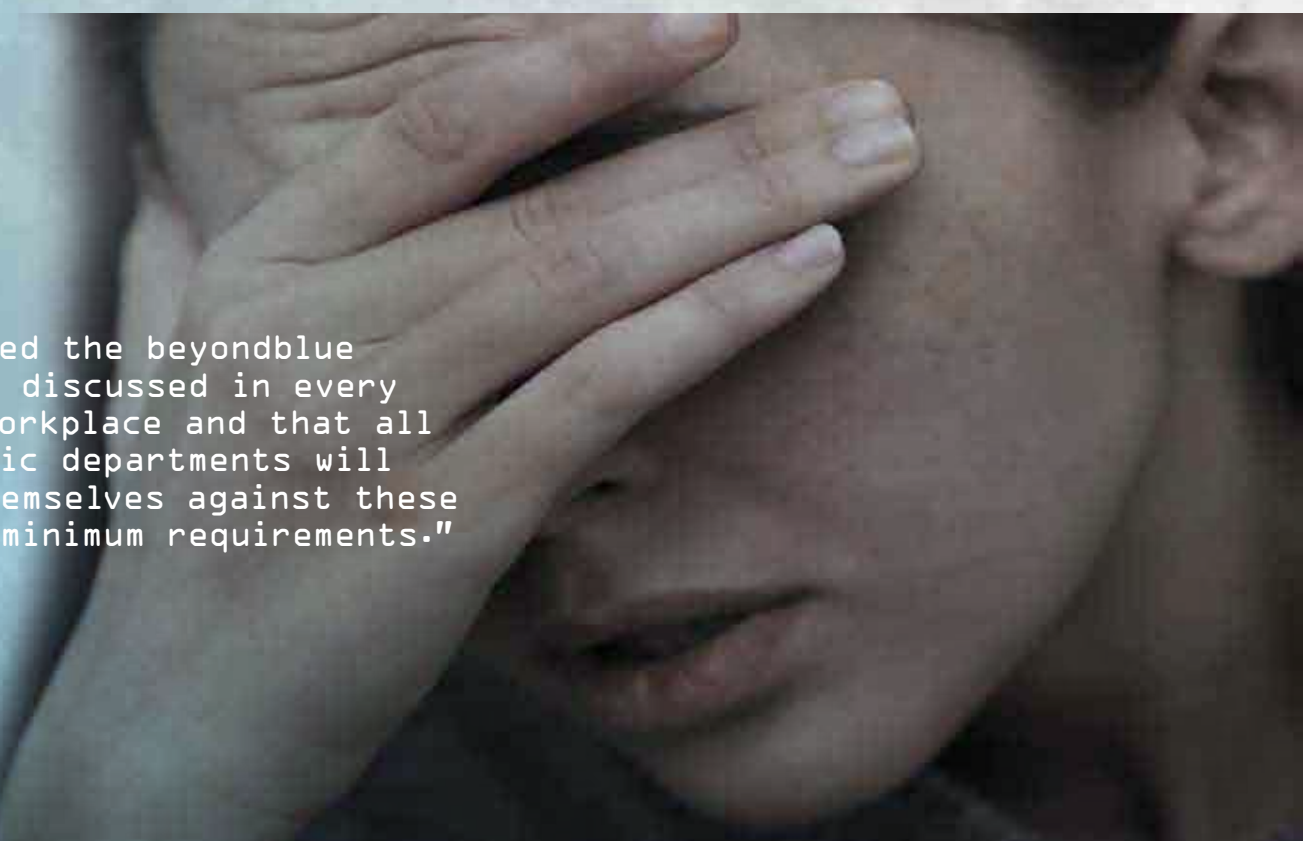
In response to these findings, beyondblue makes five recommendations for intervention.

- Promote the importance of maintaining good mental health and well-being:
 - Education and training in positive coping strategies and stress minimisation.
 - A social marketing campaign to highlight the prevalence, early warning signs and importance of seeking early intervention.
 - Encourage all doctors to have a GP outside work to promote help seeking.
 - Discourage self-prescription.
 - Address concerns about confidentiality and privacy within the workplace.

- Address the stressful and demanding nature of the work environment (to reduce short-term fatigue and long-term burnout):
 - Promoting greater work-life balance.
 - Workforce initiatives.
- Systemic intervention to address negative attitudes towards those with mental health symptoms.
 - Education early in medical career.
- Target support for vulnerable groups (females, indigenous students, rural practitioners, young doctors):
 - Specific mental health services.
 - Strengthened mentor/mentee relationships.
 - Training regarding the importance of maintaining good mental health.
 - Methods of coping with stress.
- Ongoing monitoring of the mental health status of doctors and students.

While further discussion is needed, a number of strategies should constitute a minimum response by anaesthesia departments to this report.

- All trainees and consultants should be encouraged to have their own GP so that treatment can be sought when required without fear of loss of privacy or workplace stigmatisation.
- There should be ongoing education regarding the importance of maintaining good mental wellbeing and in the use of positive methods of coping with stress.
- Mentor/mentee relationships and peer group support systems should be facilitated.
- Vulnerable groups (such as trainees) should receive targeted strategies with specific education programs and extra support.
- There should be an open discussion regarding workplace stress to identify and address those aspects of work amenable to change.
- Rostering should support safe work hours and excessive working hours should be discouraged.



"It is hoped the beyondblue report is discussed in every medical workplace and that all anaesthetic departments will assess themselves against these proposed minimum requirements."

It is hoped that the beyondblue report is discussed in every medical workplace and that all anaesthesia departments will assess themselves against these proposed minimum requirements.

At a national level, across both Australia and New Zealand, this report should catalyse a more systematic and practical approach to maintenance of good mental health amongst anaesthetists and trainees. The Welfare SIG would welcome any further comments and information about useful strategies.

For more information about doctors welfare issues please see www.anzca.edu.au/resources/doctors-welfare.

Dr Tracey Tay FANZCA, staff specialist, clinical lead, Innovation Support, Hunter New England LHD, clinical lead, NSW Agency for Clinical Innovation, former Chair, Welfare of Anaesthetists SIG

Dr Jane McDonald FANZCA, specialist anaesthetist, VMO Westmead Hospital and Westmead Private Hospital, former executive member Welfare of Anaesthetists SIG

Dr Prani Shrivastava FANZCA, staff specialist, Princess Margaret and Sir Charles Gairdner Hospitals, Chair, Welfare of Anaesthetists SIG

References:

National Mental Health Survey of Doctors and Medical Students, beyondblue, October 2013

www.beyondblue.org.au/docs/default-source/default-document-library/bl1132-report---nmhdms-full-report_web

Accessed February 10, 2014

If you are concerned about yourself or a colleague, contact

The Doctors' Health Advisory Service

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Many doctors are not in good shape

The *National Mental Health Survey of Doctors and Medical Students* was an important initiative, according to beyondblue Chair Jeff Kennett, because doctors are “at the frontline of the nation’s health”.

“We conducted this survey because, given doctors and medical students are under immense pressure and deal regularly with pain and death, we know that the mental health of many of them is poor,” Mr Kennett said.

“There was enough concern to undertake this survey and it certainly showed that a lot of our doctors are not in good shape.”

The world-first survey of thousands of Australian doctors and medical students revealed they were burnt-out, more likely to experience psychological distress and suicidal thoughts than the general community and were drinking too much alcohol.

“This can easily affect the level of care they give their patients,” he said.

Part of the solution, he believes, lies in cultural change: reducing the stigma associated with mental illness so doctors felt they could seek independent help and not “self-prescribe”.

“Doctors have to practice what they preach – what hope does a patient have if the doctor doesn’t take their own advice and seek help with mental health issues?”

It was important that doctors across all fields kept an eye out for their colleagues.

“It starts by recognising changes in your peers, asking them if they are coping and if you suspect there is something wrong, urge them to seek independent, professional help – not turn to the medicine cabinet.

“They should understand it is ok to admit they have a problem. Support is available.”

An interview with Jeff Kennett, former premier of Victoria and beyondblue chairman, is in the March edition of College Conversations.

Above: beyondblue Chair Jeff Kennett.

How ANZCA and anaesthesia have benefited from IMGS contributions

Dr Leona Wilson reminds Fellows and trainees of how important international medical graduate specialists (IMGSs) are to the anaesthesia workforce and the College. Dr Wilson is Director of Professional Affairs, IMGS and a former ANZCA president.

There are many international medical graduate specialist (IMGS) FANZCAs in our community who make a brilliant contribution to anaesthesia and our College, and I'd like to remind us about them. Most of us will have had IMGSs as some of our teachers, examiners and colleagues, and may or may not have been aware of it. IMGSs come to Australia and New Zealand by various routes and from a wide range of countries – in the last five years from 44 different countries.

In the last two centuries our two countries have been populated to a large extent by immigration. We are very good at absorbing people from many different countries and making them part of “us”,

forgetting that, for most of us, they (and we or our ancestors) were all immigrants at one time. And so, let's welcome our IMGS anaesthetists into our community and gratefully receive their contributions. I've only cited below a very few examples of the many IMGS anaesthetists in Australia and New Zealand who have contributed to anaesthesia here and served our community well. (In Australia, approximately 30 per cent of all doctors have a foreign basic medical degree, for New Zealand it's 40 per cent).

We've had many come to Australia and New Zealand with foreign basic and specialist training, who have made anaesthesia here what it is, often working in the smaller rural hospitals and providing an essential service to those populations. We have some hospitals that to a large extent are staffed by IMGS anaesthetists, and if they hadn't come, those communities would be poorly served.

In Alice Springs Hospital, for example, all six anaesthetists are IMGSs – four from India, one from Canada and one from Macedonia. Jacob Koshy, the Director of

Anaesthesia, says that since about 2005, there has been a relatively low turnover of anaesthetists in Alice Springs. He says this stability has had a flow-on effect to other specialties, leading to an increased capacity for elective surgery. There are now more full-time specialists with less reliance on locums and community confidence in the hospital had grown, he said.

Support for trainees had also grown with more trainees doing their ANZCA exams out of Alice Springs, rather than travelling to the bigger centres.

Di Khursandi is another example, working for many years in rural Queensland. Di was one of the leading lights in the moves to support doctors' health issues and the establishment of the welfare special interest group. Vanessa Beavis came to us from South Africa, and became director of anaesthesia at Auckland City Hospital and on the (anaesthesia) liver transplant roster. There's no doubt about the value of their contributions.



Dr Kerstin Wyssusek
Brisbane,
Queensland

I am a senior staff specialist at the Princess Alexandra Hospital in Brisbane and my anaesthesia interests include endocrine, hepatobiliary and transplant anaesthesia and medical education and training.

After studying in Germany, I obtained a PhD in 1994 and was awarded fellowship in 1995.

I took long service leave from my position as senior staff specialist in Berlin, to accompany my husband to Brisbane where he had accepted a one-year research contract. When

his contract was extended and the family decided to stay another year in Australia, I applied for recognition of my education and training in Germany and for specialist registration in Australia.

This was the start of an unanticipated long – and at times disillusioning – journey.

I entered the then ANZCA Overseas Trained Specialist (OTS) process in 2007 and obtained the FANZCA in 2008 after successfully completing the final fellowship examination.

I attribute my success in entering the Australian workforce and succeeding in the final exam to the selfless support received from many sympathetic anaesthetists in Brisbane, particularly from the founding members of the Overseas Trained Anaesthetists' Network (OTSAN). I am now a past president of OTSAN and

continue to be involved in international medical graduate specialist (IMGS) affairs. I am a member of the ANZCA IMGS Committee, have convened three OTSAN educational meetings and frequently present at those meetings. I played an instrumental role in introducing an ANZCA curriculum based two-year educational cycle for IMGS anaesthetists in Australia.

I am a member of the ANZCA Queensland Regional Committee and the elected formal project officer for all Queensland anaesthesia trainees. I am also a member of the ANZCA Scholar Role Sub Committee.

I have significant teaching and training responsibilities. I am a supervisor of training and an examiner at the final fellowship examination.

A watershed in ANZCA's assessment of IMGS was in 1996. It introduced a mechanism for assessing those from many more countries (previously only UK, Ireland, Canada, the US and South Africa) but asked everyone to undergo FANZCA examinations and thus gain FANZCA as the one criterion for recommendation for specialist registration. Michael Steyn, Kerstin Wyssusek and Indu Kapoor all came at this time, and now serve on the IMGS Committee, giving an IMGS perspective on the committee's deliberations. Michael has been a leader in Queensland anaesthesia and helped set up the Overseas Trained Specialists Anaesthetists' Network (OTSAN).

While we classically think of those who have done both basic medical and specialist anaesthesia training in overseas countries, when our regulatory authorities give statistics on IMGs they base this on the country of basic medical degree. Thus someone like ANZCA councillor Alan Merry, who has a University of Rhodesia degree (now University of Zimbabwe) and then gained his FANZCA with New Zealand training, will be included in the statistics on IMGs.

Alan has made a fantastic contribution to anaesthesia in New Zealand and Australia, and established anaesthesia on the national stage in New Zealand as the Chair of the Health Quality and Safety Commission and the head of Auckland University School of Medicine. He has also helped put New Zealand and Australia on the international anaesthesia stage with his research into anaesthesia safety.

Then there are the Australians and New Zealanders with our own basic medical degrees who went overseas for part or all of their specialist training. Another ANZCA councillor Pat Farrell and I both went overseas after our house surgeon years and trained in the United Kingdom, gaining FFARCS. We then returned, Pat to Australia, me to New Zealand, completed our local training having had the UK training credited towards our training time and being exempted the primary examination based on FFARCS (now FRCA). Almost a holiday with exams! This gave us an insight into UK training, and an external view of our own training, and has been useful in our work as final examination examiners and on ANZCA Council. While we were

over there, many of our compatriots continued in the UK system and gained the full specialist training with FFARCS and the certificate of higher professional training (now the CCT). Some of those later returned here, gained specialist registration based on the FFARCS (prior to 1996), and were later elected to FFARCS/FANZCA.

I've named only a very few of our IMGs above; there are so many who have made a significant contribution that there is not room to name them all, but I'd like to acknowledge their contributions as well.

Dr Leona Wilson FRCA, FANZCA
Director of Professional Affairs, IMGS



Dr Jacob Koshy
Alice Springs,
Northern
Territory

After graduation, my passion was paediatrics and after one and a half years I needed to sit an entrance examination. A surgeon friend said "this may sound really odd but you should consider anaesthetics as a specialty". He said there were great opportunities in anaesthesia and there was also the option of working with kids.

I was offered a place in anaesthesia and completed my masters at the Christian Medical College Vellore in

the south of India, then chose to work in a little mission hospital in the same state. It was a steep learning experience. Having trained with state-of-the-art machines and monitoring, I found myself faced with ancient Boyles machines and had to even learn to give ether anaesthesia using an EMO.

At the end of five years, I was ready for the next great adventure. Australia seemed a great place for opportunities for my young family and myself. I was able to fill a vacancy for an anaesthetist in Alice Springs where I landed on January 10, 2005.

The next great challenge was attempting to pass the final fellowship examination from there. With persistence and the incredible support of men such as Dr Rod Mitchell in Adelaide, Dr John Copland of Frankston Hospital and the Overseas Trained Specialist Anaesthetists Network

(OTSAN) I was admitted to fellowship in 2007. To date, nine international medical graduate specialists (IMGs) have passed their exams from Alice.

I took over as director in 2009 and have worked with an incredibly committed team of great anaesthetists. Alice Springs is a great place to live I have found enormous satisfaction in working with indigenous people.

My involvement in the College has been limited, although I was recently invited to join a committee working on the revised Continuing Professional Development Program and was involved in developing a patient satisfaction survey questionnaire. The process has been extremely rewarding and the tyranny of distance solved by technology. I certainly see international medical graduate specialists in regional centres being able to contribute a lot more to College activities.

How it works – the IMGS assessment process

The international medical graduate specialist (IMGS) assessment process “evaluates the ability of an IMGS to practise in ANZ as an unsupervised specialist anaesthetist at the standard comparable to that of a locally trained FANZCA”. In doing this, it is providing recommendations (via the Australian Medical Council) to the Medical Board of Australia (MBA) and the Medical Council of New Zealand (MCNZ), bodies that have protecting the public as their prime aim. At the same time the process needs to help fulfill ANZCA’s aim of promoting safe and high quality patient care and there is the absolute need to be fair to the IMGS being assessed.

In making recommendations about specialist/vocational registration of IMGS, ANZCA is working under legislation in our two countries, the Health Practitioner National Law Act (Australian) and the Health Practitioners Competence Assurance Act (New Zealand).

When ANZCA first receives an application, the paperwork provided is assessed to ensure that there is at least a chance that the applicant will be found to be either partially or substantially comparable to a locally trained FANZCA. Once that has been confirmed, along with their having met the MBA/MCNZ English language standard and having been in anaesthesia practice within 12 months, they are invited to a face-to-face interview in Melbourne or Wellington.

Structured face-to-face interview

At the structured face-to-face interview, a panel of four, (three Fellows and one lay person/jurisdictional representative) will decide whether the IMGS’s training and experience is:

- Substantially comparable (SC).
- Partially comparable (PC).
- Not comparable (NC).

To that of a locally trained anaesthetist. (The terminology in New Zealand is “equivalent to” and “satisfactory as”).

The criteria used at the interview cover all elements of the training, post-training experience as a specialist and continuing professional development, and are compared with that of a locally trained anaesthetist:

- Prevocational experience.
- Vocational training: duration, structure, content, subspecialty experience, supervision and assessment including examinations, and oversight of the training program, regular accreditation of training institutions against external standards.
- Experience as a specialist: case-mix, use of equipment and drugs, compliance with standards similar to those of ANZCA and of anaesthesia practice in Australia and New Zealand.
- Evidence of participation in continuing professional development, with continuous involvement in recent years being of particular importance.

Those considered SC or PC then continue with the IMGS assessment process, while those considered NC will be directed towards the general registration pathway.



Dr Indu Kapoor
Wellington,
New Zealand

I am an international medical graduate specialist (IMGS) working at Wellington Hospital in New Zealand. I received my MB BS and MD (Anaesthesiology) from New Delhi, India. I am a Fellow, by examination, of the college of anaesthetists in Ireland (FCARCSI), a Fellow of the Royal College of Anaesthetists in London (FRCA) and a Fellow of the Australia New Zealand College of Anaesthetists in Melbourne (FANZCA).

I moved to Wellington a decade ago as a registrar and was encouraged to apply for the IMGS assessment

process. I hence completed two years of clinical placement time and passed the IMGS assessment for FANZCA in 2005 (as per the requirement of the IMGS assessment process).

Since then I have trained as a paediatric anaesthetist at Starship Hospital, Auckland and the Royal Children’s Hospital, Melbourne.

My main interest is in the teaching and training of anaesthesia graduates. I am a module supervisor, a specialist study unit supervisor, an instructor on the Wellington FANZCA Final Exam Course as well as an Effective Management of Anaesthetic Crises (EMAC) instructor.

I am the education officer for ANZCA in New Zealand, a member of ANZCA’s New Zealand National Committee and IMGS Committee. I am a member of the New Zealand Society of Anaesthetists (NZSA) as well as a member of the International Aid Committee of NZSA.

As I write this passage and reflect on the last decade as an IMGS in New Zealand I am pleased with my decision to go through the process of becoming a FANZCA. Having decided to move to New Zealand I wanted to be a part of, and contribute to the anaesthesia fraternity here.

Being a Fellow of the College has offered me the opportunity to do so. Being on the IMGS Committee, I have been able to bring an Indian IMGS perspective and feel reassured that all perspectives are being heard and acted upon as the IMGS assessment process evolves. Reflecting on the assessment process itself, I have found it fair and well defined albeit long and with a definite financial outlay.

I am happy to be contacted by my IMGS colleagues in Australia and New Zealand regarding my experiences.

The assessment process following the interview consists of internal assessment, the clinical practice assessment (CPA), and an external assessment, either examination or workplace-based assessment (IMGS WBA). As well as this, the IMGS needs to do an Effective Management of Anaesthetic Crises (EMAC) course and make up any obvious deficiencies noted, such as more experience in pain medicine or cardiac anaesthesia.

External assessments

The examination (for those considered PC) can either be the IMGS examination (the final examination minus the multiple-choice paper (MCQ) or the full final examination. Some of those who are assessed as PC will be exempt from the written section, so that they only sit the anaesthesia and medical vivas. That exemption is decided at the interview, and those whose training, experience and CPD is more similar to a locally trained anaesthetist will gain it.

The IMGS WBA (for those considered SC) consists of a one-day visit by two Fellows who will observe practice in theatre, review 20 case records, interview up to 15 colleagues and interview the anaesthetist to understand their practice.

Internal assessments

Each IMGS will need to be assessed in their workplace by their supervisor. The minimum duration (12 to 24 months) and type of hospital in which it can occur (any, ANZCA accredited, ANZCA accredited for three years of clinical anaesthesia training) are set at the face-to-face structured interview. These reports must be submitted at least six monthly until all the requirements of the process have been satisfied. In the few cases where performance was not satisfactory, the IMGS will be asked to repeat that time, and may have increased assessment requirements.

