

ANZCA ALLOCATES
\$A1 MILLION IN
RESEARCH GRANTS

PNG BENEFITS
FROM OUR
OVERSEAS AID

ONLINE PROGRAM
WILL HELP GPs TREAT
CHRONIC PAIN

December 2012

ANZCA BULLETIN



FPM
FACULTY OF PAIN MEDICINE
ANZCA

2013 ANZCA Training Program is here

after 1579 days, 165 meetings, 77 workshops,
and thousands of hours' work by hundreds
of Fellows, trainees and staff.





34 ANZCA's \$A1 million for research

For the first time, more than \$A1 million has been allocated to research projects in 2013 through the Anaesthesia and Pain Medicine Foundation.



24 Our work in PNG

ANZCA's Overseas Aid Committee is making a real difference in Papua New Guinea.



30 Moving hospitals

Moving into a brand new hospital was a huge logistical exercise for the Royal Children's Hospital, Melbourne.



56 Helping GPs treat chronic pain

FPM and the RACGP have worked together to deliver a cutting-edge online education program to help GPs treat chronic pain.

ANZCA Bulletin



The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional medical body in Australia and New Zealand that conducts education, training and continuing professional development of anaesthetists and pain medicine specialists. ANZCA comprises 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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Please note that any views or opinions expressed in this publication are solely those of the author and do not necessarily represent those of ANZCA.

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We hear from a trainee, a Fellow, a supervisor, a workplace-based assessment assessor and a department head.

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President's message



Dr Lindy Roberts
President, ANZCA

ANZCA at 20 – thanks for your contributions in a big year

What a year it has been! I acknowledge everyone who has given their time, ideas and energy to our College as we celebrated our 20th anniversary. So here's a wrap of 20 achievements from a long list of collective accomplishments in 2012.

1. **Contributions to the College** by a large number of dedicated trainees, Fellows and staff – we couldn't have done it without you.
2. **The ANZCA and FPM strategic plans 2013 to 2017** – a vision for the next five years developed through asking Fellows, trainees, staff and external bodies what our priorities should be. An outline of these plans is in this edition of the *Bulletin* for your reference.
3. **ANZCA Curriculum Revision 2013** – a massive project, requiring input from many people and ready now to launch. In 2012, the College also underwent accreditation by the Australian Medical Council/Medical Council of New Zealand – preliminary findings were positive and we await the final report. Numerous curriculum support activities have occurred or are under way including interactive orientation sessions, as well as liaison with health boards and department heads to facilitate the training portfolio system introduction. More than 600 Fellows have attended workplace-based assessment training. For some practical tips about your role as the revised training program commences, see pages 14 to 21.
4. **An outstanding annual scientific meeting in Perth**, along with many other educational events – workshops, lectures, problem-based learning discussions, quality assurance meetings, the New Fellows Conference – weekday and weekend timing, metropolitan and non-metropolitan locations, ANZCA alone and in collaboration with others (especially our sister societies). Thanks to all the convenors, facilitators, lecturers and participants.
5. **The FANZCA logo** for Fellows to use on business cards, letterhead, slide presentations and emails, which came with your subscription notice for 2013 and is downloadable from the website. More about the logo is on page 8.
6. **The ANZCA Trainee Committee** has grown from strength to strength since its formation in 2004. Under the current joint leadership of Dr Michael Lumsden-Steel (Tas) and Dr Paul Nicholas (Qld), along with the chairs of each of the regional and national trainee committees, trainees provide numerous and significant contributions to College affairs. For information about how to get involved and ensure your voice is heard, contact trainee.committee@anzca.edu.au.
7. **Support for Australian regions and New Zealand** – did you know that about one in five of our staff are located in our regional offices and the NZ national office, to assist Fellows and trainees and college activities locally?
8. **Overseas aid** – supporting anaesthesia and pain medicine in developing countries through educational programs including Essential Pain Management, a trainee scholarship, and working for safer anaesthesia in countries such as Papua New Guinea – see the article on page 24.

9. **Research that changes clinical practice** – for the first time ever, over \$A1 million has been awarded for high quality research in 2013 that will address important clinical questions and change the quality of care provided to our patients. The College aims to grow this support through the Anaesthesia and Pain Medicine Foundation. Information about next year's research can be found on page 34 with a list of Fellows who have contributed on page 42.
10. **Hospital visits by our CEO** – Linda Sorrell, along with Dr Geoff Long in New Zealand, has visited many of you in your places of work this year to understand your needs, to hear your views and to answer your questions.
11. **New Zealand recognition of pain medicine** as a vocational scope of practice – an historic achievement and endorsement of the work of the College and the Faculty to advocate for the vast numbers of New Zealanders who suffer with chronic unremitting pain, ensuring a focus on interdisciplinary care with access to highly trained pain medicine physicians. An article about this milestone is on page 55.
12. **Excellent publications, podcasts and webinars** that support Fellows' continuing education and high standards of professional practice – for example, *Australasian Anaesthesia*, the *Bulletin*, e-newsletters (ASM, ANZCA, training, FPM's *Synapse*) as well as ANZCA and FPM professional documents. Podcasts, webinars and other resources are on the college website and can be used no matter where you live and work. Thanks to those who have contributed as editors, authors, presenters and document development group members in 2012.
13. **Anaesthesia stories** – capturing our history for future generations and part of a broader history and heritage strategy that includes our museum, library and archives. The achievements of Dr Rod Westhorpe, OAM, who celebrates 25 years as honorary curator this year, are highlighted in an article on page 44.
14. **A voice for anaesthesia and pain medicine in health reform debates** – through submissions to government (more than 50 so far this year), dialogue and advocacy with healthcare organisations and via ANZCA representation on external bodies. A summary of ANZCA's recent activities with government can be found on page 12.
15. **Raising the profile of our specialties** through our Communications Unit with media releases seeking to promote positive news stories and balanced debate in the interests of high quality and safe patient care. In 2012 so far, this has resulted in a potential cumulative audience of 17.8 million. A summary of our media activity in the past few months can be found on page 9.
16. **The Asian Transition Working Group** – working through consultation to effectively manage transitional arrangements for ANZCA trainees, supervisors and training departments in Asia. A specific regulation and training handbook is in development.
17. **The ANZCA Anaesthesia Allergy Subcommittee** – established this year and working with the Australian and New Zealand Anaesthesia Allergy Group (ANZAAG), to develop incident reporting and clinical guidelines to prevent and manage anaesthesia-related allergy.
18. **Quality and safety** – promoted through many of our ongoing projects – for example, safety alerts, *Bulletin* articles, mortality reviews, clinical guidelines and web-based incident reporting (webAIRS). Our regular quality and safety section is on page 64.
19. **The ANZCA Library** – expanded this year with now more than 250 journals and 150 textbooks online, as well as assistance with literature searches at library@anzca.edu.au. Some of our latest library acquisitions can be found on page 80.
20. **IMGS assessment and support through OTSAN** – the College has reviewed and updated its international medical graduate specialist (IMGS) assessment processes this year and continued its support for the Overseas Trained Specialist Anaesthetists' Network (OTSAN).

The ANZCA Council recently approved business plans and the budget for 2013. New projects for 2013 will consider the priorities outlined in the strategic plan and ensure expanded and improved services for Fellows and trainees.

I wish you all the very best for a restful, safe and happy festive season, and look forward to working with and for you again in 2013.

Chief Executive Officer's message



Ms Linda Sorrell
Chief Executive Officer, ANZCA

As we approach the final days of 2012, it is timely to reflect on the achievements of the past 12 months and look forward to what is planned for next year.

A big focus will be improving the ANZCA Continuing Professional Development (CPD) Program. The latest initiative is "CPD mobile", which allows Fellows to complete their CPD portfolio functions "on the go" using smartphones and tablets.

The enhanced layout and functionality is a result of direct feedback from Fellows. CPD mobile builds on the updated CPD portfolio, launched 12 months ago, and will be a precursor to further improvements to the program in 2013 being planned by Fellows and supported by our Fellowship Affairs team.

These improvements will tie in closely with a web-based portal, which is a major project for Fellowship Affairs in 2013. The portal is a "one-stop shop" for Fellows and trainees to interact with the College online. They can register and pay for events and have these details automatically recorded in their CPD portfolios. They will be able to update contact details and pay their subscriptions.

Trainees and their supervisors will also be able to access the new state-of-the-art training portfolio system (TPS) from their portal.

The TPS, which has just been rolled out in New Zealand, has also been keeping ANZCA staff, Fellows and trainees very busy in the final months of 2012.

The development over the past four years of a revised curriculum, led by a team of dedicated Fellows and trainees supported in particular by the Education Development Unit, comes to fruition in 2013. This project is the biggest ever undertaken by the College and has more recently involved at least 50 per cent of College staff. The launch of the *ANZCA Handbook for Training and Accreditation*, co-ordinated by the Policy team, consolidates and streamlines training and educational documents. The Training and Assessments and Records Management teams have also been busily preparing for the changes to the training program in 2013. Meanwhile, the Faculty of Pain Medicine is continuing to develop its revised curriculum for 2015.

Staff across the College continued to support successful continuing medical education events in 2012 from the hugely successful 2013 Perth Annual Scientific Meeting and FPM Refresher Course Day,

to successful special interest group meetings, the FPM Spring Meeting and events in the Australian regions and New Zealand.

Another achievement this year has been the reaccreditation process of the College and FPM by the Australian Medical Council and the Medical Council of New Zealand. Again, this is a great example of staff (in particular, the Policy Unit which co-ordinated the process) supporting Fellows and trainees.

The Policy Unit has also co-ordinated some 50 submissions to government in Australia and New Zealand on behalf of ANZCA and FPM and, from an advocacy point of view, we have had a similarly successful year promoting anaesthesia and pain medicine, thanks to the work of our Communications Unit, which has had a strong media response to the 40 media releases produced this year.

The Communications Unit also has developed the FANZCA logo, which is made up of the College coat of arms and the words "Fellow of the Australian and New Zealand College of Anaesthetists". This has been distributed to all Fellows on a CD for use on stationery and allows them to display more visibly their FANZCA post-nominals.

We aim to develop new resources for our Fellows and trainees in 2013. Our online resources continue to grow as we add to our ANZCA Library (including the LibGuides feature, which aims to present resources in a relevant and subject-related manner) and other online resources such as podcasts and webinars. In 2012, FPM was involved in the successful launch of a GP Online Education Program on pain management, in collaboration with the RACGP, and three web-based Anaesthesia Stories were produced.

The College and FPM both have new strategic plans for 2013, which have guided the business plans established by each unit within the College, including the Anaesthesia and Pain Medicine Foundation, which will continue to build on its fundraising efforts for research and education.

As I reflect on my first full year as ANZCA chief executive officer, I am amazed at what has been achieved by hard-working staff supporting an equally hard-working team of Fellows and trainees.

I wish you all a safe and happy festive season.

ANZCA in the news



Since September this year,
ANZCA has generated...

30 print stories
75 online stories
21 radio reports
178 TV reports

News about ANZCA and the Faculty of Pain Medicine has been accessed by a potential cumulative audience of more than 4.3 million people since September. Fourteen media releases have been released, generating 304 media reports. Six media releases have been issued highlighting work by the Faculty of Pain Medicine and efforts to promote better management of prescription opioids, resulting in substantial coverage around Australia including two front page stories in *The Age* newspaper in Melbourne, and one in the *Sun-Herald* in Sydney. The FPM Spring Meeting in Coolool, FPM's involvement in the Global Year Against Visceral Pain, the new GP online learning tool and recognition of pain medicine as a specialty in New Zealand were also publicised.

A trip to PNG by the Overseas Aid Committee generated 48 media reports in Australia, New Zealand and PNG, including a front page story in PNG's *Post-Courier* newspaper. Radio Australia's Pacific Beat program interviewed committee chair Dr Michael Cooper three times about ANZCA's work in PNG as part of the trip.

The combined 2012 NZ Anaesthesia Annual Scientific Meeting and the 13th International Congress of Cardiothoracic and Vascular Anesthesia was promoted, with Associate Professor David Scott from St Vincent's Hospital in Melbourne interviewed about the possible effects of anaesthesia and surgery on dementia.

ANZCA research into anaesthetic awareness was featured in the prestigious *Weekend Australian* magazine, where a potential audience of 285,644 people read about a study looking at whether there may be a genetic link to this rare experience. Former ANZCA president, Professor Kate Leslie, and Royal Children's Hospital anaesthetist, Associate Professor Andrew Davidson, were interviewed for the piece.

Meaghan Shaw
Media Manager, ANZCA

Media releases distributed by ANZCA since September

College helps train extra specialists in rural areas (*November 27*)

Research needed into anaesthetics and surgery causing dementia (*November 18*)

Far more research needed into post-surgery deaths (*November 15*)

Top presenters draw anaesthetists from around the world (*November 13*)

Report will guide anaesthesia training numbers: ANZCA (*November 9*)

Pain medicine recognition great news for those in pain (*November 2*)

Medical experts seek consensus on opioid prescribing (*October 26*)

Millions to benefit from Australian first pain management solution (*October 25*)

Pelvic pain: the last of the modern taboos (*October 15*)

ANZCA Bulletin out now: Bali bombings; hypnosis; war zone anaesthesia; revised training program; pain management in Central America (*October 8*)

Urine and drug screening proposed for chronic pain patients (*September 30*)

Children with chronic pain miss out on services (*September 27*)

Australian doctors helping children and boosting skills in PNG (*September 9*)

Australasian anaesthetists help save lives in PNG (*September 5*)

All media releases can be found at www.anzca.edu.au/communications/Media

ANZCA and government: building relationships



Australia

Health Workforce Australia

Health Workforce Australia (HWA) has released the Health Workforce 2025 report (volume three) to guide planning for medical specialist training positions required in the future. The report, released to ministers at the Council of Australian Governments meeting on November 9, includes projected demand and supply scenarios for the first time. There is a chapter on anaesthesia and on pain medicine. The report is available via: www.hwa.gov.au/health-workforce-2025.

Health Workforce 2025 is the first major, long-term study of the national health workforce in Australia out to 2025 and the publication of volume three marks the final of the current series. Volume three has one clear message – the number of medical specialists is increasing, but the workforce is not evenly distributed.

The report will help guide anaesthesia training numbers over the coming years and projects that numbers will be largely in balance over the next 15 years if current conditions prevail. The maldistribution of anaesthetists in rural and remote areas is expected to decline over time with improving access to anaesthetists in these areas. Interestingly, the report flags a scenario where improved productivity

and innovation in health workforce reform may reduce reliance on medical specialists, including anaesthetists into the future. This, however, is subject to further work and is where ANZCA will have a strong voice in future deliberations.

The ANZCA President, Dr Lindy Roberts, said the College welcomed the Health Workforce Australia's *Health Workforce 2025* report and applauded the HWA on its thorough, consultative process. The CEO of HWA, Mark Cormack, recently met Dr Roberts and ANZCA's CEO, Ms Linda Sorrell, to brief the College on the contents of the report.

Dr Roberts said the number of anaesthesia trainees in Australia was determined by the number of hospital training positions funded by government health departments and the Commonwealth's Specialist Training Program. She looked forward to the policy responses of government in response to the findings.

"The demand for anaesthetists is growing with the scope of practice broadening to include 'out of theatre' work such as preoperative assessment, postoperative pain relief, retrievals and resuscitation work," Dr Roberts said.

"ANZCA also welcomes greater co-ordination of the training pathway and appropriate support for clinical supervisors of the next generation of trainee anaesthetists."

Review of Australian Government health workforce programs

ANZCA, via the Committee of Presidents of Medical Colleges, has ensured appropriate input into the review of health workforce programs, aligned with the recently released ANZCA strategic priorities for 2013 – 2017:

- **Advance standards through training, education, accreditation and research**, which recognises the need to develop an adaptable health workforce equipped with the requisite competencies and ensures quality and safety in the health system. ANZCA is cognisant of trainees having adequate access to the full range of experiences during training that will be required for independent specialist practice.

- **Collaboration** between state health jurisdictions and hospitals to better allocate training positions at the local level. This could be supported by further collaboration between the Specialist Training Program and other funding schemes. The College is concerned at potential training bottlenecks as the large supply of medical interns make their way through the pipeline. Further increases in funding to support more specialist training in non-traditional settings, including private hospitals will be needed to address the possible shortage.

The level of specialist care is not optimal in many rural areas; ANZCA supports the creation of networks between urban and rural hospitals that require urban specialists to spend a proportion of their time in a regional or remote setting and supports further incentives for all specialists to work in rural areas in both public and private settings. This would improve access to specialist services in rural areas and increase reliability of these services.

Building leadership capacity

Training supervision is vital to ensure the quality and safety, innovation, continuous improvement and sustainability of anaesthesia. ANZCA recognises the need for increased support for training supervision. There is an increase in demand for anaesthetists as teaching



and training commitments lead to greater amounts of non-clinical time, so there is a need to “protect” dedicated education and training time.

ANZCA supports expanded teaching settings to accommodate additional trainee numbers and expose trainees to a comprehensive range of learning environments, including public and private hospitals.

Submissions

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

- Queensland Department of Health on the evaluation of the Queensland Rural Generalist Program.
- Victorian Department of Health on clinical education and training governance arrangements in Victoria.
- Australian Institute of Health/Royal Australasian College of Surgeons on national definitions of elective surgery urgency categories.
- Australian Medical Council on the review of Royal Australian and New Zealand College of Radiologists accreditation submission.
- The Australian Workforce and Productivity Agency on the skilled occupation list in relation to anaesthesia.
- Australian Health Practitioner Regulatory Authority on the review of accreditation arrangements for the medical profession.
- Confederation of Postgraduate Medical Education Councils on *Revision of the Australian Curriculum Framework for Junior Doctors*.
- Standards Australia on access to standards for the review of ANZCA professional documents.

ANZCA's past submissions, including the College's accreditation submission to the Australian Medical Council, can be found at: www.anzca.edu.au/communications/submissions.

Australian Medical Council/Medical Council of New Zealand Accreditation update

We are pleased to report that the AMC accreditation team completed their hospital site visits and their visit at ANZCA House in October 2012.

The preliminary outcomes of their assessment of the College and the Faculty of Pain Medicine are highly favourable with particular mention of the high quality of the submissions and comprehensive implementation of the revised curriculum. A final report is expected in December 2012. We would like to thank all College staff, Fellows and trainees who contributed to the assessment process over the last 12 months.

Australian Government grants – Specialist Training Program

The College is finalising a variation to our contract with the Department of Health and Ageing to extend the Specialist Training Program to 2015. Once negotiations are complete, participating hospitals should receive either new funding agreements or deeds of variation shortly thereafter.

The Specialist Training Program covers funding for specialist training positions in hospitals, as well as valuable support infrastructure projects to extend e-learning opportunities for rural trainees and specialists, teacher training workshops, and support for the Overseas Trained Specialist Anaesthesia Network (OTSAN).

Following the earlier announcement this year of a \$325 million emergency package for Tasmania's health system by the health minister, the Training More Specialist Doctors in Tasmania workforce component of the measure will provide \$40 million over three years, commencing in 2013-14 to support the training and retention of specialist doctors in the Tasmanian public health system.

Funding will be delivered as an additional component to the department's Specialist Training Program. This additional funding will provide up to two new vocational training places by 2015-16 to be managed by the College as well as funding for clinical supervisor and training co-ordinator support. The College will also receive funding for educational development and administration.

New Zealand

Review of the Health Practitioner Competence Assurance Act 2003

Consultation on the Health Practitioner Competence Assurance Act 2003 review closed recently. The New Zealand National Committee (NZNC) made an independent submission, focusing on the view that the current act is fit for purpose and there is no evidence to suggest it requires transformational review. The consultation document included discussion of workforce, welfare, pastoral care and teamwork, and while NZNC acknowledged the importance of these issues, their submission questioned whether primary legislation is the appropriate way to support progress in these areas.

Health Workforce New Zealand attended the NZNC meeting on November 14 to discuss the review and, more specifically, the issues raised in the NZNC submission.

There will be a further round of consultation in March, with a final report and recommendation due for release in July 2013.

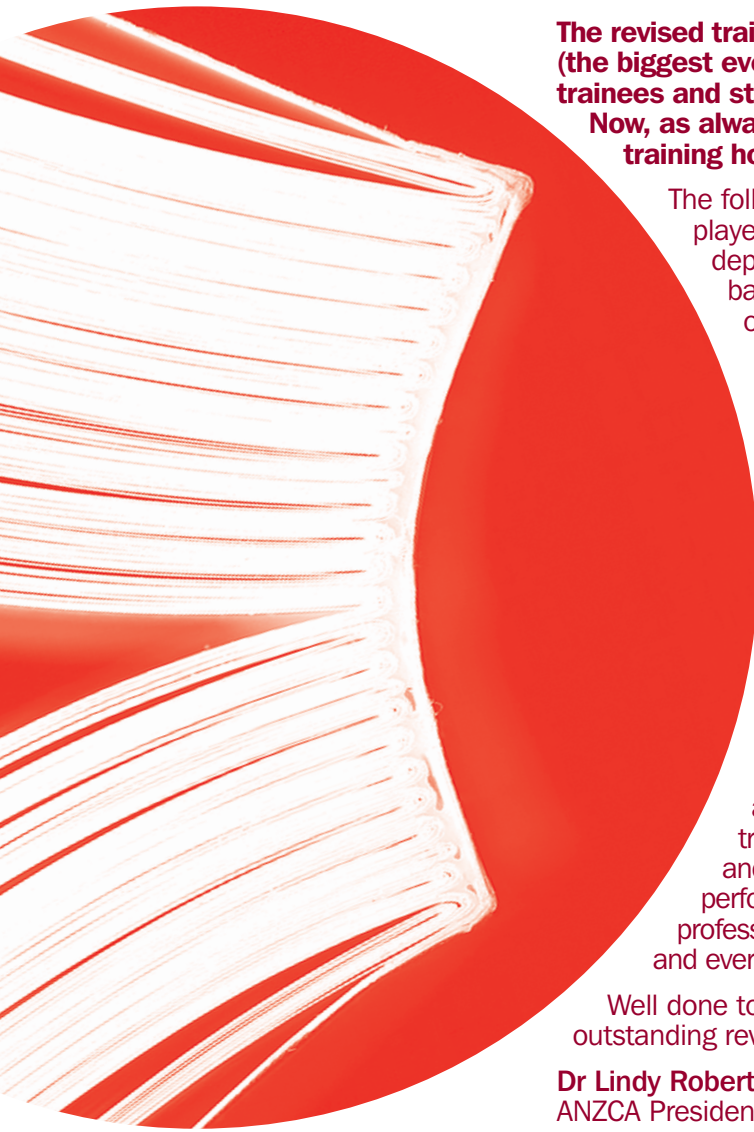
Submissions

The NZNC has developed a number of submissions recently, including letters to Pharmac on the ongoing process of developing a national preferred medicines list. The Council of Medical Colleges (CMC) is taking a more active role in co-ordinating submissions representing the views of its members. Recent examples include CMC submissions to the Medical Council of New Zealand on the review of its document *Good Medical Practice*, and a CMC submission on the review of the Health Practitioner Competence Assurance Act 2003. Colleges have the ability to endorse the CMC response and/or submit individual responses with additional information or presenting alternative perspectives.

John Biviano

General Manager, Policy
ANZCA

ANZCA's revised training program is here



The revised training program is upon us. It has been a huge project (the biggest ever undertaken by the College) with many Fellows, trainees and staff involved to ensure a world-class outcome. Now, as always, it depends on everyone in ANZCA-accredited training hospitals working together to ensure that it delivers.

The following vignettes are specifically targeted at key players – trainees, Fellows, supervisors of training (SOTs), department directors and those performing workplace-based assessments (WBAs). ANZCA educational leaders outline some practical tips for your role in the revised curriculum and how to use the training portfolio system (TPS).

The College provides extensive support – TPS orientation, a network of trained, well-briefed supervisors (education officers, SOTs, WBA champions and other Fellows), training workshops, website resources, a comprehensive training handbook as well as a TPS helpdesk and email inquiry lines. Please let us know if we can assist you. For more information visit www.anzca.edu.au/training/2013-training-program.

I am confident this will all be a great success, ensuring highly trained specialists who are ready to take on the challenges and rewards of delivering best quality and safe care for our patients. From the first to the last training stages, our graduates will record their experiences and receive constructive feedback to help improve their performance, as well as refine their lifelong skills in continuing professional development to equip them for a rapidly changing and ever more challenging professional world.

Well done to everyone who has and will contribute to our outstanding revised training program. We can't do it without you.

Dr Lindy Roberts
ANZCA President

The training program and CPD

Continuing professional development (CPD) points can be earned for training program activities.