Monitoring of progress

The College monitors each IMGS's progress in meeting all the conditions, and will invite them to come in for interviews if they are thought to be having problems with progress.

FANZCA

At the end of the process, if they've met all the conditions, they are able to apply for fellowship of ANZCA.

Dr Leona Wilson FRCA, FANZCA
Director of Professional Affairs, IMGS



**Professor
Michael Steyn**
Brisbane,
Queensland

I was trained in Scotland in both general practice and anaesthesia. On the way I completed a master of science in public health. In 1995 I was appointed as a consultant anaesthetist at the St Andrews Centre for Plastic Surgery & Burns, Chelmsford. This is one of the largest and busiest paediatric and adult burn units in the UK. I was the Royal College of Anaesthetists and Association of Anaesthetists of Great Britain and Ireland representative for the British Burn Association National Review, National Specialist Commissioning

Advisory Group (Burns) and the National Framework Team for Paediatric Intensive Care in Burns. In 2001, I moved into full-time private practice.

In 2003, our family relocated to my wife's hometown of Brisbane. I joined the Royal Brisbane and Women's Hospital as a staff specialist and became director of the department in 2005.

At that time there was little investment or strategic planning to develop anaesthetic services in Queensland. However, from 2005, significant progress has been made. As a professional group we established the Queensland Statewide Anaesthesia and Perioperative Medicine Clinical Network (SWAPNET) and I was the inaugural chair. A biannual anaesthetic directors statewide meeting has flourished and a statewide automatic anaesthetic record-keeping project now covers 43 of the 54 sites in Queensland.

At the end of last year, after seven

years of development, the University of Queensland appointed a professor of anaesthesia, Andre van Zundert.

From a College perspective, I am a member of the Queensland Regional Committee and was deputy chair for four years. I'm on the International Medical Graduate Specialist (IMGS) Committee as the deputy chair and helped establish the Overseas Trained Specialist Anaesthetists Network (OTASAN).

I strongly believe that our anaesthesia community can learn and benefit from the experiences of international medical graduate specialists, just as we, as international medical graduate specialists, have developed our professional practice in response to the challenge of changing countries. Perhaps it is a process not too dissimilar to the challenge that faces us in keeping up to date and developing over our practice career.

Educational support for IMGs is key

The international medical graduate specialist (IMGS) in anaesthesia is quite different from the local advanced trainee registrar in a number of ways. They are specialists in their native country having completed their training, and have moved to Australia, often to areas of need¹.

The influence of cultural and social differences is also important. They have to negotiate the authorities of employment, immigration, registration, ANZCA, the Australian Medical Council and in many cases the issues involved are linked and co-dependent². A key consideration is that many IMGs are Australian permanent visa holders or are in this country because of their partner or other reasons not related to real or perceived issues of anaesthetic workforce shortages. One is compelled to argue that an obligation exists to provide them with educational support.

Preparing for and completing the ANZCA examinations successfully is no trivial task. However, the low IMGs pass rate cannot be completely explained by their approaches to study and motivational behaviours as many either match or are better than the higher achieving group of local trainees³.

Rather, the issue could be lack of educational support. IMGs in anaesthesia achieved a pass rate at the specialist recognition exams that match that of local trainees when a program specifically addressing their learning needs was generated⁴. Processes and methods were devised at the Department of Anaesthesia and Peri-operative Medicine at the Royal Brisbane and Women's Hospital to measure educational outcomes from a discussion-based approach to medical education, which is assessable from remote locations.

Research in this education program has allowed a metric to be derived on the nature and content of participation in the activity that correlates with the subsequent success or failure at the examination⁴. It is feasible to use contemporary content analysis approaches to successfully provide rapid ongoing assessment of the distant exam candidate's performance. The information obtained from this novel measurement provides a better assessment of the IMGs's ongoing preparation. It provides the educator with a mechanism for appraising the IMGs's understanding of the concepts and techniques that are required to achieve success at the examination. The advantage is that a comprehensive picture can be built formatively for the IMGs and their actual level of competence.

It is easier and more productive to provide help to ensure a standard rather than criticise training in the country of origin and leave the IMGs to struggle.



Dr Vanessa Beavis
Auckland,
New Zealand

After a stint trying out obstetrics and gynaecology and a few years as a GP, I realised that a far more interesting speciality was available. I trained in South Africa in the Witwatersrand area, and thoroughly enjoyed my time right in the thick of it, including at the well-known Baragwaneth hospital in Soweto. I was awarded an FFA (SA) in 1992 – when anaesthesia was still a Faculty of the College of Surgeons.

Realising that the difference between being a refugee and an immigrant is timing, I emigrated to New Zealand in

1993. I started work as a provisional Fellow at Auckland Hospital in the Department of Critical Care Medicine and then moved to anaesthesia.

As soon as the minimum five years were up, I sought election to fellowship. This seemed to me to be the obvious way to become fully engaged with my professional community. Besides, from my observation of ANZCA from the outside, it looked like there were a bunch of smart people involved in it.

I became clinical director at Auckland Hospital soon afterwards and, on the advice of a senior member of the department, became an examiner for the part 2 exams. My 12 years of this has been one of the most professionally challenging things to do. It's also been fun. You learn so much, every time!

My next job was as a member of the perioperative medicine taskforce set up in 2004, thus starting my interest in that area of practice. This led to

the setting up of the Anaesthetists in Management Special Interest Group and the Perioperative Medicine Special Interest Group.

Not having quite enough to do (apart from running a big department, a private practice and two small children) I was elected to the New Zealand National Committee, and later chaired it for three years. At present I am the annual scientific meeting officer, on the ANZCA Council, chair the CPD Committee, sit on the Fellowship Affairs Committee, the Training and Assessments Committee and chair the Vocational Assessments Committee (IMGs) for New Zealand.

Being part of the ANZCA community has involved much hard work but it has brought with it many friends and a feeling of welcome in both Australia and New Zealand. It's been fun all the way, and I am proud to be part of it.

Many IMGs have become members of a self-help organisation called Overseas Trained Specialist Anaesthetists' Network (OTSAN) that is supported by ANZCA. It is increasing the frequency with which it offers exam preparation opportunities. Their support is now attracting more local anaesthetists to present at educational events for the IMGs audience. Through their efforts, the IMGs in anaesthesia are becoming more knowledgeable of what is pertinent for examinations and their overall pass rate is increasing, as is their knowledge of the system here in Australia.

At the same time, workplace performance during the clinical performance assessment period is monitored via supervisor assessments. Scope exists to enhance this assessment with the tools recently introduced into the ANZCA Training Program.

Professor Michael Steyn,
Director of Anaesthetics, Royal Brisbane
and Women's Hospital

References:

1. Taraporewalla K. The overseas trained anaesthetist: An educational challenge. ANZCA Annual Scientific Meeting; Sydney: Australian and New Zealand College of Anaesthetists; 2008.
2. Higgins N, Taraporewalla K, Steyn M, Brijball R, Watson M. Workforce education issues for International Medical Graduate Specialists in Anaesthesia. Australian Health Review. 2010;34(2):246-251.
3. Higgins N. Educational Support for International Medical Graduate Specialists in Anaesthesia [Thesis (Ph.D.)]. St. Lucia, Qld: The University of Queensland, School of Medicine Central; 2012.
4. Higgins N, Taraporewalla K, Steyn M, Brijball R, Watson M. Educational support for specialist international medical graduates in anaesthesia. Med J Aust. 2013;199(4):272-274.



**Dr Diana
C Strange
Khursandi**
Caboolture,
Queensland

After medical and anaesthesia training at Oxford, Cambridge and the Royal London Hospital, and producing three children, I accompanied my then-husband in 1977 to Maryborough, Queensland, where he had been offered a job by a local surgeon. We were met at the airport by a senior representative of Queensland Health, and a brief visit to the Medical Board ensured our registration!

Maryborough is a historic old city, 250 kilometres from Brisbane and at that time was a regional centre for about 35,000 people. Medical care was

supplied by the Base Hospital and a private hospital in the city. The medical and general communities were very welcoming.

Until my arrival, the delivery of anaesthesia services was in the hands of a number of general practitioners, who also provided some obstetric and surgical services.

I knew of two anaesthetists in Brisbane but otherwise I was on my own. The buck stopped with me (and some advice over the phone). There was a vestigial intensive care unit, which we developed over the years. Each year I trained up a new principal house officer (PHO), with whom I shared call after about six months. I was on one-in-one call for eight of the first 10 years.

Transfers to Brisbane were by road or air ambulance – and had to be escorted by clinical personnel from our small hospital. Oh what joy when the air retrieval services commenced, and when mobile phones arrived – patients

could be escorted to tertiary care without depleting our meagre resources and I could be on call without being tied to a landline!

I joined the Australian Society of Anaesthetists, attended state and national meetings (courtesy of weekend cover provided by my GP associates) and got to know more anaesthetist colleagues – several of whom were very supportive, especially Professor Tess Brophy, as she then was. Apart from weekends, I had to plan about a year ahead to obtain locum cover for leave from my public and private practice.

After a few years I was elected to fellowship of the then Faculty, and later served on the ANZCA Council.

My interest in welfare issues developed in those early years, as well as that of supply of anaesthesia services to rural and remote communities.

Network news – OTSAN proves a huge success



A little support goes a long way to assist overseas-trained anaesthetists, a group of ANZCA Fellows has found.

Before the Overseas Trained Specialist Anaesthetist Network (OTSAN) was established in 2006, only about 10 per cent of international medical graduate specialists who hoped to practice anaesthesia in Australia passed ANZCA's final fellowship exam.

Recognising a need to provide guidance and support to overseas-trained anaesthetists, a group of overseas-trained ANZCA Fellows established OTSAN, an independent, not-for-profit support group to help others settle in to Australian hospitals and meet College requirements.

The move paid off and the pass rate among the international medical graduate specialists associated with OTSAN has increased dramatically to between 50 and 60 per cent.

The success is attributed to networking, sharing ideas, practice sessions, educational weekend meetings in the earlier years and, more recently, to twice-yearly "boot camps" that are run a few weeks prior to the College exam. OTSAN sincerely appreciates the input from examiners, who help conduct practice exams and provide excellent feedback to international medical graduate specialists ahead of their final exam. The most recent boot camp, held in Ballarat, Victoria, on February 15 and 16, was very well received.

Last year OTSAN added an annual educational meeting to its events calendar, to be held each year at different locations around Australia. OTSAN invites all Fellows to attend these meetings.

At the first annual education meeting in Cairns in November, the OTSAN executive dedicated an award to the memory of late Dr Jürgen Dallherm. This award will be presented at the annual meeting each year to felicitate an anaesthetist showing extraordinary commitment to training and educating international medical graduate specialists.

Jürgen completed his training in 1994, and worked as an anaesthetist in Germany from 1995 to 2009. He was a passionate scuba diver and enjoyed travelling the world. He also obtained a certificate in diving medicine. He visited Australia for the first time in 1998, fell in love with the country and wanted to make it his home.

Hearing of a possibility to work as a specialist anaesthetist, Jürgen relocated to Australia with his wife, Ulrike, in 2009. He started work as an anaesthetist in Mackay, Queensland, with plans to pass the College exam and enjoy the Australian lifestyle. Unfortunately Jürgen had a fatal heart attack on October 24, 2011.

In November, Ulrike attended the presentation of the inaugural award in her husband's name to Professor Kersi Taraporewalla (Qld).

Kersi is an educator par excellence and has been College examiner for the final fellowship exam.

Moved by the high failure rate among international medical graduate specialists, Kersi catalysed the formation of OTSAN and his support for the network has been exemplary. He has been instrumental in generating up-skilling programs to assist international medical graduate specialists in Queensland.

Many OTSAN members have learnt immensely from Kersi's tutorials. He has contributed his time generously and selflessly to help international specialists get across the College exam. He truly deserves to be the first recipient of this award.

The OTSAN executive also thanks ANZCA for its ongoing assistance, in the form of both resources and secretarial support. This venture, in its present form, would not have been possible without active involvement from ANZCA.

Associate Professor Sanjay Sharma
President, OTSAN

Above from left: The OTSAN executive: Srinivas Rachakonda (general secretary), Gaurang Barot (treasurer), Tilo Klinger (regional secretary and public relations), Professor Kersi Taraporewalla (recipient, inaugural Jürgen Dallherm award), Sanjay Sharma (OTSAN president); The late Dr Jürgen Dallherm.



Listening to our Fellows

This year, ANZCA will again be surveying its Fellows. This follows the 2010 ANZCA Fellowship Survey which resulted in many positive improvements in the way the College interacts with and benefits Fellows.

The survey was conducted in March and April, 2010. Fellows were sent the survey via email and in hard copy and four focus group sessions were held at the Christchurch annual scientific meeting in May. Fifty percent of Fellows responded to the survey, which was a strong response that allowed valid conclusions to be drawn from the data, according to the researchers, ANOP Research Services.

The 2010 ANZCA Fellowship Survey resulted in many changes at ANZCA.

While the survey of anaesthetists showed that the College was performing well in a number of areas, with overall levels of Fellows' satisfaction with the College high, there were some areas showing work still needed to be done to improve the quality of services that the College provides for its Fellows.

A key element in addressing many of the issues raised by Fellows was a restructure of the ANZCA website in 2011, where areas of higher importance to Fellows were more prominently displayed – quality and safety, professional documents, education (learning), training, the library and publications and communications. The Anaesthesia and Pain Medicine Foundation is now more prominently displayed. Plans are under way for further website improvements in 2015.

Key implications of the survey and how the College responded

2010: ANZCA's core roles are quality and safety standards setting as well as education and training. Fellows are committed to high standards and quality and the maintenance of world-class standards is central to ANZCA's standing and the profession.

ANZCA continues to recognise these core roles of the College and this is reflected in the first priority of the ANZCA Strategic Plan 2013-2017 – to advance standards through training, education, accreditation and research.

A key element of this commitment was the launch last year of ANZCA's 2013 training program. The Curriculum Revision Project and the resulting training program was the biggest project ever undertaken by the College with workplace-based assessment and training portfolio system (TPS) workshops delivered throughout Australia and New Zealand throughout 2012.

It has resulted in a world-class curriculum supported by a comprehensive online handbook and regulation and the state-of-the-art TPS, a tool trainees and supervisors use to record training.

This was acknowledged by the Australian Medical Council when ANZCA, including FPM, were re-accredited for another six years to 2018.

A growing library of podcasts, often supported by webinars, covers areas including introductory training (16 podcasts), the primary exam (10), the final exam (21), the revised curriculum (11), medical education (12), indigenous health (nine), continuing professional development (two) and pain medicine (13) and the FPM Curriculum Redesign Project (four).

The College also delivers a Foundation Teacher Course and new Foundation Teacher Course (Online) which has been designed for Fellows and provisional Fellows to learn how to teach effectively. Learning resources can be found at www.anzca.edu.au/resources/learning.

The ANZCA Library, rated very highly in the survey, continues to grow, with Fellows taking advantage of online access more and more. Last year, there were more than 200,000 visits to the ANZCA Library website.

The College continues to add new or revised professional documents to its comprehensive suite (more than 60 documents can be found at www.anzca.edu.au/resources/professional-documents), disseminate safety alerts (www.anzca.edu.au/fellows/quality-safety/safety-alerts) and support WebAIRS, the anaesthetic incident reporting system of the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) to ensure quality and safety of anaesthesia and pain medicine remains at the highest levels.

2010: The CPD program needs further fine-tuning and streamlining. While there is a good level of satisfaction with the CPD program, it emerges as one of ANZCA's more important services and its ranking in terms of satisfaction lags behind its importance ranking.

"The ANZCA Library, rated very highly in the survey, continues to grow, with Fellows taking advantage of online access more and more. Last year, there were more than 200,000 visits to the ANZCA Library website."

**2014
ANZCA
Fellowship
Survey**
Strengthen
our College



The ANZCA CPD Program in 2014 reflects a modern forward looking approach with incorporating leading edge online functionality.

In 2011, the CPD online portfolio system for participants was overhauled and re-launched later that year. CPD was also given a stronger presence on the new ANZCA website which was launched in September 2011.

The CPD standard applicable to all anaesthetists and specialist pain medicine physicians in Australia and New Zealand was revised in 2013 and introduced in 2014. It reflects contemporary developments in CPD with a dual focus on evaluation of practice as well as the more traditional pure learning activities. A new, simple-to-use CPD portfolio system that allows participants to access their portfolio on any computer or mobile device was also introduced. The interface of the system was carefully designed with ANZCA and FPM Fellow input.

2010: Publications and communications need to continue to cater for a variety of delivery and content preferences. While there are no major issues with specific publications, the priority is on "important to know" information. The College also needs to cater for differing levels of computer proficiency by making publications available in print and online.

The ANZCA website content was updated and better, more logical navigation was introduced in 2011. Features included a more useful quality and safety section, a stronger presence for CPD, the library, the Faculty of Pain Medicine, the Anaesthesia and Pain Medicine Foundation and the international medical graduate specialists (IMGS) section. A comprehensive patients' information section was also added.

The 2010 survey led to new sections within ANZCA publications (for example, a new "Your ANZCA" section in the *Bulletin* is designed to explain to the wider fellowship the behind-the-scenes activities of ANZCA's committees) and College e-newsletters, which were reassessed to ensure they contained "important to know" information (for example, prominent listing of continuing medical education events and critical safety alerts). The *ANZCA E-Newsletters* was redesigned with an at-a-glance index that allows time-poor readers to click through to topics of interest to them.

(Continued next page)

**2014
ANZCA
Fellowship
Survey**
Strengthen
our College



College publications are all available on the website and the *Bulletin* and other publications are now in the downloadable, easier to read “flipbook” format. The College has also introduced with the *Bulletin* the College Conversations audio CD, which contains interviews of interest. These interviews can also be downloaded from the website.

2010: Fellows see an important role for ANZCA in representing the profession. ANZCA's representations to government and the jurisdictions, and its role as the voice of anaesthetists needs to be enhanced. The professional standing and public profile of anaesthetists' roles and responsibilities needs to be strengthened.

ANZCA's role as the professional voice of anaesthetists and specialist pain medicine physicians continues to grow with much work undertaken by the College's Policy unit both in Australia and New Zealand, where a new policy officer was appointed in 2011.

To illustrate the College's activities as the “voice of anaesthetists” the *ANZCA Bulletin* started an “ANZCA and government” section in 2011, highlighting the College's interactions with and submissions to governments in Australia and New Zealand. Submissions can be found at www.anzca.edu.au/communications/submissions.

Improvements to ANZCA's New Zealand communications were enhanced with the appointment in July 2010 of a communications specialist in the New Zealand office.

The College's engagement with the media continues to grow with the College media team seeking out good anaesthesia and pain medicine stories (for example, at scientific meetings and through research announcements) and preparing 20-30 media releases a year. In 2011, the College introduced the ANZCA Media Award and started hosting journalists at the annual scientific meeting to encourage coverage of anaesthesia and pain medicine.

The *Bulletin* also now prominently displays its “ANZCA in the news” section, which highlights media activity initiated by ANZCA, listing media releases issued and the resulting media responses.

On October 16, 2013 the College re-launched National Anaesthesia Day, an exercise that involved many Fellows and trainees actively promoting their profession in their hospitals through staffed foyer displays, hanging the specially designed posters and distributing new web-based patient information sheets. A media campaign on the day also drew attention to the profession and raised its profile.

2010: There is a desire for greater recognition of voluntary contributions by Fellows and for more assistance in carrying out these roles.

Support for Fellows undertaking voluntary activities for the College has grown since the survey with the development of teacher courses, both face-to-face and online.

“ANZCA’s role as the professional voice of anaesthetists continues to grow with much work undertaken by the College’s Policy unit both in Australia and New Zealand.”



Key findings in 2010

- A high level of satisfaction by Fellows with ANZCA overall (71 per cent satisfaction score).
- Strong usage of many of ANZCA’s services, indicating the College’s relevance and value to the profession.
- A high level of satisfaction with College staff (77 per cent satisfaction score).
- Six in 10 Fellows regarded the annual subscription fee as reasonable or at least acceptable.
- The College’s most important roles are seen to be quality and safety, professional standards setting, as well as education and training.
- More than half the fellowship (55 per cent of respondents) reported undertaking voluntary roles and nearly eight in 10 (78 per cent) are involved in teaching roles.
- Fellows see particular strengths in the College’s professional documents, the annual scientific meeting, the library, publications and communications.
- Slightly lower levels of satisfaction were evident in survey responses relating to the College’s CPD program, and ANZCA’s role as the professional voice of anaesthetists.
- There is a reasonable level of satisfaction among Fellows with the ANZCA website.
- There is scope to improve the ease of access to and use of ANZCA’s CPD program.
- There was relatively low understanding among Fellows of the roles and responsibilities of office holders in the College, and low awareness of the ANZCA Foundation (now Anaesthesia and Pain Medicine Foundation), particularly among new Fellows.

The College also developed a series of teaching and learning cases for use with the 2013 curriculum and supervisor orientation and support resources are being developed to be launched on ANZCA’s new learning and collaboration management system in July 2014. This will include tools for Fellows undertaking important teaching and supervisors roles to access resources, share resources and collaborate in supportive networks.

Since 2010, ANZCA presidents have embraced the need to acknowledge the voluntary contributions of Fellows and express gratitude via various means, such as personal letters, speeches, messages in College publications and ASM presentations.

2010: There is a desire for greater speed, responsiveness and further streamlining of College administrative processes.

Since 2012, a number of ANZCA departments have had customer service charters developed. The aim of each charter is to give a clear delineation of responsibilities of individuals within departments and units to provide Fellows,

trainees and other stakeholders with the best service possible, for example, timely responses to queries.

Those who have had service charters developed include Fellowship Affairs and Training and Assessments, Information Technology, the Australian regions and New Zealand, with other units in the College completing their’s in 2014.

The charters are supported by the Manage Engine ServiceDesk product, a customer service tool which tracks requests and the time it takes for staff to respond.

Last year the College also delivered the ANZCA website-based MyANZCA portal, allowing Fellows and trainees to update their details online and register online for ANZCA and FPM-run continuing medical education events. The portal also allows the online payments of subscriptions, annual training fees and donations to the Anaesthesia and Pain Medicine Foundation.

The 2010 survey has provided the College with a benchmark against which progress can be measured in 2014.

Clea Hincks, General Manager,
Communications ANZCA

New online books and books for loan

New online books

Online textbooks can be accessed via the ANZCA Library website: www.anzca.edu.au/resources/library/online-textbooks



Abdominal transplantation / Niemann, Claus U. [ed]; Fleisher, Lee [ed]. -- Philadelphia: Elsevier, 2013. Anesthesiology Clinics.



Practical management of pain / Benzon, H T [ed.]; Rathmell, J P [ed.]; Wu, C L [ed.]; Turk, D C [ed.]; Argoff, C E [ed.]; Hurley, R E [ed.]. -- 5th ed -- Philadelphia, PA: Elsevier/Saunders, 2014.

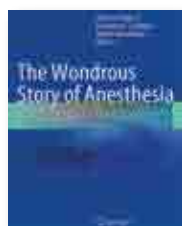
Anaesthesia and Intensive Care Medicine now online!



The ANZCA Library is pleased to announce that the popular journal *Anaesthesia and Intensive Care Medicine* (AICM) is available online to all trainees and Fellows through the ANZCA website. Anaesthetists and intensivists in training find AICM an invaluable source of up-to-date information, with the curriculum of both the primary and final examinations covered over a three-year cycle.

New books for loan

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



The wondrous story of anesthesia / Eger, Edmond I.[ed]; Saidman, Lawrence J.[ed]; Westhorpe, Rodney N.[ed]. -- 1st ed -- New York, NY:Springer, 2013.



Managing obstetric emergencies and trauma: The MOET course manual. / Grady, Kathryn M. [ed]; Howell, Charlotte [ed]; Cox, Charles [ed]. -- 2nd ed -- London: RCOG Press, 2007.



Comprehensive treatment of chronic pain by medical, interventional, and integrative approaches: The American Academy of Pain Medicine textbook on patient management / Deer, Timothy R.[ed]; Leong, Michael S.[ed]; Buvanendran, Asokumar [ed]; American Academy of Pain Medicine [ed]. -- 1st ed -- New York, NY: Springer; Springer, 2013.



Saving life... or prolonging death: finding the way in a world of medical technology / Corke, Charlie F; Steinbock, Bonnie. -- 1st ed -- London: Erudite Medical Books, 2010.



Along with AICM, *ClinicalKey* provides access to a high quality specialised collection of anaesthesia and pain-related online journals and books. Sign up for a personal account to download article/ chapter PDFs, save searches and use the presentation maker.

Access *Anaesthesia and Intensive Care Medicine* by logging in to the ANZCA Library online journal list with your College ID and password: www.anzca.edu.au/resources/library/journals

New platform for online textbook searching



In early 2014, the *AccessAnesthesiology* and *AccessMedicine* platform, including *Harrison's Online*, was updated and revamped. New features include:

- Smarter search with an updated search algorithm for better filtering.
- Responsive design for mobile providing great viewing experience no matter what device you use.
- Enhanced custom curriculum functionality so creating a curriculum program through the online platform is even quicker and easier.



New ECRI safety publications

From 2014, *Health Devices* will no longer be published as a print magazine but will provide articles and reviews online. Contact the library if you are interested in receiving updates from this publication.

Health Devices, Vol. 42, No. 11, November 2013

- Top 10 health technology hazards for 2014, including:
 - Alarm hazards.
 - Infusion pump medication errors.
 - Occupational radiation hazards in hybrid Ors.
 - Inadequate reprocessing of endoscopes and surgical instruments.

Health Devices, Vol. 42, No. 12, December 2013

- The Cerebral Oximetry Marketplace.
- Six Steps to an Alarm Management Plan.

Operating Room Risk Management, December 2013 updates

- Perioperative Documentation.

Operating Room Risk Management, February 2014 updates

- “Controlled Exposures to Nitrous Oxide during Anesthetic Administration” and “Desflurane” now included in the Analysis “Waste Anesthetic Gases”.
- Fatigue in Healthcare Workers.
- Occupational Exposure to Blood or Body Fluids.

Latest anaesthesia and pain medicine research

All articles can be sourced in full text from the Library's online journal list: www.anzca.edu.au/resources/library/journals

Anesthesiology, January 2014, Volume 120, Issue 1

Introduction to the Anesthesiology Medical Education Theme Issue

Articles include:

- Avoiding professional extinction.
- Time to flip the pain curriculum?
- But what if there are no teachers...?
- Can physician performance be assessed via simulation?

International Anesthesiology Clinics, Winter 2014, Volume 52, Issue 1

Quality Management in Anesthesiology, Volume 2: Advanced Topics

Articles include:

- Characteristics of a high-quality anesthesia practice.
- Sentinel events and how to learn from them.
- Decision-making errors in anesthesiology.
- The global anesthesia crisis and continuous quality improvement.

Anaesthesia, January 2014, Volume 69, Issue Supplement s1

Anaesthesia for the Elderly

Articles include:

- The ailing anaesthetist.
- The ageing anaesthetist.
- The tiring anaesthetist.

Contact the ANZCA Library

www.anzca.edu.au/resources/library

Phone: +61 3 9093 4967

Fax: +61 3 8517 5381

Email: library@anzca.edu.au

The use of activated charcoal filters for malignant hyperthermia-susceptible patients

Purging a “contaminated” anaesthetic machine is an essential part of management of patients at risk of malignant hyperthermia (MH) susceptibility¹.

Very few anaesthetic departments have a dedicated vapour-free anaesthetic machine for planned use in a known or suspected MH susceptible patient. The internal circuitry of current anaesthetic workstations is complex and inhalational agents are retained more readily than older models and flushing these machines takes longer to reach an appropriate concentration of anaesthetic^{2,3}. This can be especially problematic in the setting of time critical requirements for general anaesthesia, for example, emergency general anaesthetic for caesarean section. The accepted safe level of inhalational agent is 5ppm⁴. This was determined using halothane (the most potent trigger of an MH reaction), therefore other inhalational agents are presumed safe with levels <5ppm. Purging a machine can be prolonged^{2,3} although the time period can vary with different researchers. A period of flushing a machine for up to 70 minutes is inconvenient, time consuming and costly.

Activated charcoal filters (ACFs) for purging an anaesthetic machine were first suggested by Greene in 1986⁵. Later Gunter⁶ found that a Quick Emergence

Device™ reduced residual concentration of sevoflurane to <5ppm in 10 minutes using a Dräger Fabius anaesthesia machine. More recently Birgenheier⁷ using an Apollo anaesthesia machine found that using Vapor-Clean ACFs on both inspired and expired limbs of a contaminated machine, volatile concentration with desflurane and sevoflurane fell to <2ppm in two minutes. The measurement, however, was only continued for 90 minutes. MHAUS⁸ (Malignant Hyperthermia Association of United States) later recommended changing ACFs every hour.

Recent research⁹ on the clinical use of ACFs conducted at the Royal Melbourne Hospital has been published in *Anaesthesia and Intensive Care*. The investigators sought to answer a range of questions about the configuration/number of ACFs required in the circuit, the safe duration for ACF usage and whether an anaesthetic machine needed to be flushed prior to inserting the ACF to achieve safe conditions for patients at risk of MH susceptibility. Experiments were performed on Datex-Ohmeda Aisys anaesthesia machines. The machines were contaminated for two hours ventilating a test lung and using isoflurane 1.5 per cent, desflurane 6 per cent and sevoflurane 2 per cent. Fresh gas flow was set at two litres/minute. Vapor-Clean™ activated charcoal filters (Dynasthetics LLC) containing 50 cc of activated charcoal in a polypropylene filter mesh were used.

MHANZ (Malignant Hyperthermia Australia & New Zealand) is the group of anaesthetists and scientists who test for MH susceptibility and advise ANZCA on MH-related policy. The following are our recommendations that follow from the results obtained by Melbourne investigators.

MHANZ recommendations for the use of activated charcoal filters in the preparation of anaesthetic machines for patients at risk for MH susceptibility:

1. Remove vaporisers from the anaesthetic machine.
2. Flush circuit for 90 seconds with oxygen or air at 10 litres/minute using the ventilator with a two litre test lung attached.
3. Change full breathing circuit and soda lime while maintaining flushing at 10 litres/minute (the ventilator is left unchanged).
4. Insert activated charcoal filters on both the inspiratory and expiratory ports of the breathing system. (NB: while Bilmen & Gillies⁹ demonstrated the efficacy of using a single ACF on the inspiratory limb of a circle circuit, MHANZ recommendation is that two ACFs are used to remove the risk of incorrectly placing a single filter on the expiratory limb which is *ineffective*).
5. Maintain fresh gas flow of 10 litres/minute for 90 minutes from the commencement of the anaesthetic.
6. After 90 minutes it is safe to reduce FGF to three litres/minute.



7. ACFs can be used at three litres/minute until a total of 12 hours has elapsed from the commencement of the anaesthetic.
8. ACFs are single-use items.
9. In the event of an MH crisis, the addition of ACFs to the anaesthetic machine may be of benefit⁷, but this has not been proven clinically. Clinical priorities in an MH crisis remain: dantrolene administration (2.5mg/kg), high fresh gas flows, treatment of arrhythmia/acidosis and active cooling.

Vapor-Clean ACFs are available in New Zealand through Jackson Allison Medical and Surgical Limited, but are awaiting TGA approval in Australia. The cost of a pair of ACFs is approximately \$A130.

Malignant Hyperthermia Australia & New Zealand

Dr Teresa Bulger, Palmerston North Hospital

Dr Kirsty Bennett, Palmerston North Hospital

Dr Robyn Gillies, Royal Melbourne Hospital

Dr Brad Hockey, Royal Melbourne Hospital

Dr Elaine Langton, Wellington Hospital

Dr Philip Nelson, Royal Perth Hospital

Dr Neil Pollock, Palmerston North Hospital

Dr Neil Street, Westmead Childrens Hospital

Dr Mark Waddington, Christchurch Hospital

Dr Kristine Wardle, Royal Perth Hospital

References:

1. Kim TW, Nemergut ED. Preparation of modern anesthesia workstations for malignant hyperthermia-susceptible patients. *Anesthesiology* 2011; 114: 205-12.
2. Jones C, Bennett K, Kim TW, Bulger TF, Pollock N. Preparation of Datex-Ohmeda Aestiva and Aisys anaesthetic machines for use in malignant hyperthermia susceptible patients. *Anaesth Intensive Care* 2012; 40: 490-497.
3. Shinkaruk KS, Nolan K, Crossan BS. Preparation of Datex-Ohmeda Aestiva anaesthetic machine for malignant hyperthermia cases. *Anesthesiology* 2008; 109: A279.
4. Maccini RM, Wedel DJ, Kor TM, Joyner MJ, Johnson ME, Hall BA. The effect of trace halothane exposure on triggering malignant hyperthermia in susceptible swine. *Anesth Analg* 1996; 82: S287.
5. Green ER Jr. Malignant hyperthermia; removal of volatile anesthetic agents from the breathing circuit using activated charcoal. *Anesthesiology* 1986; 65: 240-1.
6. Gunter JB, Ball J, Than-Win S. Preparation of Drager Fabius anesthesia machine for the malignant hyperthermia-susceptible patient.
7. Birgenheier N, Stoker R, Westenskow D, Orr J. Activated Charcoal Effectively Removes Inhaled Anesthetics from Modern Anesthetic Machines. *Anesth Analg* 2011; 112: 1363-70.
8. www.mhaus.org
9. Bilmen JG, Gillies RL. Clarifying the role of activated charcoal filters in preparing an anaesthetic workstation for malignant hyperthermia-susceptible patients. *Anaesth Intensive Care* 2014; 42: 51-58.



webAIRS news

Change of ANZTADC chair



The Australia and New Zealand Tripartite Anaesthetic Data Committee – ANZTADC – was formed in 2006 following the recommendations of two taskforces set up by Professor Michael Cousins during his tenure as ANZCA president. These were the Quality and Safety taskforce and the Data taskforce. Both taskforces included representation from Australian Society of Anaesthetists (ASA) and the New Zealand Society of Anaesthetists (NZSA) in addition to ANZCA. Tripartite support continued, resulting in the formation of ANZTADC. This committee continues to function with the close support, ideas and knowledge of the three founding organisations. Professor Alan Merry led the formation of the committee and has guided it through its infancy into the mature organisation that it is today.

Following the development of a strategic plan and evaluation of existing software, webAIRS, a web-based anaesthetic incident reporting system, was created. The program is based on knowledge of best practice in incident recording and has become a pre-eminent morbidity and mortality reporting resource in Australia and New Zealand. Professor Merry led the development of a robust framework for both committee function and software development with a focus on integrating webAIRS into a tool that is available in every anaesthetic department and private practice group in Australia and New Zealand.

It had always been intended that the chair of ANZTADC would rotate periodically and the incoming chair is Dr Neville Gibbs, who is well known as chief editor of the journal *Anaesthesia and Intensive Care* and for his previous role as chair of the ANZCA Mortality Subcommittee. Dr Gibbs' experience will be invaluable, as webAIRS has now collected a critical mass of around 2000 critical events, which will be analysed and published.

ANZTADC wishes to thank Professor Merry for supervising the creation of the ANZTADC Committee and the webAIRS website. His expertise and insight has been invaluable and he will stay involved as a committee member. ANZTADC warmly welcomes Dr Gibbs for this next phase of analysis and the publication of existing and future data.

Program improvements

The webAIRS program has been updated to include a feature that allows use of a single email address to log in to multiple hospitals, day surgeries or private practice. In order to add additional sites to an existing account, log in and select "Register" from the menu. Registered users can select from existing sites or can add new sites. For Fellows without an existing account, register as a user and then select or add sites as above. Local administrator functions have been upgraded and more user functions will be added this year to give feedback to all users.



webAIRS
Anaesthetic Incident
Reporting System
from ANZTADC

ANZCA and Airway SIG annual scientific meetings in Singapore 2014

A summary of the webAIRS airway incidents will be presented at the Airway SIG meeting, which immediately precedes the 2014 ANZCA Annual Scientific Meeting (ASM) in Singapore. webAIRS had collected 556 incidents in the respiratory category as of February 15. Of these, 359 were airway related. A summary of the events, the risk factors and outcomes will be presented.

At the ASM, webAIRS data will be presented in the "Human factors and patient data" session on Thursday May 8. This session is titled "A standardised but flexible approach to managing anaesthetic incidents" and will explore the active use of data to improve safety in anaesthesia.

2014 ANZCA CPD Program

Reporting, case discussion or analysing incidents using webAIRS qualifies for two credits per hour in the new Practice Evaluation CPD category. After reporting an incident, there is an option to email a confirmation of the credits to your email address. This provides a convenient way to document this online CPD activity as well as assisting Fellows who may find it difficult to attend larger meetings as a result of distance, time or other constraints.

Email: mculwick@bigpond.net.au

Administration support:
anztadc@anzca.edu.au

To register visit www.anztadc.net and click the registration link on the top right hand side.

Demo at www.anztadc.net/demo

Alerts

Recall of B Braun SANGOFIX IV administration sets and HEIDELBERG extension tubing

Investigation of several Australian reports of leakage from the in-line Safsite injection site of these products has revealed that on disconnection of a luer connector or syringe used to access the injection site a resealing problem may occur. The risk of fluid leakage from the valve is loss of fluid, medication or blood (may be significant in a paediatric patient). Although all implicated products/batches have been recalled, B Braun, in consultation with the TGA, has recommended the following interim corrective action:

Attach a standalone Safsite valve to the in-line injection site (see diagram). The additional Safsite valve will then function as the injection site for the duration of the use of the line. The valve can be used for injection or infusion therapy and does not need to be removed.



Multiple recalls of infusion pumps – GemStar, Life Care and Plum family models

Hospira Australia advises that these infusion pumps are subject to multiple recall actions relating to a wide variety of safety issues. Hospira, in consultation with the TGA, is undertaking numerous corrective actions and has written to healthcare facilities providing information on each problem.

The following link provides detailed information:

www.tga.gov.au/safety/alerts-device-hospira-infusion-pump-131218.htm#info-consumers-hp

ECRI alerts

Potential occlusion of GE Vital Signs Breathing Circuits by port cap

GE Vital Signs Breathing Circuits have been distributed with 15mm blue port caps as a loose component and/or 22mm blue port caps attached to certain ports. The caps are not intended to be part of the final circuit assembly and if the circuit is used with the cap in place there will be occlusion of gas flow. GE recommends visual inspection of breathing circuits before use with removal and discard of 15 or 22mm blue caps attached to any ports. All circuits should be pressure tested for leaks and flow tested for obstructions prior to use.

Philips HeartStart Monitor/Defibrillators: Electric component may fail, potentially resulting in failure to deliver therapy during emergency

In some units manufactured between 2005 and 2012 an electrical component may fail and incorrectly indicate that the device is ready for use. The AED tests itself at regular intervals and if it emits a triple chirp alert this may indicate that a serious problem has been detected, which could prevent the AED from delivering therapy in an emergency. Philips should be contacted. If the AED emits a pattern of triple chirps during an emergency, press the flashing blue i-button and follow the voice prompts.

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



Dean's message



The upcoming Faculty of Pain Medicine Refresher Course Day and annual scientific meeting (ASM) in Singapore will be events not to miss.

The joint ASM of the Faculty, ANZCA and the Royal Australasian College of Surgeons (RACS) will be the most exciting conference we have participated in for many years. The parallel scientific programs and social events make this meeting packed for choice of workshops, speakers both national and international, and for choice of social events with our surgical colleagues.

Personally, the 2014 ASM will have the added significance of marking the end of my term as Faculty dean, a position that has been all-consuming and a role I feel extremely privileged to have held.

This issue of the *Bulletin* and this message will be the last in my term as dean. It is timely to reflect on the past two years.

I leave office with the utmost confidence that we, as a Faculty, continue to be on the right path. Our strategic plan, as a guiding document, is serving us well. We are well served by the focus on strengthening our governance within the Faculty and the College, and from the consistency and adherence to detail of the administrative processes we have adopted. There is increasing clarity in how we function for our Fellows and trainees, and the processes required to gain the most from our College for the Fellows.

To maintain an international standing in any field of medicine requires a vision to extend beyond the administration and regulation of our core roles of training, assessment and maintenance of standards for Fellows and of training facilities. Our strategic plan has mapped ambitious goals to co-ordinate the tireless contributions of Fellows to contribute to major projects. The evolution and growing reputation of the Faculty as the stewards of our still-young speciality, is well served by the Faculty's ambitions to make effective and meaningful contributions to education and research that benefit both the medical field and the community at large.

Our focus on research and education serves our Fellows and trainees by providing a reinvigorated training program and assessment, as well as a technically advanced and increasingly user-friendly continuing professional development system. The standard of specialist graduating from our training program maintains the Faculty's international reputation for innovation and leadership in this field.

The Curriculum Redesign Project has moved rapidly from conception through needs analysis and multiple iterations of a solution to an advanced stage of development, on track for delivery next year. This very co-operative process, to which many Fellows and recent trainees have contributed, has involved a major philosophical shift in teaching and in learning, and the revised curriculum and training program may well redefine the discipline of pain medicine.

Also in this area, the significant delivery of online education for general practitioners and ambitious plans for expansion to improve quality and availability of education for primary health workers has attracted international interest, enhanced our reputation and, importantly, has been endorsed by the provision of further significant funding to continue these educational aspirations.

In the area of research, the electronic persistent pain outcome collaboration (ePPOC) and the pain device implant registry (PDIR) will be pivotal, long-term contributions to improve the quality of clinical practice and patient care. These projects also will serve to elevate the profile of the Faculty and College in the years ahead, enhance our reputation and with it the opportunities for further funding. Establishing a reputation for effective delivery of such significant projects engenders confidence in the Faculty as a worthy recipient of grant funds and expands our opportunities to build on these projects in the future.