	Category and level	CPD credits
Workplace-based assessments (WBA)		
Case-based discussion (CbD)	C3L2	Three per hour
Mini-clinical evaluation exercise (mini-CEX)	C3L1	Two per hour
Direct observation of procedural skills (DOPS)	C3L1	Two per hour
Multi-source feedback	N/A	N/A
Learning about WBA (passive learning)	C1L1	One per hour
Learning about WBA (interactive learning)	C1L2	Two per hour
Teaching colleagues about WBA	C4L1	One per hour
Teaching sessions	C4L1	One per hour

For more information see www.anzca.edu.au/fellows/continuing-professional-development.



The revised training program ensures ANZCA's trainees remain at the forefront of anaesthesia.

Dr Paul Nicholas,
Co-chair, ANZCA Trainee Committee

The trainee

The advent of the 2013 revised curriculum is only a short time away now, with it initially being rolled out from mid-December in New Zealand, although it has undergone an extensive design and development period, which commenced in mid-2008.

The revised curriculum is based around the CanMEDS principles, with seven ANZCA Roles in Practice and seven ANZCA Clinical Fundamentals alongside the 12 specialised study units (SSUs) that trainees complete as they progress through training.

Fundamental to this are a number of changes to the previous curriculum – mapping of learning outcomes to all the components and stages of the training, a greatly increased number of workplace-based assessments over the training program together with the development of several different methods of workplace-based assessment, a defined volume of practice (VOP) that trainees must achieve before completion of different stages of the training program, the reintroduction of the formalised provisional fellowship year, and lastly the introduction of the training portfolio system.

The training portfolio system is a massive move forward in technology, with a trainee's entire progress through the training program and assessment system being stored online, and accessible to both the trainees and various levels of information being available to Fellows

acting in a supervisory capacity. Trainees will also have day-to-day, and in fact case-to-case interaction with the training portfolio system, as this is where they will enter information about the cases and procedures they are doing. Although many trainees kept logbooks in the past, they have not been mandated, whereas now, at the end of training, every trainee will be able to state what they have seen and done over their training program.

The mapping of learning outcomes to all the elements of the curriculum, but also to different stages of training, such as introductory or basic, allows trainees to have a very definite direction as to where they should be heading, but also the ability to compare themselves with the accepted standard, and a focus, if necessary, to direct their efforts to where they are deficient.

Assessment drives learning – and success in the final examination was testament to that! The much increased number and methods of WBAs in the new curriculum provides trainees with the opportunity to have their training progression observed and documented, with good and outstanding practice being witnessed, but equally will allow areas on which a trainee needs to refocus to be highlighted and discussed, with the aim being that after a period of consolidated learning, a further assessment can occur with the progress being clearly observed.

Trainees will complete a provisional fellowship year in their last year of training. As completion of the final examination and the SSUs is compulsory before entering the provisional fellowship year, it will enable trainees to have the opportunity to consolidate their knowledge and practice before becoming a specialist, but safe in the knowledge that they have completed the majority of their assessments, and without the pressure of the final exam. Gone will be the time when you could pass the final exam on a Saturday, and be a Fellow on the Monday.

The revised curriculum represents a large shift in the teaching and assessment of anaesthesia training in Australasia, and any change in a system may be associated with some teething and adjustment issues for both the trainees and Fellows. The revised curriculum, though, is a world-class training program, and will enable ANZCA, its Fellows and, of course, its trainees, who are the future Fellows, to remain at the forefront of anaesthesia, and will vastly assist the College with its goal – advancing anaesthesia, improving patient care.





The future Fellows of the College will be well prepared for their careers in anaesthesia, thanks to this program.

Dr Vincent Sperando, FANZCA
Liverpool Hospital, NSW

The Fellow

Many Fellows out there may be asking themselves what all the fuss is about. Why are we going through so much trouble revising the curriculum when we have an adequate one now that is producing competent anaesthetists? All the revised curriculum is going to achieve is to create more work for Fellows. Is this really true?

While there will be more formal feedback given to trainees, this may actually reduce the workload. You may find your registrars are asking you to observe them perform procedures more often, or they may want to discuss a case with you. So how might these changes reduce our workload?

Observing a trainee performing a procedure will encourage us to get involved in teaching trainees earlier and to give immediate feedback. If done well, this should lead to our trainees reaching a level

of competency early in their training. This should improve the quality and safety of our profession. It should also translate into less supervision required from Fellows for the later years of training. The discussions of cases as well should translate into trainee with better judgment.

The move away from a module-driven curriculum to one that highlights the key fundamental aspects of our profession will also assist Fellows. The move away from the concept of anaesthesia as a surgical service towards perioperative physicians will emphasise all aspects of our practice. This should give our profession more respect and recognition. It will also distribute the registrars around more evenly, as the volume of practice logging includes subspecialties such as orthopaedic, regional and thoracic with less emphasis on cardiac anaesthesia.

Fellows running lists that were traditionally not allocated registrars should see more support. The trainees should benefit by becoming better general anaesthetists and they can still choose to subspecialise post-fellowship.

The revised curriculum as a whole moves our training program into modern times. We should all be proud of the achievement that has been accomplished with the input from many Fellows and trainees.



Handbook and regulation updates

Please note that updates to the *ANZCA Handbook for Training and Accreditation* and the complementary *regulation 37* have been approved following the November Council meeting.

These updates are summarised in the change control register at the beginning of each document.

Please always refer to the ANZCA website for the most up-to-date versions: www.anzca.edu.au/training/2013-training-program.





The anaesthesia department head is crucial in co-ordinating key people involved in the training program – the supervisors and tutors.

Dr Vanessa Beavis, FANZCA
Auckland City Hospital, NZ

The department head

Dear head of department,
By now you will have received (an alarming amount) of material to assist you with implementing the revised curriculum. Please don't take fright, your supervisor of training knows and understands it well, so is able to guide you through – provided you allocate them sufficient clinical support time. A higher degree in acronym interpretation is helpful, but in case you don't have one, there is an appendix on the website to help with cracking the code.

Dr Brian Spain's clear description of the revised curriculum in September's *ANZCA Bulletin* provides a great summary of the changes. Briefly, anaesthesia practice is made up of seven ANZCA Clinical Fundamentals alongside seven ANZCA Roles in Practice (based on the CanMEDS principles). Now there will be simultaneous teaching of the clinical fundamentals and core study units. Core study units are taught as three training periods (introductory, basic and advanced). Twelve specialised study units (SSUs) cover the knowledge and skills required for specific areas. Twelve months of provisional fellowship training (PFT) completes the training.

To achieve this, you must have a supervisor of training (SOT) who is keen, enthusiastic, skilled and, above all, well supported.

All departments will need workplace-based assessment (WBA) assessors, who must hold a FANZCA or have an ANZCA ID number. In most departments all anaesthesia specialists and provisional Fellows can be WBA assessors. The need for other specific roles will depend on the number of trainees, their level of training and the volume and scope of work in the department. It is recommended that every department has a person nominated for each of the supervisory roles. However, the same person can hold multiple roles, especially if your department is small. In the case of some of the specialised study unit supervisor roles, individuals may even provide supervision across a number of departments in the same rotation. The only roles that cannot be held by the same person are head or deputy head of department/director and the supervisor of training, who cannot be the same person.

Most departments will have a clinical fundamentals tutor, that is a primary resource and expert in a particular fundamental, for example, safety and quality; specialised study unit supervisors (loosely aligned to the old module supervisors); introductory training tutors, responsible for the development of all basic knowledge and skills during the trainee's first six months; a departmental scholar role tutor, who will evaluate the internally assessed scholar role activities; and finally a provisional fellowship supervisor.

As head of department, your responsibility is to ensure these tutors have sufficient time allocated to carry out these duties.

Trainees and hospital administration must be informed about the process of registration with ANZCA as the revised curriculum requires trainees to be registered with ANZCA before they can begin to count accrued training time, cases for volume of practice and workplace-based assessments. This may impact on recruitment and appointment cycles and timing.

These changes also may have implications for the type/title of the role trainees are appointed into at the start of their training and, importantly, the point at which they can contribute to the after-hours roster. Similarly, at the other end of training, some trainees will not conveniently enter their year of provisional training at the start of the hospital training year, and some "manoeuvring" may be needed. Some departments may offer specific provisional fellowship jobs to provide subspecialty training, which might have different criteria from the provisional fellowship training year, so defining those differences will be important for potential applicants.

Most existing ANZCA trainees will transition into the revised curriculum at the beginning of the 2013 hospital employment year, however all ATY3s and some ATY2s will continue in the old system for the remainder of their training. It may be a bit messy in departments that have a mix of trainees on the new and old systems, but this will work itself out in about two years and SOTs should be able to manage this.

The information technology capability of the department may need to be upgraded so that trainees and workplace-based assessment assessors can access the training portfolio system. ANZCA will already be working with your hospital IT department, but it may be worth checking that it is all on track.

There is no doubt that we will have a better product at the end of the training, so thank you for your part in producing great specialists of the future.





Essential guidance and support of trainees through the training program is the domain of the supervisor of training.

Dr Sarah Nicolson, FANZCA
Auckland City Hospital, NZ

The supervisor of training

For all those involved in training anaesthetists in Australasia, the beginning of the 2013 hospital employment year looms large, for no one more so than supervisors of training.

Many of us have had a good look at any holidays planned for this summer. While tempting to take to the beach for the whole summer, our trainees and departments will need us around during this time – trouble-shooting, liaising and translating a new language of acronyms.

At my training site I've been running through a checklist of areas I need to confirm are ready to go. I have considered administrative tasks and issues relating to trainee teaching and learning. The list includes:

- Trainee transition – do the trainees know if they are transitioning to the new curriculum, or are they remaining under the 2004 curriculum (all ATY3s and some ATY2s)?
- Training portfolio system access – is my hospital's information technology capable of running the training portfolio system; where and how will my department access it?
- Managing dual curricula – how will I continue to assess trainees in the old system, while running the new?

- Volume of practice requirements and rostering implications – what subspecialty areas of practice does my department provide for trainees in our rotation? Can trainees access this experience?
- Supervisory roles – do I have people to help in every supervisory role? Do all those currently involved in training have a role in the new curriculum?
- Teaching programs – have my local course convenors thought about adapting their course to fit the revised curriculum? Are there gaps, for example, advanced life support teaching, airway management simulation? Have I got anything in place for introductory trainees?

And then there is the management of trainees under the new curriculum to consider. Again there is a list, the most important items of which are:

- New in-training assessment process – do I know what a CPR, CPP, SSUR and CUR are?
- The logistics of the introductory training period and the initial assessment of anaesthesia competence – making sure that any doctors new to anaesthesia are ready to go for ANZCA training – accrual of training in the revised curriculum is prospective; gone are the days of “get on with the work, and we'll figure out how to count it for training later”.

Any individual who wants to start training needs to be registered as a trainee with the College before they can start the

introductory training period. This means evidence of a training post in an ANZCA-accredited hospital, 24 months' prevocational medical education and training completed and registration with the College.

- Workplace-based assessments (WBAs) – do trainees and Fellows in my department know what these are and how to do them?
- Support/resources – do I know where to find information and assistance – the curriculum document, the handbook, regulation 37, my education officer's email?

While there is a lot to plan for, there should also be lots of help.

Your head of department should be working with you to facilitate training for your trainees, especially around access to experience appropriate to their required volume of practice. Your head of department should also be able to sit down with you and discuss appropriate colleagues to invite to become clinical fundamental tutors and specialised study unit supervisors – these are people who you will be able to go to, to help trainees through most areas of training.

My head of department was very helpful in identifying colleagues who would be keen to be involved in training, or were looking to expand their non-clinical repertoire.

Outside your own training site, you have a rotational supervisor, now with an official ANZCA role, and an education officer, who can both provide support with trainee allocations, training site organisation and difficulties you may come across with trainees and training.

Last, but definitely not least, is the ANZCA website – a vast resource for all things training. Compared with the old supervisor of training folder I was sent when I first started, the ANZCA website is a dynamic, searchable resource, and if I can't find what I need there, it provides me with an email address for someone who can answer my questions. As the beginning of 2013 comes and goes, I will continue to look to the College website for curriculum updates, answers to questions I have yet to think of, and updates on this new curriculum.





Workplaced-based assessments provide an improved structure for teaching, critical thinking and reflection, and rich feedback in all areas.

Dr Emily Wilcox, FANZCA
Westmead Hospital, NSW

The workplace-based assessment assessor

The implementation of workplace-based assessment (WBA) into the revised ANZCA curriculum follows an extensive review of the current curriculum with a contribution from the workplace-based assessment committee. The committee found that while the examinations in the current ANZCA curriculum are of a high standard, the curriculum's focus on the acquisition of knowledge could be improved in teaching and assessing other important areas, such as skill acquisition and demonstration of professional attributes.

Introducing workplace-based assessments as an assessment tool provides an improved structure for in-and out-of-theatre teaching, critical thinking and reflection, and rich feedback in all areas of professionalism. The tools are used in a clinical setting, with the aim of ensuring that the trainee not only has required knowledge but also can demonstrate flexibility of that knowledge in their clinical performance. This formalises the type of teaching that already occurs in a less official way in ANZCA training.

The four workplace-based assessment tools in focus: mini-CEX, DOPS, CbD and MsF

The mini-clinical evaluation exercise (mini-CEX) is the real-time assessment of the clinical performance of a trainee in a structured format. The aim is the evaluation of performance from pre-operative assessment through to the recovery discharge phase. The mini-CEX assesses attributes such as clinical knowledge (planning and preparation, crisis handling), skills, and professional attributes (vigilance, communication, efficiency). Either the trainee or assessor may initiate the mini-CEX. Ideally a case should be chosen which places the trainee on their "learning edge", that is the case is challenging but can be managed independently.

The direct observation of procedural skills (DOPS) workplace-based assessment is a tool used to assess a trainee's performance of an actual clinical skill. This will usually involve a patient in a clinical setting, but may also incorporate a task trainer, such as in a simulated failed intubation scenario. The aim is to provide structured feedback in all areas of the skill including knowledge (for example, relevant indications and contraindications, anatomy, consent), technical performance and management of complications, and professional attributes.

The feedback component of both the mini-CEX and DOPS is the most important component of each tool. The process usually involves trainee self-reflection followed by specific constructive assessor feedback. The format involves a discussion of the case and its completion by the trainee, with the most important areas being the degree of intervention and overall level of supervision required.

The case-based discussion (CbD) is the assessment of a discussion with a trainee, which is centred on a clinical case that the trainee has managed independently. It will take up to 45 minutes to complete. The CbD assesses reasoning and decision-making, knowledge and understanding, documentation and reflective learning. Before the meeting, the trainee should choose at least three cases, and the assessor may decide which case is most useful for the discussion.

Multi-source feedback (MSF) is a workplace-based assessment tool used once during each of the training periods. Feedback is sourced from a wide variety of colleagues working with the trainee, such as other anaesthetists and other work colleagues, anaesthesia, pain and recovery staff, ward and theatre nurses, midwives and patients. The aim is to obtain a global assessment of professional attributes such

as communication, crisis and resource management and prioritisation. Particularly useful is the assessment of out-of-hours work, where pressures are often greater. A minimum of seven assessment forms should be returned to the supervisor of training.

Benefits to training

Workplace-based assessments are individually formative. Taken together they provide specific and global feedback required for the clinical placement reviews. Obvious benefits include ongoing quality feedback in a structured process. This hopefully ensures consolidation of a trainee's progress, and critically identifies issues early with the ability to form a training plan. From the trainees' perspective, the frequent opportunity for appraisal assists their confidence and ability to self-evaluate and develop core professional skills.

Any Fellow or provisional Fellow of the College may complete workplace-based assessments. In addition, any specialist in an ANZCA-accredited department may perform workplace-based assessments. There are minimum mandatory workplace-based assessments to be completed within each training period; therefore it is important that every member of the department contributes towards trainees' completion of workplace-based assessments.

Continuing professional development credits may be claimed for performing workplace-based assessments, which reflects the importance of the tools with respect to ongoing education, reflection and teaching. The introduction of workplace-based assessment to the revised curriculum will provide the most accurate assessment of trainee performance in a real-time clinical setting.

For further information about the revised training program go to www.anzca.edu.au/training

Sailing to a career high

“You need a lot of mental skill, you need a lot of concentration, patience and perseverance, and an ability never to give up.”



Dr Lyndall Patterson has found parallels between her sailing successes and anaesthesia career, as Meaghan Shaw discovered.

A lifetime of sailing has helped refine the anaesthesia skills Brisbane doctor and Australian Yachtswoman of the Year, Dr Lyndall Patterson, has needed in an impressive career, which has included helping separate two pairs of conjoined twins.

Keen concentration, anticipation and resourcefulness helped Dr Patterson win the 2010 Radial Laser Grand Masters World Championship off Hayling Island, near the Isle of Wight, in the United Kingdom.

In the final heat, the Brisbane anaesthetist overhauled a strong American male contingent, with a report noting her success “once again underlines her outstanding prowess and sheer tenacity”. It was the first time a female sailor won the overall masters title.

The win led to Dr Patterson being anointed the 2011 Australian Yachtswoman of the Year – a title she has just relinquished to Beijing silver medalists. She was also awarded 2011 Queensland Yachtswoman of the Year.

“I enjoy the tactics,” Dr Patterson says of sailing. “Although people might think it’s a physical game, it’s actually quite a tactical game and you need a lot of mental skill, you need a lot of concentration, patience and perseverance, and an ability never to give up.

“And you need to be resourceful because things change, and change quite quickly – either conditions, weather, approaching other boats. You’ve got to actually plan and think ahead and read a situation, read what the wind’s doing, read the clouds, just know what’s going to happen next. And in many ways, there is some parallel with anaesthesia.”

The knowledge Dr Patterson has gained from sailing has proved useful when passing on tips to the hundreds of registrars she has mentored over 16 years

as a supervisor of training (SOT) at the Royal Brisbane and Women’s Hospital, a role she dropped this year as she thought it was time to hand over.

However, she continues to train registrars and remains a rotational co-ordinator, helping to place anaesthesia trainees through central Queensland, a region that stretches from Brisbane to Rockhampton.

Dr Patterson grew up on Sydney’s north shore and began sailing with her younger brother, Michael Coxon, also an accomplished sailor and Sydney-to-Hobart racer, at the Hunters Hill junior sailing club.

At age 11, she won her first Australian title in a sabot dinghy at Gosford in 1966.

In 1977, she won the inaugural World Women’s Sailing Championship, which was also held off Hayling Island, making her return win there all the more special. Other world women’s titles include Holland in 1978, and women’s masters championships in Melbourne in 1999 and Cadiz in Spain in 2003.

She says it was an anaesthesia consultant, Dr Doug Wilson, who first recognised her aptitude for anaesthesia when she was working as a principal house officer at Nambour General Hospital on Queensland's Sunshine Coast. He told her: "I think you'd make a good anaesthetist ... you concentrate well, and you anticipate, and you think well".

"Not many people in medicine give you very positive feedback ever really," she remarks. "So these positive comments sparked my investigation of what I needed to do to become an anaesthetist."

She was 33 at the time, with two young daughters, and hadn't really thought about anaesthesia as a career. She applied for a training position, missed out, but took a punt on a junior job in intensive care at the (then) Royal Brisbane Hospital. Five months later, a training position became available at the hospital, and she began her training.

Dr Patterson uses the experience to encourage aspiring trainees not to give up if they're first rejected for a training position.

"I often say to registrars who haven't started anaesthesia, if that's their passion and they don't get on to a training program initially, their turn will come. Just keep trying. If that's something they want to do, they will get opportunity with time."

Similarly, like many trainees, she took two attempts to pass her primary exam, despite her best efforts. It's another lesson she passes on to trainees to persevere with their studies. "As I say to my registrars, you won't be lucky and pass, but you may be unlucky and fail."

Dr Patterson is a self-effacing and modest leader who has been a mentor to many of the trainees going through the Royal Brisbane and Women's Hospital, as well as at Brisbane's Royal Children's Hospital where she also works. She describes herself as "a good mother figure".

"It's quite a tough challenge to be an anaesthetist and many people find it's the first time they've ever stumbled at an exam or had a knockback in their life and so it's very confronting and can be soul destroying," she says. "It doesn't mean you're a bad person and I think that's where people need support."

Her own mentor was the well-regarded paediatric anaesthetist, Dr John Board, at the Royal Children's Hospital, who helped nurture her passion for paediatric anaesthesia.

"I would be very proud if I could be a John Board clone and many people say, 'Oh, yes. You are a Boardy clone'," she reflects. "He taught me everything I know about paediatric anaesthesia, I think it would be fair to say."

She is a member of the Queensland paediatric anaesthesia liver transplant team and has anaesthetised for more than 30 paediatric liver transplants since 1995. She also was involved in the separation of two sets of conjoined twins at the Royal Children's Hospital in 2000 and 2001.

Her role as a supervisor of training came about because her first consultant job at Brisbane's Royal Children's Hospital was funded by the liver transplant team for only 12 months. She was subsequently offered a job at the Royal Brisbane Hospital, which allowed her to continue pursuing her passion for paediatric anaesthesia at the Royal Children's Hospital, but the trade-off was they were looking for a supervisor of training.

"I had no idea what it involved," she says. "I was told I just needed to sign a few forms, but the role was much bigger than that."

She says training by the College for supervisors has helped. "It's been an enormous learning curve. I've learnt something about education, and I knew nothing about education before I started. I was trained in medicine, not in teaching."

She also has learnt much from the registrars, who help her keep abreast of current articles and opinion. "I'm getting quite a bit of my own personal CME done vicariously through the registrars."

After 16 years in the role, many as the sole supervisor of training, Dr Patterson decided to withdraw earlier this year. Three supervisors of training, plus one being mentored into a future position, now fill the role as training numbers and College requirements have increased.

Her advice to other supervisors of training is: "Promise nothing and be absolutely fair to everybody". By that, she explains, she means listen carefully to all trainees' concerns, but don't be swayed by the more vocal registrars' requests at the expense of those more reticent.

"I think most people would say I have been fair," she says.

Trainee Dr Ben Crooke says Dr Patterson was a great support when he had an issue juggling his work commitments and a long-distance relationship.

"Lyndall was the most understanding person I think I've ever had discussions with in terms of that," he says. "She can see your point of view and tries to the best of her abilities to make things as easy as they can be."

"And inside theatre, she's certainly somebody you want to be around when bad things are happening. She has a calming influence. I think she's seen and done probably everything."

"But in theatre she isn't someone to take over. She's always there to guide rather than to be first in line, which is nice, especially as you're going through your training."

Dr Rudy van der Westhuizen was trained by Dr Patterson and is now one of the supervisors of training at the Royal Brisbane and Women's Hospital.

"The amount of work she's done as a single person is phenomenal," he says. "We've got basically a team of four people, SOTs, taking over from her ... But she hasn't totally dropped off. She's still got her hand in, for which we're grateful because she's got all that experience and she's here for us to ask advice. We're lucky to have her."

Dr van der Westhuizen describes her as "a complete anaesthetist". "She's got a hell of a lot of experience being involved in major paediatric cases ... and liver transplants in Queensland. And she's still maintained that humbleness and approachability even with that experience and status that she's got."

Her humbleness is in evidence as she reflects on her career. "I actually find the sailing's a more interesting part of me than medicine," Dr Patterson says.

"I definitely am an accomplished sailor. I'm not sure that I'm an accomplished anaesthetist, but I probably am. I have done a good job as the SOT and I recognise that."

Opposite page: Dr Lyndall Patterson leading the field in the 2010 masters off Hayling Island.

ANZCA helps boost skills and resources in Papua New Guinea



A recent trip to PNG reveals how ANZCA's Overseas Aid Committee is making a real difference to PNG anaesthesia, writes Meaghan Shaw.

The smile said it all. After living with constant throbbing pain in her arm for five months, 14-year-old Merolyn was finally pain-free.

The little girl from Papua New Guinea's Southern Highlands arrived at the Mt Hagan Hospital with advanced cancer, her left arm swollen with a huge ulcerating Ewing's sarcoma.

The first time ANZCA Overseas Aid Committee Chair, Dr Michael Cooper, met her on a paediatric surgical trip in September, she was lying in bed, withdrawn and depressed.

"She was in severe pain from her arm cancer and was getting absolutely no pain relief, which is a huge problem in developing countries due to no drug availability and very restrictive government policies about opioid use and availability," Dr Cooper said.

"We started her on ordinary regular oral morphine tablets, which made a huge difference. The next day, she was sitting up, walking a little and smiling."

For more than 10 years, Dr Cooper and his surgical colleague from the Children's Hospital at Westmead in Sydney, Associate Professor Albert Shun, have been travelling each year to PNG to perform life-saving operations on children and train local specialists in advanced paediatric surgery and anaesthesia.

Dr Cooper also has made four one-week trips to PNG to help train the country's anaesthetic scientific officers and, as the new head of ANZCA's Overseas Aid Committee, recently visited to provide support and resources for the country's anaesthetic services.