On a personal note, I have been inspired by the vision, competence, commitment and persistence of the people with whom I have worked over the last two years. The Faculty General Manager, Helen Morris, and the Faculty staff have been unwavering in their support and for this I am very grateful.

The Faculty maintains an enviable tradition of high fellowship engagement in its affairs. Many hands make light work and of course, the contrary is also true. I remind Fellows to recognise the value of their fellowship to their own professional reputation and opportunities this has afforded them. Significant amounts of voluntary time and effort are required to sustain the Faculty and all its functions. I appeal to all Fellows to consider committing some time back, and to playing a meaningful role in furthering the vision of the Faculty and College. The first step is to contact your regional committee or the offices of FPM and ANZCA on St Kilda Road, Melbourne, or simply answer one of regular calls for volunteers.

Don't hesitate. See you in Singapore.

Associate Professor Brendan Moore
Dean, Faculty of Pain Medicine

Admission to fellowship

By examination:

Kim Hattingh, FRACGP (SA)

Meena Mittal, FANZCA (Vic)

Joshua Surian Daly, FANZCA (Qld)

Phillip Kriel, FANZCA (WA)

Jason John Scott, FANZCA (Qld)

Sampath Sanjay Prabhu, FANZCA (SA)

Hema Malini Rajappa, FRACP (NSW)

Jacqueline Annette Evans, FANZCA (Qld)

By election:

Paul Rolan, FRACP (SA)

We are pleased to report that this takes the total number of FPM Fellows to 368.

2014 Faculty board election

Nomination forms for election to the FPM Board were circulated to Faculty Fellows in November. Five nominations have been received for the three vacancies and will now proceed to a ballot. In accordance with Faculty regulations, at least one of these vacancies must be filled by a Faculty Fellow with FANZCA. The remaining two vacancies may be filled by any Faculty Fellow.

2014 examinations

The written exam will be held across FPM regional and national offices on Friday, November 7. The clinical exams will be held at the Royal Adelaide Hospital, South Australia, on November 29 and 30. The closing date for exam registrations (written and clinical) is Monday September 22.

2014 Pre-Exam Short Course

The 2014 Pre-Exam Short Course will be held from September 19-21 at the ANZCA/FPM Queensland Regional Office.

Dunedin meeting for FPM

The FPM New Zealand National Committee is meeting on March 20 in Dunedin, in association with the NZ Pain Society's annual scientific meeting. Guest speakers at the committee meeting include the Ministry of Health's chief medical officer, anaesthetist Dr Don Mackie, and NZ Pain Society president Dr Brigitte Gertoberens. Agenda items include the pain medicine workforce in New Zealand and the place of chronic pain in the health statistics.

FPM Curriculum Redesign Project

Many FPM Fellows are now actively engaged in the FPM Curriculum Redesign Project. Recent progress includes development of the FPM Roles in Practice and the nine essential topic areas (ETAs).

Importantly, the revised FPM curriculum will reframe the nature of the discipline from a predominantly biomedical orientation to truly biopsychosocial, with a greater emphasis on social and psychological factors in the science and experience of pain. A modified CanMEDS© framework is being utilised, wherein the clinician role is the core of the curriculum document.

By remarkable coincidence, the conceptual framework that has been developed is similar to that proposed in a recent article by FPM Honorary Fellow Professor Daniel Carr: *Time to flip the pain curriculum?* Carr DB, Bradshaw YS. *Anesthesiology*. 2014 Jan;120(1):12-4. The full article can be accessed through the ANZCA Library online journal list.

Further details about the FPM Curriculum Redesign Project and an overview of the revised training program can be accessed via the FPM website, www.fpm.anzca.edu.au/training/curriculum-redesign-project. Inquiries can be directed to fpm.crp@anzca.edu.au.

FACULTY OF PAIN MEDICINE
AUSTRALIAN AND NEW ZEALAND
COLLEGE OF ANAESTHETISTS

PAIN AT
THE
CUTTING
EDGE:
SURGERY
AND PAIN

REFRESHER COURSE DAY AND FACULTY DINNER

SUNTEC SINGAPORE, CONVENTION
AND EXHIBITION CENTRE
SUNDAY MAY 4, 2014

The program will precede the ANZCA and FPM Annual Scientific Meeting which for the first time will be held in conjunction with the RACS Annual Scientific Congress. It is headlined by international guests Professor Audun Stubhaug and Professor Jane Ballantyne and will be complemented by the RACS invited international speakers Professor Robert Foreman and Professor Dirk De Ridder. There will also be speakers from Australia, Singapore and Hong Kong providing surgical, anaesthetic and pain medicine perspectives.

The meeting will be of value for specialists and trainees from all disciplines who have an interest in pain medicine.

PROVISIONAL PROGRAM:

Session 1: Plenary: The science of surgery and pain

Session 2: Opioid therapy – International perspectives and challenges

Session 3: Optimising peri-operative pain management and surgical outcomes

Session 4: Pain after surgery – new directions in neuromodulation

FPM ANNUAL DINNER:

The East India Rooms, Raffles Hotel Singapore

REGISTRATION:

Registration is now open. Please visit www.fpm.anzca.edu.au/events/2014-refresher-course-day to register online or to download the registration brochure.

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Opioid abuse fuels drug debate

Opiates claim Kiwi lives

PILL-PUSHING PENSIONERS

The sources of pharmaceuticals for problematic users of benzodiazepines and prescription opioids

Tougher drug rules likely

■ Study takes hard look at fentanyl prescribers

Iron stolen to fund habit

Seroquel hits the street

Survey details level of illicit antipsychotic use

Opiate suppliers are drug dealers, not GPs

Fentanyl: how many must die?

■ Bereaved mother's warning to drug users

Painkillers growing drug of choice

Painkiller-laced heroin link to dead actor

Chronic pain, pain relief, prescription opioid abuse and addiction present ongoing challenges for specialists.

Opiates and opioids are, outside the medical field, interchangeable terms. There is, however, a distinction: opiates are drugs derived from the opium poppy plant. The term "opioid" describes any compound that binds opioid receptors in the brain and produces effects characteristic of naturally occurring opiates.

The misuse of prescription opioids and the challenge it represents for medical professionals are dominant themes in the media and a topic of discussion among specialist pain medicine physicians. Not surprisingly, the aspect of "harm" – addiction, morbidity – overshadows that of rational therapy for people experiencing pain.

In Australia, over the 20 years from 1990 to 2010, the population increased by 29 per cent, the pharmaceutical opioid base supply increased by 228 per cent and per capita opioid consumption increased from about 90mg morphine equivalent to about 350mg.

This in itself may not be a problem. However, there has been an increase in overdoses and other morbidity related to pharmaceutical opioids over this same period. Similar trends can be found in other developed countries, although Australia's statistics lag well behind those.

The Faculty of Pain Medicine's Director of Professional Affairs, Professor Milton Cohen, said first it was important to identify the "problem" within figures showing increased use and increased harm.

He believes it comes down to a tension between two public health issues: undertreated chronic pain and societal abuse of opioid analgesics. On the one hand, increased prescription of opioids may reflect better recognition of the problem of pain in the community; on the other, acknowledging the abuse of prescribed substances does not necessarily call for prohibition.

"There are two main issues that can lead to the misuse and subsequent harm from opioids, including addiction, noting that opioids themselves are less addictive than benzodiazepines and less addictive than alcohol," Professor Cohen said.

"One is inappropriate prescription – the wrong person being prescribed the wrong drug for the wrong indication (condition), such as fear or anxiety, which commonly accompanies the experience of pain.

"The other is unsanctioned use of a prescribed drug: use by someone for whom it was not prescribed, or use of the drug in a way that was not prescribed – such as excessive dosage or injecting a drug prescribed for oral use."

Professor Cohen said opioids have been used for decades and remain predictably successful in cases of acute injury as well as in pain associated with cancer, such as tumours invading bone.

However, it is only since the early 1990s that the use of opioids in chronic non-cancer pain has been explored, as long-acting oral and transdermal preparations of opioids were developed.

Professor Cohen takes a considered approach to the use of opioids and the concerns around their use.

With respect to the use of these medications in patients with chronic non-cancer pain, he believes the important question is: how effective are they?

"Clinical trials have been very difficult to conduct, due largely to the heterogeneity and complexity of the clinical population," he said.

"All that has been shown is that opioids offer modest improvement in chronic pain, and are most effective over a short period.

"The problem is that until relatively recently the treatment of chronic pain wasn't seen as holistic ... there was an excessive reliance on medication."

Professor Cohen believes there is a place for opioids in the treatment of chronic pain but a modest improvement of pain does not indicate a need to increase the dosage or the duration of the prescription. This understanding is important for appropriate prescription.

"Ten years ago we might have pushed the dose and/or prolonged the period of treatment, with the assumption that doing so would give a better result, but that did not work and also side effects became more of a problem."

Prominent among the side effects is impaired cognitive function, especially in the elderly.

“The vast majority of the world’s population does not have access to opioids. In our privileged society that does have access to opioids for the treatment of pain, the problems of their inappropriate prescription and unsanctioned use demand better education and support.” Professor Milton Cohen.

DRUGS CRISIS

More seniors resorting to up-selling medications in desperate cash crunch

‘Hillbilly heroin’ proves deadly

Gateway can help

Robber jailed for painkiller thefts

Tragic cost of addiction

Inquest hears of drug user’s final moments

Fentanyl deaths prompt overdose warning

DRUG FEARS REVIVED

Timely alert on fentanyl

Advertising pain killers a deadly idea

The Faculty’s professional document on the use of prescription opioid analgesics, currently under review, acknowledges that the use of opioid analgesic drugs in the management of patients with chronic non-cancer pain is controversial.

Recommendations include:

- The use of opioids is only part of a multimodal program for people with chronic pain.
- Opioid prescription, if used, is only a trial within that program and the effectiveness of the drug in improving the quality of life of the patient is the most important outcome.
- If the trial is not working, the prescription of opioid analgesics must be reviewed.
- In order to prevent problems, dose and time limitations of the prescription should be observed.

Former FPM Dean Dr Penny Briscoe agrees that opioid misuse and abuse are a problem but argues that unsanctioned use is limited to a small proportion of patients. Addiction problems are largely confined to unsanctioned use.

“Opioids should be a short-term trial to see if there is an improvement in function and quality of life,” Dr Briscoe said.

“Only if there is improvement should we continue and then only with the recognition that treatment of chronic pain is not simply about drugs.”

A multidisciplinary approach, which includes a psychological appraisal, is critical.

“Medication has an extremely limited role in the management of chronic pain and should be introduced only after a comprehensive holistic assessment,” Dr Briscoe said.

“Opioids are not the first line of treatment – we need to address all facets of the patient’s presentation that can impact on their pain and how they manage it.

Patients, she said, are often looking for a “magic cure” for chronic pain and ask if it will ever go away.

“Does chronic pain ever go away? Yes it does, it is often a matter of retraining the brain and with time it is possible to switch the brain off to those inputs of pain.”

Dr Briscoe said medication was the first line treatment of managing acute pain. When managing acute pain, however, specialists need also to be aware of the environment in which the pain is occurring.

“But about 20 per cent of that population will go on to develop chronic pain,” she said.

“Chronic pain can involve changes to the nerves and to the spinal cord, the central nervous system becomes sensitised and is still sending messages of pain once the injury has been healed.

“Opioids are good for tissue damage and injury and can be useful (in chronic pain) if it improves the quality of life.

“But what we are talking about here is moderation.”

Ebru Yaman,
Media Manager, ANZCA

Policy on opioids and chronic pain

“There has been a historical tension between acceptable and unacceptable use of opioids, and over where the boundaries lie between them, reflected in the history of opioid control. In contemporary medical practice the use of opioids is largely defined by the existence of pain. This is reflected in the development of the distinct specialties of pain medicine and addiction medicine. One result has been a separation of facilities for pain and addiction management, such that a patient may cross from one world to the other, or falls between the two worlds. This has a parallel in the historical disjunct between mental illness and addiction, so-called ‘dual diagnosis’.”

Definitions relating to pain:

Pain “can be defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.”

Chronic pain “is conservatively described as continuous or recurrent pain that persists past the normal time of healing, most commonly about three months’ duration.”

From the *Prescription Opioid Policy: Improving management of chronic non-malignant pain and prevention of problems associated with prescription opioid use*, (produced by the Royal Australasian College of Physicians in association with FPM, 2008) page 23. www.fpm.anzca.edu.au/resources/professional-documents/documents/

Essential Pain Management program shifts to indigenous communities

It is well recognised that the indigenous people of central Australia face the myriad challenges in relation to social, economic and health issues. The factors behind these issues are often multi-factorial and interwoven.

Persisting pain conditions feature among these health challenges. The high rates of diabetes, chronic health conditions and trauma all contribute to this.

Much of the primary healthcare delivered in central Australia is provided by Aboriginal health practitioners who utilise the benefits of ongoing relationships with the communities in which they work, coupled with a deep understanding of the complex relationship between health and culture.

As is the case with many health interventions, the greatest benefits in pain management can often be achieved with relatively simple strategies. Associate Professor Roger Goucke and Dr Wayne Morriss have developed the Essential Pain Management (EPM) program to facilitate the management of pain in developing countries, where health workers primarily deliver primary healthcare.

EPM has now been delivered in a large number of countries, with much success. Given the similarities of this model of healthcare to that in central Australia, it was decided to trial the EPM course in Alice Springs. EPM also focuses on a holistic pain which includes an extensive discussion on non-pharmacological treatment options that hopefully will fit well with discussions on social determinants of health (pain).

The program was delivered in December 2013, to an audience of 10 Aboriginal health practitioners. Grappling with notions of what pain is provided an important opening session, followed by discussions about how chronic pain is now managed in remote central Australian communities and barriers to management.

Discussion also included the concept of neuropathic versus nociceptive pain, and the need to differentiate the two in terms of management. It was not surprising that this proved challenging, though ultimately productive.

Indigenous communities face challenges in terms of excessive paracetamol use, and at times inappropriate use of opioids and these issues were also raised.

Pre- and post-course testing suggests that we were successful in raising the awareness and knowledge of pain management. However there is no doubt that teaching in a cross cultural setting has its own challenges, and that Aboriginal health practitioners face a daunting task in their role of managing a wide range of problematic issues of which pain management is only one.

The next stage of the EPM process includes exploring whether any of the participants would like to undergo “train the trainer” in pain management. To be able to support such a transition from pupil to teacher would of course be instrumental in facilitating a locally sustainable model of pain management teaching.

Dr Rod Mitchell
Chair, ANZCA Indigenous Health Committee



Above from top: Instructors and participants in December's Essential Pain Management course in Alice Springs; Interactive discussions at the Alice Springs course; Dr Ivan Lin physiotherapist and participants in the Geraldton course, Eric Dalgety, Graham McDonald and Gloria Jones with completion certificates in Geraldton.

Perioperative medicine: A step in the right direction



The Alfred hospital in Melbourne has developed the first perioperative medicine fellowship of its kind in Australia and New Zealand.

“Clearly, the full scope of the role of perioperative physician is not currently covered by any single medical training scheme or college. Integrated cross-specialty training programs will be required to deliver this training and define appropriate qualifications.” (Grocott 2012)

Grocott and colleagues eloquently describe the need for a more integrated approach to manage the surgical patient. The future of anaesthesia lies with perioperative medicine. If we are to see our specialty thrive in the future we must embrace our role as leaders in perioperative medicine.

At The Alfred, we see perioperative medicine as a natural extension of our role as anaesthetists.

Under the leadership of Professor Paul Myles, we have invested significant resources into research in areas of perioperative medicine. We also have developed an academic program in perioperative medicine with a successful course, diploma and masters program in conjunction with Monash University.

In 2013, we developed the first genuine perioperative medicine fellowship where anaesthetists and trainees can gain necessary skills, collaborate and foster relationships to provide optimal perioperative care. This fellowship is the first of its kind in Australia and New Zealand.

In 2013, as the perioperative medicine fellow, I divided my clinical time equally between anaesthesia and clinical medicine. Each week I attended respiratory rounds, a high-risk cardiology clinic and general medicine rounds with ongoing

exposure to both elective and emergency anaesthesia.

Weekly respiratory rounds provided a sound basis to assess, optimise and manage high-risk patients including those with pulmonary and sleep disorders.

As the cardiology fellow in clinic, I was involved in assessing patients referred from the community and anaesthesia pre-admission clinic. This would vary from patients with reduced exercise tolerance or cardiac symptoms presenting for surgery to those with abnormal perioperative tests. The aim was to optimise these patients while co-ordinating communication with anaesthetists and surgeons. Working in the cardiology clinic also gave me an opportunity to work on a one-to-one basis with a senior cardiologist.

Finally, post-operative general medical rounds provided exposure to post-operative surgical patients. Here I was involved in managing high-risk surgical patients. The goals of this round were to better manage pre-existing medical conditions and any post-operative complications.

These experiences have led to changes in our preadmission and perioperative management of patients who are at high risk of perioperative morbidity and mortality. Surgical patients with sleep-disordered breathing are now linked to our sleep unit for medical management on the ward if required. We have developed guidelines for use of CPAP machines in our recovery room with a pathway for management once patients are discharged to the ward.

We also have developed specific criteria for the medical input into post-operative patients. The recovery room criteria is evidence-based and has been made possible by close collaboration between medical, surgical and anaesthesia specialties. In the future we aim to use this criteria set up a perioperative care unit to

potentially improve outcomes of all high-risk patients presenting for surgery.

The 12-month fellowship also provided fruitful ground to continue research in the area of perioperative medicine. We have audited our practice of routine preoperative tests. Anaesthetists now order a significant number of routine tests when clinically indicated, leading to better resource utilisation, less patient harm and improved efficiency of the perioperative process.

We have successfully instituted the “Stop before the op” smoking cessation program to encourage patients to cease smoking during the perioperative period.

This unique fellowship provides necessary skills and knowledge in a growing area of anaesthesia and potentially fills a knowledge gap for patients undergoing major surgery. It provides a collaborative and integrated approach to manage high-risk patients while also fostering closer relationships with other hospital departments.

I encourage trainees to consider a unique and challenging fellowship in an area that can improve management systems and patient outcomes. I also encourage other hospitals to drive such programs through the support of anaesthesia leadership and hospital management in order to achieve best practice and expert care of surgical patients.

Dr Arvinder Grover

Staff anaesthetist, The Alfred, Melbourne

For further information about the fellowship, please contact the Department of Anaesthesia and Perioperative Medicine at The Alfred, Melbourne, on email a.grover@alfred.org.au or phone +61 3 9076 2000.

Reference:

1. Grocott et al. Editorial I. Perioperative medicine: the future of anaesthesia? *British Journal of Anaesthesia* 108 (5): 723-6 (2012).

ANZCA has a long history of supporting groundbreaking research, which has had a major impact on patients' lives. Our series of articles on some of the projects ANZCA has helped fund continues.

Study reduces risk of death and complications in elderly

Elderly patients face a significant risk of death and/or major complications after elective and emergency non-cardiac surgery. It's both a privilege and a challenge for anaesthetists to help older patients recover as well as possible from surgery so they can live high quality disability-free lives. ANZCA funded research is helping reach this goal.

While we may remark at the expense of our surgeons that "the operation was a great success, but the patient died", ANZCA-funded research has proven that in many ways this is true. The REASON study, a prospective study of 4158 elderly non-cardiac surgical patients in 23 hospitals in Australia and New Zealand, reported that by 30 days post-operatively, one in 20 patients had died and one in five had suffered a major complication¹. The study also showed that patient factors (age and factors reflecting comorbidity, disability and frailty) were more important predictors of a poor outcome than the type of surgery. To many anaesthetists, including the study's authors, these remarkable results came as a surprise and provided an impetus to find effective preventive measures for death and major complications, including myocardial infarction.

Perioperative myocardial infarction (MI) represents a largely silent epidemic among elderly non-cardiac surgical patients. Around 5 per cent of elderly patients will suffer a perioperative MI and, at 30 days post-operatively, around 10 per cent of these patients will have died². Others will have sustained a cardiac insult that puts them at risk of arrhythmias, cardiac failure and further ischaemia/infarction.

ANZCA's Anaesthesia and Pain Medicine Foundation has provided seed funding for several large multi-centred trials aimed at preventing this common complication. This support has been crucial to success with National Health and Medical Research Council (NMHRC) funding and other national grant bodies.

The Master Trial recruited 915 high-risk mainly elderly patients undergoing major abdominal surgery and randomised them to intraoperative epidural or intravenous analgesia.³ Cardiovascular event rates were high but not associated with analgesic technique. The B-Aware trial, also supported by ANZCA, included a large number of older patients.⁴ The incidence of MI was not different between bispectral index-guided anaesthesia and routine care, but a long-term follow-up demonstrated an association between persistent low bispectral index values and increased risk for MI.⁵

This provocative result is being pursued in the Balanced Anaesthesia Study (www.balancedstudy.org.nz). This study received pilot grant funding from ANZCA before attracting large national grants in three countries. Finally, the ENIGMA-1 trial randomised patients (30 per cent of who were aged >65 years) to nitrous oxide-free or nitrous oxide-based anaesthesia, and raised a suspicion of excess cardiovascular morbidity following nitrous oxide exposure.⁶

The ENIGMA-2 trial was designed to provide a definitive answer to this question and will report its results soon.⁷ The ENIGMA trials received seed funding from ANZCA as well as major support from the NHMRC. ANZCA Fellows have also made contributions to major international studies seeking pharmacological solutions for the problem of perioperative MI in elderly non-cardiac surgical patients.^{8,9}

None of these studies could have been completed without the tremendous support of ANZCA Fellows and staff, through our foundation, research

grant program and the ANZCA Trials Group, or the efforts of hundreds of enthusiastic ANZCA Fellows and research nurses at hospitals around our region. Congratulations on your success – you've made a difference!

Professor Kate Leslie, MBBS, MD, M Epi, FANZCA
Chair, Anaesthesia and Pain Medicine Foundation Committee

References:

1. Story DL, K, Myles P, Fink M, et al. Complications and mortality in older surgical patients in Australia and New Zealand (the REASON study): a multicentre, prospective, observational study. *Anaesthesia* 2010; 65: 1022-1030.
2. Devereaux P, Xavier D, Pogue J, et al. Characteristics and Short-Term Prognosis of Perioperative Myocardial Infarction in Patients Undergoing Noncardiac Surgery: A Cohort Study. *Ann Intern Med* 2011; 154: 523-528.
3. Rigg J, Jamrozik K, Myles P, et al. Epidural anaesthesia and analgesia and outcome of major surgery: a randomised trial. *Lancet* 2002; 359: 1276-1282.
4. Myles P, Leslie K, McNeil J, Forbes A, Chan M, Group B-AT. A randomised controlled trial of BIS monitoring to prevent awareness during anaesthesia: The B-Aware Trial. *Lancet* 2004; 363: 1757-1763.
5. Leslie K, Myles P, Forbes A, Chan M. The effect of bispectral index monitoring on long-term survival in the B-Aware trial. *Anesth Analg* 2010; 110: 816-822.
6. Myles P, Leslie K, Chan M, et al. Avoidance of nitrous oxide for patients undergoing major surgery: A randomized controlled trial. *Anesthesiology* 2007; 107: 221-231.
7. Myles P, Leslie K, Peyton P, et al. Nitrous oxide and perioperative cardiac morbidity (ENIGMA-II) Trial: Rationale and design. *Am Heart J* 2009; 157-62: 488-494.
8. Devereaux P, Yang H, Yusuf S, et al. Effects of extended-release metoprolol succinate in patients undergoing non-cardiac surgery (POISE trial): a randomised controlled trial. *Lancet* 2008; 371: 1839-1847.
9. Devereaux P, Sessler D. The Potential Role of 12 Agonists for Noncardiac Surgery. *Anesthesiology* 2012; 116: 1192-1194.

Taking control of our learning; how proactive are we as trainees?

Times of change ✓

Healthcare is one of the greatest focuses of modern life. In recent years there has been phenomenal change in both lifestyle choices and attitudes of the population towards its health needs and the role of the medical community. Individuals have adopted a substantially more active and autonomous role in their own health and wellbeing.

Naturally, this has led to increasing public interest in the development of well-rounded, experienced and trustworthy doctors, and greater scrutiny from media and societies worldwide. This topic promises to remain of central public health importance, and fundamental to international healthcare development.

The training of medical professionals has also undergone remarkable change, not least of these in anaesthesia. The introduction of structured, target-based training programs provides a common pathway to ensure certain predetermined professional standards are met. The aim is to develop high quality, safe, experienced anaesthetists with whom the public can have the utmost confidence. It is our duty and responsibility to be the best we possibly can.

Where do anaesthesia trainees fit in? ✓

With this in mind, is it enough to glide through training from one stage to another, guided by the curriculum and our supervisors of training? Or should we take more control of our own learning? Predictably the answer is likely to be the latter. This prompts us to question:

“How good are we at driving our own learning? Are we motivated and proactive enough when it comes to self-directed professional development?”

Our nature as anaesthetists is such that we continually endeavor to “better” ourselves. Nobody thinks of themselves as mediocre and nobody aspires to mediocrity. This should therefore also apply to our training aspirations.

Why should we drive our learning? ✓

The truth? We enjoy our careers! We all want to be more skilled at our chosen profession. As anaesthetists we are rarely content to “settle”. We are inquisitive, critical thinkers who continually strive to improve our knowledge and skills for the benefit of patients – and that, I believe, is the key to job satisfaction. What makes all the hard work and extra curricular activities worthwhile is seeing self-development and enhancing patient care and the belief that we are delivering the best anaesthetic care possible. That is why we chose medicine, and anaesthesia, as a career and it is ok to admit to enjoying our job!

Variety is the spice of life! ✓

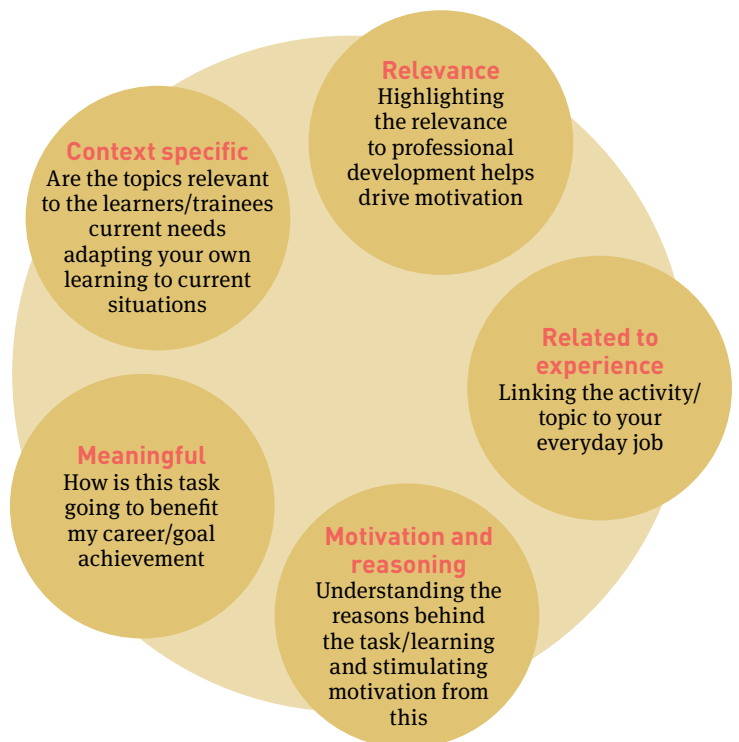
Not only does self-directed learning ensure we are up to date, current and developing professionally, it also opens up multiple potential pathways. The variety of interests and opportunities within anaesthesia is endless. Without proactively seeking these, we could unknowingly be missing out on some really great career and life experiences. To name a few: rural programs, travel, teaching, outreach programs, event support, volunteer and charity work, disaster medicine, graduate study, hyperbaric medicine and expedition medicine.

Where to start? ✓

Logbook, training portfolio system, workplace-based assessments, audit, presentations, exams, courses – these are just a few of the balls we have to juggle as trainees, often outside of the everyday work schedule. I am sure I am not the only trainee who has sat updating my logbook entries and wishing I had been more organised at the time.

It can feel a little overwhelming but it is important to remember these tools are there to help us achieve our goals and become better anaesthetists. To be able to record, quantify and produce evidence of prior achievements provides a great deal of confidence and self worth and reinforces our progression.

As adult learners, there are key aspects to the success of active learning, without which we are likely to fall into the trap of box-ticking (which to some extent must be accepted) and resentment of the whole process.





Tips for new trainees ✓

Congratulations on being appointed a training position! This is a huge achievement and is the gateway to the best career in medicine (I have no doubt most anaesthetists would agree.) The good news is that the start of any training provides an opportunity to hit the ground running. Below are a few tips from current trainees that they believe will help to make that start both productive and enjoyable:

Be proactive. Reviewing patients pre- and post-anaesthesia makes you a better anaesthetist. Plan the anaesthetic you would give (even if this is not the end technique it is still very useful).

Organising time. This is probably the most important factor in reducing stress and increasing productivity.

Enthusiasm. If you are enthusiastic you will get so much more out of training and your peers – and you will encourage others to be enthusiastic also.

Get to know your supervisor of training early on – they are invaluable!

Become familiar with the curriculum: what you need to do and when – nothing is more stressful than realising that you have missed a vital component with little time left to correct it.

Keep up to date. The training portfolio system is there to help; if at all possible start early and keep your “run rate” of assessments up to date.

Enjoy your daily routine and lists. This is the bread and butter of anaesthesia and the reason that you are training.

Anaesthesia training is challenging, demanding and intense, but above all should be rewarding and enjoyable. Driving our own learning and achieving our goals can only help us to become happy, well rounded, professional trainees.

“Too often we are so preoccupied with the destination, we forget the journey” (unknown author)

Dr Catherine Goddard, Trainee
Fremantle Hospital, Western Australia

Out of Africa: more than coffee beans and the Big Five



The challenges – and rewards – of working in Tanzania are many, varied and sometimes surprising.

In retrospect I should never have left the safety of the hospital and ventured up the hill to our home in Bugarika, Mwanza. When it rains here it does so in tropical bursts; despite sheltering under a tree I eventually had to hail a taxi and arrived home soaking wet.

My (medical) wife and I are volunteers on the staff of the local teaching hospital, the Bugando Medical Centre (<http://bugandomedicalcentre.go.tz/>), which opened in the early 1970s. Management of the hospital is unusual – a joint arrangement between the Tanzanian Government and the Catholic Church.

My working day starts at 7.30am discussing with trainee nurse anaesthetists the cases booked for theatre that day. When they read, they lower their gaze and mumble. There is always something of interest from which I can do some ad hoc teaching. Initially we met in the recovery room, noisy and unventilated; now we have access to a classroom in the teaching block.

On some days I have a useful discussion with my head of department before heading to the ICU to check on ventilated patients and deal with any equipment issues; one day I was informed that one of the ventilators had “failed without warning”. Further investigation revealed that a nurse had removed the power plug of the UPS (uninterruptible power supply) – the battery eventually ran down.

“Dr Derrick – we tried to use the defibrillator yesterday and it would not work – could you please check it?” After the third such comment we suspected that the problem was user error rather than machine failure. Technical advice from our ever-helpful biomedical engineers at Flinders Medical Centre in Adelaide confirmed that the machines were probably OK. In getting together the equipment required for machine testing we stumbled across the cause of the problem – the staff were using ultrasound coupling gel rather than conductive gel. Well, they may look the same but “gels ain’t gels”.

For the first four months I had a fruitful relationship with the visiting volunteer engineer and we successfully

completed some equipment installation, maintenance and repairs. One of our successes was to reconfigure two unused enflurane vaporisers to deliver isoflurane. Our department has no budget for new equipment; fortunately we have a free and almost infinite supply of isoflurane. Unfortunately our popularity and success caused severe embarrassment to the engineering department and my colleague was forced to resign. I got off with a warning!

Occasionally I pay a visit the chief pharmacist to discuss issues including the latest critical shortage of essential medications such as induction agents or local anaesthetics. Our supply situation ranges from unpredictable to disastrous. One Sunday morning I was recalled to the hospital: the two anaesthetists on-call had both disappeared, there were no batteries for the laryngoscopes and no oro-pharyngeal airways.

Email correspondence with colleagues around the globe takes up some of my time, as does preparation of lectures for the trainee nurse anaesthetists and the medical students.

The qualified nurse anaesthetists are down on numbers and morale, so there



“Although people care for their immediate family and slightly beyond that, there is an invisible barrier beyond which they do not care.”

is little opportunity to teach them as a group or even to address a departmental meeting. We regularly lose patients in the operating room, recovery ward and the ICU – there is no data collection and no audit process.

Entire operating days are cancelled for many reasons, the most common being failure of the water supply. Individual surgical cases are often cancelled because of severe anaemia or untreated hypertension.

In October 2012 we shipped a wooden crate from Adelaide to Mwanza. When the crate eventually arrived I sat for two days in the hospital receiving stores waiting for the staff to open the crate and distribute the goods according to my instructions. Three ‘recycled’ ventilators are now installed and working in the ICU. The mortality rate in the ICU remains high due to a combination of apathy, ignorance and neglect. There are some bright lights among the local staff – they will need continuing encouragement or they move on to other wards, other hospitals or overseas.

A container load of monitors and other equipment from the US was delayed several months and when the equipment finally arrived was missing

one third of the shipment, including the blood pressure cuffs and wall-mounting brackets. An entire operating microscope disappeared and was later discovered at a rural hospital hundreds of kilometres east of Mwanza. Another container from the US has been held up for seven months due to conflict over the customs duty. This shipment includes badly needed operating theatre lights and patient transport trolleys.

There is an enormous difference between the Western way of thinking and the developing world way of thinking, as we see it expressed here in Tanzania. However long we were to spend here we are unlikely to get to the bottom of it. The fundamental difference between our Western healthcare culture and that which we experience here is in caring.

Although people care for their immediate family and slightly beyond that, there is an invisible barrier beyond which they do not care. We see this in the neglect of women left labouring with inadequate covering on theatre trolleys while awaiting caesarian delivery. Perhaps the needs have been so great for so long that this apparent apathy represents a defence against professional burnout.

Early this year I was called back to the hospital late one evening as neither of the other senior members of the department would agree to attend. At the hospital I had to defuse a nasty stand off between a young inexperienced surgeon and an older and wiser nurse anaesthetist. We compromised by operating on the fittest child first. Once I had seen how bad the surgeon was, I refused to do the second case, insisting it wait until morning when fresh staff were available.

Unlike the departments of medicine and surgery, our anaesthetic department at Bugando does not get many Western visitors. They have been reluctant to come because there has never been someone to co-ordinate their visit and help them to prepare. I remain optimistic that someone will be inspired to come and teach. If you relish challenge you know who to call...

Dr Derrick Selby, FANZCA

Above from left: Bugando Medical Centre; Physiology lecturers visiting from Germany; Dr Derrick Selby tutoring in the IT classroom; Some members of the class of 2012 shortly before graduation with Dr Selby; Psychiatrist poring over the latest (donated) journals; Dr Selby poised to prise open the wooden crate containing the ventilators; Obstetric fistula patients modelling some donated clothes.

The law and expert evidence

As you become more senior in the ranks of the profession, you may be flattered one day to receive a letter or phone call from a law firm seeking your opinion as an expert anaesthetist. Be very careful before you say yes. There is a whole body of law about expert evidence. A blunder can ruin your standing and good name.

Your duty as an expert is to the court, not the party who is paying you. Your role as an expert is to assist the court to understand technical and complex professional matters that would not be within the scope of a jury or a judge to understand without your help. Your other important duty is to assist the court to establish the standard of care.

Five rules

There are five common law rules of expert evidence¹.

Expertise rule – you must be qualified in the area of science in which you are offering evidence. The onus is on the expert to satisfy the court as to his or her expertise². Courts have been applying high standards for expert witnesses “*the expert’s evidence must explain how the field of ‘specialised knowledge’ in which the witness is expert by reason of ‘training, study or experience’, and on which the opinion is wholly or substantially based’, applies to the facts assumed or observed so as to produce the opinion propounded*”³.

When preparing written reports, I recommend starting any opinion with a brief outline of your qualifications not only as an anaesthetist but with the particular subject matter, for example, complicated obstetric anaesthesia or orthopaedic cases.

Area of expertise rule – to be qualified as an expert, your field of specialised knowledge must be recognised generally as a valid area of science (medical sciences qualify, but you must have specific expertise in the relevant subfield of that discipline too. Clairvoyance or cosmology will not suffice!).

Basis rule – there must be a credible basis for any statement made by you. A published authority or a statement that is based on your (vast) experience is admissible – but be prepared to defend the latter if cross examined.

Common knowledge rule – if a fact is within the reasonable scope of common knowledge of a jury, such as the interpretation of basic issues of fact, for example, differing claims by litigants as to who really said what to whom, you must not express an opinion, for this may be seen as an attempt by an expert to advocate for a party. A trap here is to be asked about the validity of consent for a procedure that has gone wrong. Never offer an opinion on this. Consent disputes are straight legal matters based on the facts; the court is the “trier of fact”. In the wake of *Rogers v Whitaker*⁴, your own ideas as to validity of consent are irrelevant.

The ultimate issue rule. There is an *ultimate issue* (that is, a **legal** issue) in any legal case – in medical matters it is typically “negligent or not negligent” and in criminal matters, “guilty or not guilty”. You must never express an opinion on these points. Never try to be “judge and jury” – this is, perhaps amazingly, a common fault in written expert reports. The reports from one rogue anaesthetist some years ago contained allegations of “Gross negligence” against an anaesthetist, by the (highly paid) plaintiff’s expert (!). Not only were these easily rebutted as nonsense by experienced clinicians, the expert was lucky that this matter never went to court – he would have been severely criticised by the judge – and this will surely appear in law reports and be your death knell as a court expert.

The term “gross negligence” is the standard for criminal cases of manslaughter. You must never introduce notions like this into civil cases. Just as you would not tolerate a lawyer telling you how to give an anaesthetic, never try to impose your own ideas of “justice” on a court.

Written expert reports

The modern disclosure standards in Australian courts mean that you will invariably be asked for a written report. The “Perry Mason” type of court ambush will not happen. There are risks here too, especially when dealing with lawyers.

They too make errors and can be sued in negligence.

Lawyers are busy and may delegate tasks to secretaries or clerks. (Beware year 10 students on work experience too). In one case where I gave an opinion for the defendant doctor’s solicitors, the plaintiff solicitor’s clerk had been asked to photocopy the plaintiff expert report for service on the defendant. Under that report in the file were printouts of emails between the plaintiff expert and lawyer. Unfortunately they too were copied and attached to the copy of the expert report. These were quite “chummy” and included words like: “*Dear A, Here is my report. Is this what you want – I can change things if you like. Cheers, B*”. This would have been dynamite if the expert had been confronted with it in court – needless to say, the case was rapidly withdrawn.

In a leading English case⁵, one of the last to come before the famous Lord Denning, it became apparent that there had been collusion between two obstetricians who were providing opinions for the plaintiff’s side and their barrister – they had apparently conspired to alter parts of their opinions in the barrister’s chambers. In the Court of Appeal, Denning MR said,

“(Their) joint report suffers to my mind from the way it was prepared. It was the result of long conferences between the two professors and counsel in London and it was actually ‘settled’ by counsel. In short, it wears the colour of special pleading rather than an impartial report. Whenever counsel ‘settle’ a document, we know how it goes. ‘We had better put this in’, ‘we had better leave this out’ and so forth. A striking instance is the way in which Professor Tizard’s report was ‘doctored’. The lawyers blocked out a couple of lines in which he agreed with Professor Strand that there was no negligence”⁶.

“Exit experts forever”. Courts have as yet been fairly lenient with experts whose judgement has been “coloured”. But one day someone may well overstep the mark and be found in contempt of court or even guilty of conspiring to pervert the course of Justice.

Should you accept a brief as an expert, it would be very wise to seek some advice from a colleague with experience in report writing as to the style of writing – but if you have definite views, do not be pressured to change them. Also, as word processors are universal, use only

the one file and make corrections on that file so that things you write initially are deleted as the written opinion is refined. In contentious matters, all your files and correspondence can be subject to subpoena. Send only your final report to the instructing solicitor. If there is any expansion or clarification needed, provide this as a separate supplementary report – never change the original sent to the lawyers. If you find you were wrong in the main report, it is no disgrace to say so in the light of later evidence. Never take sides in a legal case. If your report is not favourable to the side that is seeking your opinion, so be it. It is up to the lawyers whether to serve your opinion on the other side.

The medical defence bodies tell us that in about 80 per cent of negligence cases, the ultimate outcome is there is no negligence. Whenever you are sent a brief, it seems good practice to start with the premise that the doctor is more likely than not to have done nothing that falls below the standard of care. Presume nothing and sift very carefully through the medical file.

Include a concise and relevant CV with your opinion. Thirty research papers on obscure science are less likely to impress a judge than a simple statement that you have, for example, 25 years experience with difficult intubations if airway failure is the issue. Pomposity and arrogance may only make your fall to humiliation that much harder if your opinion is not preferred to those tendered for the other side of a case. If you are openly criticised by a judge, wave goodbye to that career as an expert.

Just as most medicine is practised outside hospital, so most suits against doctors never reach a courtroom. Carefully thought out and accurate reports by experts will ensure that cases are settled one way or another behind closed doors in lawyer's offices. That way we and our colleagues can get on with caring for our patients.

Honest, accurate and detailed reports that fully explain relevant issues should be the reason that you stay out of court – and so should your colleagues who are sued.