Common problems facing PNG anaesthetists and other health workers include drugs that are out of date or ineffective due to heat exposure, oxygen supplies running out, sterilisers breaking down, unreliable equipment, such as uncalibrated halothane vaporisers, and no disposables, particularly for paediatric

anaesthesia. Rats are sometimes found chewing on drug vials and mosquitoes buzz around the operating theatre.

In the middle of this year, no surgery was carried out for a month other than in emergencies as the drug supply for the whole country had run out. Blackouts also pose constant problems, sometimes due to faulty infrastructure and sometimes due to hospitals not paying their electricity bills.

"I always carry torches in my bag and a headlamp for Albert so we can at least keep going by torchlight," Dr Cooper says.

Then there are the more deep-seated, systemic issues in PNG: a lack of anaesthetists, a lack of training opportunities, and a lack of critical care equipment and facilities, such as intensive care units.

These are not unusual problems in any developing country, but they are ones that ANZCA's Overseas Aid Committee has decided to address.

Overseas Aid Committee support

Formed two years ago, the committee decided to make PNG the focus of its work in developing countries, funding two to three training trips per year, teaching the Essential Pain Management course, offering scholarship opportunities to consultant anaesthetists in PNG and other developing countries, and providing much-needed equipment and resources.

This work builds on the relationship between PNG and the College, which started in 1993 when Professor Garry Phillips began conducting training in PNG and was subsequently appointed Honorary Professor of Anaesthesia at the University of Papua New Guinea. ANZCA Fellows Dr Chris Acott, Dr Wayne Morriss, Associate Professor Roger Goucke, Dr Richard Morris, Dr Roni Kreiser, Dr Michael Stone, Dr Andy Fenton and examiner Dr Terry Loughnan have all been active in providing assistance.

PNG is a country of seven million people, about half of whom are under the age of 15 and 80 per cent of whom live in rural areas. It is one of the few countries in the world where maternal mortality is going up, nearly doubling from 370 deaths per 100,000 live births in 1996, to 733 deaths in 2006.



Above from top left: Merolyn smiling and pain-free after surgery; Dr Michael Cooper and Associate Professor Albert Shun; the first use of the new Lifebox pulse oximeter at Mt Hagen with ASO Mr Londe Kalylia and assistant ASO Mr Frank Bangap.

“This is all about transferring skills and building capability, expertise and experience in the PNG medical system.”

And despite a booming mining-based economy and job creation through the new natural gas liquefaction plant and pipeline, little of the country's wealth flows through to the population, with annual spending on health only about \$A50 per person.

The country has only 15 consultant anaesthetists working in public hospitals, 12 anaesthetic registrars and about 100 non-medically trained anaesthetic scientific officers (ASOs), who complete a one-year diploma and provide the bulk of PNG's anaesthesia services. In some remote rural areas, a rural medical officer with two months' anaesthesia training does both the surgery and the anaesthesia at the same time using a ketamine infusion.

Dr Cooper says for several years, no anaesthetic trainees were coming through the system, partly due to the traditional male culture, which had seen medical graduates gravitating to surgical training to become the “big chief” rather than to anaesthesia, which is seen as more subservient.

“I'm pleased to say since there's been a bit more support for PNG, with the College taking on PNG through sponsorship by the Overseas Aid Committee, there have been more trainees, including female trainees,” Dr Cooper says. “And they're good quality trainees, they're bright, they're motivated and they're doing well.”

In September, Dr Cooper attended the largest-ever annual PNG Medical Symposium, and was the first anaesthetist to address the main meeting of nearly 800 registrants, where he donated on behalf of the College 93 Lifebox pulse oximeters to go to 40 PNG hospitals.

The donation was welcomed as many of the hospitals don't have oxygen monitors or, if they do, the probes don't work as the circuits have burnt out due to power blackouts. The Lifebox pulse oximeters overcome this problem by working on both mains and battery power. One of the pulse oximeters at Mt Hagen had been out of order since July, so the donated ones were quickly put to use during Dr Cooper's surgical visit.

At the Society of Anaesthetists of Papua New Guinea's 25th anniversary meeting held in conjunction with the symposium, Dr Cooper also donated on behalf of the Overseas Aid Committee 40 sets of 11 key anaesthesia textbooks appropriate for developing countries and specifically aimed at the anaesthetic scientific officers. He called this the “Real World Anaesthesia Library”.

Dr Cooper says there is an enormous need for educational support for the ASOs as they earn less than about \$A15,000 a year, work in remote locations and cannot afford to travel. They have poor access to internet or computers, which are often virus ridden, and can't afford expensive textbooks.

“ASOs form the backbone of anaesthesia in PNG,” Dr Cooper says.

“There are over 40 hospitals in the country where surgery is performed, but currently only three hospitals have consultant anaesthetists on staff.

“I think the roll-out of the library will make a big difference to the ASOs doing grass roots anaesthesia out in the little peripheral places because they're the least supported of all, and that's who we're trying to help.

“They really appreciate their educational materials. I noticed today at the hospital one of the ASOs had a drug doses book from the Children's Hospital at Westmead that I gave him about three or four years ago and it's pretty dog-eared and worn and he still carries it every day.”

Training in PNG

One of the reasons for so few anaesthetists is the lack of training opportunities.

PNG Chief Anaesthetist Dr Duncan Dobunaba says there are about 12 medical students showing interest in anaesthesia but the difficulty is finding hospital positions for them and consultants to oversee them. Most of the consultants are concentrated in Port Moresby, where they help train the 10 ASOs and other medical students who graduate each year.

“Most of the current specialists are burnt out,” he says. “We could attract more registrars if we had the training programs in place but the local experience is exhausted very quickly.”

(continued next page)



Above from top right: Mt Hagen paediatric surgeon Dr Ben Yapo, Associate Professor Albert Shun, Dr Michael Cooper and Dr Maria Moguna; the Mt Hagen team in action; Dr Chris Acott and Dr Michael Cooper with PNG's anaesthetists and anaesthetic scientific officers after they have received donated textbooks.

ANZCA helps boost skills and resources in Papua New Guinea

continued

Sending registrars or anaesthetists to Australia for more training is difficult due to the language test required for overseas graduates. One consultant anaesthetist, Dr Arvin Karu, is currently working at the Children's Hospital at Westmead, funded by a Royal Australasian College of Surgeons (RACS) Rowan Nicks scholarship.

Dr Karu called upon the PNG government to better fund training in a letter to the local *Post-Courier* newspaper in September, in which he commended Dr Cooper, Dr Acott and Associate Professor Shun for helping to save PNG lives through their regular trips.

"Many health workers and doctors have also benefited from working with them in terms of acquiring new skills and knowledge," Dr Karu wrote.

"I would also like to suggest to the health department and national government be serious and spend more and invest in manpower training in specialist areas of healthcare where we are lacking in skills and expertise or short in numbers.

"We cannot continue to rely on overseas visiting teams for another 30 years."

Society of Anaesthetists of PNG president and the head of anaesthesia at the University of PNG, Dr Harry Aigeeleng, agrees there is a problem with training places and funding. On average, one consultant anaesthetist graduates each year from the university.

Dr Aigeeleng was the first lecturer in anaesthesia in PNG, initially seconded to work under Professor Phillips in 2003. At the end of this year, after a decade as the sole lecturer in anaesthesia, he will return to private practice. His overwhelming wish is for additional teaching staff at the university and extra help with training.

"I'm really in debt for what the College is doing but I'd really love to have these guys stay more than two weeks!" he says. "I'm really grateful for what ANZCA has done for us through the ANZCA Fellows who come up and support us by providing all the equipment and books. And I'm particularly grateful to those guys who come up on a very regular basis. I hope that other Fellows will consider coming up too."

Mt Hagen surgical trip

The chance of training with visiting ANZCA Fellows is keenly appreciated by the PNG trainees and anaesthetic scientific officers, so Dr Maria Moguna jumped at the chance to accompany Dr Cooper and Associate Professor Shun to Mt Hagen in September.

The pair's annual two-week volunteer surgical trip, funded by AusAID and managed by RACS, helps ensure local doctors and anaesthetists have the skills needed to improve the lives of millions of PNG children.

"This is all about transferring skills and building capability, expertise and experience in the PNG medical system," Dr Cooper said.

Dr Moguna is a shy, reserved PNG anaesthetic registrar so, when tears roll down her cheeks as she discusses the opportunity to work with Dr Cooper, her reaction speaks louder than words. "Truly as registrars it brings tears to our eyes," she says, dabbing her face and apologising. "I'm sorry. I'm not the only one to share this sentiment."

It was fortunate any surgery took place at all since the week before the trip, the hospital's sterilisers had broken down and equipment had to be sent for sterilisation to nearby Kudjip Missionary Hospital, an hour away by a pothole-riddled road.

And the first afternoon of surgery was stopped due to the theatres and nursing staff being needed to treat an influx of patients due to a local tribal fight over the weekend.

Tribal fights, domestic violence and drink driving are some of the most common causes of primary trauma in PNG, along with treating the results of traditional doctors' attempts at bush thoracotomy and craniotomy.

Mt Hagen hospital imposes a 300 kina (A\$150) fine for patients presenting with bush thoracotomy. It also fixes a higher charge for patients with gun or spear wounds (68 kina), but treats women and children injured by tribal fights, or victims of sexual or domestic violence, for free.

The operating theatres, labelled "Haus Katim" in Pidgin English on the building's door, are directly above the hospital's morgue and wailing from relatives waiting to collect bodies is regularly heard during procedures.

About 30 patients are waiting to see the paediatric team at the clinic on the first morning and more come during the week as they hear the team is in town.

Dr Cooper recalls one trip to Rabaul about five years ago when a father and his child had been waiting for a month for him and Associate Professor Shun to arrive.

"The father had brought his child by boat and canoe from some remote area and just waited patiently in the ward for a month for us to walk through the door," he says. "So we absolutely made sure that his child got its operation."

Many of the children waiting have congenital abnormalities and are much older than similar patients in Australia and New Zealand where their conditions would be treated soon after birth. One mother was visibly upset and racked with guilt for not having brought her six-year-old daughter, who had an anorectal anomaly, to see Associate Professor Shun and Dr Cooper earlier.

The girl had a temporary colostomy and an anterior sagittal anorectoplasty to separate the rectum and vagina and can expect a complete recovery.

"Her mum was in tears on our ward round on the last day thanking us for giving her daughter the chance of a normal life as she grew up," Dr Cooper says.

The pair helped oversee many complex surgeries in Mt Hagen, including bowel reconstructions, draining fluid from the brains of babies with hydrocephalus and fixing congenital abnormalities. They performed 25 major and six minor operations.

"One of the operations was a baby with all the bowel born outside of the abdomen, which is a very challenging condition," Dr Cooper said. "Most of these babies, or nearly all of them, die in PNG."

Another case involved resuscitating a newborn baby in foetal distress. The baby died in the neonatal nursery that night, probably due to a lack of ventilation and intensive care support.

“Her mum was in tears on our ward round on the last day, thanking us for giving her daughter the chance of a normal life as she grew up.”

PNG experience

Dr Cooper first went to PNG as a medical student in 1981 for three months, working at Mendi, the provincial capital of the Southern Highlands Province, in one of the most remote and wildest parts of the country.

At the same time, Associate Professor Shun was a surgical registrar in Rabaul. He first returned about 15 years ago because he was concerned that children weren't getting good paediatric surgical care.

“I think it's important for people working at home to understand what third world medicine's about,” Associate Professor Shun says. “You learn to be adaptable and you challenge the dogma that you have. It makes you better thinkers about other ways of approaching a problem.”

Dr Cooper joined him 12 years ago when it was apparent some of the surgeries were beyond the ability of the local anaesthetic services.

“The highlights have been that we've been invited back,” Dr Cooper says. “I think that's a compliment – that what we're doing is beneficial, they give us a lot of support and always line up more work every time we come back.”

Mt Hagen anaesthetic scientific officer Mr Paul Jeff worked alongside Dr Cooper during the trip. “It's a real privilege having Dr Cooper here,” he says. “We can get skills from him and ask a lot of questions.”

Dr Cooper says he enjoys teaching the ASOs the basics and has learnt much about the art of teaching.

“In the operating theatre, it's very much a random teaching exercise depending on the case you're doing and what sort of anaesthetic you're going to give,” he says. “If things are fairly stable and straightforward, I might just pull another topic out of the air and say, ‘What do you know about this?’”

He also passes on tips about general paediatric anaesthesia skills such as inhalational inductions, airway management, getting drips in, monitoring and fluids.

“It's still basic anaesthesia,” he says. “It's not the sophisticated anaesthesia that we're used to in Australia and New Zealand. Most of the drugs that are here are no longer used in Australia, they have a lot of supply problems with oxygen supply, black outs, and disposables, especially for smaller children. Post-operative pain management is poorly done, mainly through fear and a lack of training. I think the EPM courses will certainly make a difference but that will take time.”

For little Merolyn, she had a good night's sleep after Dr Cooper ensured she was given proper medication to relieve the pain from the Ewing's sarcoma during his first ward round. Later that week, most of her left arm was amputated to prevent the cancer ulcerating further and causing more pain and infection.

Dr Cooper said this was essentially a palliative procedure, as the cancer had spread to her lymph nodes and possibly behind her eye. The anaesthetists adapted a catheter from existing equipment, which was placed near the main arm nerves to regularly inject local anaesthetic for two days to prevent pain.

“Merolyn had no pain despite a major amputation of her arm near the shoulder and was sitting up and smiling and said, ‘Thank you for helping me’ when we left her,” Dr Cooper said. “Her long-term outlook was poor but at least she could go back to her village and be cared for by her family in her final illness.”



Above from top right: Surgery at Mt Hagen hospital; a baby with hydrocephalus and a Lifebox pulse oximeter; the tribal welcome at the PNG Medical Symposium's cultural night. Parental consent was obtained to use photos of patients.

Airway management in Papua New Guinea

With incidents ranging from snake bites to road trauma and tribal fights, good airway management is important in PNG.

If you're ever travelling to Papua New Guinea, try to steer clear of the aggressive Papuan taipan. It has an "approach distance" of seven metres, which means it will strike first if you're within a seven-metre radius, probably before you've registered that it's there.

Worryingly, it's six times more potent than the Australian coastal taipan and lives in high concentrations in the heavily populated regions of Port Moresby and the Central Province, feeding on a plentiful supply of rats and mice.

The prevalence and aggressiveness of the Papuan taipan, coupled with PNG's other venomous snakes – the death adder, brown snake and the rarer Papuan black – means that despite advances in first aid and antivenom, the number of snake bite fatalities has risen in PNG.

According to venom expert Mr David Williams, who attended the Society of Anaesthetists of Papua New Guinea's meeting in September and is working on a PNG snake bite project for the Australian Venom Research Unit, the emergency department at Port Moresby General Hospital treats on average 300 to 400 snake bite patients a year, most between December to April. It is not uncommon to see six patients lined up waiting for treatment.

With travel difficult in PNG and a lack of health services, many patients don't arrive at hospital within four hours of a bite, after which antivenom will be ineffective and there is a 75 per cent chance the patient will require intubation. This means that appropriate airway management can be life saving.

The treatment of snake bite victims, resuscitation and appropriate airway management were hot topics at the recent 25th anniversary meeting of the Society of Anaesthetists of PNG, held in conjunction with the largest-ever annual PNG Medical Symposium.



Good airway management is also required when treating the high number of trauma cases presenting to PNG hospitals due to road accidents and tribal fights, as well as for the numerous cases of head and neck cancers caused by high rates of smoking and betel nut chewing. Red splashes of betel nut – chewed-up and spat-out – cover the roads and pavements of PNG like bloodstains.

Royal Adelaide Hospital senior anaesthetist, Dr Chris Acott, has been travelling to PNG two to three times a year over the past 11 years to conduct airway training and to assist an oral and maxillofacial surgeon with head and neck surgery. He's also been involved in diving medicine and the Australian Venom Research Unit.

"Medicine's given me a very privileged life and I see this as giving back," he says.

At the anaesthetic meeting, Dr Acott and ANZCA Overseas Aid Committee Chair, Dr Michael Cooper, conducted difficult airway workshops with fiberoptic intubation as well as oxygen therapy workshops for about 65 of the country's anaesthetists, registrars and anaesthetic scientific officers (ASOs).

Dr Acott sees fiberoptic intubation training as important to build the capacity of the country's anaesthetists and ASOs, who will perform a tracheostomy if they can't get access to a patient's airway.

For the past five years, Port Moresby General Hospital has had the country's only fibroscope in the public health system but it is not used because no one is proficient in operating it.

Dr Acott hopes to change this with training and extra resources. The first fiberoptic intubation by a PNG anaesthetist was conducted in July at Alotau Provincial Hospital by Dr Lisa Akelisi-Yockopua, who has been training with Dr Acott in PNG.

"Ninety per cent of the tracheostomy patients I've seen here in Papua New Guinea over 11 years have all got tracheal stenosis, a narrowing of the trachea," Dr Acott explains.

The resulting scar tissue cannot be lasered like in Australia and New Zealand and can ultimately lead to suffocation.

"And a lot of them have tracheostomies because they haven't been able to open their mouths for operations. If I can teach them (anaesthetists) how to intubate and we can get the instruments ... then I'm hopefully saving many people from having a tracheostomy and the consequences of tracheal stenosis."

An anaesthetic registrar, Dr Elizabeth Inaido-Lee, who participated in the workshops, hopes she will soon be able to use the fibroscope at Port Moresby.

"Dr Acott is the only person who is exposing us to the fibroscope and hopefully with these skills we're learning



from him now we can go back to use the one that's hanging in our theatre," she says.

"We've had a few sessions with Dr Acott before. I can only speak personally. I have applied a lot of the things he's taught us over the months that he's come over and I'm pretty confident of his techniques. I'm excited to apply them. We're all, I think, with a normal patient prepared for normal intubation, the ones we're conventionally used to. But we're hoping to go and now try these skills with the tools that we have available."

Dr Acott first went to PNG as a medical registrar in 1972 and his first case at the Lae hospital was treating a victim of a tribal attack who had a spear through him. Outside, his attacker was waiting to get his spear back.

"It was invaluable training," he says. "It taught me to stand on my own two feet; it taught me to think in situations I'd never been confronted with before and how to work through them."

The regular training visits by Dr Acott and Dr Cooper have led them to be considered "wantoks" – or people who speak the same language as the locals – and their opinion and advice was highly sought after at the anaesthesia meeting.

The best research paper of the symposium was won by an anaesthetist in charge of the intensive care unit at the Port Moresby General Hospital, Dr Greg Tokwabilula, for his paper, "Physiological

function and outcomes in a major intensive care unit in Papua New Guinea". The paper was overseen by Dr Cooper and it was the first time the award was made to an anaesthetist.

It was presented at the symposium's cultural night held in the security of the army barracks, and featuring a welcoming party of tribal warriors, dance performances from various tribes performed on the dusty parade ground and a huge buffet with a roast pig on a spit.

The anaesthesia meeting's presentations also revealed disturbing maternal mortality rates and a lack of awareness of cardiopulmonary resuscitation guidelines, which led to a proposal to set up a PNG resuscitation council, with assistance from Dr Acott and Dr Cooper.

"Whatever we do has to be requested by the PNG anaesthetists," Dr Cooper says. "I don't think it's our role to come in and say you should do this or you should do that. We can only advise or recommend or teach but it's got to be driven by their want and needs."

Meaghan Shaw
Media Manager, ANZCA

"Dr Acott is the only person who is exposing us to the fibrescope and hopefully with these skills ... we can go back to use the one that's hanging in our theatre."

From left to right: Dr Chris Acott providing airway management training; Dr Elizabeth Inaido-Lee; a Papuan black snake; Dr Michael Cooper providing airway management training.

The move: the logistics of moving hospitals



With major new hospitals under construction or planned around Australia and New Zealand, including specialist children's hospitals being built in Perth and Brisbane and mooted for Christchurch, there has been great interest in the new Royal Children's Hospital, Melbourne.

The move

The planning for the new Royal Children's Hospital (RCH) was a monumental task.

The new site, adjacent to the old hospital, allowed free rein to plan from the ground up with design optimising work practices and patient flows as well as taking full advantage of the parkland setting.

There were a series of key planning decisions that facilitated a very smooth move process. Those decisions were very much based on the particular circumstances for the RCH.

The patients would be moved by RCH staff by internal pathways. This was only possible due to the new building being adjacent. The increased complexity if formal patient transport vehicles using external routes were used would have utterly changed the logistics of the occasion.

The move of patients would occur on a single day. The RCH is the designated statewide trauma centre for paediatrics in Victoria and provides other specialised services. Patient care for emergencies and in-patients would need to continue during the move. On the day of the patient move both the old and new hospitals would need to be fully functioning with appropriate staffing, including "MET" teams for medical emergencies in both locations.

For the plan to move all patients on a single day to work, it was clear that months of preparation would be required, with key interventions implemented before the move.

- **Orientation and education.** All staff would have to be appropriately orientated to the new hospital and understand the new work practices, geography, information technology, communications and security before the first patient arrived.

This education was arranged at a hospital-wide level, with staff also educated on new practices specific to their local work areas, divisions and departments. Mandatory generic orientation to the new hospital infrastructure and non-medical emergency procedures was conducted

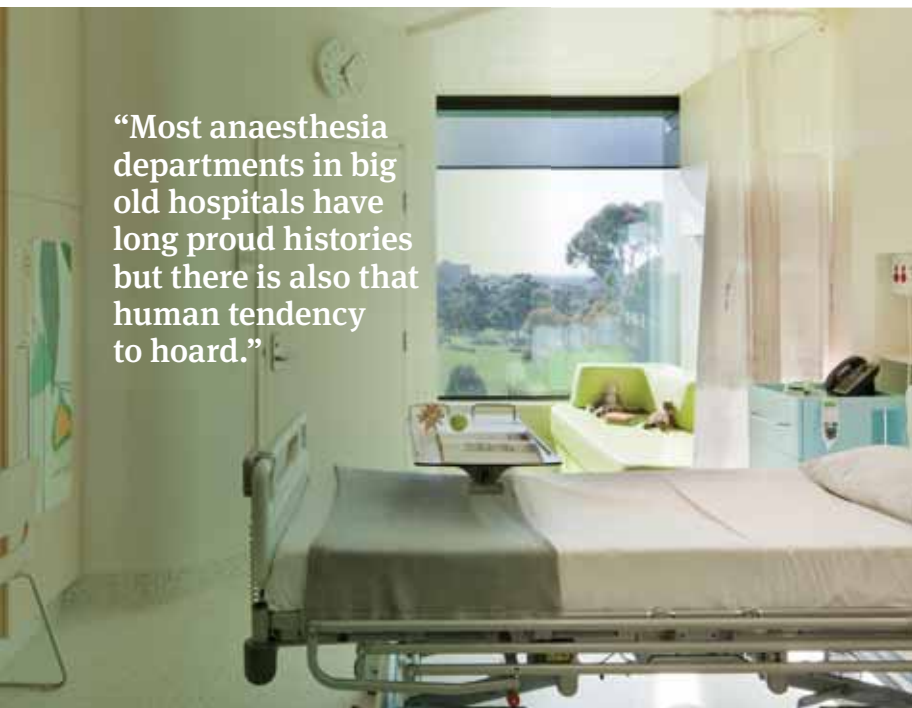
by the staff of the consortium building and managing the new hospital. Staff would only be issued their photo ID (which allows security access) for the new hospital once they had completed their whole-of-hospital orientation. At area and departmental levels, staff were further orientated to local procedures. "Mock" patient moves and clinical scenarios were run to trial the systems and ensure familiarity with the new environment.

- **Staffing.** To achieve orientation and education goals, staffing in the months before the move would have to allow for running the old hospital, education and testing for the new hospital plus "mock move" exercises. The patient move day would require staff for both hospitals plus patient move teams. More than a year before the move, staff were informed that there would be some restrictions on leave around the move to ensure the extra staff required for planning and education.
- **Clinical activity around the move.** To decrease activity on patient move day, and allow adequate staff to be available, a detailed program designed to minimise patient numbers in the hospital on the day of the move, yet also minimise disruption to patient services was formulated.

Opposite page: The new Royal Children's Hospital. Photo: The Royal Children's Hospital, Melbourne

This page below from left: An inpatient room in the new hospital. Photo: Shannon McGrath; Royal Children's Hospital staff formed an impromptu guard of honour as the last patient was moved to the new hospital. Photo: The Royal Children's Hospital, Melbourne

“Most anaesthesia departments in big old hospitals have long proud histories but there is also that human tendency to hoard.”



In the week before the move, and for some time after the move, elective bookings were tapered and cases selected to minimise the number of patients requiring intensive care and inpatient beds when the move occurred.

It was predicted that, even with the best preparation, staff would need time settling into the new hospital and routines, so the tapering of elective admissions did not ramp back up immediately after the move. As some have described it: “It is stressful and difficult when you start work at a new hospital. What gets you through normally, is the fact that the regular staff, familiar with the environment, are the majority. When a whole hospital moves, even with orientation and a team of trained ‘super-users’ and ‘orientees’, everyone is on a learning curve.”

- *Pragmatics of the patient move.* Mock move procedures were designed to be much more than a mere practice run. Data from the mock moves was used to provide the detail for the final plan for patient move day.

Detailed information was gathered about timing of patient and equipment moves and how best to manage a range of issues including how to ensure a safe flow of people in the access corridors between the old and new hospitals; how “MET” responses would be conducted if necessary for moving patients; and how to ensure appropriate security and privacy for patients and families, as the event was clearly going to generate enormous interest from the media and the public.

Security staff played a vital role in achieving a number of these goals. Access to the new hospital was restricted to staff and patients and appropriate members of the patients’ families during the actual move.

- *Mid-week move.* Moving mid-week, on a Wednesday, allowed two full normal working days either side of the move to maximise access to support for last minute issues relating to the transition.

Operating theatres

There would be no elective surgery booked for patient move day. In-patients still being treated in the old hospital could have emergency procedures performed in the old hospital if necessary.

Any surgery commenced overnight before the move could be completed in the old hospital. Patients admitted to

the new hospital, or already transferred, would have any emergency procedures required performed in the new hospital. Staffing in both hospitals would allow for the full range of possible procedures to be performed in either hospital “on the day”. “In-charge” supervisory anaesthesia consultants were in place at both venues.

The procedures for transporting patients were detailed and well planned. These procedures were very clear for ward and critical care patients.

After much discussion about recovery patients, it was decided that no recovery room patients in the old hospital would be transferred directly to the new hospital. All old hospital recovery patients would be transferred to a ward or the intensive care unit in the old hospital and then moved to the new hospital.

Apart from some anaesthesia Fellows who had completed neo-natal intensive care unit (NICU) rotations and who were seconded to assist with NICU patient transfers (having participated in mock patient moves) no other anaesthesia staff had direct involvement in patient transfers from old to new hospital.

At 8am, the old emergency department closed to new patients and the new hospital emergency department opened. Once the last patient in the old hospital was moved, by mid-afternoon, there would be no further direct clinical care provided in the old hospital.

(continued next page)

The move: the logistics of moving hospitals

continued

Some staff moved in the two weeks prior to and after patient move. For example, sterilisation services were relocated to the new hospital before the patient move and some pathology services shifted after the patient move.

Offices

Our departmental offices were moved on the Sunday morning before the Wednesday patient move. Professional movers transferred staff office content (mainly papers) using crates supplied to staff prior to their move. Essentially there was a box per full-time consultant and a few “extra” for the department.

Most anaesthesia departments in big old hospitals have long proud histories but there is also that human tendency to hoard. We had detailed information about our new offices and staff and storage space which were as close as possible to the new theatres but still consistent with the new hospital model of separating office and clinical areas.

The infrastructure of the new hospital would be managed by the consortium that had won the public private partnership bid. This did mean that the accreted memorabilia of decades that had accumulated in a department could

not be assumed to have storage or wall space in the new hospital. It was a great incentive for a monumental spring clean.

Essentially, we had enough storage space for what was mission critical (and a bit more) and there are systems in place where permission to hang historic photos and similar can be sought.

The hospital provided access to efficient scanners and, where possible, scanned department documents were saved on the new hospital servers and originals appropriately disposed. Other documents were scanned but the originals stored off-site. Surprisingly few documents have needed to be kept in the department in hard copy.

A previous weakness in our IT for many staff was the tendency to use “their” local computer hard disk for electronic storage of key documents which were not routinely backed up and data lost if the local hard disk crashed. The new hospital system allowed all staff to transition to having their own secure central server space which can be accessed by personal logon from any intranet computer. These off site servers are backed up regularly so data is now more accessible and there is a lower risk of data loss.

Conclusion

There is a lot more to building a new hospital than having a successful patient move day, but it made a big difference to the transition that the actual move was well planned.

All patients including the critical care high risk patients were safely moved. The less critically ill patients and accompanying family members appeared to actually enjoy their move, appreciating that they were part of what was clearly an historic occasion.

The staff, similarly, had a strong sense of contributing to what, for most, will be a once in a lifetime opportunity with a huge multidisciplinary team unfolding a complex plan with great success.

Dr Ian McKenzie

Director, Department of Anaesthesia and Pain Management
Royal Children's Hospital, Melbourne

The author would like to acknowledge the support of RCH Corporate Communications in the preparation of this article.

ANZCA announces 2013 funding for medical research



The ANZCA Council has approved the funding of \$A1,054,691 through the Anaesthesia and Pain Medicine Foundation for research projects in 2013. The funding supports 16 project grants, including a scholarship grant for a PhD student; two continuing project grants; one novice investigator grant; one simulation/education grant; two academic enhancement grants; the Douglas Joseph Professorship and the Pilot Grant Scheme.

These important research initiatives will be carried out in leading hospitals and universities in Australia, New Zealand and Hong Kong and will continue to advance and maintain a high international standing in safety and quality patient care in anaesthesia, intensive care, perioperative medicine and pain medicine.

Research awards

The **Harry Daly Research Award** has been awarded to **Associate Professor Brendan Silbert** for his project "Continuation of long term anaesthesia cognition evaluation (LOTACE Study)".

The **John Boyd Craig Research Award** has been awarded to **Clinical Associate Professor Nolan McDonnell** for his project "Evaluation of the safety of intrathecal administration of magnesium sulphate in a sheep model".

The **Mundipharma ANZCA Research Award** has been awarded to **Professor Matthew Chan** for his project "Vascular events in noncardiac surgery patients cohort evaluation (VISION): Ntpro-BNP study".

The **St Jude Medical ANZCA Research Award** has been awarded to **Associate Professor Philip Siddall** for his project "Levels and associations of existential distress in people with persistent pain".



Douglas Joseph Professorship

ANZCA congratulates Professor Britta Regli-von Ungern-Sternberg (above) for the award of the quadrennial Douglas Joseph Professorship for 2013. This prestigious award is open to Fellows of the College in Australia, New Zealand, Hong Kong, Malaysia or Singapore who are making an outstanding contribution to the advancement of the speciality to pursue scholarship and research in human anaesthesia. The tenure of the professorship is one year and Britta will hold the courtesy title 'Douglas Joseph Professorship of Anaesthesia'.

Britta was appointed as the first Chair of Paediatric Anaesthesia at the University of Western Australia in Australasia in 2010. Following her anaesthesia training in Switzerland, she came to Perth in 2007 working as a consultant anaesthetist in the Department of Anaesthesia and Pain Management at the Princess Margaret Hospital for Children.

In the past five years, Britta has been an invited speaker at 18 international meetings and 10 national meetings. She is a member of the editorial advisory board of Paediatric Anaesthesia and is a reviewer for 10 international peer review journals in Anaesthesia, Respiratory Medicine, Pediatrics and Critical Care. She has published three book chapters and 70 peer-reviewed articles. In addition, Britta supervises advanced medical science students at the University of Western Australia and Princess Margaret Hospital for Children as well as anaesthesia trainees for their mandatory and elective research modules.

*Above from left: Professor Michael Reade;
Associate Professor Marianne Chapman (right).*

Her main research interests relate to the prediction and prevention of respiratory complications in paediatric anaesthesia, lung function changes during anaesthesia, the evaluation of different airway devices, as well as the impact of anaesthesia in early life on a child's neurodevelopment. Most of her projects are performed within a large international collaborative network consisting of paediatric anaesthetists, intensivists, respiratory physicians, psychologists and pain specialists.

The Douglas Joseph Professorship emolument will assist Britta in pursuing one of her proposed studies, which involves assessing the utility of exhaled nitric oxide measurements in children at a particularly high risk for respiratory complications in comparison to a well control group. This non-invasive measurement tool has the potential to help clinicians identify children at a particularly high risk for respiratory complications, which may enable anaesthetists to optimise the child's individual management perioperatively.

Britta will deliver the Australasian Visitor's Lecture at ANZCA's Annual Scientific Meeting in Singapore in 2014 as part of the Douglas Joseph Professorship.

Academic enhancement grants

Transcriptional regulation of chronic post-surgical pain

\$90,000

In a series of studies using cellular and whole animal models, the investigators plan to characterise the roles of peroxisome proliferator-activated gamma coactivator 1 α (PGC1 α) and p300/CREB-binding protein association factor in the production and modulation of chronic post-surgical pain. They will also determine the clinical relevance of these molecules by conducting a genome association study to identify the related genetic variations for the development of chronic pain in a large cohort of patients undergoing a wide spectrum of surgery.

The investigators hypothesise that PGC1 α and PCAF are important transcriptional regulators that modulate the expression of downstream pro-nociceptive genes for the initiation and maintenance of chronic postsurgical pain. Furthermore, polymorphisms of these genes are associated with higher risk of chronic pain after surgery.

The expected findings will direct development of preventative and therapeutic strategies and will enhance our ability to identify patients at risk for chronic post-surgical pain. The social and economic benefit to patients, their families and society as a whole in terms of decreasing the number of patients who are disabled by chronic pain after surgery will be significant.

Professor Matthew Chan, the Chinese University of Hong Kong, China.

Evaluation of cryopreserved platelets for the treatment of perioperative haemorrhage

\$85,646

Platelet transfusion is an essential component of life-saving coagulation management. However for logistical reasons and in order to optimally use this scarce resource, platelets are not stored in smaller hospitals or in deployed

Australian Defence Force (ADF) field hospitals. Platelets must be used within five days of donation or else discarded. At present around 29 per cent of donated platelet units are wasted because they exceed their shelf life.

Cryopreservation, a technology developed by the US Navy, allows platelets to be frozen and stored for up to two years. This technology may allow smaller hospitals to provide platelet transfusions, reduce overall platelet wastage and possibly produce better patient outcomes through more effective haemostasis. Deployed by the Dutch armed forces, cryopreserved platelets have recently been given to Australian soldiers in NATO hospitals in Afghanistan, with seemingly good effect. However, the evidence supporting the effectiveness and safety of frozen platelets is limited to animal studies and a single clinical trial involving 73 patients. There is currently insufficient to justify a change in Australian clinical practice or regulatory approval.

The Australian Red Cross Blood Service has conducted extensive evaluation and optimisation of this military technology, and now has a product ready for a definitive clinical trial. The ANZCA-supported program of research will have both clinical and preclinical components. The safety and efficacy of cryopreserved platelets will be evaluated in a pilot clinical trial in bleeding surgical patients. Mechanisms of clot formation with cryopreserved and conventional platelets will be assessed in a sheep model of traumatic haemorrhage.

The ultimate outcome of this program of research will be to demonstrate the utility and cost-effectiveness of cryopreserved platelets, compared to conventional liquid-stored platelets, for use in the management of active bleeding. If this approach is found to be effective, there is a high likelihood that many lives will be saved and resources more efficiently managed, particularly in outer metropolitan, rural and remote Australian hospitals and amongst ADF personnel.

Professor Michael Reade, Australian Defence Force, University of Queensland and Royal Brisbane & Women's Hospital.

ANZCA announces 2013 funding for medical research continued



Project grants

Continuation of Long-Term Anaesthesia Cognition Evaluation (LOTACE) study

\$36,795

Changes in memory and thinking are known to occur after surgery and anaesthesia, especially in the elderly, but the full extent of these changes over the longer term has not been studied. Since over a million anaesthetics are administered in Australia every year to individuals over 60 years old (those at risk), the investigation of cognition changes after anaesthesia and surgery is an important problem with far-reaching implications.

This project is a continuation of the “Long-term anaesthesia cognition evaluation (LOTACE) study”, which received funding to commence in 2012 to investigate the incidence of very mild or mild dementia in elderly patients two years after they have undergone anaesthesia and surgery for total hip joint replacement. Recent evidence, based on animal studies and the investigators’ preliminary clinical studies, has shown that cognitive dysfunction after anaesthesia and surgery may not be limited to short-term post-operative cognitive dysfunction (POCD) but may be the forerunner of dementia in the long-term. Taken together, these studies provide a sound case for investigating if dementia follows anaesthesia and surgery at two years.

In addition, recent advances in the understanding of Alzheimer’s disease, based on cerebrospinal fluid (CSF) analysis, allows the opportunity to not only investigate whether a CSF profile

can predict POCD, but also whether Alzheimer’s disease pathological processes are implicated as the cause of POCD and subsequent dementia.

Therefore identification of the extent and severity of cognitive changes after anaesthesia and surgery is an important step in ameliorating the problem. If spinal fluid analysis is able to identify those at risk, this would allow the use of therapies for Alzheimer’s disease to be used in conjunction with anaesthesia to help prevent this problem.

**Associate Professor Brendan Silbert,
Associate Professor David Scott,
St Vincent’s Hospital, Melbourne.**

Vascular events In noncardiac Surgery patients cOhort evaluation (VISION): NTpro-BNP study

\$60,000

Current models using preoperative clinical factors are inadequate to predict adverse vascular outcomes after noncardiac surgery. There is now compelling evidence from non-surgical population, as well as encouraging data from our systematic review, that measurements of the N-terminal fragment of brain natriuretic peptide (NT-proBNP) may indicate major post-operative vascular complications. The investigators believe that perioperative monitoring of NT-proBNP will facilitate timely identification of the vulnerable patients at risk of developing a serious adverse event. This will provide the earliest opportunity for perioperative physicians to optimise patient management and will help to prevent devastating post-operative vascular complications.

The primary aim of this study is to determine the prognostic significance for NT-proBNP measurement to predict major vascular complications at 30 days and one year after noncardiac surgery. As a secondary aim, a two-stage analysis will be performed to determine the threshold concentration of NT-proBNP beyond which there is an increased risk of post-operative vascular complication.

The findings of this study will be of considerable social and economic significance. If this study confirms the utility of NT-proBNP as an indicator of early myocardial injury, this should instigate a fundamental change in the practice of perioperative medicine around the world to incorporate monitoring of NT-proBNP into routine post-operative care.

**Professor Matthew TV Chan, The
Chinese University of Hong Kong,
Prince of Wales Hospital, Hong Kong**

A randomised clinical non-inferiority trial of equipotent phenylephrine and metaraminol infusions at the time of spinal anaesthesia for elective caesarean delivery

\$29,913

Caesarean section is one of the most commonly performed procedures in Australia and many other countries. Approximately 90 per cent of all caesarean deliveries in developed countries are conducted under regional anaesthesia. Due to the high incidence of maternal hypotension in this clinical situation, it is routine to use a sympathomimetic drug to support the blood pressure.

This area of study is of primary relevance to the practice of obstetric anaesthesia. Over the past decade ephedrine has

been largely replaced by phenylephrine because it is more effective in preventing maternal symptoms associated with hypotension and it results in better neonatal acid-base status. Metaraminol shares similar pharmacological properties with phenylephrine, but has had minimal investigation in the obstetric population.

In pregnancy there are no human data comparing phenylephrine and metaraminol, both of which appear preferable to ephedrine for most obstetric patients having spinal anaesthesia for caesarean delivery. The study will compare these two well-known sympathomimetic drugs with respect to neonatal and maternal outcomes. Should metaraminol be found to be non-inferior to phenylephrine, this would support its suitability in this setting and further validate another commonly available drug.

Professor Michael Paech, the University of Western Australia, Clinical Associate Professor Nolan McDonnell, King Edward Memorial Hospital for Women, Western Australia.

Evaluation of the safety of intrathecal administration of magnesium sulphate in a sheep model

\$58,563

Magnesium is a naturally occurring substance in the body, which has demonstrated analgesic properties. Of particular relevance for pain management is that magnesium blocks a specific receptor, the N-methyl-D-aspartate receptor, which is important in acute pain and in the prevention of chronic pain. Hence there is the potential benefit for both acute and chronic postoperative pain by targeting this receptor in the perioperative period. However, this receptor is difficult to target at the spinal cord level with traditional treatments. A paucity of data precludes its widespread clinical use, especially in regards to potential neurotoxicity and safety that need to be addressed in an animal model prior to conducting a large-scale clinical trial.

This is a two-part study examining for potential clinical and neurotoxicity in sheep. In the first part of the study, sheep will have escalating daily doses of intrathecal magnesium sulphate administered. These sheep will be assessed for clinical evidence of toxicity

and the cerebrospinal fluid levels of magnesium will be determined to provide pharmacokinetic data. In the second part of the study, sheep will have three intrathecal injections of magnesium at doses at, and just above, those that are planned to be used clinically. At the completion of the study, the investigators will examine the spinal cord and surrounding structures of the sheep for evidence of any neurotoxicity.

This study has a number of potential benefits, the major being that the information provided will assist with the ethical approval for the commencement of clinical studies. In addition, the study will provide pharmacokinetic data on the distribution of intrathecally administered magnesium and also provide evidence of the dose range where clinical toxicity may be demonstrated, which will assist with future dose estimations in humans.

Clinical Associate Professor Nolan McDonnell, King Edward Memorial Hospital for Women, Professor Michael Paech, the University of Western Australia.

Levels and associations of existential distress in people with persistent pain

\$51,510

This project focuses on an area of research that has received much attention in the wider medical community, but so far very little attention in the field of pain medicine. Existential distress describes the profound loss of a sense of meaning and purpose that accompanies physical and psychological trauma that threatens a person's identity and sense of self. It is a contributor to overall suffering and has been demonstrated to be linked to deep feelings of isolation, hopelessness, helplessness and a desire to end life. Although widely recognised in the palliative care and other domains, there is very little information available about the issue of existential distress in people with persistent pain.

The study will use a sample of convenience design, examining three sample groups: one with persistent non-cancer pain; one with advanced cancer and a sample of age and gender matched healthy controls. Correlational analysis will be performed to determine associations between existential distress and other variables.

Determining the levels of existential distress in people with persistent pain and how it is related to pain intensity and functioning has the potential to help understand the extent to which it contributes to pain. This understanding will be directly applicable in informing and providing direction in targeting this component which preliminary information suggests is a major contributor to overall suffering.

Associate Professor Philip Siddall, Dr Melanie Lovell, Greenwich Hospital, NSW.

A life-cycle assessment of reusable and single-use laryngoscopes

\$10,200

There is a growing interest in the financial and environmental costs of healthcare in the setting of fiscal constraints and climate change. Life-cycle assessment (LCA) is a scientific method that models financial and environmental costs of a product over its whole life cycle. LCA has often been performed in industrial settings, but rarely in medicine. Previous LCA studies by the investigators have shown conflicting environmental and financial costs for reusable versus single use variants of drug trays and central venous catheter insertion kits. Laryngoscopes are used extensively within anaesthesia to provide appropriate safe intubations and can be reusable or single use. This study will examine the life cycles of reusable and single-use laryngoscopes.

Knowledge of both the financial and environmental costs of reusable and single-use laryngoscopes will aid anaesthetists in choosing a device in an informed manner. Ultimately a series of life cycles of anaesthetic equipment, drugs and processes is envisaged to develop a scientific foundation to a more sustainable anaesthetic practice.

Dr Forbes McGain, Western Hospital, Professor David Story, The University of Melbourne, Melbourne.

Opposite page from left: Professor Michael Paech; Dr Kelly Byrne; Dr Forbes McGain.

ANZCA announces 2013 funding for medical research continued



Pharmacokinetic-Pharmacodynamic modelling of sevoflurane

\$80,000 including scholarship

The investigators aim to create a pharmacokinetic-pharmacodynamic model for sevoflurane and examine some likely covariates that may affect the relationship between end-tidal anaesthetic concentration and resulting arterial concentrations and central nervous system effects.

There has been little human research conducted on the relationship between end-tidal volatile anaesthetic concentrations and the resulting arterial concentrations and no studies of the relationship between arterial concentrations found and resulting anaesthetic depth. This study will be a clinical study of patients during operations and therefore be of direct relevance to every-day anaesthesia. The study will inform the debate on the accuracy of modern processed EEG monitors such as bispectral index as well as improving our understanding of the relationship of age, sex, ASA status, obesity and poor respiratory function on resulting anaesthetic depth using anaesthetic vapours.

Associate Professor Timothy Short, Professor Gil Hardy, Associate Professor Simon Mitchell, Dr Robin Kang, Research Fellow, University of Auckland.

The investigation of novel endothelin receptor antagonists and nitric oxide stimulators in the treatment of pulmonary hypertension and right heart failure

\$56,880

A critical area of pharmacological research is the development of new therapy directed at the pulmonary circulation. This is particularly relevant for the treatment of pulmonary hypertension and right heart failure where patients with these conditions continue to have significant morbidity and mortality.

This study aims to investigate and compare the effects of novel selective and dual endothelin receptor antagonists on pulmonary vascular tone and right heart failure. The effect of simultaneous nitric oxide stimulation, using a Guanylate cyclase stimulator, will also be investigated. The investigator hypothesises that the effect of endothelin antagonism on the pulmonary circulation and right heart will be enhanced by nitric oxide pathway stimulation.

This research has wide application with the potential to treat patients with pulmonary hypertension, occurring either acutely during cardiac surgery and critical illness, or in chronic pulmonary disease states.

Dr Paul Soeding, The University of Melbourne.

Preoperative predictors of early post-operative adverse events

\$33,000

There is a significant incidence of adverse events in the early post-operative period, yet interventions such as extended recovery rooms, ward outreach teams and high dependency/intensive care units can have an important impact on patient outcome. In the face of finite resources and variable access to specialised post-operative care, early identification of at-risk patients is important to provide targeted interventions/care for those most likely to benefit.

The aim of this study is to use key patient and surgical data to develop a model that identifies at-risk patients. The specific hypothesis is that a model will have sufficient specificity and sensitivity to have clinical utility as an early triage tool to assist clinicians direct patients to care pathways best matched to their needs. Over a six-month period, data will be collected on 2000 patients having elective non-cardiac surgery involving post-operative admission to hospital. Data on serious adverse events in the recovery room and post-operative wards will be collected using data collection forms in recovery, hospital databases and case notes.

Mechanisms for early identification of at-risk patients and direction to specialised care, matched to need, will potentially reduce post-operative complications and enhance the efficient use of healthcare resources.

Professor Guy Ludbrook, Associate Professor Arthas Flabouris, Dr Thomas Painter, Royal Adelaide Hospital, South Australia.

Above from left: Clinical Associate Professor Nolan McDonnell, Associate Professor Arthas Flabouris, Professor Guy Ludbrook and Dr Thomas Painter; Associate Professor Philip Peyton; Associate Professor Philip Siddall.

The Augmented versus Routine approach to Giving Energy Trial (TARGET) in intensive care: a feasibility study

\$34,300

It is widely believed that adequate nutrition is important for optimal clinical outcomes following critical illness. The enteral route is favoured based on clinical evidence, but it is well documented that nasogastric delivery of nutrition frequently does not meet energy goals.

The aim of the proposed feasibility study is to provide baseline data to allow for the planning and funding of a larger multi-centre trial to determine if the delivery of additional energy to critically ill adults over the first 10 days of their ICU stay affects clinically important outcomes.

The primary aim of this feasibility study is to determine if additional energy can be successfully delivered to critically ill adults via the nasogastric route using the simple technique of increasing the energy concentration in the nutrient formulation. All management of the nutrient delivery will remain the same. The investigators hypothesise that the delivery of a concentrated formulation at the usual rate for a normo-caloric formulation will result in the delivery of more energy to the critically ill, mechanically ventilated adult than the normo-caloric formulation. This will determine if adequate separation of energy 'dose' between the two groups occurs. This feasibility trial will also provide information on the mortality rate of the study group as 90-day mortality will be the primary outcome in a larger study. The trial will also provide information to optimise study design of a large multi-centre trial (potential recruitment rate, estimated treatment effect size and baseline mortality and sample size). In addition information provided by this study will allow us to modify the study protocol, and provide preliminary data to strengthen a planned grant application for a multi-centre trial. It is extremely important to provide this crucial information to guide the safe and effective prescription of nutrition to critically ill patients in the future.

Associate Professor Marianne Chapman, Dr Adam Deane, Royal Adelaide Hospital; Associate Professor Sandra Peake, the Queen Elizabeth Hospital, Adelaide; Associate Professor Andrew Davies, the Alfred Hospital, Melbourne.

Determinants of urinary output response to intravenous frusemide in patients with acute kidney injury

\$36,000

Acute kidney injury (AKI) is very common in patients after major surgery or with critical illness, and is associated with significant attributable morbidity and mortality. Large doses of intravenous frusemide are widely used to increase urine output in patients with AKI. This traditional way of managing AKI with large doses of intravenous frusemide largely stems from a lack of understanding about the determinants of urinary output response to frusemide in patients with AKI. Evidence suggests that excessive frusemide may in fact be harmful, including inducing ototoxicity and increased risk of renal impairment. Furthermore, using large doses of frusemide to delay dialysis may also be associated with a higher mortality in severe AKI than early dialysis.