Dr Jim Wilkinson, MHL FANZCA

Dr Jim Wilkinson FANZCA holds a Masters Degree in Health Law from The University of Sydney. He has offered expert opinion in coronial cases and matters at common law in the Supreme Courts of NSW, the ACT and Western Australia.

References:

1. These have been partly incorporated into various Evidence Acts in some jurisdictions. The principles still hold.
2. "An expert must qualify himself before the court". *HG v The Queen*, [1999] HCA 2 (Feb 1999); 160 ALR 554, at 563 per Gleeson, CJ.
3. *Makita Pty Ltd v Sproules* [2001] NSWCA 305; (2001) 52 NSWLR 705 at 744 per Heydon J (Justice Dyson Heydon gave the leading judgement in *Makita*. Since elevated to the High Court of Australia, he was on the full bench which gave a unanimous decision in *Dasreef Pty Limited v Hawchar* [2011] HCA 21 That latter case is now the leading authority (and strong authority with the Full Bench unanimous) on admissibility of expert

evidence and sets a very high standard. The days of "hacks" appearing with regularity for plaintiff lawyers or defendant insurance companies seem long past.

4. *Rogers v Whitaker* [1992] HCA 58; (1992) 175 CLR 92. Every doctor in practice in Australia should read this case report thoroughly. It is widely misconceived as a case about "informed consent" whereas the heart of the issue is negligent advice.
5. *Whitehouse v Jordan* [1981] 1 All ER 267. The defendant obstetric registrar was found by the House of Lords to be not guilty of negligence – he had applied forceps to deliver a baby after 22 hours in labour. The child had brain damage. The shonky performance of three senior colleagues who connived to alter reports against him would likely have been fatal to the plaintiff's case.
6. (1980) 1 All ER 650 at 655:



Melbourne anaesthesia breakthrough saves lives



A little known discovery of global significance earned Dr James Villiers a three-minute standing ovation at a presentation in Victoria.

The chances were, at best, extremely slim: a series of unlikely events that led to the discovery of a previously unknown and unnamed disease. How improbable that 21-year-old Ronald Evans would be hit by a car in 1960 directly outside the Royal Melbourne Hospital. That the young man would need urgent surgery for his significant injuries – and that the notion of anaesthesia would terrify his family. At the time of his accident, 54 years ago, 11 of Mr Evans' relatives had died under anaesthesia. Malignant hyperthermia, it is now known, is a very specific genetic disease. It was misfortune enough for this young man to have inherited it, but his double misfortune of a compound fracture of his tibia and fibula right outside a major tertiary hospital led to a ground-breaking discovery.

Anaesthetist Dr James Villiers, now retired, was a visiting anaesthetist at the Royal Melbourne Hospital that day and the care he took in the treatment of Mr Evans, taking careful note of his family's concerns, was the first step towards understanding this disease.

Dr Villiers and the surgeon, Mr Kingsley Mills, took the family's concerns and their disastrous family history concerning anaesthesia very seriously.

As anaesthetist and former ANZCA museum curator Dr Chris Ball has written: "His [Ron Evans'] mother was there in no time to ensure that no one gave her son an anaesthetic and insisted that their own doctor be called. It is well documented that they were assured that the problem seemed to lie with ether and that the new drug now available, halothane, was an inhalational anaesthetic used for induction and maintenance of general anaesthesia."

It wasn't the case. Malignant hyperthermia is not an allergic reaction but a complex genetic disorder. It is a rare, life-threatening condition and in those who carry the genes, anaesthetic drugs can overwhelm the body's capacity to supply oxygen, remove carbon dioxide, and regulate body temperature. If it isn't treated quickly it leads to death.

"The most common anaesthetic at that time was ether," Dr Villiers said.

"It was thought by some that ether was the cause of death; it was thought that provided ether was avoided all would be ok. At that time, many procedures occurred outside city centres and were done by a GP who may have only had access to ether."

Not knowing what we know now, many believed that a newer form of anaesthesia, halothane, was "better". "Halothane is in fact a much more potent trigger of malignant hyperthermia. This condition is not an allergy, it is a genetic malformation of some of the factors involved in contracture of the muscles."

"I listened to their concerns and we didn't take this family history at face value," he said.

"Malignant hyperthermia is a rare, life-threatening condition and in those who carry the genes, anaesthetic drugs can overwhelm the body's capacity to supply oxygen, remove carbon dioxide, and regulate body temperature."

Mr Mills and Dr Villiers went to the patient's ward, despite the operating theatre being ready to begin the list. There they verified the anaesthetic history with the family and by telephone with the patient's general practitioner.

After their investigations, they "cautiously began the operation".

"We spent as little time as possible in surgery and the halothane was switched off as soon as the patient began to exhibit unusual signs."

The patient was monitored in the recovery room, oxygen administered and ice packs applied to his body – all moves that saved the life of Mr Evans and an unknown number of lives since. Dr Villiers describes himself as an "accidental stumbler" upon the disease and is reluctant to take any praise as a pioneer in the area.

"I had this first case; it was previously not recognised as a disease," he said.

Ronald Evans recovered uneventfully and all pathological tests available in those days were normal.

"I then took this unusual story to the professor of medicine at Melbourne University. He listened to my story and it was a trigger for further investigation."

Dr Villiers spoke about his experience to a meeting of the ANZCA Victorian Regional Committee in 2013 and his presentation was followed by a three-minute standing ovation from almost 300 delegates, according to meeting convenor Dr Peter Seal. "Jim had a vital role in the identification of this disease," Dr Seal said.

"He took such care, under the pressure of a surgical list, to take histories and then managed this patient under incredibly difficult circumstances.

"It is a little-known discovery, but of Nobel Prize-winning significance."

Ebru Yaman
Media manager, ANZCA

A key member of the malignant hyperthermia research team, Professor Michael Denborough, passed away in February. Read the obituary on page 90.

POISE 2 and ENIGMA II: Major milestones reached

The Trials Group has reached major milestones this year with two of its large multicentre clinical trials, POISE 2 and ENIGMA II, completing recruitment. We eagerly await the results of those trials to be announced at the opening plenary session at this year's ASM. POISE 2 investigators from the three highest recruiting sites, Royal Adelaide Hospital, Royal Hobart Hospital and Geelong Hospital, will travel to Washington DC this month (March) to hear the POISE 2 results first-hand. We are also excited to welcome a new Trials Group co-ordinator to the team.

ANZCA Trials Group Strategic Research Workshop, Palm Cove, Qld, August 8-10

The 6th annual workshop will be held at Sea Temple Resort, Palm Cove. The workshop brings together experienced and early career researchers, medical professionals and study co-ordinators from Australia, New Zealand and Hong Kong. The meeting aims to strengthen the collaborative approach to multicentre research in anaesthesia, perioperative medicine, and pain medicine. The meeting aims to encourage, promote and mentor researchers to engage in clinical research to improve patient outcomes. In addition, recent achievements of the ANZCA Trials Group, including updates on current clinical trials and research activities, will be showcased. The program will feature keynote presentations in the areas of health economics and biostatistics and include a workshop on the Friday afternoon for research co-ordinators and early career researchers. The social program includes a welcome BBQ and a dinner at the Reef House Restaurant on Friday and Saturday evening respectively, allowing delegates and their partners a chance to relax and socialise in tropical Palm Cove.



Members of research teams, including medical professionals, allied health professionals, research co-ordinators, and early career and experienced researchers with an interest in multicentre research in anaesthesia, perioperative and pain medicine, are encouraged to attend. The meeting also offers a great update for anaesthetists on the latest trends in our field.

Researchers are strongly encouraged to submit abstracts to present new research ideas to the trials group.

For further information about the workshop, speakers, presentation guidelines and to register, please visit: www.anzca.edu.au/fellows/Research/anzca-trials-group-events.html

Pilot Grant Scheme applications

The ANZCA Pilot Grant Scheme assists Fellows who wish to conduct pilot studies for high-quality multicentre trials that will potentially attract National Health and Medical Research Centre or other large-scale peer-reviewed funding. ANZCA allocates \$20,000 each year to the ANZCA Trials Group to administer a fast-tracked pilot grant scheme for Fellows to undertake pilot trials and surveys. Grants of up to \$10,000 are available each year and applications for two-year grants will be accepted. Fellows wishing to apply for a pilot grant are encouraged to present their research proposal at the strategic workshop at Palm Cove this year. Deadlines for 2014 applications are June 10 and September 10. For further information about the Pilot Grant Scheme and to download the guidelines, visit: www.anzca.edu.au/fellows/Research/trials-group/pilot-grant-scheme.html

Karen Goulding and Anna Parker
ANZCA Trials Group Co-ordinators

Staff changes



We are very pleased to welcome Karen Goulding to the ANZCA Trials Group, replacing Stephanie Poustie, who retired last year. Karen was previously employed as a project officer at the Victorian Comprehensive Cancer Centre where she co-ordinated a range of projects for the Gynaecological Oncology Research Collaborative. Karen's basic research and public health skills position her perfectly for her new role as the ANZCA Trials Group co-ordinator.

Thank you to Anna Parker who was acting in the position and is now working with Professor David Story as research manager of the Anaesthesia, Perioperative and Pain Medicine Unit, Melbourne Medical School, The University of Melbourne. Anna will remain with the trial group one day a week, co-ordinating the POISE 2 study and assisting with Trials Group activities. Sofia Sidiropoulos is continuing to co-ordinate the BALANCED study.

REGIONAL ANAESTHESIA IN ETHIOPIA



Learning can go both ways when you run international training programs, as a group of Perth specialists discovered in Ethiopia.

In September 2013, a team of regional anaesthesia enthusiasts from the Royal Perth Hospital embarked on an African adventure. Professor Krishna Boddu led the team, with the aim of taking ultrasound-guided regional anaesthesia (USGRA) to Addis Ababa, Ethiopia.

Professor Boddu had run five USGRA workshops in developing countries prior to this, and our anaesthesia department conducted the 13th and 14th biannual USGRA courses last year in Perth.

We believe that the education, knowledge and opportunity to acquire these skills should be available to all anaesthesia practitioners. We believe education can enhance the safety of patient care in developing nations, while inspiring local anaesthetists and giving them an opportunity to gain hands-on-experience with equipment that is otherwise unavailable. The greatest challenge facing anaesthetists in the developing world is a lack of resources, both in terms of equipment and opportunities to travel and participate in training. We aimed to take the course, resources and skills to them.

The ultrasound-guided regional anaesthesia course offers didactic lectures, combined with “real-time” scanning on human volunteers and “real-time” cadaveric teaching to enhance the learning points and reinforce the core knowledge. Day two was hands-on; we anaesthetised a pig to enable the simulation of working with regional catheters and multiple stations with a skilled regionalist guiding the local

participants while they scanned human volunteers. (It was with relief and joy that we visited our pig a few days later to find him recuperated and eating in the hospital garden.)

With the exception of Professor Boddu, this was our first international volunteer course abroad and it was a tremendous learning curve.

We were unprepared for the logistical challenges, the most onerous of which was taking \$A750,000 worth of sponsored equipment, along with donated medicines, stock and anaesthesia equipment, through customs in Africa. We were fortunate to have support from the medical school in Addis Ababa and – after much negotiation – customs released our equipment a day before the course began.

It was wonderful to see the ingenuity and entrepreneurial spirit with which all obstacles can be overcome, even apparently simple things, such as sourcing the necessary cables to connect the equipment for our multi-media presentation.

Much of the organising was done while sharing daily meals of injera, the national Ethiopian dish.

Our lifeline was Wondwosen Goshu, a native Ethiopian nurse anaesthesia practitioner in Houston, Texas. Wondwosen and Professor Boddu had worked together at Memorial Hermann Hospital, University of Texas, Health Sciences at Houston, and it was his dream to bring educational opportunities to his homeland. Our second lifeline was Wondwosen’s cousin, Mimi, a local social anthropology student. Mimi spent countless hours translating Ahmeric (a semitic language spoken in Ethiopia), helped us navigate the cultural intricacies and showed us a beautiful and inspiring side of the city.

Our team also comprised Diana Davidson, a nurse anaesthesia practitioner from Pennsylvania who has been involved with Black Lion for many years, my anaesthesia consultants from the Royal Perth Hospital, Dr Matthew Haggett and Dr Adriano Calzolari, our regional nurse, Mrs Kazuko Rollerson and resident medical officer Dr Shani Macaulay.

In Ethiopia we worked closely with the medical faculty of Addis Ababa University, based at Black Lion Hospital (Tikur Anbessa), the largest general public hospital in Addis. The dean, Dr Mahlet, and the head of the anaesthesia department, Dr Akalu, welcomed us and provided support during our trip. We were privileged to tour their theatre complex and saw that as the training and primary government hospital for Addis Ababa, the Black Lion has a mix of high acuity and complex anaesthesia-surgical cases. We met the three trainee anaesthetists, who explained that most of the anaesthesia workload is handled by nurse anaesthetists. As specialist anaesthetists, their duties included overseeing a multitude of rooms and to run the highest risk theatres, such as thoracics.

Our course attracted around 60 participants from Black Lion Hospital, including anaesthetists, nurse anaesthetists, orthopaedic trainees, emergency department doctors, the professor of anatomy and his senior lecturer and an occasional neurosurgeon.

A quick pre-workshop survey revealed most of the participants were using anatomy-based landmarks to perform their blocks. There was one ultrasound machine in the hospital emergency department, which was not used for regional anaesthesia.

“It was wonderful to see the ingenuity and entrepreneurial spirit with which all obstacles can be overcome.”



During our first few days we met the local trainees and some nurse anaesthetists. While giving an impromptu lecture on neuraxials, anatomy and complications, we discovered that outside of spinal anaesthesia for obstetrics, no one had conducted an epidural. One of the anaesthesia residents had seen one performed by a visiting anaesthetist but didn't have the equipment to perform them.

The message was repeated the following week at the Gandhi Memorial Hospital, a public hospital for women and children, where we were invited to present at a weekly academic meeting. Our presentation covered acute and chronic pain strategies available in a resource-strapped environment. We also took an ultrasound machine to teach the theory around transverse abdominal plane (TAP) blocks, and show how they could be performed using direct-vision or the ultrasound machine and probes available at the maternity hospital.

It was not all work, and under Mimi's guidance we were introduced to jazz clubs, were moved to tears at the Red Terror Martyr's Museum and stared in wonder at the wares for sale at Merkato markets, the largest open-air market in Africa.

Our involvement in this outreach initiative proved a wonderful and enriching experience. Our Ethiopian colleagues had vast theoretical knowledge; most could quote textbooks and everyone was keen to learn about the technology available in anaesthesia and medicine.

Questions have been raised about the appropriateness of taking such a workshop, along with ultrasound equipment, to a country without access

to the technology. I believe Dr Macaulay best expressed the sentiments of our team: “What we were doing is creating opportunity. Opportunity to change practice and to take those skills and build upon them over a lifetime. Furthermore the workshop was more than just teaching ultrasound guided nerve blocks. It was about educating the medical staff on pain and providing effective multimodal analgesia. The concept that pain leads to suffering and that this suffering does not have to be a mandatory part of the experience of being a ‘patient’...”

Our department is now planning the 15th USGRA course to be held in August. Our greater challenge, however, will be the following week when we take our course to Ortho One Orthopaedic Specialist Centre in Coimbatore, India. As we start planning these sometimes daunting ventures, it is imperative we reflect on what we have learnt.

I, personally, learnt so much from the workshop and stay in Addis Ababa. While we taught new skills and gave our colleagues a chance to feel, manipulate and handle new equipment, they left us with a deeper appreciation for our environment, an acute awareness of how privileged we are in the resources we have available, and a sense that the world is ever expanding. As educators, I believe it is our duty to stand on the precipice, extending a hand to help bring our fellow practitioners into the future with us.

Dr Christine Grobler, MBChB DA(SA) FCA FANZCA
Specialist anaesthetist, Department of Anaesthesia and Pain Medicine, Royal Perth Hospital
Clinical lecturer, University of Western Australia, Perth, WA

Above from left: The entrance to College of Health Sciences, University of Addis Ababa, Black Lion Hospital; The university dean, Dr Mahlet, welcomes Professor Boddu and our team. Pictured from rear left are Dr Grobler, Dr Calzolari, Dr Macaulay, the head of the hospital's anaesthesia department Dr Akalu and Dr Haggett; Dr Calzolari teaching regional catheter techniques on anaesthetised pig model; Dr Grobler and Haggett teaching sonoanatomy; Downtown Addis Ababa; Paying a cultural visit. Pictured from left: Mimi, Dr Macaulay, Dr Grobler, Professor Boddu and Dr Haggett.

Fundraising doubles and prominent leaders join the cause

The foundation sincerely thanks the Fellows who generously supported this appeal by making donations with their 2014 subscriptions.

The appeal raised more than \$A33,000 (and rising), a 27 per cent increase on the 2013 appeal.

Your generous gifts mean the foundation can fully support more Fellows' research and education projects in anaesthesia, pain and perioperative medicine. This in turn means anaesthetists and pain medicine specialists can continue to play roles of increasing significance and recognition in developing better quality, safety and patient outcomes across perioperative and pain medicine, locally and internationally.

Fundraising growth in 2013

Excluding ANZCA's regular annual contribution to support research grants, income from the foundation's fundraising program during 2013 increased by 99.7 per cent on the previous year to reach \$247,816.

Factors contributing to this encouraging growth included increased donations from Fellows and patrons, a philanthropic grant from the Ronald Geoffrey Arnott Foundation for the Essential Pain Management program, and Pfizer Australia's new sponsorship of the foundation's pain medicine research grants program.

Fundraising from Fellows was assisted by a direct-mail appeal in August, ongoing giving commitments from several new patrons, donations from foundation functions and the newsletter in the June issue of the *ANZCA Bulletin*, and donations made to the appeal included in the annual subscriptions notice mailing.

New Board of Governors members

January saw the appointment of four new members to the Board of Governors, the foundation's new group of influential supporters who will work with staff to develop contacts and networks to help build the fundraising program.

Bruce Brook is the chair of Programmed Maintenance Services and a non-executive director of CSL Limited, Boart Longyear and Newmont Mining Corporation. He is a member of the Australian Securities and Investments Commission's Director Advisory Panel and his executive roles have included chief financial officer of WMC Resources, and deputy chief financial officer of ANZ Banking Group.

Priscilla Bryans is a partner in the head office advisory team at the law firm Herbert Smith Freehills in Melbourne. She is a member of the Law Council of Australia's Business Law Section, and of the Australian Institute of Company Directors' Law Committee, and works with major listed public company clients including Telstra, Toll Holdings, Suncorp Group, Transurban, Newcrest, ANZ, Federation Centres, GUD Holdings and Bendigo and Adelaide Bank.

Robert Bazzani is the Victorian chair of KPMG. Prior to his role as chair, Rob was a partner in Corporate Finance, national head of mergers and acquisitions, and a member of the KPMG Mergers and Acquisitions Global Executive Team. He is a member of the Aviva Asia Holdings Ltd Advisory Board and a member of the board of AsiaLink, Melbourne, and is a former board member of FilmFest (Melbourne International Film Festival).

Sir Roderick Deane also has joined the Board of Governors and will remain a member of the foundation committee (formerly the foundation board). Sir Roderick is chair of the IHC Foundation, New Zealand's largest voluntary welfare charitable organisation, chair of Pacific Road Group in Sydney, and a director of Woolworths Ltd in Sydney, and has previously been chair of Fletcher Building Ltd, the ANZ National Bank, Telecom New Zealand, and Professor of Economics and Management at Victoria University of Wellington.

The foundation warmly welcomes Sir Roderick, Mr Brook, Ms Bryans and Mr Bazzani to its Board of Governors and looks forward to working closely with them to increase the support for research and education.



New web page makes donating easy

In line with the College's delivery of enhanced online information management tools, the foundation's new online donations page went live in late 2013. For Fellows who have been thinking about supporting life-saving research and education in the specialties, but have been too busy to get around to it, the new facility makes giving easier than ever. The page can be found by clicking the foundation's "quick link" button on the ANZCA homepage, or by clicking the "donate now" button on any of the foundation's web pages.

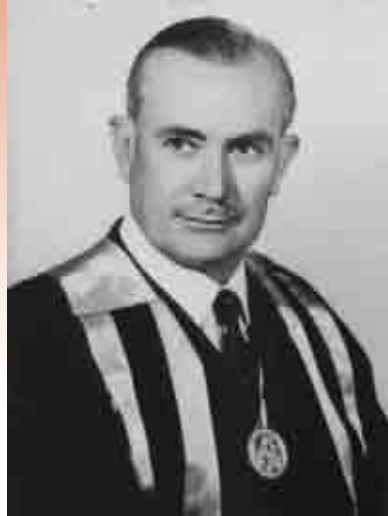
Thank you to all those Fellows who have given generously. Gifts can be made by mail or by calling Rob Packer at the foundation on +61 3 8517 5306.

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.