By defining the determinants of urinary output response to frusemide and its pharmacodynamics and pharmacokinetics in patients with AKI, this study will contribute significantly to the current understanding of the pathophysiology of AKI.

This research will provide vital scientific data as to the possible roles of frusemide in AKI, potentially changing clinical practice in managing patients with AKI.

Clinical Associate Professor Kwok-ming Ho, Clinical Professor Tomas Corcoran, Royal Perth Hospital; Professor Jeffrey Lipman, Dr Jason Roberts, Royal Brisbane and Women's Hospital; Professor Anne Barden, Professor Trevor Mori, University of Western Australia.

Antibiotic, sedative and analgesic drug pharmacokinetics during extracorporeal membrane oxygenation (ASAP-ECMO) – understanding altered pharmacokinetics to improve patient outcomes

\$35,000

Extracorporeal membrane oxygenation (ECMO) temporarily supports patients with severe cardio-respiratory failure who have failed maximal conventional treatment. As ECMO is a supportive therapy, effective drug treatment directed at reversing the underlying disease process is critical to ensure a successful outcome. Substantial changes in equipment, techniques and duration of support have occurred. The investigators have demonstrated that ECMO further affects drug pharmacokinetics (PK) in the most severely ill patients who already have significant PK changes due to the effects of critical illness. It is therefore important that the factors that affect drug PK during ECMO are studied to reduce therapeutic failure and drug toxicity and improve patient outcomes.

Currently there are limited data to guide clinicians in prescribing many widely used medications for patients on ECMO. This increases the chances of therapeutic failure and drug toxicity. This study will help to deliver better sedative and antibiotic drug protocols for patients who receive ECMO. Optimal sedation and antibiotic therapy in critically ill patients is known to improve outcomes and this study will assist clinicians in achieving this goal. This will broaden the scope of this life-saving technology to many more patients with severe heart and lung disease.

The aims of this study are firstly to develop population PK models for antibiotic, sedative analgesic drugs and their relevant metabolites in critically ill patients receiving ECMO and, secondly, to develop guidelines for optimising the use of medications during ECMO.

Dr Daniel Mullany, Dr Kiran Shekar, Professor John Fraser, The Prince Charles Hospital; Dr Jason Roberts, Royal Brisbane and Women's Hospital; Professor Maree Smith, The University of Queensland, Australia.

ANZCA announces 2013 funding for medical research continued

Anaesthesia exposure in early childhood: long-term effects on cognition and neurodevelopment

\$30,000

The safety of anaesthesia exposure in young children has been questioned after the discovery of apoptotic neurodegeneration in immature animals exposed to anaesthesia. Long-term neurocognitive changes, including deficiencies in learning, memory, motor activity, attention and behaviour have been identified after anaesthetic exposure in animal models.

The aim of the study is to determine whether there is an association between anaesthesia exposure in early childhood and subsequent long-term neuropsychological deficits. The study will also be examining whether there is a minimum duration of anaesthetic exposure required for neurocognitive impairment to occur. The investigators propose to perform an analysis of an existing prospective birth cohort to determine the relationship between anaesthetic exposure in children under three years old and neurocognitive outcomes at age 10, after adjusting for comorbid disease. The study will use data from the Western Australian Pregnancy Cohort (Raine) Study based at the Telethon Institute for Child Health Research in Perth, which was established in 1989 to look at the effects of ultrasonography in pregnant women. The study continues to follow up the children, who are now adults, examining a number of factors addressing life events, health and behaviour. To supplement the data in the Raine database, medical and anaesthesia records will be obtained and analysed at Princess Margaret Hospital for Children, Perth, WA.

This study will further investigate whether early anaesthesia exposures are associated with long-term neuropsychological deficits. This may identify further areas for research and may aid in decision making by doctors and parents as to the optimal timing of elective surgery.

Professor Britta Regli-von Ungern-Sternberg, Dr Mary Hegarty, Princess Margaret Hospital for Children, Western Australia.

Investigation of the effect of anaesthetic choice on ventilation-perfusion scatter and lung gas exchange using the MIGET

\$30,000

Deterioration in the efficiency of lung gas exchange is universal in patients under general anaesthesia and can be life-threatening in patients with critical impairment of lung function. A variety of mechanisms contribute to this including changes in airway resistance and lung compliance and hypoventilation. However the major contributor to this impaired gas exchange is increased ventilation-perfusion (V/Q) scatter, which produces wider alveolar-arterial gradients for oxygen and carbon dioxide. In patients with severely impaired lung function, morbid obesity or during laparoscopic surgery, this can present a significant challenge to the anaesthetist in maintaining physiological homeostasis.

The aim of this study is to compare the changes in V/Q distribution and matching in patients that follow establishment of general anaesthesia in patients randomised to inhalational anaesthesia with sevoflurane, with those found in patients randomised to propofol TIVA, using the multiple inert gas elimination technique (MIGET). This will be correlated with measured indices of gas exchange in each group.

The investigator's primary hypothesis is that the increased V/Q scatter in patients, which accompanies general anaesthesia with sevoflurane is significantly worse than that seen with intravenous anaesthesia with propofol as measured using the MIGET. This will be tested in patients with both normal and severely impaired lung function undergoing surgery.

The information gained from this study will improve understanding of the comparative pharmacology of the modern anaesthetic agents, and of the physiological changes occurring in laparoscopic surgery. It will also provide useful data to the anaesthetist in their choice of agent for optimal management of patients with impairment of gas exchange or lung function undergoing major surgery.

Associate Professor Philip Peyton, Austin Health, Melbourne.

Tramadol vs morphine for refractory post-operative pain in the recovery room

\$10,000

The proposed study is to recruit patients from the recovery room who have ongoing pain despite receiving postoperative morphine. These patients would be randomised to receive either tramadol or further morphine for their ongoing pain. The primary outcome measure would be time from first administration of study drug to readiness for discharge from the recovery room. Secondary outcome measures would be pain scores while in the recovery room, total time spent in the recovery room and the presence of opioid-related side effects.

There is little evidence as to the best way to treat refractory post-operative pain in the recovery room. This study aims to compare these two commonly used and widely available medications and its results will guide anaesthetists to the optimal strategy for these patients.

Dr Kelly Byrne, Professor Jamie Sleigh, Dr John Barnard, Waikato Hospital, New Zealand.

Hyperbaric Oxygen to Treat Radiation Induced Xerostomia (HOTRIX)

\$30,000

Xerostomia is a common and often painful and unpleasant side effect to radiation therapy for patients with cancer of the head and neck. It leads to a multitude of unpleasant symptoms and puts patients at risk of developing risk factors for osteoradionecrosis. Xerostomia is a globally recognised problem, which has no recommended treatment other than prevention. Hyperbaric oxygen therapy (HBOT) may offer one. The specific aims of this study are to conduct a randomised controlled trial of HBOT to treat radiation induced xerostomia in order to demonstrate increased saliva flow, reduced symptoms and improved quality of life. Secondly, to demonstrate that HBOT converts pathogenic bacterial community in the oral micro environment into a normal community.

Dr Susannah Sherlock, Associate Professor David Reid, Associate Professor Robert Webb, Dr Alan Bourke, Royal Brisbane and Women's Hospital, Queensland

Novice investigator grant

Improving anaesthesia techniques in cancer patients as a modulatory pathway to improving cancer outcomes.

\$19,764

This project seeks to quantify the behaviour of the lymphatic system during the perioperative period in patients undergoing cancer surgery. Knowledge of the lymphogenic spread of cancer is well established and it is likely that lymph flow may increase during surgery. It is important therefore, to improve understanding of the behaviour of lymphatics at the time of surgery and whether anaesthetic techniques can minimise the spread of tumour cells during the time of cancer treatment.

Recent scientific evidence from the Peter MacCallum Cancer Centre has shown that cancers associated with high rates of recurrence release hormones that increase the flow in lymphatic vessels. These hormones are released in greater amounts during the time of surgery. Interestingly, the behaviour of lymphatics under spinal/epidural anaesthesia has never been studied in humans. A team of researchers from the Department of Anaesthetics, Radiation Oncology and Diagnostic Imaging at the Peter MacCallum Cancer Centre will investigate whether anaesthetic techniques can minimise lymphatic flow and therefore the spread of tumour cells at the time of cancer resection. The investigators hope to build on the knowledge of the lymphatic system to research methods that inhibit these hormones increasing lymphatic flow.

The potential implications of this research are far reaching and may modify the anaesthetic techniques for all forms of cancer surgery in an attempt to reduce patients' perioperative morbidity and reduce their long-term risk of cancer recurrence.

Dr Jonathan Hiller, Peter MacCallum Cancer Centre, Melbourne.

Simulation/education grant

Anaesthetic call-out as a predictor of medical management in a simulated OR with a complete OR team

\$29,620

Failures in teamwork and communication have been found to make a substantial contribution to adverse events and suboptimal care. Shared understanding is important for co-ordinated teamwork, and it seems that sharing of information by way of a call-out would enhance shared understanding in the operating room (OR).

The investigators aim to determine whether an aspect of teamwork predicts medical outcome, specifically, whether the quality of an anaesthetist's communication to the team (referred to as a call-out) following an intra-operative crisis predicts the quality of medical management in a simulated surgical case.

The study will use observational methodology and video-recorded simulations to quantify team communications involving information sharing between anaesthetists, surgeons and the rest of the OR team at the time of an unanticipated critical anaesthetic event. The anaesthetist's call-out and the teams' medical management of the case will both be scored according to quantitative metrics. The investigators also aim to catalogue the kinds of responses that other team members make to team-targeted communication by the anaesthetist. The scores for call-out will be correlated with measures of medical management, and high scores investigated with qualitative analysis of transcript data to establish effective patterns of behaviour.

Associate Professor Jennifer Weller, Professor Alan Merry, University of Auckland, New Zealand.

Grant review process

Thank you to all reviewers who reviewed a grant, and in some cases two, for your invaluable contribution to the Foundation's grant application review process. The ANZCA Research Committee is extremely grateful for your assistance.

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

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

For the research committee members and grant reviewers for the 2013 grant round visit www.anzca.edu.au/fellows/Research/anzca-research-information.html

Foundation grants leverage government research funding



The Anaesthesia and Pain Medicine Foundation's distribution of \$A861,000 for research projects this year and just over \$A1 million for projects in 2013 is still a relatively small investment in medical research funding terms.

Yet these foundation grants are having an increasingly significant impact on advancing anaesthesia and pain medicine by leveraging large grants for follow-on studies.

There is a strong connection between many of the foundation's research grants and the dramatic emergence of ANZCA Fellows as successful applicants for large government grants and fellowships involving major studies and multicentre clinical trials.

In October 2012, Australia's National Health and Medical Research Council (NHMRC) and New Zealand's Health Research Council awarded over \$10 million for studies in anaesthesia-related medicine led by ANZCA Fellows, representing more than 1 per cent of its entire 2012 funding allocation for all medical research disciplines across Australia.

Talking about the role played by the foundation's research grants, ANZCA's immediate past president Professor Kate Leslie said: "Pilot studies are critical to success at NHMRC. The Balanced Study pilot was funded by a (foundation funded) ANZCA Trials Group pilot grant. It showed that the study was feasible and that our anaesthetists were enthusiastic about participating in the trial."

A project including several ANZCA Fellows and led by Professor Paul Myles, the Restricted versus Liberal Fluid Therapy in Major Abdominal Surgery (RELIEF) study, was developed using the findings of a pilot study funded by the

foundation. The project secured the top-ranked NHMRC grant in Australia, out of more than 3700 applications.

After receiving the grant, Professor Myles commented: "We've come a long way from when I received my reviews for my very first (and unsuccessful) NHMRC application, which stated, 'this project application is surprising because I didn't think anaesthetists do research'."

In another example of a case where foundation grants have leveraged additional resources, Associate Professor Nolan McDonnell and Associate Professor Tomas Corcoran were each awarded a three-year Clinician Research Fellowship of \$500,000 through the West Australian Department of Health and the Raine Research Foundation in November. The subject of Associate Professor McDonnell's fellowship will be the neuraxial magnesium analgesia studies, initially funded by a grant from the foundation.

There were 15 applicants for these fellowships. The awards to Dr McDonnell and Dr Corcoran represented two of only four successful applications.

Thanks to rigorous investigation by Fellows in these and many other foundation-funded projects, ANZCA's Anaesthesia and Pain Medicine Foundation is providing donors and sponsors with an effective way to make significant, positive impacts on the quality and safety of anaesthesia, pain medicine and perioperative medicine.

The foundation greatly appreciates the support of all its sponsors and donors, especially those listed here (donors who have given \$A100 or more in the past 12 months). For all support inquiries, please email rpacker@anzca.edu.au or call +61 3 8517 5306.

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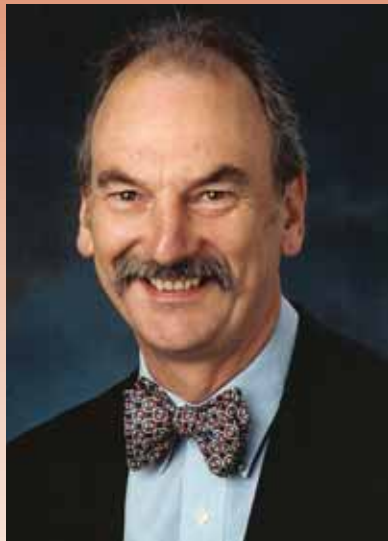
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Dr Rod Westhorpe and the Geoffrey Kaye Museum



Dr Rod Westhorpe has given 25 years of dedicated service as the honorary curator to the Geoffrey Kaye Museum. It is now one of the best anaesthetic equipment museums in the world.

Rod Westhorpe began his career in Ballarat where the then director of anaesthesia, Sid Giddy, influenced him – along with several others – towards his choice of specialty. He went to England to train in anaesthesia and finished up at Hammersmith Hospital, Post Graduate Medical School.

In 1977, Dr Westhorpe returned to the Royal Children's Hospital in Melbourne as a registrar and the following year joined the staff. His incisive organisational capacity soon became evident along with his interest in equipment. He demonstrated that there would quickly be substantial cost savings if the hospital converted from cylinder to piped nitrous oxide. He regularly became involved in difficult cases (Mucopolysaccharidoses) and undertook research into the relative safety of methoxyflurane in children and the changing position of the larynx during growth. He always maintained high standards of communication and care of his patients and their families and showed concern for the wellbeing of theatre staff.

Dr Westhorpe also had a mechanical bent. He rebuilt a Ferrari as a hobby and developed, with research biomedical technician Denis Clare and a student from RMIT, an ergonomic anaesthetic machine. The machine included features such as the capacity to be raised or lowered to suit the anaesthetist's height, flexibility to have the anaesthetic tubing come from the appropriate side of the machine and easy-to-read sloping LED flowmeters. He was also involved with Denis Clare in developing a compact ventilator for theatre use (known as the Clare ventilator), which was produced commercially. Unfortunately these developments were overrun by the production of workstations by big commercial companies.

The museum

The founding secretary of the Australian Society of Anaesthetists, Dr Geoffrey Kaye had a great interest in equipment and began to develop a collection in 1939 for the benefit of teaching. It included cut-down equipment, for example valves, so that people could see how they worked. This collection came to be housed in the Royal Australasian College of Surgeons, which at the time included the Faculty of Anaesthetists.

In 1985, part of my brief as the Lennard Travers Professor was to try to reactivate the museum. Peter Penn, who had been a conscientious honorary curator from 1958 to 1980, had died. Gerry Westmore succeeded him but did not have the time

to devote to it. At the time, the collection had recently been moved and was being housed in the attic! Although Peter Penn had catalogued the collection, there was not enough space to store and exhibit it. Knowing Rod Westhorpe's interest in equipment, I approached him to help. His interest and industry was rewarded in 1987 when the Board of the Faculty of Anaesthetists appointed him honorary curator.

When ANZCA became independent in 1992, the Geoffrey Kaye Museum moved to Ulimaroa. At first it was housed in what is now the store, then the display area was moved to the foyer of ANZCA House before it again moved to the fifth floor.

Over the next few years, Dr Westhorpe worked hard to bring the display up to the standards that museologists would expect for a museum. He liaised with other major anaesthetic museums, particularly the Wood Library Museum in Chicago and the Charles King collection at the Association of Anaesthetists headquarters in London, to standardise the cataloguing system. This facilitates an exchange between museums of spare examples of equipment. The Melbourne collection, with more than 8000 items, is larger than either of these.

In 1989, when the editorial board of *Anaesthesia and Intensive Care* was reviewing the cover of its journal, it was suggested that photographs of pieces from the museum could be used to bring the collection to anaesthetists around the world. Dr Westhorpe embraced the



idea and, with help from the honorary assistant curator, Dr Christine Ball of The Alfred hospital, they have provided photographs and commentary on the items ever since. They recently launched a book of these covers, *Historical Notes on Anaesthesia and Intensive Care*, which makes an outstanding contribution to the history of anaesthesia.

The Geoffrey Kaye Museum is one of ANZCA's most valuable and best-known assets. It has been used for teaching. For many years, Dr Westhorpe has taken each batch of registrars from the Royal Children's Hospital to visit it as part of their enlightenment on the history of our specialty. He, Dr Ball and others have hosted visiting groups from the community and have helped to increase their understanding of anaesthesia – a worthwhile public relations exercise that can only help the image of anaesthetists and anaesthesia. It is sad to reflect that there are people who do not appreciate its importance and have tried to diminish its place in the College. This should never be allowed to happen.

Dr Westhorpe is recognised worldwide for his contribution to the history of anaesthesia. He convened the history section of the World Congress of Anaesthesiologists in Sydney in 1996; people from 20 countries presented, more than any other section. During that congress he gave one of the pre-eminent lectures in the Harold Griffith symposium. He delivered the Lewis Wright Lecture, sponsored by the Wood

Library Museum, at the American Society of Anesthesiologists meeting. And his international contribution continues as he helps to organise an international history of anaesthesia meeting in Sydney and convenes a satellite meeting at the College in Melbourne in January.

Dr Westhorpe has had a distinguished career as a paediatric anaesthetist, ANZCA councillor, as trade liaison officer and many other roles including president of the Australian Society of Anaesthetists, but especially as a historian and honorary curator of the Geoffrey Kaye Museum, for which he is known worldwide. He was also one of the founding members of the Australian Patient Safety Foundation and was a member of several standards committees. He was recently recognised with an Order of Australia Medal. He has been fortunate in having the wonderful support of his colleague, Dr Ball, and staff who have managed the museum.

Dr Kester Brown, AM, MD, FANZCA
Former Director of Anaesthesia, Royal Children's Hospital, Melbourne

Above from left: Dr Rod Westhorpe; ergonomic anaesthetic machine with a Clare ventilator on top; the Geoffrey Kaye Museum in the attic of the Royal Australasian College of Surgeons, 1985; equipment in the old museum; Rod Westhorpe talking to Professor Nick Gravenstein (Florida) in the museum in Ullmaroa.

Dean's message



It is rare that writing this message presents an opportunity to address and announce so many positive events. The last three months have been both extremely busy and very exciting for the Faculty.

Since mid-September, the Faculty has hosted a very successful spring meeting, launched a comprehensive and aspirational five-year strategic plan, launched our on line GP pain education initiative in collaboration with the Royal Australian College of General Practitioners and in partnership with Bupa Health Foundation, as well as working through the rigorous Australian Medical Council (AMC) specialty reaccreditation process alongside ANZCA.

With so much achieved in such a short time, it is rare indeed to be able to have reserved the most significant news until last. Yet this is true. In recent weeks the Faculty has received official notification from the Medical Council of New Zealand that pain medicine has been recognised as a standalone specialty in New Zealand. This is the most significant endorsement of our Faculty since the Australian Medical Council recognised pain medicine as a standalone specialty in Australia in 2005.

This keenly anticipated and hard fought for decision, recognises the importance of pain medicine as a field requiring specialised skills and qualities to address this common complex and for the most part untreated epidemic in our society.

Such significant achievements do not occur easily and special thanks on behalf of the Faculty must go to Dr David Jones (our immediate past dean), Professor Ted Shipton (Vice-Dean), Dr Kieran Davis (board member from NZ), Associate Professor Milton Cohen (Faculty Director of Professional Affairs) and Ms Heather Ann Moodie and staff of the New Zealand ANZCA Regional Office, for their hard work and persistence over many years to secure this landmark achievement.

The Faculty of Pain Medicine's 6th Annual Spring Scientific Meeting was a resounding success again this year, held at the beautiful Palmer Coolum Resort on Queensland's Sunshine Coast, the meeting was strongly supported by our industry partners and well attended by our Fellows. Dr Jerome Schofferman from San Francisco was an enlightening and charming visiting speaker, who contributed significantly to both the academic and social aspects of the meeting.

Highlights of the meeting included sessions on new rheumatoid anti-inflammatory medication, pediatric pain and a surgical perspective of assessment and management of spinal pain.

The Faculty's online educational initiative for general practitioners was also officially launched at the FPM spring meeting and subsequently at the GP12 meeting on the Gold Coast. Dr Eleanor Chew, of Queensland, represented the RACGP at the spring meeting launch. The launch at GP12 was officiated by newly

incoming President of the RACGP, Dr Liz Marles, and medical director of Bupa Australia, Dr Paul Bates. The education program was very well received at both conferences. On behalf of the Faculty, I would like to thank our partners at RACGP and the Bupa Health Foundation as well as the many Fellows who voluntarily contributed their time and knowledge to this important project.

October was also a very busy month for the Faculty, most especially because of the week-long series of Australia Medical Council interviews ending a one-month process of reaccreditation of the Faculty. The AMC process was undertaken in close co-operation with the same process for ANZCA. Early feedback from the process has been very positive. On behalf of the Faculty I would like to thank Dr Lindy Roberts (ANZCA President), Ms Linda Sorrell (ANZCA CEO) and John Biviano (ANZCA General Manager, Policy) for providing so generously their time and experience to make this very large project run so smoothly.

As this exciting and productive year draws to a close, we can, as a Faculty, reflect confidently on our achievements.

I would like to thank the Faculty Board for the energy and vision with which they have approached all tasks in their generous service to the Faculty this year. I would like to also take this opportunity to thank Helen Morris and our Faculty staff who unfailingly support us, our hard working committees, along with ANZCA President, Council, CEO and staff for making the Faculty and ANZCA, an organisation we can all be proud of. I wish you all a safe and happy festive season and I look forward to 2013 being another year of prosperity for us all.

Associate Professor Brendan Moore
Dean, Faculty of Pain Medicine



Faculty of Pain Medicine 2012 examination

The 2012 Faculty of Pain Medicine examination was held from November 23-25 at the Auckland City Hospital, Auckland. Twenty-two of the 28 candidates were successful. The Barbara Walker Prize for Excellence in the Pain Medicine Examination was awarded to Dr Meena Mittal (Vic). A merit award went to Dr Laurent Wallace (NSW).

Admission to fellowship of the Faculty of Pain Medicine

By examination:
October 4, 2012

Romil Jain, FCICM (NSW)

We are pleased to report that this takes the total number of Fellows admitted to 332.

Clockwise from top left: Award recipients Dr Laurent Wallace and Dr Meena Mittal with the Chair of Examinations, Dr Meredith Craigie; Successful candidates; Court of Examiners.

Training unit accreditations

Following successful paper reviews, St Vincent's Hospital, Sydney, and the Kowloon East Cluster Pain Unit, United Christian Hospital, Hong Kong, have been re-accredited for pain medicine training.

FPM Board Election

Nominations close on February 1, 2013 for one vacancy on the FPM Board. This vacancy must be filled by a nominee holding Fellowship of the Royal Australian and New Zealand College of Psychiatrists.

A vision for the Faculty by 2017

Since its formation in 1998, the Faculty of Pain Medicine (FPM) has grown into an organisation with more than 300 Fellows in Australia and New Zealand. FPM fellowship is widely recognised as a high-quality qualification, based on a sound curriculum, excellent clinical exposure and robust continuing professional development.

The Faculty has a proud history of engagement with the community, particularly through its contribution to the National Pain Strategy and its membership of Painaustralia.

The Faculty will arrive in 2013 with a strong foundation through the hard work and dedication of its boards and members; however we need a guide for the future to ensure that FPM continues to grow and thrive, and to provide safe, high-quality pain medicine services to the community.

The FPM Strategic Plan 2013-2017 is a clear statement of what FPM does, what we aspire to be and how we will get there. The plan is based around our mission and vision, and three strategic priorities. These priorities are deliberately broad and interrelated to allow for flexibility, innovation and refinement of our work through to 2017.

Developed with input from the FPM Board, regional committees, Australian and New Zealand College of Anaesthetists (ANZCA) and external stakeholders, the strategic plan is based on agreed goals and priorities, and a shared understanding of the challenges we face and the opportunities that are available to us.

It signals an exciting new phase for FPM. The FPM Strategic Plan 2013-2017 aligns with that of ANZCA, reflecting the relationship between the College and the Faculty while addressing issues specific to the Faculty.

In this environment of growth, innovation, change and challenge, the focus of the Faculty remains constant and begins and ends in the community. The problem of persistent pain continues to be misunderstood and access to information and safe, effective treatment must be improved. We have an ongoing responsibility to promote the discipline of pain medicine and to increase the numbers of doctors who are confident and competent in this discipline so we can better serve the needs of the community.

Associate Professor Brendan Moore
Dean, Faculty of Pain Medicine

FPM Strategic Plan 2013-2017

Mission

To serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine

Advancing pain medicine: Improving patient care

Vision

To reduce the burden of pain in society through education, advocacy, training and research

Strategic priorities

Build fellowship and the Faculty

Build the curriculum and knowledge

Build advocacy and access

Objectives

- Increase the number of trainees and Fellows
- Strengthen the framework of the Faculty
- Establish clear policies and procedures throughout FPM

- Deliver a world-class training program
- Support research that adds to the evidence base for pain medicine
- Collaborate with other colleges and training providers to provide appropriate pain medicine education to health professionals

- Promote and support a unified understanding of pain in the health sector and wider community
- Engage with and influence key stakeholders and decision makers
- Improve access to pain medicine services

FPM Spring Meeting



The FPM Spring Meeting was held from September 28-30 at the Palmer Coolum Resort, Queensland. The meeting was very successful with more than 120 delegates registered and strong healthcare industry support. The meeting saw the launch of the FPM Strategic Plan 2013-2017 and the FPM/Royal Australian College of General Practitioners (RACGP) educational initiative for general practitioners, with Dr Eleanor Chew (Queensland) representing the RACGP. Both launches were very well received. The international invited speaker from the United States, Dr Jerome Schofferman, presented on “Ethics, financial conflicts of interest – effects on clinical care, research and education”, “Failed back surgery – aetiologies and treatment” and “Whiplash injuries”. The meeting also featured many local speakers, presenting on a range of topics including paediatric pain cases and post-injury pain.

Two media releases were issued to publicise the meeting. One release promoted South Australian anaesthetist and specialist pain medicine physician Dr Meredith Craigie’s paper on children with chronic pain missing out on services, which was covered by the Hospital and Aged Care magazine, as well as New Zealand Doctor online, the Health Improvement and Innovation Resource Centre, and the World Pain Foundation. Another media release promoting former FPM Dean Dr Penny Briscoe’s paper proposing urine and drug screening for chronic pain patients was covered at the time by the *Financial Review*, *The West Australian* newspaper, *Australian Doctor* and New Zealand Doctor online, and later by all Fairfax papers.

Above clockwise from top left: Delegates gather for lunch; Dr Humphry Cramond, Professor Tess Cramond and Professor Julie Fleming; Morning tea; Convenor and Dean Associate Professor Brendan Moore, Dr Jerome Schofferman and Convenor Associate Professor Leigh Atkinson. Professor Michael Cousins and Associate Professor Brendan Moore and Dr Jerome Schofferman.

New Zealand accredits pain medicine as a specialty



Pain medicine is now recognised as a specialty in New Zealand after the Medical Council of New Zealand (MCNZ) decided to accredit it as a vocational scope of practice. This is a successful outcome to an application process that started more than three years ago.

The accepted scope of practice is: “The biopsychosocial assessment and management of persons with complex pain, especially when an underlying condition is not directly treatable. The scope of pain medicine supplements that of other medical disciplines, and utilises interdisciplinary skills to promote improved quality of life through improved physical, psychological and social function.”

The prescribed qualification is fellowship of the Faculty of Pain Medicine of ANZCA (FFPMANZCA), which is an additional fellowship obtainable only by a medical practitioner who already holds another relevant specialist qualification acceptable to the Faculty of Pain Medicine Board.

On October 31, the MCNZ advised that this new scope and qualification would be gazetted to come into effect on December 3 this year. The accreditation is for a period of five years, to 2017.

The Faculty will be required to submit annual reports to the MCNZ, with the first due for the period ending December 31, 2013.

In making its application to the MCNZ, the Faculty, through ANZCA’s New Zealand office, pointed out the costs to sufferers, their caregivers and society generally of inadequately managed pain. It said recognition of the scope would boost the specialty in New Zealand leading to better outcomes for the estimated nearly one in five New Zealanders suffering from chronic pain.

FPM Dean Associate Professor Brendan Moore said that the MCNZ accreditation had put the practice of pain medicine in New Zealand on the same footing as in Australia, where it has been recognised as a stand-alone specialist qualification since 2005.

“There is now a single unified training and accreditation system, and qualification, for recognising pain medicine specialist physicians across Australia and New Zealand,” Associate Professor Moore said.

“Australian and New Zealand specialists with backgrounds in anaesthesia, surgery, rehabilitation medicine, psychiatry and general medicine have worked together for 15 years to establish and progress the training, examination and continuing professional development of pain medicine specialists.

“The medical council’s decision recognises these achievements and the expertise of New Zealand specialists who

have contributed to the development of this specialty in New Zealand, Australia and internationally.”

In a letter to New Zealand FPM Fellows about the decision, FPM Vice-Dean, Professor Ted Shipton, of Christchurch, referred to there being a paucity of specialist pain medicine physicians in New Zealand. He said the MCNZ’s decision would lead to a growth of interest in pain medicine and should create better access to pain services for the New Zealand population.

“The challenge to the Ministry of Health and the district health boards in New Zealand is to adequately resource and expand chronic and acute pain management services in New Zealand,” Professor Shipton wrote.

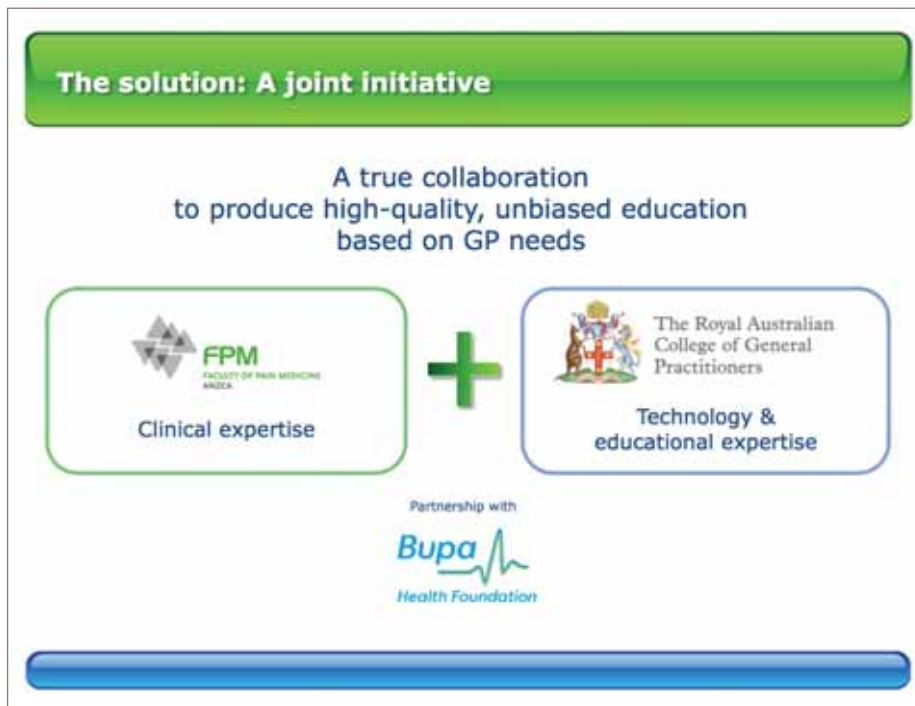
He thanked ANZCA and FPM staff and Fellows involved in achieving the accreditation goal.

The two-stage application process was led by ANZCA’s Director of Professional Affairs, Dr Steuart Henderson, the immediate past FPM dean, New-Zealand based Dr David Jones, and Heather Ann Moodie, the General Manager of ANZCA’s New Zealand National Office.

Susan Ewart,
ANZCA Communications Manager, NZ

Above from left: FPM Dean Associate Professor Brendan Moore; FPM Vice-Dean Professor Ted Shipton and immediate past FPM Dean Dr David Jones.

GPs go online in an innovative learning initiative



The Faculty and RACGP have worked together to deliver a cutting-edge online education program to help GPs treat chronic pain.

On June 1, 2011, the Bupa Health Foundation announced the winners of their health awards at the Sydney Opera House. The Faculty of Pain Medicine (FPM) and the Royal Australian College of General Practitioners (RACGP) were jointly awarded \$200,000 to develop a cutting-edge, online, education program to help GPs treat chronic pain.

Education of primary healthcare professionals remains one of the greatest challenges in delivering accessible, high quality medical treatment to people suffering chronic pain.¹

This field of education continues to be majority funded and dominated by pharmaceutical industry sources and, while these initiatives are often expensive, expansive and of very high quality, there is an inherent risk of commercial bias. This manifests in selection of medical advisors and presenters, topic selection and ultimately content.^{2,3}

This situation necessarily causes ethical concerns.^{2,3}

In the current political environment there is very little government funding allocated to badly needed health education.

The concept of a greater educational initiative for the Faculty of Pain Medicine was identified three years ago at a FPM Education Committee strategic planning focus day. The funding provided by the Bupa Health Foundation award allowed this initiative to proceed with the co-operation of the RACGP and with independent content control.

There has been increasing international focus on challenges in pain medicine.

John Loeser articulated the issues in his clinical update for the International Association For the Study of Pain (IASP) in January of this year¹. His challenging insights have been widely referenced and quoted since the time of this publication. Loeser identified and described what he considers, the five most preeminent crises in pain management today. In his own words: "Of all these issues, I believe that the one that is most critical is the education of healthcare providers"¹.

The sheer number of patients affected, up to 20 per cent of the population in Australia, dictates that the overwhelming majority of healthcare for patients with chronic pain must come from primary care providers. For this reason, education must be aimed first and foremost at general practitioners.

Specific education of pain physiology, assessment and management is very rare in Australia, New Zealand and

internationally in undergraduate medical curriculums. Loeser lamented this "woeful inadequacy in pain education for both undergraduates and advanced trainees"¹.

Our aim was to present unbiased, prioritised, educational messages as interestingly, engagingly and as accessibly as possible while emphasizing core themes in pain medicine to capture the attention of the approximately 22,000 GPs across Australia.

The Bupa Health Foundation (and its MBF predecessor) has been instrumental over the past decade in funding major pain initiatives, including the pivotal Australian pain prevalence study in 2001⁴ and *The High Price of Pain* report by Access Economics in 2007⁵. The foundation was a key supporter of the National Pain Summit in 2010.

The demonstrable, independent governance of this project is its great strength. An independent Curriculum Development Committee (CDC) was formed to select topics, which were then sent to the FPM Education Committee to select and invite specialists to represent the Faculty as content providers and writers of each topic.

The structure of the project is outlined in the diagram on the opposite page.

Opposite page from top: Associate Professor Brendan Moore (FPM Dean) presenting at the launch; Dr Liz Marles (President RACGP) presenting at the launch.



Latest technology is used as the catalyst to attract the attention of GP's to this active learning module in a market that is highly competitive for their attention. In an Australian first, the active learning module is accessible online via iPads, other tablet devices and on smart phones.

Planning, organisation, finance and project time lines were overseen at a steering committee level. Strict governance and oversight drove the project through the many unanticipated obstacles to be delivered on time and on budget.

The project was launched jointly at the FPM spring scientific meeting in Coolom in September and at the GP's annual conference, GP12, at the Gold Coast four weeks later. It was well received by both audiences.

Most importantly, I would like to thank our project partners.

Our sincere thanks and gratitude goes to our collaborative partners at the RACGP, for sharing this vision and providing the guidance and experience to see the project through to fruition.

Our thanks go to the Bupa Health Foundation for their grant funding and for their ongoing faith in our partnerships over more than 10 years. Thanks also goes to Janssen-Cilag, for facilitating grant application and early project co-ordination and to Animated Biomedical Productions, for working with our group of largely IT novices and producing such a polished product.

Finally, to the dedicated Fellows of our own Faculty and invited experts, who, as always, contributed so generously and freely of their time and expertise to this project, thank you.

Associate Professor Brendan Moore
Dean, Faculty of Pain Medicine

References:

1. Loeser J. Crises in Pain Management. IASP Clinical Updates. Vol XX Issue1 Jan 2012; Five
2. Schatman M. The Medical-Industrial Complex and Conflict of interest in Pain Education. Pain Medicine 2011;12:1710-1712
3. Schofferman J. The Medical-Industrial Complex, Professional Medical Associations, and Continuing Medical Education. Pain Medicine 2011;12:1713-1719
4. Blyth et al. 2001 Epidemiology of Pain in Australia
5. Access Economics Report: The High Price of Pain. 2007

Curriculum Development Committee comprised six GPs nominated by RACGP and three FPM fellows nominated by the Faculty. Each undertook independent research to identify more than 20 topics worthy of consideration.

These topics were then distilled, refined, combined and prioritised by the Curriculum Development Committee and six connected one-hour topics were selected.

Consideration was given to how the topics would fit together to create a cohesive and relevant active learning module (ALM). There was consensus that certain pain topics, for example, physiology of pain, had to be understood first in order to effectively further understand how to assess and consider appropriate management strategies. On this basis, topics were divided into three 'core' and three 'elective' modules.

Topics were sent to FPM Education Committee, who selected and invited experts from across Australia to form six content committees. The invited experts were drawn from all Australian states and were representative of the wide diversity of primary disciplines within the Faculty's fellowship.

The modules were developed with clearly defined learning objectives and used illustrations and animations to make them engaging. They are case-

study based, interactive and include questionnaires to ensure effective comprehension and completion of each unit.

The six topics and their authors are listed.

Module 1: Making an effective pain diagnosis I – a whole person approach
Associate Professor Brendan Moore, Dr Chris Hayes, Associate Professor Milton Cohen

Module 2: Making an effective pain diagnosis II – the impact and management of psychosocial factors
Associate Professor Michael Nicholas, Dr Newman Harris

Module 3: Effective pain management – a whole person approach to managing chronic pain
Dr Penny Briscoe, Dr Jane Trinca

Module 4: Neuropathic pain
Professor Rob Helme, Associate Professor Ray Garrick

Module 5: Identification and management of low back pain in general practice
Dr Max Sarma, Associate Professor Helen Slater, Associate Professor Andrew Zacest, Dr Stephanie Davies

Module 6: Opioids in pain management
Associate Professor Roger Goucke, Professor Stephan Schug, Dr Rupert Backhouse

FPM Board meeting report

October 2012

Report following the board meeting of the Faculty of Pain Medicine held on October 29, 2012.

Death of Fellows

The board noted with regret the death of Fellow Professor Issy Pilowski (SA). A tribute to Professor Pilowski was presented by Professor Michael Cousins at the Faculty's Spring Meeting in Cooloom and will be published in *Synapse*.

Honours and awards

The dean conveyed on behalf of the Faculty, acknowledgment and congratulations for the following appointments:

- Dr Leona Wilson – awarded the ANZCA Robert Orton Medal for distinguished services in anaesthesia.
- Dr Kerry Brandis – awarded the ANZCA Council Citation in recognition of significant contributions to College activities.
- Professor Michael Cousins – Honorary Doctor of Science, McMaster University in Ontario Canada.
- Professor David Story (Vic) appointed Chair of the Centre for Anaesthesia, Perioperative Medicine and Pain Medicine, School of Medicine, University of Melbourne.

Relationships

Australasian Faculty of Rehabilitation Medicine (AFRM)

Dr Stephen de Graaff, President-elect and Chair, Policy and Advocacy Committee, AFRM (RACP) met with the board to discuss areas of common interest and opportunities for engagement.

Royal Australasian College of Surgeons (RACS) pain medicine section

The RACS Annual Scientific Congress (ASC) in Auckland in May 2013 will include a pain section. The 2014 ASC will be combined with neurosurgery and will be co-located with the ANZCA/FPM ASM. Professor Peter Teddy is convening the RACS pain program under a theme of "Dilemmas in surgical pain management" and is working with the ANZCA and FPM Scientific Convenors to co-ordinate contributions from each group with the aim of attracting a broad audience.

Royal Australian College of General Practitioners (RACGP)

The GP online learning initiative collaboration between the FPM, RACGP and the Bupa Health Foundation was officially launched at both the FPM Spring Meeting in Cooloom on September 29 and at

the RACGP GP12 meeting on the Gold Coast on October 26. The dean spoke at both launches and a combined FPM/RACGP/Bupa media release attracted media attention. This will be the first active learning module to be available through the *GP Learning* platform on iPad and iPhone, promoting accessibility.

Painaustralia

Among recent achievements was a meeting with the Federal Health Minister, Tanya Plibersek, and policy advisor Kate Lee which had been positive. National Pain Week in July generated considerable publicity.

A combined boards meeting of the Australian Pain Society, New Zealand Pain Society, FPM and ANZCA had been convened in Melbourne in March 2012 and a further meeting occurred in Cooloom in October to discuss how best to collaborate in advancing the National Pain Strategy.

A key pillar of the Faculty's strategic plan is to build advocacy and access through collaborative initiatives with Painaustralia and the pain societies.

Corporate Affairs

Strategic planning

The FPM Strategic Plan 2013-2017 was launched at the FPM Spring Meeting outlining the Faculty's vision and plan for the future. This is now available on the FPM website at www.fpm.anzca.edu.au/about-fpm/structure-and-governance.

2013 Business Plan

The board endorsed the 2013 FPM Business Plan outlining the objectives, initiatives and actions to be undertaken in the coming year.

Australasian Medical Council (AMC) reaccreditation

The AMC accreditation team visit occurred during the week of October 15. Feedback in the preliminary report was positive. The team's final report with their recommendations is awaited. The board acknowledged those who provided input to the process and noted that alignment with ANZCA's thorough processes had reflected favourably on the Faculty.

New Fellow board position

Recognising the benefits of input from trainees and new Fellows in the decision-making processes, the establishment of a new Fellow representative to the board will be explored. In the interim, steps will be taken to seek and correlate feedback from regional committee new Fellow representatives.

Trainee affairs

Part-time and interrupted training

The board approved criteria for the

assessment of proposals for part-time training with a view to increasing flexibility. All proposals for part-time training will be assessed on the basis of being at least 50 per cent full-time equivalent and with a demonstrated ability to satisfy all the components of training during the course of training.

Curriculum Revision 2015

The board approved the high-level outline of the new curriculum and program and endorsed the proposed project deliverables. The budget for the project was approved for submission to council for approval as a capital project.

A project governance structure was approved to streamline the decision-making process and to ensure work is appropriately delegated to project groups to avoid cost overruns and time blowouts. As well as Faculty representatives, ANZCA's CEO, general manager strategic projects office and general manager education will participate in the project governance group.

Fellows attending a forum on the curriculum redesign convened in conjunction with the FPM Spring Meeting in Cooloom gave positive feedback.

Summative assessment regulation

The board resolved that regulation 3.2.8 be amended to remove the requirement that an applicant offered the summative assessment without further training as a pathway to fellowship be required to register as a trainee six months prior to the examination. Candidates will be able to register as per the normal requirements of the examination.

Examinations

Examiners

The board endorsed the appointment of the following as examiners for a period of three years:

Dr Ming Chi Chu, FANZCA

Dr Gary Clothier, FAFRM (RACP)

Associate Professor Philip Siddall, PhD

Dr Clayton Thomas, FAFRM (RACP)

Associate Professor Andrew Zacest, FRACS

Dr Michael Vagg, AFRM (RACP)

The board endorsed the re-appointment of the following examiners for a period of three years:

Professor Michael Cousins, FANZCA

Associate Professor Pamela Macintyre, FANZCA

Dr Owen Williamson, FRACS

Dr Paul Wrigley, FANZCA

Clinical case study

New clinical case study guidelines and assessment criteria were ratified and will be updated on the Faculty website and promulgated to trainees and supervisors of training.

Examiner training assessor

The board approved the appointment of a recently retired examiner, familiar with each component of the Faculty's examination, as an examiner training assessor on the panel of examiners. The appointment will be made by the examination committee.

Training unit accreditation

The Kowloon East Cluster Pain Unit (Hong Kong) and St Vincent's Hospital (Sydney) have been re-accredited as tier one units.

The board resolved that terms of reference for both the Training Unit Accreditation Committee and the Education Committee be reviewed and altered to reflect that the position of supervisor of training will be ratified by the Education Committee.

Dr Peter Cox was confirmed as Supervisor of Training for Westmead Hospital, NSW.

Professional

Specialty recognition – New Zealand

Subsequent to the board meeting, the Faculty was advised officially that the Medical Council of New Zealand has accredited pain medicine as a scope of practice in New Zealand for a period of five years until 2017 – a very welcome outcome to a two-year application process. The new scope and its associated qualification (Fellowship of the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists – FFPMANZCA) will come into effect on December 3, 2012.

Submissions

The Faculty has recently contributed to the following submissions which can be viewed at www.anzca.edu.au/communications/submissions/government-submissions-2012:

- Review of Australian Standard Classification of Occupation, First Edition, Revision 1 – September 2012.
- Royal Australian and New Zealand College of Radiologists Accreditation – September 2012.
- Changes to *Health Practitioner Regulation National Law Act* regarding international criminal history checks – August 2012.

In September, a joint PainAustralia and FPM submission was made at short notice to the NSW Agency for Clinical Innovation Pain Management Network

to apply for funding to replicate the GP online education model for pain education for primary care and allied health practitioners.

Support for developing countries

The board formally acknowledged the remarkable personal efforts of Associate Professor Roger Goucke and Dr Wayne Morris in advancing the Essential Pain Management (EPM) initiative which has been an enormous success. EPM has now been widely delivered throughout the Pacific Islands and has been translated into Vietnamese, Mongolian and Spanish with consideration for translating into Swahili.

Fellows with an interest in teaching in low and middle income countries, Aboriginal health, or Australian undergraduates are encouraged to contact Associate Professor Goucke.

The dean, on behalf of the board, paid tribute to Associate Professor Goucke for his ongoing dedication and service to the College in promoting access to pain medicine throughout the third world through this initiative. His activities reflect extremely positively on the international profile of both the FPM and ANZCA.

Fellowship affairs

New Fellows

Dr Romil Jain, FCICM (NSW) is congratulated on his admission to FPM fellowship.

New Fellows' Conference 2013

Dr Dilip Kapur (SA) was nominated as the board representative to the 2013 New Fellows' Conference. Two new Fellow representatives will be nominated after the closing date of November 2.

Continuing Professional Development (CPD)

2012 Spring Meeting – September 28-30 – Coolum

The board congratulated convenors, Associate Professor Leigh Atkinson and Associate Professor Brendan Moore, on the success of this meeting. The well-received program included the launches of the GP online education initiative and FPM Strategic Plan 2013-2017.

2013 ASM and FPM Refresher Course Day and ASM – 3 May & 4-8 May – Melbourne Sofitel on Collins, Melbourne. Theme: "Selling Pain Science – Communication and Cultural Competition". Scientific Convenor, Dr Michael Vagg.

2013 Spring Meeting – 25-27 October 2013 Byron at Byron Resort and Spa, Byron Bay, is confirmed as the venue for the 2013 Spring Meeting. The meeting will be

convened by Dr Michael Vagg with a theme to coincide with the IASP Global Year Against Visceral Pain with an emphasis on gynaecological/pelvic pain.

2016 Annual Scientific Meeting, Auckland ANZCA has appointed Dr Michal Kluger, FANZCA, FFPMANZCA as convenor. The Faculty's 2016 scientific convenor appointment is currently under consideration.

Research

ANZCA research grants

Three grants (of the 16 successful applications) were awarded to investigations with a pain focus:

- Associate Professor Philip Siddall (NSW) – *Levels and associations of existential distress in people with persistent pain.*
- Dr Kelly Byrne (NZ) – *Tramadol versus morphine for refractory postoperative pain in the recovery room.*
- Dr Nolan McDonnell (WA) – *Evaluation of the safety of intrathecal administration of magnesium sulphate in a sheep model.*

The St Jude Medical Research Award was given to Associate Professor Philip Siddall.

The John Boyd Craig Research Award was given to Dr Nolan McDonnell.

An academic enhancement grant was awarded to Professor Matthew Chan (HK) for *Transcriptional regulation of chronic postsurgical pain.*

Electronic Persistent Pain Outcomes Collaboration (ePPOC)

The recruitment process at the University of Wollongong for an ePPOC manager and a statistician will commence upon release of funds from NSW Health. A pilot will initially commence in NSW before drawing in data from other states in a national benchmarking process. There will be an opportunity to review the agreed national dataset prior to implementation nationally.