Foundation Fellows from NSW



In past editions of the *Bulletin*, we have profiled the foundation Fellows of the Faculty of Anaesthetists, Royal Australasian College of Surgeons, when it was formed in 1952. In this edition, we profile the 10 from NSW.

The 10 NSW founding Fellows of the Faculty of Anaesthetists, Royal Australasian College of Surgeons included names synonymous with anaesthesia and the development of the profession in Australia.

The 10 included two deans of the Faculty (Dr James McCulloch and Dr Leonard Shea) and Dr Harry Daly who won the Faculty's inaugural Orton Medal in 1969.

In 1973 dinners were held across Australia and New Zealand to celebrate the 21st anniversary of the formation of the Faculty in 1952.

At the NSW Regional Committee dinner, four of the foundation Fellows attended – Dr Harry Daly, Dr Phillip Jobson, Dr Andrew Distan Morgan and Dr Leonard Shea.

Short biographies of the 10 founding Fellows from NSW follows.

Dr Harry Daly MB ChM (Syd) 1918, FRACP 1947 was a significant figure in the founding of the Faculty of Anaesthetists, RACS in 1952. He was Vice-Dean of the Faculty 1953-55 and was awarded the Faculty's inaugural Orton Medal in 1969. Dr Daly was one of the founders of

the Australian Society of Anaesthetists (ASA) in 1934 and had a close interest in anaesthetic education. Dr Daly died in June 1980 and his work is honoured through ANZCA's Harry Daly research fellowship, offered since 1982 [known as the Harry Daly research award since 2011], and the Harry Daly Museum at Australian Society of Anaesthetists offices in Sydney.

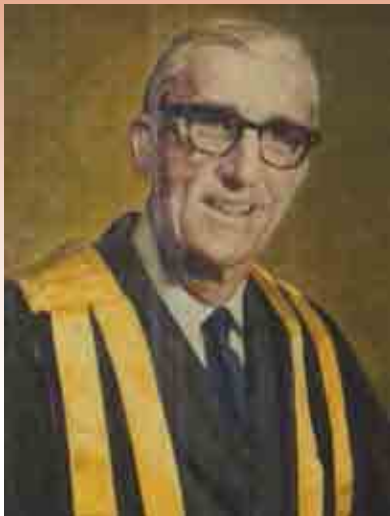
Dr Phillip Jobson MB BS (Syd) 1935 became a Senior Resident Medical Officer in Anaesthetics at the Royal Prince Alfred Hospital (RPA) in Sydney in 1936. In 1939 he was appointed an Assistant Honorary Physician to the RPA and Anaesthetist to the Department of Neurosurgery. Dr Jobson served as an inaugural member of the NSW State Committee of the Faculty of Anaesthetists, RACS, from 1955 onwards. Dr Jobson retired from private practice in 1985 and died in 2005, the last Australian Foundation Fellow.

Dr Andrew Distin Morgan, MB ChM (Syd) 1924, Diploma in Anaesthetics, Royal Colleges of Physicians and Surgeons (DA RCP&S) 1936, FIGA (USA) 1939, OBE, was a paediatric specialist regarded as one of the practitioners who, along with Dr Margaret McLelland and Dr Mary Burnell, laid the groundwork for paediatric anaesthesia in Australia. Dr Morgan travelled to the UK in 1938 to obtain his anaesthetic qualification. He visited Dr Ivan Magill in England, and in the USA visited Drs Waters, Lundy and Rovenstein. At this time a portable anaesthetic machine was built to Dr Morgan's specification by A. Charles King Proprietary of London¹.

Dr Leonard Shea MB BS 1937 (Syd), DA 1946 (Syd) became the fifth Dean of the Faculty of Anaesthetists, RACS in 1964. Dr Shea was the first Chairman of the Court of Examiners of the new Faculty of Anaesthetists, RACS, and Dr Ross Holland noted in 1987 that the high standards were a consequence of Dr Shea's shrewd recognition of the requirements for the Australasian Faculty to be treated as an equal by her English counterparts². Dr Shea was Vice Dean of the Faculty 1961 to 1964, Dean of the Faculty 1964 to 1966 and President of the ASA 1962 to 1963. Dr Shea received the Faculty of Anaesthetists, RACS Medal in 1980.

Dr Ivor Hotten MB ChM (Syd) 1923, DA RCP&S 1939, MRACP 1940, FRACP 1948 accepted an Honorary Anaesthetist position at the Royal Prince Alfred Hospital, Sydney in 1930. He became the hospital's tutor in anaesthetics in the same year and henceforth maintained a lifelong commitment to post-graduate medical education.

Dr Lucy MacMahon MB ChM (Syd) 1924 was invited in July 1951 to join the new Faculty as a foundation Fellow. At this time Dr MacMahon shared her professional office address with Dr Harry Daly at 143 Macquarie Street, Sydney. Soon afterwards Dr MacMahon retired from anaesthetic practice to marry a Sydney barrister, Louis Hogan and relocated to the Bathurst area.



Third Pugh Day lecture
“Cobras, chloroform and
consumption – the life and
times of Joseph T. Clover”



Dr James McCulloch MB ChM (Syd) 1924, MRACP 1945, DA (Syd) 1950 became the fourth Dean of the Faculty of Anaesthetists, RACS in 1961 and served in this position until 1964. He served as President of the ASA from 1954-1955. Dr McCulloch died in 1984 and Dr Douglas Joseph wrote in an obituary article of “his amazing ability to encourage young aspirants into anaesthesia without any hint of coercion or false representation of the specialty”³.

Dr Stuart Marshall MB 1925, ChM 1935 (Syd), DA RCP&S 1938 served as ASA President 1951-1952 as work was in full swing to found the Faculty of Anaesthetists, RACS. Dr Marshall was a member of the NSW State Committee, Faculty of Anaesthetists, RACS, from 1955-1958. Dr Gwen Wilson wrote in 1987 that the influence of Dr Marshall and Dr Daly “was enormous and their recruitments to the specialty quite selfless... they followed their recruits with interest and encouragement and both, to the end of their lives, were always available for advice and delighted with anaesthetic gossip from home and abroad”⁴. Dr Marshall died in 1967.

Dr Clive Paton MB ChM 1922 (Syd), DA (Syd) 1945 worked from a Macquarie Street, Sydney, address for many years. Dr Paton published a number of articles on anaesthesia, for example, “Anaesthesia in Labour and Caesarean Section”, MJA 15 Nov 1947, pp. 589 – 592, and assisted with the Diploma in Anaesthetics course at the University of Sydney.

Dr Ivan Schalit MB BS (Melb) 1936, DA RCP&S 1946 was the first Staff Specialist anaesthetist in Australia and established the Newcastle Department of Anaesthesia. During his distinguished career Dr Schalit created two post-operative wards at the Royal Newcastle Hospital, which were the forerunners of recovery and intensive care wards.

Further information about the New South Wales Foundation Fellows can be found at www.anzca.edu.au/about-anzca/History/history.html#archives

Fraser Faithfull, ANZCA Archives, with assistance from **Dr Richard Bailey**, **Professor Garry Phillips** and **Professor Barry Baker**

References:

1. Morgan, A D, “A Portable All-Purpose Anaesthetic Machine”, MJA, August 19, 1939, p. 284
2. Holland, R, Obituary: Dr L T Shea, RACS Bulletin, November 1987, p. 39
3. Joseph, D, Obituary: James Fishbourne McCulloch, RACS Bulletin, July 1984, pp. 34-35
4. Wilson, G, Fifty Years – The Australian Society of Anaesthetists 1934 – 1984, published 1987, ASA, Edgecliff NSW, p. 242

Above from left: Dr Harry Daly; Dr Leonard Shea; Dr Ivor Hotten; Dr James McCulloch; Dr Clive Paton.



William Pugh gave the first anaesthetic in Australia just as Joseph Clover was finishing his medical studies and training to be a surgeon. Ultimately his

career led him to become the leading anaesthetist in Victorian London. Discover what led to this highly commendable career move and the many patients he encountered on the way – from royalty to the supremely reckless.

Speaker: Dr Christine Ball, Honorary Curator, ANZCA

When: Sunday June 15, 2014 at 2pm

Venue: Meeting Room of the Queen Victoria Museum and Art Gallery, Launceston (Inveresk site).

Sponsors: Launceston General Hospital Historical Committee and the Launceston Historical Society.

New Zealand news



Scholarship winners from left: Dr Sam Grummitt, Dr James Moore and Dr Kathryn Hagen.

BWT Ritchie Scholarship winners

Three ANZCA trainees or first-year Fellows have been awarded \$NZ15,000 each towards overseas fellowships under the 2013 BWT Ritchie Scholarship program. Dr Kathryn Hagen of Auckland, Dr James Moore of Wellington and Dr Sam Grummitt of Christchurch were chosen from an unusually high number of quality candidates, making selection very difficult.

Dr Hagen was awarded FANZCA in March 2013 and has just completed a year-long fellowship in neuro and vascular anaesthesia at Auckland City Hospital. She is now based in Ireland with her husband and two young sons, undertaking a research and regional anaesthesia fellowship at Cork University Hospital. Dr Hagen hopes to build on networks she has developed through her work on various committees, including chairing the NZ Trainee Committee in 2010.

Dr Moore has just completed fellowships in anaesthesia and intensive care, and helped to establish a Hospital Trauma Committee at Wellington Regional Hospital. He also served on the MCNZ's Education Committee and with the St John Ambulance Service. Dr Moore will use his scholarship to help fund a 12-month fellowship in cardiothoracic anaesthesia and critical care at Papworth Hospital, Cambridge, England, starting mid-year.

Dr Grummitt's scholarship will support his work at Vancouver General Hospital as a general clinical fellow with a focus on major non-cardiac surgery, including colorectal, hepatobiliary, vascular, etc. He also hopes to expand his perioperative skills, particularly in echocardiography. Dr Grummitt recently completed his final FANZCA examination, having been based at Christchurch Hospital for the past three years. His wife and young twin sons will accompany him to Vancouver.

Applications for the 2014 BWT Ritchie Scholarship close on October 31. Information about how to apply, past recipients and their uses of the scholarship is available at www.anaesthesiaeducation.org.nz.

Busy year ahead for NZNC

With a general election in New Zealand planned for late 2014.

ANZCA CEO Linda Sorrell, NZNC Chair Dr Nigel Robertson, and FPM's NZNC Chair, Dr Kieran Davis, held a round of visits in Wellington on March 6.

The visits included the Minister of Health, Tony Ryall, to discuss ANZCA's policy on advising patients to quit smoking, the NZNC's position on assistants to the anaesthetist, workforce issues, and medical college involvement in identifying and dealing with poorly performing doctors.

Other meetings were held with the opposition health spokesperson, Annette King (Labour), the chief executive officer of the Medical Council of New Zealand (MCNZ), Philip Pigou, and the Ministry of Health chief medical officer, Dr Don Mackie. The last meeting also included representation from Health Workforce New Zealand.

The first NZNC meeting of the year was on March 7, with agenda topics including the outcomes of the political meetings, MCNZ competence and compliance issues, planning for the NZNC's 2015 annual scientific meeting in Wellington, revisions to the ANZCA Continuing Professional Development (CPD) Program, including for general registrants, developments with the assistant to the anaesthetist role, and discussion on training matters.

A mid-year forum for clinical directors is also planned as well as participation in National Anaesthesia Day on October 16, an annual general meeting in August in Queenstown and a fourth Part 3 Course in December. Preparation is under way for an NZNC annual scientific meeting to be held in Wellington in November 2015.

Above from left: Dr Nigel Robertson, Dr Kieran Davis, the Hon Annette King and Linda Sorrell; Dr Nigel Robertson, Linda Sorrell, the Hon Tony Ryall, Dr Kieran Davis and Heather Ann Moodie.

Wider career view for registrars

At the 2013 Annual Registrar Meeting held at Auckland City Hospital on December 6, registrars were encouraged to look past attainment of FANZCA to their future careers as Fellows of the College and as anaesthetic specialists. Presentations covered the scholar role, ANZCA in New Zealand, academia, private practice and “why should I hire you”. A roundtable discussion involved seven Fellows talking about their experiences and taking questions from the floor.

There were seven presenters in the scientific session and the presentations were all of a high standard, showing significant effort. The judges, Auckland University Associate Professor Simon Mitchell, ANZCA NZNC Chair Dr Nigel Robertson and NZ Society of Anaesthetists’ President Dr Ted Hughes, awarded the prizes as follows:

- ANZCA prize for best scientific presentation: Dr Tristan Bennett (anaesthetic registrar, Auckland City Hospital) for “Rapid infusion of iron polymaltose in pregnancy – an audit of acute infusion related side effects”.
- NZ Society of Anaesthetists’ prize for best quality assurance presentation: Dr Catherine Meer (obstetric anaesthetic fellow, Auckland City Hospital) for “Intrauterine foetal resuscitation and category 1 caesarean section at National Women’s Hospital: An audit of practice”.
- Caduceus prize for excellence in anesthesiology research: Dr Chang-Joon Kim (anaesthetic registrar, Auckland City Hospital) for “Prevalence of preoperative anaemia in patients having cardiac surgery and its impact on clinical outcome”.

With the introduction of the scholar role, the 2014 annual registrar meeting will see a change in format to the research section. Trainees will be invited to submit posters of their audits and research, which will be displayed throughout the day, giving registrars an opportunity to learn how to prepare a scientific poster and display their work. The best posters will be invited to give an oral presentation in the afternoon session.

Dr Nicola Broadbent, chair of the Anaesthesia Continuing Education Committee at the Auckland District Health Board, thanked ANZCA, the NZ Society of Anaesthetists and Braun for their sponsorship of the 2013 event.

From the new NZAEC chair



Chairing the New Zealand Anaesthesia Education Committee (NZAEC) rotates between the ANZCA NZNC and the NZ Society of Anaesthetists (NZSA) on a two-yearly basis. It is important that the two representative bodies continue to work together in the education arena and I thank the outgoing chair, Dr Kerry Gunn (NZNC), for the excellent platform he has set. Dr Gunn has set a high standard for

me to follow having performed a fantastic job in facilitation, planning and support of educational activities.

The committee’s other members are Dr Jennifer Woods (NZNC), Dr Nigel Robertson (as NZNC Chair), Dr Rob Carpenter (NZSA) and Dr Ted Hughes (as NZSA President).

I have been a specialist anaesthetist in Christchurch for just over 14 years and my clinical interests include cardiothoracic, regional anaesthesia and pre-admission. I was clinical director of the Christchurch department for six years and now lead the anaesthesia service for the West Coast District Health Board. The majority of my working week is spent in Christchurch Hospital. I am also a primary examiner, a member of the Primary Examination Sub-Committee, an NZ CORE (resuscitation) instructor and tutor for the Christchurch primary exam course.

Having gained an understanding of the issues facing rural hospitals, I fully support the NZAEC’s anaesthesia visiting lectureship program and this project has some excellent speakers for 2014. New Zealand meetings are of very good quality and those dedicated to a single theme can deliver real value for time spent.

I would like to reiterate Dr Gunn’s comments from two years ago: New Zealand anaesthetists understand what is needed for their ongoing education and NZAEC is there to facilitate projects that will deliver now and in the future. Please email your ideas and help shape our education program.

Dr Graham Roper, graham.roper@cdhb.govt.nz

Assistants to anaesthetists

Dr Geoff Long met with the Anaesthetic Technicians Advisory Committee of the Medical Sciences Council in January to discuss a proposal to reduce the length of training for anaesthetic technicians. Dr Long explained that ANZCA’s professional document PS08 *Recommendations on the Assistant for the Anaesthetist* was under review but it was possible the emphasis would be placed on the competencies required rather than the duration of training. With nurses recently proposing a separate anaesthetic nurse training pathway, the NZNC favours common training, or at least common assessment, for all assistants to the anaesthetist. Discussion on the nurses’ proposal is continuing through a working group.

Australian news

Tasmania



State of (the) Art Meeting a great success

The Tasmanian Regional Committee has broken attendance records with the largest number of delegates ever at the 2014 Tasmanian Annual Scientific Meeting, held on the first weekend of March.

Based on the theme “State of (the) art”, conference presentations highlighted recent research on links between general anaesthesia, post-operative cognitive decline and dementia. There also were hands-on workshops providing experience in the use of spinal and brachial plexus ultrasound.

Delegates from around the country, including ANZCA president-elect Dr Genevieve Goulding, joined locals to hear international guest speaker Professor Jose Carvalho discuss the latest trends in obstetric anaesthesia.

Afternoon sessions on anaesthesia in the developing world and future issues facing anaesthetists rounded out a varied and dynamic scientific program.

The poster session proved to be of a high standard with Dr Anders Bown awarded the prize for his work on “An audit of oxygen saturations of women using remifentanyl PCA in labour”.

It was the first time the venue at the Medical Sciences Precinct at the University of Tasmania had been used for a meeting of this magnitude, and it ably met the conference needs for presentations, workshops and a central hub for catering and trade displays.

Chair of the Tasmanian Regional Committee and meeting convener Dr Nico Terblanche was thrilled with the conference and subsequent feedback.

“The 2014 meeting has set a high standard for meetings to follow,” Dr Terblanche said. “The combination of a motivated planning committee of ANZCA and Australian Society of Anaesthetists members, staff support from ANZCA and the University of Tasmania, as well as the support of trade and our guest speakers, ensured a highly successful meeting. I would like to thank everyone involved.”

The social events with a strong arts flavour added to the scientific program, with cocktail function at the Despard Gallery on Friday evening followed by a long-table banquet at the Tasmanian Museum and Art Gallery on Saturday.

The scientific program co-ordinator, Dr Peter Wright, was very pleased with the conference and valued the great contributions from all of the speakers. Work already is underway on the 2015 meeting, which Dr Wright is convening.

The 2014 Tasmanian registrar day was held on Friday February 28 and was a great success. The day was attended by 19 Tasmanian trainees. It started with a breakfast followed by Professor Carvalho presenting “Obstetrics experience for the trainees”, a detailed exploration of spinal anaesthesia for registrars. Neonatologist Dr Hamish Jackson ran a neonatal resuscitation workshop with small group workshops and scenarios. In the final presentation, Dr Robert Bown took trainees on a fascinating trip back in time and spoke about the changes in anaesthetics since he began his anaesthetic training in 1968 at the Royal Hobart Hospital. We have travelled a long way in 46 years! The registrars are looking forward to the next trainee day in 2015.

Above clockwise from top left: Professor Jose Carvalho presenting at the ASM; trainee day workshop; Long table banquet at the Tasmanian Museum and Art Gallery; Hands on workshop a key feature of the ASM; Professor Jose Carvalho and ANZCA president-elect Dr Genevieve Goulding.

Victoria



Final Fulltime Course, Monday February 10 to Friday February 14

The first Pre-Fellowship Course for trainees for 2014 was run from Monday February 10 to Friday February 14 at the College.

Attendance for this course was better than planned with a total of 64 trainees, including participants from New Zealand and interstate. There was general appreciation for the planning and organisation and much comment was made on the excellent content of the program, which is due, in no small way, to our participating lecturers.

I would like to take this opportunity of thanking our lecturers for their valuable contribution and the Victorian Course Co-ordinator, Mrs Cathy O'Brien, for her planning, organisation and diligence in bringing the program together.

Dr Glenn Downy
Convenor

Australian news (continued)

South Australia and Northern Territory



Maurice Sando Memorial Lecture continuing medical education meeting

The 7th Maurice Sando Memorial Lecture was held on November 27 in the week preceding the annual scientific meeting, with guest speaker Professor Alexander Butwick from the Department of Anesthesiology at Stanford University, California. Dr Butwick presented on “Management of uterine atony and oxytocin update” to more than 50 attendees at the Women’s and Children’s Hospital. His presentation was video-conferenced to anaesthesia consultants and trainees in Alice Springs, Darwin and regional South Australia.

Outstanding feedback was received for Dr Butwick’s presentation and attendees enjoyed the post-presentation socialising, where they had the opportunity to speak to Dr Butwick about his areas of specialty in preventative and therapeutic strategies for managing obstetric haemorrhage, maternal haemostasis and haematologic-related outcomes-based research in obstetrics.

Dr Butwick thanked the joint ANZCA/Australian Society of Anaesthetists Continuing Medical Education Committee and the Burnell Jose Trust for the opportunity to tour South Australian hospital anaesthesia departments and speak with consultants and trainees. His comments were very positive about the specialty and standards of training and he had much to take back to share with colleagues in the US.

Clockwise from top left: Burnell Jose Visiting Professor, Dr Alexander Butwick, presenting at the Maurice Sando Memorial Lecture; Attendees at the Maurice Sando Memorial Lecture “Management of uterine atony and oxytocins update”; ANZCA Fellow Dr Anthony Laver and retired Fellow Dr John Crowhurst; SA NT CME Committee Chair, Dr Nathan Davis, visiting professor/speaker, Dr Alexander Butwick and SA NT CME Past Chair Dr Bill Wilson.