Pain Device Implant Register

Discussions have commenced with statisticians at the Data Management and Analysis Centre (DMAC) at the University of Adelaide to advance this initiative. The National Joint Replacement Registry is currently co-ordinated within that department. The next steps will be to develop a business plan and questionnaire and determine pilot centres. Funding avenues are being explored.

Resources

Finance

The board approved the Faculty's 2013 budget and fee schedule, based on the delivery of initiatives proposed in the Faculty's Strategic Plan and 2013 Business Plan.



From left: Geneva; The “broken chair” sculpture is on the square in front of the Palace of Nations in Geneva, Switzerland.

International Society for Quality in Health Care (ISQua) Conference 2012

The 29th International Society for Quality in Health Care (ISQua) conference was convened in Geneva, Switzerland October 21-24.

ISQua is a global organisation that seeks to “inspire, promote and support continuous improvement in safety and quality of healthcare worldwide”. It undertakes activities associated with healthcare costs and benefits as well as continuous research into the effectiveness of care. In addition it is involved in the benchmarking (accreditation) of healthcare facilities, and performs the unique role of assessing the standards of accrediting organisations.

This year’s conference title was “Advancing quality and safety for all: now and in the future”.

A number of themes emerged during the conference. These included placing patient safety higher on the agenda of health reform; implications of social media in enhancing safety and quality; the healthcare cost and quality paradigm; moving to patient/person centred outcomes; and the implications of accreditation requirements on health organisations.

It was interesting to note that anaesthesia was used as a case study in an early plenary session to illustrate how a focus on quality and safety can have profoundly positive effects on patient

morbidity and mortality. Examples were given concerning improvements in equipment, resources and human factors that have led to a tenfold reduction in anaesthesia related mortality since the 1980s.

Dr Margaret Chan, the Director-General of the World Health Organization (WHO), opened the conference. She noted that while patient safety has been on the WHO agenda for 10 years it will take an even higher priority in 2013, possibly with a specific focus on medication safety. In Dr Chan’s words “medication errors cause deep indignation”. The patient safety agenda will be discussed at the WHO general assembly in May 2013.

Professor Sir Liam Donaldson presented the second opening address with a wide-ranging strategy of change and health reform. Sir Liam has served as chair of the World Alliance for Patient Safety since its creation in 2004 and was named the WHO Envoy for Patient Safety on behalf of the director general of WHO in 2011. Sir Liam was also the chief medical officer for the UK from 1998 to 2010. Sir Liam’s talk focused on seven future strategies. They were: building a leadership community; safer technologies; extracting value from data; a stronger evidence base for solutions; more work in low and middle-income countries; deeper patient and citizen involvement; and extensive education programs.

A number of speakers recognised the implications of the power of social media in reference to adverse events. It is no longer acceptable for health services to undertake protracted reviews of adverse events in isolation of affected patients

when details of an incident are explored in almost real-time via social media. It is expected that patients will be actively involved in incident review and that these reviews will be more timely.

The Director of Transformational Change in the National Health Service in the United Kingdom (UK), Jim Easton, gave an elegant explanation of the cost/quality belief system – “better quality costs more if you keep the system the same”. He argued that it is unsustainable to continue to grow healthcare costs faster than a country’s gross domestic product (GDP). In the UK, government has mandated a 20 billion pound (\$A30.7 billion) saving program for health over a five-year period. It was impressive to hear that two years into the program savings of 9.8 billion pounds (\$A15 billion) have been achieved to date, while quality has been measurably improved. The strategy used to achieve this outcome has been a framework for change that focuses equally on all eight elements of the framework, actively moving away from implementing only parts of the framework at any one time. The idea of implementing pilot schemes and hoping for diffusion of ideas was deliberately rejected.

The eight elements were:

- A shared organisational purpose.
- Leadership for change with specific focus on the skills needed to understand the change process.
- The spread of innovation using marketing strategies.
- The use of an improvement methodology – it doesn’t matter which one but train people to use it.

- The rigorous delivery of change programs, and be less forgiving if progress doesn't meet targets.
- Transparent measurement; it is unethical NOT to publish data.
- System drivers; align processes, incentives and payment systems to enable change.
- Engagement and mobilisation of the right people.

The key message is that all elements of the framework have to be implemented concurrently, and have to be done well. Organisations cannot pick and choose particular elements.

The importance of the patient voice continues to be an overriding theme at safety and quality conferences. Specific examples were given of the role of the patient voice in the incident management continuum. They were prevention to avoid harm, such as empowerment of patients to call a MET, or patients requiring health professionals to wash their hands; immediate response to harm and the place of open disclosure in this response; incident analysis including reasonable ways for patients to participate including fact gathering; meeting and follow up with patient/family following an incident – this addresses the poor perception that patients often have of the outcome of the analysis; and closing the loop – share learning with others and involve patients and their families in this process.

One of the nine thematic tracks at the conference was “accreditation and regulation of systems and professionals”, and the implications of multi-accreditation requirements on health services were noted during a session. Comment was passed that the burden on health services is prevalent in Australia and New Zealand. Health services are assessed against national safety and quality standards, professional college standards, state-based junior medical workforce standards and other technical standards such as National Association of Testing Authorities (NATA). Some form of mutual recognition may relieve part of the burden.

ISQua's 29th conference in Geneva in 2012 involved 1200 delegates, with representatives from 70 countries. There were 100 expert speakers, 250 sessions, 500 posters and six plenary sessions. Many of the sessions were in French and English, accessible by headphones.

National Health and Medical Research Council project grants 2013

Congratulations to ANZCA Trials Group investigators who were awarded two grants in the latest National Health and Medical Research Council (NHMRC) research grant rounds totaling over \$5 million dollars.

The Restrictive versus Liberal Fluid Therapy in Major Abdominal Surgery (RELIEF) Trial was deemed as category 7 following expert peer review. Only three of the 3700 project grant applications received this score. RELIEF was in the top 25 per cent of the category, making it the top-ranked grant in the country. This is outstanding! The approved budget for this grant is \$2,384,173.35 over four years. The FANZCA investigators are Professor Paul Myles, Associate Professor Tomas Corcoran, Associate Professor Philip Peyton and Associate Professor David Story. The RELIEF pilot study was funded by ANZCA¹. In addition to this project grant, Professor Myles was awarded a NHMRC Practitioner Fellowship worth \$380,000 over five years.

The Balanced Study on the influence of anaesthetic depth on patient outcome after major surgery was awarded \$2,893,794.64 over five years. The FANZCA investigators are Professor Kate Leslie, Associate Professor Timothy Short, Professor Matthew Chan, Professor Paul Myles, Professor Michael Paech and Associate Professor Tomas Corcoran. The Balanced Pilot study is also funded by a Health Research Committee grant of more than \$NZ1.2 million in New Zealand (principal investigator Associate Professor Short). ANZCA¹ also funded the Balanced Pilot Study. The ANZCA Trials Group has been awarded more than \$16 million in project grants from the NHMRC. Support from the Anaesthesia and Pain Medicine Foundation, has been pivotal to this success. If you are interested in participating in any of these trials, please contact trialsgroup@anzca.edu

Both the Balanced Study and the RELIEF study will be presented for investigator participation at the Collaborative Clinical Trials in Anaesthesia and Intensive Care in Prato

Italy June 3-5, 2013. This meeting will run in conjunction with the Australian and New Zealand Intensive Care Society (ANZICS), and will follow the European Society of Anaesthesia meeting in Barcelona. Anaesthetists interested in participating in these trials are encouraged to attend.

Peri-operative Ischemic Evaluation-2 Trial: POISE-2 trial update

The ANZCA Trials Group would like to acknowledge the outstanding contribution that Dr Tom Painter and his team from the Royal Adelaide Hospital in South Australia are making to international multi-centre research in anaesthesia. This site has recruited its 50th patient for the POISE-2 trial since it began the study in December 2011. This represents 37 per cent of all patients recruited in Australia and New Zealand. In addition Dr Painter's team has contributed over 400 (22 per cent) patients to the Aspirin and Tranexamic Acid for Coronary Artery Surgery: ATACAS Trial.

Research staff at the Royal Adelaide include Professor Guy Ludbrook, Dr Tom Painter, Ms Sue Lang, Dr Guy Christie-Taylor, Dr Elizabeth Tham, Ms Helen Mackay and Ms Crystal Eldridge. Well done to everyone on such a strong collaborative effort!

Survey research publications

Two surveys that were facilitated by the ANZCA Trials Group have been published or presented. They were:

Weller J.M., Henning M. Impact of assessments on learning and quality of life during anaesthesia training in Australia and New Zealand. *Anaesthesia and Intensive Care*. 39 (1) (pp 35-39), 2011.

Heard C, Heard A, Dinsmore J. How difficult is it to identify anterior neck structures in the CICV scenario? *ASA* October 14, 2012. Denver Colorado USA.

Stephanie Poustie
ANZCA Trials Group Co-ordinator

References:

1. The Anaesthesia and Pain Medicine Foundation.



Anaesthesia hand hygiene: Are we doing enough?

Evidence suggests the average anaesthetist should engage in the order of 20 to 30 hand hygiene episodes per hour in the operating theatre¹ and compliance with recommended hand-hygiene practice by anaesthesia providers has been a cause for concern for some time.²

In a recent observational audit at one large teaching hospital, where anaesthetists knew they were being observed, compliance varied from 13 to 30 per cent of observed hand-hygiene opportunities, similar to previous studies.³

Five per cent of patients experience surgical site infections despite appropriate antibiotic prophylaxis and this rate has not been reduced with intensive improvement of intraoperative surgical asepsis.^{4,5}

Contamination of anaesthesia workspace, gloves, instruments and equipment has been demonstrated in numerous studies since the 1980s.^{1,2,6,7} Although contamination does not equal infection, the evidence for this is mounting. Infection is directly related to microbial load and increasing contamination results in higher rates of patient intravenous line (stopcock) contamination, particularly following the first patient on the list.⁸ Most evidence points to infection from the environment or the patient's own microflora, but healthcare provider flora also has been implicated, although inadequately studied.

Bacterial contamination of the anaesthesia work area increases significantly from commencing anaesthesia until conclusion and transmission of bacterial organisms, including vancomycin-resistant enterococcus, to intravenous stopcock sets has been demonstrated in 23 to 32 per cent of cases studied.^{8,9}

Intraoperative bacterial transmission to the intravenous port site has been shown to originate from the anaesthesia provider in approximately 5 per cent of cases and transmission to the anaesthesia environment, which occurs in almost 90 per cent of cases, originates from the anaesthetist about 12 per cent of the time.¹⁰

Several microbial reservoirs contribute to stopcock contamination both within and between cases respectively; 47 to 64 per cent environment, 14 to 23 per cent patient, and 21 to 30 per cent provider hands.⁸ Highly contaminated work areas increased the odds of stopcock contamination by 4.7 times and contaminated intravenous tubing is associated with a trend toward increased nosocomial infection rates and an increase in mortality.^{8,9}

Mounting evidence indicates that the contaminated hands of anaesthesia providers serve as a significant vector for patient environmental and stopcock contamination in the operating room and that improved hand hygiene is significantly associated with a reduction in stopcock contamination.^{8,9}

Hand hygiene

Compliance with recommended hand hygiene practice by anaesthesia providers has been a cause for concern for sometime.

- Five percent of patients experience surgical site infections despite appropriate antibiotic prophylaxis.
- Although contamination does not equal infection the evidence for this is mounting.
- Contaminated intravenous tubing is associated with a trend toward increased nosocomial infection rates and increased mortality.
- Mounting evidence indicates that the contaminated hands of anaesthesia providers serve as a significant vector for patient environmental and stopcock contamination in the operating room and that improved hand hygiene is significantly associated with a reduction in stop cock contamination.
- Up to thirty percent of individuals are asymptomatic carriers of *S. aureus* alone.
- Highly contaminated work areas markedly increased the odds of stopcock contamination.

The operating room environment is “colonised” through shedding organisms from the “microbiome” of every individual entering it. Up to 30 per cent of individuals are asymptomatic carriers of staphylococcus aureus alone.¹¹ Although the evidence is still limited, a multimodal approach to reducing each microbial reservoir in the operating theatre may reduce intraoperative bacterial transmission. Careful extensive decontamination of the entire anaesthesia workspace between cases is essential (second case phenomena) and careful hand decontamination (glove removal, antiseptic jell hand wash and cleaned hand re-gloving) is an important step towards reducing environmental contamination and transmission between reservoirs. Attention is also drawn to the College document *PS28: Guidelines to Infection Control in Anaesthesia* (2005).¹²

Dr Robert Fry, ANZCA
Anaesthesia Quality Chairman,
Auckland City Hospital

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1. Zingg W and Pittet D. Stopcock contamination: The source does not explain it all. *Anesth Analg* 2012;114:1151-2
2. Lessard MR, Trepanier CA, Gourdeau M, Denault PH. A microbiological study of the contamination of the syringes used in anaesthesia practice. *Can J Anaesth* 1988;35:567-9
3. Pittet D, Stephan F, Hugonnet S, Akakpo C, Souweine B, Clergue F. Hand-cleansing during postanaesthesia care. *Anesthesiology* 2003;99:530-5.
4. <http://www.nice.org.uk/nicemedia/pdf/CG74NICEGuideline.pdf> Oct 2008
5. Antisepsis in the Time of Antibiotics: Following in the Footsteps of John Snow and Joseph Lister *Anesth Analg* 2011;112:1-3
6. Bennett SN, McNeil MM, Bland LA, et al. Postoperative infections traced to contamination of an intravenous anesthetic, propofol. *N Engl J Med* 1995;333:147-54.
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8. Loftus R, Brown J, Koff M, Reddt S, Hears S, Patel H, Fernandez P, Beach M, Corwin H, Jensen J, Kispert D, Huysman B, Dodds T, Ruoff K and Yeager M. Multiple reservoirs contribute to intraoperative bacterial transmission. *Anesth Analg* 2012;114:1236-48
9. Loftus R, Koff M, Burchman C, Schwartzman J, Thorun V, Read M, Wood Tand Beach M. Transmission of pathogenic bacterial organisms in the anaesthesia work area. *Anesthesiology* 2008;109:399-407
10. Loftus R, Muffly M, Brown J, Beach M, Koff M, Corwin H, Surgenor S, Kirkland K and Yeager M. Hand contamination of anaesthesia providers is an important risk factor for intraoperative bacterial transmission. *Anesth Analg* 2011;112:98-105
11. Van Belkum A, Melles DC, Nouwen J, van Leeuwen WB, van Wamel W, Vos MC, Wertheim HFL, Verbrugh HA. Coevolutionary aspects of human colonization and infection by *Staphylococcus aureus*. *Infect Genet Evol* 2009;9:32-47
12. Australian and New Zealand College of Anaesthetists ABN 82055042 852 Guidelines on Infection Control in Anaesthesia PS28 (2005).

Safety alert – caution with chlorhexidine

In recent years the number of cases of chlorhexidine anaphylaxis diagnosed at many Australian and New Zealand anaesthetic allergy clinics has increased. This has now become an area of increased research focus for the Australian and New Zealand Anaesthetic Allergy Group (ANZAAG) and the Anaesthetic Allergy Subcommittee of the Quality and Safety Committee of ANZCA.

All anaesthetists should be aware of the potential for chlorhexidine to cause anaphylaxis and to refresh their knowledge on anaphylaxis management. It is important to recognise that patients may be exposed to chlorhexidine in many forms, including urethral gels, impregnated central lines and skin wipes and preps. In many cases, particularly when the antigen is absorbed transmucosally, the onset of anaphylaxis is delayed from the administration. This may result in the diagnosis being delayed or missed.

An increasing push from health regulators to use chlorhexidine in an increasingly wide variety of clinical uses is expected. Debate continues about where the line should be drawn between the benefits of the excellent antiseptic properties of chlorhexidine versus the risk with its use.

Anaesthetists are reminded to be vigilant for signs of anaphylaxis in the perioperative setting and to include chlorhexidine on the list of possible antigens when referring for allergy workup if the patient has been exposed to chlorhexidine in any form. Additionally, chlorhexidine containing wipes should not be used for disinfecting IV bungs and should be allowed to dry on skin before invasive procedures are undertaken.

Dr Michael Rose

Chair, Australian and New Zealand Anaesthetic Allergy Group (ANZAAG) Chair, Allergy Subcommittee, Quality and Safety Committee of ANZCA Director, Royal North Shore Hospital Anaesthetic Allergy Clinic

Successful candidates

Primary examination July/September 2012

One hundred and ninety two candidates successfully completed the Primary Fellowship Examination at this presentation and are listed below:

Ben Wilson	ACT	Malcolm Ronald James Bannerman	NSW	Li Ling Yeow	Qld
Brandon James Burke	ACT	Marc James Capon	NSW	Lynton Ashley Hargrave	Qld
Christopher Harold Van Leuvan	ACT	Megha Jain	NSW	Mary Catherine O'Shea	Qld
Katie McCloy	ACT	Melissa Susan Jackson	NSW	Mazyar Danesh Firooz Adabi	Qld
Ramprasad V	ACT	Michael Julian Hicks	NSW	Mbakise Pula Matebele	Qld
Alexandra Nadine Simmons	NSW	Michelle Jane Castro	NSW	Michael Francis Hussey	Qld
Alfred Tanaka Mahumani	NSW	Neelam Bhala	NSW	Mitchell James Lawrence	Qld
Alice May Whyte	NSW	Nicola Alexandra Moore	NSW	Peter Michael Kerr	Qld
Andy Chih-Wei Ho	NSW	Niklas Ove Jaakko Thapper	NSW	Rachel Claire Bourke	Qld
Blake Kesby	NSW	Patricia Carroll	NSW	Rebecca Elizabeth Roach	Qld
Brad Alexander Sheridan	NSW	Pradeep Rajendran	NSW	Rochelle Leigh Ryan	Qld
Brenton Peter Coats	NSW	Richard Hall	NSW	Roland Bartholdy	Qld
Caroline Clare McCombie	NSW	Robert John Scott	NSW	Sachin Verma	Qld
Chaminda Wijeratne	NSW	Sarah Louise Boyle	NSW	Shaun Emmanuel De Cruz	Qld
Chiong Hui Tiong	NSW	Sean Wesley Wright	NSW	Tara Leigh Smith	Qld
Christopher James McMahan	NSW	Sharon Lisa McGregor	NSW	Timothy Rose	Qld
Christopher James Mumme	NSW	Sivapathasundaram Achuthan	NSW	Vedharathnam Balsubramaniam	Qld
Daniel Moi	NSW	Solmaz Bezyan	NSW	Eddie Khoo	SA
David Eric Champion	NSW	William Breton Bestic	NSW	Kristopher Alexander Nolan Usher	SA
David Healy	NSW	Megan Anne Walmsley	NT	Linda Le	SA
David Richard Denman	NSW	Adam John Hicks	Qld	Mark Philip Plummer	SA
Eng Tiong	NSW	Anna Louise Milanovic	Qld	Melissa Jusaitis	SA
Gowri Jegasothy	NSW	Annette Carin Lye	Qld	Rachelle Anh Augustes	SA
Hoi Tin Rex Yuan	NSW	Ashlea Jane Meehan	Qld	Robyn Ruth Wangui Maina	SA
Jade Shandler	NSW	Babitha Kudakandira Basappa	Qld	Salam Adil Naeem Al-Khoury	SA
James Christopher Atkins	NSW	Daniel Hyde	Qld	Tanya Przybylko	SA
Jasveen Kaur Chadha	NSW	David Edwin Young	Qld	Benjamin Laurence Snow	Tas
Jatinder Paul Grewal	NSW	David W Wood	Qld	Christopher James Wilde	Tas
Joshua Frank Rijdsdijk	NSW	Eliza Jane Doneley	Qld	Jack Douglas Madden	Tas
Kieran Paul Somerville	NSW	Elizabeth Joanne McLellan	Qld	Pravin Dahal	Tas
Lee Zimmer	NSW	Emilia Gisella McGhee	Qld	Adrian Scott Grigo	Vic
Lois Gayeon Oh	NSW	Gerard Michael Eames	Qld	Alison Margaret Jarman	Vic
Louisa Frances Lowes	NSW	Helen Elizabeth Miles	Qld	Anastasia Mellios	Vic
		Irene Hsin-Hsuan Doo	Qld	Andrew Thomas Woolley	Vic
		Jade Danielle Jones	Qld	Anna Jane Loughnan	Vic
		Jim Hao-Chun Yen	Qld	Anneliese Renee McBride	Vic
		Jodie Anne Beuth	Qld	Annie Poon	Vic
		Jonathon Paul Fanning	Qld	Christopher Larnoch Johnson	Vic
		Julia Elizabeth Day	Qld	Daniel Banyasz	Vic
		Julie Lee	Qld	Daniel Gunther Stanszus	Vic
		Katherine Anne Steele	Qld	Danielle Catherine White	Vic
				David James Brewster	Vic

Dennis Eng Keat Teh	Vic	Greta Claire Pearce	NZ
Dylan Rajeev Rajeswaran	Vic	Hannah Mary Gibson-Lapsley	NZ
Grace Chieng	Vic	Heather Louise Short	NZ
Gregg Miller	Vic	Heng-Yi Wu	NZ
Jacqueline Louise Robson	Vic	Jacqueline Gwenda Blay	NZ
Jacquelyn Maree Evans	Vic	Jean-Paul Marc Banane	NZ
James Ming Zeng	Vic	Jennifer Ellen Hudson	NZ
John Ozcan	Vic	Johanna Renate Pigou	NZ
Jonathan Luke Begley	Vic	Kiew Chai Law	NZ
Julia Alexandra Dubowitz	Vic	Laura Wei Shaan Kwan	NZ
Justin Mark Nazareth	Vic	Linda Xue Zhou	NZ
Karl Alan Ruhl	Vic	Mark William Fisher	NZ
Kathryn Lee Hersbach	Vic	Michael Frederick Hamilton	NZ
Li-Ni Lin	Vic	Philip Garbutt	NZ
Matthew Durie	Vic	Raymond Patrick Casey	NZ
Matthew Thomas Blair	Vic	Reuben John Miller	NZ
Matthew Wai Kei Lee	Vic	Ryan James Kavanagh Salter	NZ
Nancy Fammartino	Vic	Tobias Michael Betteridge	NZ
Omeed Mohammed Nouri Albazzaz	Vic	Ho Yan Jenny Luk	HK
Peter John Commons	Vic	Jieting Ding	HK
Samuel Timothy Costello	Vic	Ka Chung Shek	HK
Soon Yee Teoh	Vic	Ka Kit Chan	HK
Stephanie Pei Pei Chen	Vic	Manimala Dharmangadan	HK
Sze Ying Ng	Vic	Sumire Sasaki	HK
Tessa Pamela Smith	Vic	Vivian Nga Man Lau	HK
David Baguley	WA	Ying Tung Etonia Pang	HK
Emily May Fergie	WA	Yip, Chi Pang	HK
Graeme Howard Johnson	WA	Angela Yun June Tan	Sing
Jeremy Ian Milne	WA	Chau Keen Chong	Sing
Josef Marian Ferguson	WA	Daphne Moo	Sing
Nicolaas Edward Charles		Haji Satry Haji Sani	Sing
Patrick Velzeboer	WA	Ho Ying Ci	Sing
Rajiv Menon	WA	Hui Jian John Paul Lew	Sing
Amanda Catherine Gimblett	NZ	Margareth Kwok H M Kurniawan	Sing
Anthony James Carrie	NZ	Michelle Bee Hua Tan	Sing
Antony Sione Aho	NZ		
Chen Gong	NZ		
Daniel Brook Wood	NZ		
Duane John English	NZ		
Elizabeth Alexandra Louise West	NZ		
Grace Pui Yee Choy	NZ		

Merit certificates

Merit certificates were awarded to:

Andrew Thomas Woolley	Vic
Annette Carin Lye	Qld
Blake Kesby	NSW
Christopher Larnoch Johnson	Vic
Daniel Brook Wood	NZ
Daniel Moi	NSW
Earlene Silvapulle	Vic
Eddie Khoo	SA
Emilia Gisella McGhee	Qld
Gregg Miller	Vic
Heng-Yi Wu	NZ
James Ming Zeng	Vic
Jennifer Ellen Hudson	NZ
Jim Po-Chun Liou	NSW
Joanne Louise Chapman	NSW
Julia Elizabeth Day	Qld
Justin Mark Nazareth	Vic
Ka Chung Shek	HK
Laura Wei Shaan Kwan	NZ
Linda Xue Zhou	NZ
Manimala Dharmangadan	HK
Matthew Durie	Vic
Ryan James Kavanagh Salter	NZ
Stephanie Pei Pei Chen	Vic
Vivian Nga Man Lau	HK
Yip, Chi Pang	HK

Clarification: In the June *ANZCA Bulletin* the successful candidate Shirin Jamshidi's name was misspelt. We apologise for the error.