Part 0 orientation course

The SA/NT regional office conducted the ANZCA/ASA Part 0 orientation course for new trainees in January. SA/NT Trainee Committee Chair, Dr Sam Lumb, conducted the informative course with presentations from Dr Ken Chin in relation to rotational issues and Dr Christine Hildyard on workplace-based assessments assessments. Dr Elizabeth Chye presented on the part 1 long course format and invited trainees to attend these weekly lectures and participate in presenting topics as part of their curriculum revision and Chelsea Hicks provided information on GASACT and its benefits. Trainee welfare was discussed and the SA/NT education officer, Dr Margaret Weise was present to meet new trainees. The SA/NT Rotational Anaesthetic Training Scheme had eight new trainees who commenced their training at the beginning of February in ANZCA-accredited hospitals.

Right, clockwise from top left: Riverbank trade display; Dinner attendees Dr Min-Oi Lee, Dr Scott Ma and Dr Brigid Brown; Guest speakers Dr Anne Sved Williams and Dr Elizabeth Connolly; SA/NT CME Chair Dr Nathan Davis presenting visiting Professor Dr Alexander Butwick the Burnell Jose Visiting Professorship Award and ANZCA cufflinks; Guest speaker Dr Dee McCormack; Guest speaker Dr Tim Porter and SA/NT CME Committee Member Dr Andrew Thomas.



“Anaesthesia and all things obstetric” meeting

The combined ANZCA/ASA South Australian and Northern Territory Triennial Burnell-Jose Visiting Professorship annual scientific meeting (ASM) was themed “Anaesthesia and all things obstetric”.

The one-day ASM was held on November 30 at the Adelaide Convention Centre followed by a delegate dinner with 104 delegates in attendance, including 6 per cent trainees. The scientific program was delivered by 10 guest speakers including the visiting professor in attendance, Dr Alexander Butwick MBS FRCA MS, assistant professor in the Department of Anaesthesiology at Stanford University School of Medicine, California.

All Dr Butwick’s talks were well received with comments such as “he is an example to all of us on how to be an educator and presenter at the highest level”. His areas of specialty included research interests in preventative and therapeutic strategies for the management of obstetric haemorrhage, maternal haemostasis and haematology related outcomes based research in obstetrics. Thirteen healthcare and financial industry companies were corporate supporters of the event providing an excellent trade display to delegates.

Western Australia



Course for new trainees

The GASACT Part 0 Course is run for new trainees who have been selected to start on the WA rotational training program. The course aims to provide trainees with an introduction to the anaesthetic program as a whole – where to start, what to expect and a few hints on how to find their feet.

The 2014 GASACT Australian Society of Anaesthetists Part 0 Course was held on Thursday February 6 at the Byrneleigh Hotel in Nedlands. Sovereign Plus and MDA National sponsored the course, which was attended by 25 trainees and their partners. The speakers delivered well-prepared and punchy speeches offering a balance of perspectives. Feedback on the evening from both new trainees and their partners/support people was very positive. The ANZCA Part 0 Course was held on the February 7 at the ANZCA office, Jodi Graham, Jay Bruce, Irina Kurowski and Nirooshan Rooban attended, as well as 15 trainees. The trainees had an opportunity to mingle and get to know the training expectations and the curriculum.

A one-day training program that covers a mixture of lectures and smaller group workshops (airway, regional, echo, focused sessions for Part 1 and Part 2 prep etc and potentially SIM?). There will also be sessions on wellbeing/financial planning, exciting fellowship options, discussion on challenging cases encountered after hours. This course is aimed at Anaesthesia registrars in WA with approximately 30 people attending. More information will follow as soon as the course program is finalised. The first WA regional meetings have been held for the year. The Australian Society of Anaesthetists Committee met on February 10 and the Western Australian Regional Committee met on February 11. The Education Officer/Supervisor of Training Committee held its annual dinner and first meeting at The Heritage on January 30.

The primary exam was held on February 24 at the WA office, we wish the trainees well with their results. The final exam will be held on March 21 and 22 and we wish trainees well in their studies leading to the exam.

A medical expo will be held at Burswood on Swan on March 11, we look forward to meeting the new students who may be interested in anaesthetics.

The WA conference dates for this year are:

- Autumn Scientific Meeting, March 15, University of Western Australia;
- Winter Scientific Meeting, July 26, University of Western Australia.
- Country Meeting, October 17 to 19, Pullman Resort Bunker Bay.

Australian news (continued)

New South Wales



Part Zero: An Induction to Anaesthesia takes off

The 2014 “Part Zero: An Induction to Anaesthesia” course on March 8 was a popular way to spend a quiet Saturday afternoon. Despite clear sunny skies outside, more than 70 interns, residents and registrars flocked to the Royal Prince Alfred’s Education Centre to learn more about the exciting life of an anaesthetic registrar.

After an initial welcome from the NSW Regional Trainee Committee, the day kicked off with Dr Katherine Jeffrey, Dr Chetan Reddy and Dr Trylon Tsang reminding us what being an anaesthetic trainee was about, as well as the various prestigious organisations a budding young anaesthetic trainee could join. This was followed by Dr Pat Farrell covering “What is ANZCA?”, Dr Dave Gillespie and John Neal “Please don’t Work in a regional centre!” and Dr Simon Martel highlighting the structure of training and the new ANZCA curriculum.

Afternoon tea was followed by a presentation by Dr Ken Harrison of Careflight’s guide to career choice (as well as his family photo album!). Dr Donald Innes discussed attributes of the successful anaesthetist, cultivating them as a trainee and Dr Jane McDonald covered mentorship. Professor Gordon Parker of Black Dog Institute rounded off the afternoon with his presentation on mental health and happiness.

Despite squeezing a lifetime’s worth of information into five hours, morale remained high thanks to the entertaining and informative lectures. The day was rounded off with a question and answer session followed by drinks at the local. Thanks go to all the presenters, the 2013 Regional Trainee Committee, and Tina Papadopoulos from the NSW ANZCA office for all her work behind the scenes.

NSW Part II Refresher Course

The NSW Regional Committee again conducted a very successful Part II Refresher Course In Anaesthesia at Royal Prince Alfred Hospital from February 10-21.

The course enabled candidates sitting for the final fellowship examinations a greater understanding of anaesthesia. It included seminars, panel sessions, demonstrations, lecturers and informal tutorial. A highlight on the last day of the course was the anatomical workshop held at Department of Anatomy and Histology, University of Sydney, which enlists the help of seven lecturers in a hands-on workshop. A special thanks to all the speakers who devoted a huge amount of time and effort in assisting the candidates to prepare for their final examinations, and especially to Dr Chris Wong.

Queensland

The Queensland Combined ANZCA/Australian Society of Anaesthetists (ASA) Continuing Medical Education Committee is pleased to announce the 38th Qld ANZCA ASA State Conference will be held on July 19. The theme of the conference is “Go where and do what?!?! – Anaesthesia in the challenging environment”.

The single-day meeting will include lecture-style presentations, hypothetical panel discussions with a question and answer format and small group practical sessions. Learn about the work your colleagues are doing in remote, risky locations, work through similar scenarios in discussion and practice emergency response scenarios in hands-on sessions.

All Fellows are invited to attend. Numbers may be limited so please register early to ensure you secure a place.

Queensland's Annual Registrars Scientific Meeting

This is your opportunity to present your formal project to a forum of peers at the Annual Registrars Scientific Meeting on April 5. This event is open for all to attend.

Further information is available from the Queensland Regional Office +61 7 3846 1233 or qldevent@anzca.edu.au

CME evening lecture

Dr Tim Henwood presented “The benefits of exercise in late and very late life” and spoke passionately regarding exercise and the major benefits. He cited that 60 per cent of the adult population are not participating in regular physical activity; 30 per cent are not exercising at all; fewer than 50 per cent of older adults ever receive a suggestion to exercise from doctors; more than 250,000 deaths recorded each year are attributed to inactivity; the biggest difficulty is not only initiating but maintaining long term lifestyle changes. There was a strong response from everyone at the lecture and a big thank you to Dr Tim Henwood.

Australian Capital Territory



Overseas anaesthetists win awards

Solomon Islands anaesthetist wins inaugural Garry Phillips prize



From left: Dr Pauline Wake, Dr Harry Aigeeleng, Dr Lisa Akelisi-Yockopua, Associate Professor Terence Loughnan, Dr Jack Puti, Dr Arvin Karvu and Dr Michael Cooper.

Dr Jack Puti, a Solomon Islands anaesthetist who trained in Papua New Guinea is the inaugural winner of the 2012 Garry Phillips Prize for outstanding achievement in the Papua New Guinea Masters of Medicine final examination.

His prize was presented in February at the Pacific Super Meeting a satellite meeting held prior to the Asian Australasian Congress of Anaesthesiologists (ACA) and Australasian Symposium on Ultrasound and Regional Anaesthesia (ASURA) in Auckland. This was the first combined meeting of the Pacific Society of Anaesthetists, the Society of Anaesthetists of Papua New Guinea and the Micronesia Anaesthesia Society. The award was presented by Dr Michael Cooper, Chair, ANZCA Overseas Aid Committee.

The Garry Phillips Prize is awarded by ANZCA in conjunction with the University of Papua New Guinea, School of Medicine and Health Sciences. The prize was named after Professor Garry Phillips from Adelaide due to his long involvement in PNG. In his 20s Professor Phillips spent time as a cadet patrol officer or "Kiap" at Kikori in the gulf province and on returning to Australia he studied medicine. In 1993 he returned to PNG as an instructor on the first Early Management of Severe Trauma (EMST) course held in the country. He subsequently became the first visiting Professor of Anaesthesia to PNG from 1995 to 2006, supporting the further development of anaesthesia as an emerging specialty and the development of the anaesthetic scientific officer course at the University of PNG.

The 2013 winner of the Garry Phillips Prize will be awarded later this year.

Scholarship won by Mongolian anaesthetist



From left: Dr Chris Scarff, Dr Mungun Banzar, Dr Wayne Morriss and Dr Michael Cooper.

Mongolian anaesthetist Dr Mungun Banzar attended the combined Asian Australasian Congress of Anaesthesiologists (ACA) and Australasian Symposium on Ultrasound and Regional Anaesthesia (ASURA) meeting held in Auckland in February as the recipient of the Anaesthetic Services Group Victoria scholarship.

In conjunction with the Overseas Aid Committee and the Anaesthesia and Pain Medicine Foundation, Anaesthetic Services Group Victoria has been offering an annual scholarship since last year to foster leadership in anaesthesia and pain medicine in developing countries by providing a qualified anaesthetist the opportunity to attend an Australian or New Zealand scientific conference.

Dr Banzar, who is working at the National Centre of Maternal and Child Health of Mongolia, said she was excited at the opportunity to attend the meeting where she was able to learn more about the latest evidence-based medicine and looked forward to sharing what she learned with colleagues, trainees and nurses upon her return to Mongolia.

Dr Peter Brine, AM, FANZCA

1924 – 2013



Peter Brine was born on December 27, 1924, in Lancashire UK, and died in Albany, WA, on October 6, 2013. His wife Brenda, children Nigel and Pippa, and grandchildren Mia, James, Thea and Bryce survive him.

During his long life, Peter pursued many interests with passion, and his achievements within and outside medicine were outstanding. His family home was in Norbreck, Lancashire, and he was a talented boy chorister, winning many choral contests and developing a love of music that lasted all his life. His secondary education was at Blackpool Grammar School and he originally intended to study engineering. World War Two interrupted these plans and he served in the Royal Air Force for four years, two of which were in India when, as he said, his eyes “were opened to the rest of the world”.

After the war Peter studied medicine at Cambridge and Kings College Hospital, London. According to the stories he told, the Cambridge years were noted for cricket, rugby, golf and squash and exams were passed “eventually”. Peter and Brenda Jowett married in 1949, their families having known each other for many years. It was a long and happy marriage of two people whose joy in each other’s achievements and interests was always obvious.

Peter completed his anaesthetic training at Kings and had already developed an interest in paediatric anaesthesia. However misgivings about the medical situation in the UK led the family to move to Canada to the small town of Cabri, in Saskatchewan, where he was the town general practitioner for three years. The stories of this period were colourful, especially about the trials of the prairie winters. Nigel relates that the ambulance was also the hearse, and that it often contained an empty casket, an emergency kit and Peter’s golf clubs. Peter also found that he was expected to be the town vet and cope with some unusual problems. He was much respected in Cabri, but the medical political situation in Canada became difficult, and to Australia’s great benefit Peter decided to pursue his paediatric anaesthetic interests as a full-time anaesthetist at Princess Margaret Hospital for Children (PMH) in Perth. It was an inspired appointment for PMH.

He and Brenda, Nigel and Pippa arrived from Canada into a typical Perth heatwave in 1964 and rapidly settled into the lifestyle in what he described as a house on a sand hill at City Beach – an attractive display home for the Commonwealth Games.

The early 1960s at PMH were exciting but frustrating for paediatric surgery, paediatric anaesthesia and the developing field of intensive care. Until then, diagnoses and perioperative care was in the hands of the physicians, who viewed surgeons and anaesthetists as mere technicians despite their specialist training. In particular, the introduction of prolonged nasotracheal intubation by Allen and Steven in Adelaide had enabled the anaesthesia department to take over aspects of the care of medical patients, which the physicians were at first reluctant to relinquish. Opposition to an intensive care unit led to the patients being scattered throughout the hospital with varied standards of nursing expertise and often late referral.

Peter joined this busy and exciting scene as the second full-time anaesthetist. From the beginning it was obvious that he would be an enthusiastic, very skilful and congenial colleague who was willing to put in the long hours required both by the intensive care requirements and by the widening scope of anaesthesia in all the surgical specialties. Nigel’s comment that Peter’s children saw very little of him during this time was undoubtedly true. Such was his dedication that the hospital’s administration hoped that with two full time anaesthetists, the visiting anaesthetists could be dispensed with, an untenable concept, as they too were essential for the development of the anaesthetic and intensive care services. It was not until 1969 that a small intensive care unit with a dedicated physician lightened the load of the anaesthetic department. It was several years before 24-hour specialist nursing care was provided.

Peter spent two years as a full-time anaesthetist before entering private practice in 1966. He then spent half his time at PMH and a large part of his private practice working with children at St John of God Hospital, Subiaco. He worked with many surgeons in all the paediatric specialties and especially with paediatric surgeons Alasdair MacKellar and Gordon Baron-Hay. It is interesting to have his operative and perioperative account of one of their most challenging patients (an infant with an enormous haemangioma also described in Alasdair MacKellar's memoirs), which attests to Peter's outstanding standards of care.

He remained a loyal member of the Department of Anaesthesia at PMH until his retirement in 1989 when he was appointed emeritus consultant anaesthetist.

One of his many major achievements was the establishment of the Same Day Surgery Unit in 1974, only the second such unit in Australia. This was achieved in minimal time in a hospital not noted for rapid change, with little administrative opposition. From the beginning it flourished with none of the predicted catastrophes and it was the forerunner of many such units, both paediatric and adult, in WA. It is hard to remember the days when even the most straightforward surgery required admission for two nights.

Peter also was an early exponent of local anaesthetic blocks combined with general anaesthesia, which contributed to the relief of post-operative pain and proved particularly useful in same-day surgery.

He was an outstanding and popular teacher of anaesthetic registrars. He always preached the importance of the team approach; he worked "with"

surgeons and objected to surgeons who referred to "my" anaesthetist in a patronising way. Indeed, he seldom worked with such surgeons. He placed great emphasis on high ethical standards in the speciality of anaesthesia and in the medical profession generally. His advocacy for the status of anaesthetists was mainly through the Australian Society of Anaesthetists (ASA) where he was the federal president between 1976 and 1978, a source of pride because he was then still technically an Englishman. He also became president of the Medical Board of WA (1981 to 1994) and was a member of the Australian Medical Council and the National Specialist Qualification Advisory committee. He became a Fellow of the Australian Medical Association in 1989 for these contributions to the profession.

In 1996 he was appointed a Member of the Order of Australia (AM) for services to paediatric anaesthesia and intensive care.

He was an outstanding public speaker and his opening address to the 2000 ASA Congress in Perth on "professionalism" exemplified his approach to life, the profession and our duty of care to our patients and ourselves. It should be widely read.

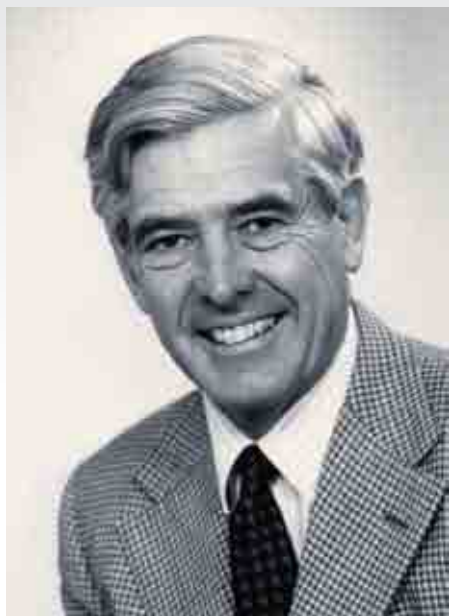
These achievements make him sound a very serious person, but he had a wonderful sense of humour and wide interests outside medicine. He was a great raconteur and any gathering where Peter was present was never dull. Some of his best stories related to a memorable expedition along the Canning Stock Route in 1972, a feat very few West Australians have achieved. He described himself as a "one-eyed sandgroper" and so Australian that he ultimately barracked for Australia against England at cricket.

He was a great golfer and a proud member of Lake Karrynyup Country Club, where he delighted in defeating young players who were deceived by his grey hair. He would then defeat them at the billiard table as well. His highest achievement was to win the Winter Cup, defeating the professionals.

Peter and Brenda retired to Albany, where Pippa lives with her family, and they happily enjoyed the lifestyle and the view of Oyster Harbour from their home. Peter died in Albany, his health having declined after a stroke three years ago.

Dr Nerida Dilworth, AM, FANZCA

Professor Michael A Denborough, AM , FANZCA 1929 – 2014



Michael Antony Denborough was born in Rhodesia in July 1929.

From his early teenage years, Michael envisioned his future as a doctor and the persistence he showed in pursuing his medical education was a strong personality trait also reflected in his later achievements. Michael studied at the University of Cape Town and was granted a Rhodes scholarship to study at Oxford.

His clinical years began as resident medical officer at National Heart Hospital in London in 1958 and it was while he was studying and working in London he met his Australian-born wife, Erica. Michael and Erica settled in Melbourne in 1960 where he began work as first assistant (research fellow) at the University of Melbourne and Royal Melbourne Hospital.

It was at the Royal Melbourne that Michael was charged (because of his interest in genetics) by his supervising professor, Richard Robert Haynes Lovell, to investigate a family who were remarkable for their sad history of anaesthetic deaths.

Michael led an investigation into this family and coined the term malignant hyperpyrexia (MH) in a letter published in the *Lancet* in 1960. This letter and a follow-up article two years later entitled “Anaesthetic deaths in a family” in the *British Journal of Anaesthesia* were the first publications describing MH as a familial condition. For Michael, they were the start of a lifetime’s investigation.

After 14 years at Royal Melbourne Hospital, Michael moved to the John Curtin School of Medical Research in Canberra where he was a professorial fellow from 1974 to 1991 and continued his remarkable research, expanding to include muscle disorders with a relationship to MH. From 1992 to 1994 he was professor at the John Curtin School of Medical Research at the Australian National University, retiring in 1995 to the role of emeritus professor.

Michael’s achievements have been formally honoured over the years. In 1972 he was awarded the Eric Susman Prize from the Royal Australian College of Physicians and in 1982 he was honoured with a gold medal at the Fifth International Congress on Neuromuscular Diseases in Marseilles. In 1999, Michael was appointed a member of the order of Australia for services to medicine.

Outside of medicine, Michael was a passionate anti-nuclear campaigner. He was absolute in his opposition to war and the development and sale of weapons. He, Erica, and others founded the Nuclear Disarmament Party in 1984 and he maintained a solo vigil outside parliament house in Canberra for 52 days campaigning to stop the war in Iraq. In his children’s words, he charged himself and others to “do something positive to save the world each day”.

Michael was a gracious gentleman. He was supporter of the individual – his actions reflect his belief that one man could make a difference – and he not only lived this dogma but also translated it to patient care, research and politics. As a teacher, Michael has been described as a gentleman physician most memorable to young students for showing a keen interest in their practical education and focusing on the doctor-patient relationship. His legacy lives on in the lives of MH families and in all those who practice anaesthesia.

Michael died on February 8 and his memorial service was held in Melbourne on Valentine’s Day. His children’s reflections at his memorial service described a father who loved unconditionally and was immensely proud of his family. He celebrated their achievements and encouraged them in their endeavours. Michael is survived by his wife Erica, his children Paul, Liz, David and Kate and his many grandchildren.

Vale Michael Antony Denborough – your contribution will not be forgotten.

Dr Robyn Gillies MBBS (Hons) FANZCA
Department of Anaesthesia and Pain Management
Malignant Hyperthermia Diagnostic Unit
Royal Melbourne Hospital