Renton Prize

The Court of Examiners recommended that the Renton Prize for the half year ended December 31, 2012 be awarded to:

Mark Philip Plummer	SA
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Successful candidates

continued



Final examination August/October 2012

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

Andrew Deacon	ACT
David Richard Neale	ACT
Jennifer Anne Myers	ACT
May Ke-mei Leung	ACT
Will Matthiesson	ACT
Chloe Louisa Tetlow	NSW
Danelle Dower	NSW
Daniel Thomas Orr	NSW
Don Franciskuge Jeewaka Perera	NSW
Emma Louise Rosenfeld	NSW
Eugene Andre Mansour	NSW
Felicity Anne Bowen	NSW
Fredy Surianto	NSW
Iain Campbell Stewart	NSW
Julia Catherine Lesley Birch	NSW
Karthik Nagarajan	NSW
Katherine Lavis	NSW
Michelle Ming Yee Kwok	NSW
Michelle Yian Fern Lye	NSW
Nandanam Varatharajan	NSW
Ngaroma Tiritia Steele	NSW
Robert Bishop	NSW
Sancha Claire Robinson	NSW
Shona Chung	NSW
Simon Alexander Collins	NSW
Adel Wesley	Qld
Alexander Angus Cottle	Qld
David Fung	Qld
Gregg Ross Masterson	Qld
Hsing-I Gina Hsu	Qld
Jeffrey Francis Mott	Qld
Nigel Adam Thomson	Qld
Nigel Burnet	Qld
Patrick James Nelmes	Qld
Petrus Johannes Kotze	Qld
Sadhish Kumar Shanmugam	Qld

Satnam Singh Solanki	Qld
Stacey Swinkels	Qld
Suran Dhanapala	Qld
Vesselin Naoumov Petkov	Qld
Adeline Siu Yin Fong	SA
Alexandra Elizabeth Zanker	SA
Bjorn Pederson	SA
Lok Yin Evelyn Cheng	SA
Nicole Enid Wylie	SA
Philippa Louise Lane	SA
Seong Chien Wei	SA
Simon William Patrick Roberts	SA
Suzanne Louise Cartwright	SA
Anders John Bown	Tas
Joanna Elizabeth Jane Walsh	Tas
Sandy Zalstein	Tas
Shaun Daniel O'Brien	Tas
Ayantha Harshini Ralph	Vic
Bruce David Newman	Vic
Carsten Aase	Vic
Charlotte Jane Heldreich	Vic
Dean Bunbury	Vic
Gabriel Berra	Vic
Ian Nguyen	Vic
Michelle Diana Gerstman	Vic
Raviram Ramadas	Vic
Shaktivel A/L G Palanivel	Vic
Simon Hendel	Vic
Thambiliyagoda Gamage	
Gayani Iresha Amarajeewani	
Dissanayake	Vic
Brian Mun Wei Hue	WA
Candy Skye Edwards	WA
Leena Kumari Nagappan	WA
Mohd Yusme Reza Mohd Yusoff	WA
Amy Louise Gaskell	NZ
Chao-Yuan Chen	NZ
Chrysanthus Marlin De Silva	NZ
George Ripley Gorringer	NZ
Han Tuan Truong	NZ
James Raymond Broadbent	NZ
Matthew Ronald Miller	NZ
Paul Grant Young	NZ
Ravi Shankar Manda	NZ

Sam Wong	NZ
Tong Wei Chung	NZ
Tuang Ik Loy	NZ
Vaishali Yatin Kharkar	NZ
David Tak-Wai Leung	HK
Hong Yip	HK
Tung Hoi Ying Queenie	HK
Cindy Thomas Joseph	Mal
Choo Wee-Sen	Sing
Lau Yie Hui	Sing
Oriana Ng	Sing
Paul Cheng Loon Chan	Sing
Rohit Vijay Agrawal	Sing
Swapna Thampi	Sing
Thong Sze Ying	Sing
Wilfred Wei Ming Lim	Sing
Ashokka Balakrishnan	Sing

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

Madhav Venkateswararao	
Pendyala	NSW
Namrata Singh	NSW
Ali Zwain	NSW
Zoran Stojkovski	NT
Desire Banda	Qld
Justin Louis Booyse	Qld
Isaivaine Lingham	Qld
Gertrude Rudo Mutika	Qld
Ilamurugu Kaliaperumal	SA
Medhat Wahba Fouad Wahba	SA
Jens Rossberg	Vic
Anja Beilharz	WA
Narinda De Mel	WA
Melissa Gildenhuys	WA

Cecil Gray Prize

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended December 30, 2012, be awarded to:

Anders John Bown	Tas
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Merit certificates

Merit certificates were awarded to:

Simon Alexander Collins	NSW
Jennifer Anne Myers	ACT

Special interest group event

2012 Combined SIG – Simulation, Education, Welfare and Management in Anaesthesia



Beautiful Sanctuary Cove on Queensland's Gold Coast was the venue for this year's Combined SIG meeting, which took place from September 21-23. The theme of the meeting, "Workforce: Future force", was chosen by the Management SIG, which also was responsible for convening the meeting.

The meeting was intended to emphasise the people aspect of anaesthesia rather than the science behind it, and this goal was achieved thanks to an incredible line up of speakers, thought-provoking topics and highly engaged delegates. We were pleased to attract approximately 100 delegates and the feedback received was overwhelmingly positive.

The opening session set the tone for what was to be a superb meeting, and covered the crucial topic of clinical leadership in medicine.

Professor Joñ Clark, the keynote speaker and a senior Fellow in leadership development, gave an inspirational talk on how doctors can improve patient care and healthcare services by becoming engaged in management and leadership. Dr Peter Steer, a neonatologist and paediatrician from Queensland, offered proof of this concept by speaking about his experiences during the development of vital paediatric services in Canada and Australia.

This session was followed by two days of lectures and workshops that covered a wide variety of topics within the umbrella of each SIG, all of them well attended and resulting in lively debate both within the sessions and informally. Some of the topics covered included controversies with EMAC and other forms of simulation training, how to identify and cope with bullying in the workplace, the impact of medico-legal matters on doctors, and the relevance of peer-review groups in anaesthesia practice.

Workshops were popular and the pre-meeting workshop on the "accidental manager" was particularly relevant and enjoyable. The Australian Institute of Management ran a series of workshops about bullying, mentoring and time management, and Dr Natalie Smith, of the Education SIG, presented workplace-based assessment training, which was very useful to all those who attended.

Last but not least, the social events were well attended and judging by the noise and activity, thoroughly enjoyable! The conference dinner was held at Warner Bros. Movie World, where roller coaster riding and dancing continued well into the night and a good time was had by all.

Finally, as convener of the 2012 meeting, I wish to thank Professor Thomas Bruessel, chair of the Management SIG, and Ms Hannah Burnell, ANZCA SIG Co-ordinator of ANZCA, for their unfailing encouragement and support.

The 2013 meeting will be headed up by Dr Prani Shrivastava, of the Welfare SIG, and she is already hard at work putting together another fabulous program to match the fabulous location – The Outrigger Hotel at Noosa – from September 20-23. We hope to see you there next year!

Dr Lisa Zuccherelli
Convener

Above clockwise from left: Hyatt Regency Sanctuary Cove; Dr Ross Lamplugh and Dr Lisa Zuccherelli; Dr Tracey Tay and Maurice Hennessy; Professor Joñ Gibbs and Dr Di Khursandi; Practicing laryngoscopes.

New Zealand news



Speaker quality the drawcard for NZ conference

The NZ Anaesthesia Annual Scientific Meeting and the 13th International Congress of Cardiothoracic and Vascular Anesthesia (ICCVA) combined conference held in Auckland in November proved an outstanding success, with more than 650 attendees registered by opening time.

Guests included more than 100 distinguished speakers from the US, Canada, Australia, New Zealand and 12 other countries, along with representatives from the healthcare industry.

ANZCA co-hosted the conference along with the NZ Society of Anaesthetists (NZSA) in association with the (US) Society of Cardiovascular Anesthesiologists.

The conference organisers, drawn from practising anaesthetists at Auckland City Hospital and led by co-convenors Dr Marian Hussey and Dr Ivan Bergman, put together an extensive program covering the cardiothoracic and vascular anaesthesia specialties, as well as a wide range of other anaesthesia topics.

The scientific co-convenor, Professor Alan Merry, said the quality of the speakers was clearly a drawcard, with probably the best line up of speakers ever seen for a New Zealand anaesthesia conference.

Delegates showed great appreciation for both the general stream subjects and the specialist cardiothoracic and vascular streams, with plenary sessions full throughout the event. There was similar support for the extensive range of workshops, breakfast sessions and problem-based learning discussions as well as for the 50 electronic poster sessions, which attracted entries from 13 countries.

At the gala dinner, ANZCA President Dr Lindy Roberts presented members of the anaesthesia department at Christchurch Hospital with the ANZCA citation awarded earlier this year for their outstanding performance during the time of the Christchurch earthquakes.

Last year's NZ Anaesthesia ASM dinner initiated the practice of soliciting donations for the World Federation of Societies of Anaesthesiology Lifebox Project, and raised around \$NZ25,000. At this year's dinner, Dr Maurice Lee talked about the using that money in Vietnam for 60 pulse oximeters and again called for donations, raising a further \$NZ18,000.

The 2013 NZ Anaesthesia ASM will be held in Dunedin from November 6 to 9.

Susan Ewart
Communications Manager, New Zealand

Above clockwise from top left: Morning tea amid the healthcare industry exhibition; ANZCA President Dr Lindy Roberts pictured with Christchurch Hospital Department of Anaesthesia representatives after presenting them with an ANZCA citation (from left: Dr Lindy Roberts, Anaesthetic Technician Andrew Sandison, Senior Medical Officer Dr Chris Harrison and Provisional Fellow Dr Rob Young); The NZ Anaesthetic Technicians' Society (NZATS) held their conference in parallel sharing the opening reception (from left: NZATS CEO Karen Bennett and outgoing NZATS President Michele Peck); International speakers Professor Al Perrino (left) from Yale University with Professor Bruce Spiess from the Virginia Commonwealth University Medical Center in the US; At the pre-dinner drinks, from left: Dr Mohua Jain from Wellington Hospital, Dr Rachele Williamson, Dr Jennifer Woods and Dr Paul Smeele, all from Christchurch Hospital; At the opening reception sponsored by the healthcare industry (from left: NZNC Chair Dr Geoff Long, NZSA President Dr Rob Carpenter, Dr Lucas Sikiotis from Waikato Hospital and Dr Chris Horrocks from Wellington Hospital).



Visiting lectureships

The New Zealand Anaesthesia Education Committee (NZAEC) has awarded three NZ Anaesthesia Visiting Lectureships for 2013. The lectureships provide funding for the lecturers to take their highly recommended presentations to two regional centres each.

Dr Matthew Taylor from Middlemore Hospital will present on “enhanced recovery after surgery”, looking at practices that have been adopted in his hospital with impressive results. His talk focuses on aspects of patient optimisation perioperatively in order to decrease morbidity, improve patient care and decrease the time that patients need to spend in hospital for elective colorectal surgery.

Professor Brian Anderson from Starship Children’s Hospital in Auckland is the most published paediatric anaesthetist in Australia and New Zealand and an international expert in paediatric pharmacology. Dr Niall Wilton, who nominated him, considers that presentations from Professor Anderson on “age-related pharmacology in anaesthesia” and “aspects of paediatric anaesthesia and intensive care” would be of great interest and benefit to centres that do some paediatric anaesthesia.

The third 2013 Visiting Lecturer is Dr Rachele Williamson, who will present on “Christchurch quake: New Zealand’s darkest day”. Dr Williamson is a member of the Christchurch Group (Research into Seismic Events) which is drawn from a number of specialities and has collected data from events around the Christchurch earthquakes. She has access to accurate raw data on patterns and types of clinical presentations and first-hand experience of the events on February 22, 2011. Dr Williamson describes the factual events with good “hard” data but also colours in the emotional and practical implications of maintaining service during a natural disaster. The impact of her presentation is to shake people’s complacency over their familiarity with their personal and facility plans and illustrate how no plan survives first contact with reality.

Ephedrine

Following representations from the New Zealand National Committee (and others), the Ministry of Health has advised that ephedrine needed for emergency use is now exempt from regulation 28 of the Misuse of Drugs Regulations 1977.

Last year, ephedrine was reclassified as a Class 2B controlled drug under the *Misuse of Drugs Act 1975*, with consequent secure storage requirements that made it far less accessible when needed in an emergency. The NZNC wrote to the ministry requesting that patient safety not be compromised by the new requirements when it came to drafting the associated regulations.

In September this year, the ministry’s chief medical officer, Dr Don Mackie, advised ANZCA that the ministry had determined that “ephedrine injection is required for immediate use in an emergency and is exempt from the custody of controlled drugs requirements provided in regulation 28(1) of the Misuse of Drugs Regulations 1977. In practical terms, this exemption means that ephedrine injection can be stored for use in an emergency situation in a non-secure place:

- On a resuscitation cart in a hospital or medical facility.
- Within an obstetric (or other) ward where epidural anaesthetics are administered.
- Within an intensive care unit.”

The exemption applies only where the clinical need for access to ephedrine is supported by evidence and has been reviewed and agreed by a hospital’s drugs and therapeutics committee. It also applies only to the storage requirements.

As with all other Class B controlled drugs, ephedrine use must be recorded in a controlled drug register and any losses of ephedrine injection must be reported to the Medicines Control Team at the Ministry of Health and investigated by the healthcare facility.

The exemption will be subject to review, particularly if there is evidence of product diversion or abuse – ephedrine and pseudoephedrine were reclassified as Class B2 drugs because of concern about their abuse and diversion to manufacture methamphetamine.

HPCA Act review

Health Workforce New Zealand (HWNZ) is considering the 142 submissions it received on the review of the *Health Practitioners Competence Assurance Act 2003* including one from the ANZCA New Zealand National Committee (NZNC).

Further consultation on any proposed changes to the legislation is scheduled to take place in March and April 2013 before a final report is submitted to Cabinet by mid-year.

In its November *Stakeholder Bulletin*, HWNZ said the act’s primary aim remained the protection and promotion of public safety, while taking account of a changing health environment where practitioners worked in integrated and multi-disciplinary teams.

“Legislation also needs to support practitioners to work flexibly and at the top of their professional scope, and to strike a balance between safe practice and an appropriate level of pastoral care for individual practitioners,” HWNZ said.

ANZCA’s submission focused on the need to maintain patient safety as the primary purpose and focus of the act. It said regulation of health practitioners must support this purpose; however, this did not preclude processes other than or additional to the current ‘one size fits all’ approach.

The NZNC commented on the importance and effectiveness of the anaesthesia team, particularly the role of anaesthetic technicians (currently regulated under the act), and noted that the act as it stood did not compromise this team approach. The committee also advocated for further research and the use of robust evidence and informed policy options before any significant changes were made to the act.

Above from left: Dr Matthew Taylor; Professor Brian Anderson; and Dr Rachele Williamson.

Queensland



Mission Beach report

Anaesthetists from the tropics gathered at the Castaways Resort in Mission Beach for the third Biennial Mission Beach Anaesthesia Conference. The event was a relaxed gathering of anaesthetists from the various regions of north Queensland, including Darwin, Cairns, Townsville and Mackay, and has become a popular event providing a meeting point to discuss clinical issues, and for families and colleagues to catch up with one another.

The conference is set in the picturesque and relaxed setting of Mission Beach and a relaxed dress code is strictly enforced – board shorts and sandals! Sunset drinks overlooking the palm-studded beach were enjoyed by all and the provision of children's meals and eating area added to the inclusive and friendly nature of the conference.

Another highlight was a game of soccer on the vast expanse of beach, where more than 40 anaesthetists and their families battled it out – age was no barrier and, although there were a few casualties, mainly over-ambitious middle-aged anaesthetists, no ambulances were required!

Once the frivolities were over there was time for some informative and thought-provoking talks, which opened up lively discussions and debates. The sessions were well attended and covered myriad issues affecting anaesthetists in northern and regional Australia and ethical issues experienced in contemporary anaesthesia. Final exam practice vivas were scheduled as part of the program, as was an informative workshop on the intricacies of the ANZTADC program. A panel discussion on post-operative analgesia for obstetrics concluded the conference.

The success of the conference was due to the hard work and organisation of Emile Kurukchi, Andy Potter and Mark Fairley, who orchestrated one of the region's best-attended and most successful anaesthetic conferences. One can only say it was Mission accomplished!

Regional education officer visits Queensland hospitals

The ANZCA training region covered by Queensland extends from Cairns in the far north of the state to northern NSW and Darwin.

Teaching departments are diverse and vary in size from two or three trainees in regional areas to up to 35 or more in the major metropolitan centres in the south-eastern corner.

This year, the Queensland Regional Committee secured funds from the Queensland Health Ministerial Taskforce, which enabled the regional education officer to visit some of the ANZCA training sites outside the south-eastern corner.

In October, regional education officer Dr Jeneen Thatcher visited Rockhampton Base Hospital where she met with staff specialists, senior staff and trainees. Dr Thatcher gave a presentation on the new curriculum, followed by informal discussions. During the day-long visit, trainees were given an opportunity to meet individually with the Dr Thatcher to discuss specific training needs and address any concerns.

Later in October Dr Thatcher visited far north Queensland, spending a day in each of the Cairns, Townsville and Mackay hospitals. After a curriculum presentation, valuable discussions ensued around issues of implementation and transition. Some issues were taken 'on notice' back to the College.

The visits have been a valuable experience for the regional education officer, Fellows and trainees and provided Dr Thatcher with opportunity to meet face-to-face with those working hard outside the major metropolitan centres of south-east Queensland.

Dr Thatcher now plans to visit hospitals in Bundaberg, Hervey Bay, Maryborough and Lismore before the end of the year and to visit outer metropolitan hospitals early in 2013 before the start of the new hospital training year.

Above from left: Dr Andrew Potter, Dr Emile Kurukchi and Dr Mark Fairley; Dr Sean McManus, Dr Emile Kurukchi and others playing soccer.

Opposite page above from left: Queensland regional education officer Dr Jeneen Thatcher meeting with Fellows and trainees in Cairns; Dr Thatcher (fourth from left) visits the Mackay Hospital anaesthetic department; Dr Thatcher (centre) during her visit to Townsville anaesthetic department.



Queensland regional report

As the end of the year approaches, education and training support activities for 2012 are coming to an end and preparation for 2013 is well underway with an emphasis on implementing the revised curriculum.

Significant effort has been invested this year in preparing Fellows filling College representative roles, trainees and anaesthetic departments for the revised curriculum. As each aspect of the curriculum was finalised, an energetic band of Queensland Fellows led by the Queensland regional education officer Jeneen Thatcher, ensured that details were communicated to all stakeholders. Queensland supervisors of training are well versed in workplace-based assessments and the training portfolio system.

The Queensland Regional Committee has secured funding from the Queensland Health Ministerial Taskforce to support delivery of anaesthetic services in regional areas. This grant is funding visits by the regional education officer and workplace-based assessor champions to regional hospitals to support supervisors of training and trainees in the workplace during the next 12 months. Visits to date have provided valuable feedback. The grant is also supporting the continuation of the podcast/webinar project commenced last year. Podcasts addressing learning outcomes of introductory training are being recorded. A series of webinars will be held February to March 2013. Three more recording sessions and two additional webinar series are planned next year.

Again this year, retired anaesthetists have been invited to lunch at the Queensland office. While only small numbers attend this event it is greatly appreciated by these Fellows, who also are frequent participants in continuing education activities.

All Queensland regional committees have conducted their last meetings for 2012 and have acknowledged the contribution of hard working members with offsite break-up dinners.

The education and training calendar for 2012 has concluded. The Queensland Regional Committee would like to acknowledge the work of a dedicated and capable band of course convenors, lecturers and mock examiners who have offered trainees the following valuable learning opportunities:

- Primary lecture series – semester one and two (one Saturday a month for five months).

- Primary exam preparation course (two weeks of intensive exam preparation).
- Final exam preparation courses (two by one-week of intensive exam preparation).
- Primary and final viva practice sessions (eight sessions throughout the year).
- Primary residential viva weekend.
- Annual registrars' scientific meeting.
- Podcasts and webinars funded from the Queensland Health Ministerial Taskforce Grant.

Thanks is also extended to the members of the ANZCA/Australian Society of Anaesthetists Combined Continuing Medical Education Committee who hosted a well attended one-day conference and four informative evening lectures.

Australian Capital Territory



Annual general meeting

The ACT region held their annual general meeting on November 12 in the local office with lots of local issues being discussed. Attended by ANZCA CEO Ms Linda Sorrell, it was a great opportunity for some of the local Fellows to meet her and raise any concerns they held. It was also timely for getting some of the salient points of the curriculum revision out to a wider audience. Locally, we have also held our annual registrar workshop on November 1. It was held at the Canberra Hospital this year with Dr Patsy Tremayne from Sydney speaking to our local trainees about exam preparation and approaches to exams. It was very well received with lots of positive feedback from our local trainees who were able to attend.

South Australia and Northern Territory



Anaesthesia and the failing organ

The ANZCA/ASA SA and NT Annual Scientific Meeting “Anaesthesia and the failing organ” was held on Saturday, November 3 at The Sanctuary, Adelaide Zoo. With nearly 100 delegates in attendance and an excellent speaker program, it was a very successful and highly commended meeting by attendees. The Continuing Educational Committee were pleased to see ANZCA trainees in attendance along with Fellows of the College and several nursing staff who work closely with anaesthetists and surgeons in the area of organ donation.

The scientific program was delivered by 10 guest speakers. Interstate speaker Dr Aric Bendorf is currently completing his PhD at the University of Sydney at the Centre for Values, Ethics and Law in Medicine and spoke of his research using comparative analysis of international organ donation systems to determine what is required for Australia to improve its deceased organ donation rate. Associate Professor Toby Coates, Renal Transplant Nephrologist at the Central Northern Adelaide Renal and Transplantation Service, Royal Adelaide Hospital and Associate Professor of Medicine, University of Adelaide, gave a very well received talk on principles of immunosuppressive therapy, current immunosuppressive drugs and understanding rejection and strategies to prevent rejection. The convener and SA and NT Chair of the Continuing Education Committee, Dr Nathan Davis, would like to thank all the speakers for their time and for sharing their experiences and areas of expertise, as well as to acknowledge the corporate support of the seven healthcare industry companies in attendance. The next SA and NT annual scientific meeting will be held in November 2013 and will be the triennial Burnell Jose Visiting Professorship Meeting.

Tasmania



Activities in Tasmania

The combined ANZCA/Australian Society of Anaesthetists Tasmanian annual scientific meeting will be held at The Tramsheds in Launceston from March 15-17. A mid-year meeting at the Freycinet Lodge, near Coles Bay, is also planned for August 3-4 with a medico-legal theme.

As a new innovation, two pilot anatomy workshops are being developed with the Anatomy School at the Menzies Centre, University of Tasmania. These are being co-ordinated by Dr Nico Terblanche from the Royal Hobart Hospital. Current planning is for a half-day workshop which will incorporate use of ultrasound for regional blocks. Provisional planning is for an upper limb workshop, followed by a lower limb workshop later in the year. Numbers will be limited to maximise individual participation.

Recently, the Federal Government wrote to ANZCA announcing extra funds for training in Tasmania. The Regional Committee is working with ANZCA to prepare submissions for this funding.

Lastly, it is with considerable regret that the Tasmanian Regional Committee received the notice of resignation from our Regional Co-ordinator, Di Cornish, who has been with us for more than 20 years. We wish her well for the future.

Western Australia



WA Regional Office

The WA Regional Office has been busy co-ordinating events and tutorials.

The ANZCA/Australian Society of Anaesthetists WA combined continuing medical education meeting presented 'Updates in anaesthesia 2012: Hectic obstetrics and frenetic anaesthetics'. The event was held from October 12-14 at Pullman Resort, Bunker Bay, Dunsborough, WA. The plenary speaker was Professor Warwick Ngan Kee, the Director of Obstetric Anaesthesia in the Department of Anaesthesia and Intensive Care at the Chinese University of Hong Kong. The meeting was attended by 84 delegates and convened by Dr Celine Baber. It was a massive success and the WA office thanks all those involved in organising the conference.

The GASACT movie night was held on the October 25 for all ANZCA and Australian Society of Anaesthetists trainees to attend at Ace Cinemas in Subiaco.

Part II tutorials have continued to be held at the ANZCA office and through the hospital campuses. Trainees are signing up for the new round of tutorials which commence in November.

The WA office is preparing for the new curriculum through teleconferences with Oliver Jones and Allan Meers. The regional education offer/supervisor of training committee has been walked through the new trainee portfolio system and the Western Australia Regional Committee will see the new system on the November 27 when Oliver and Allan meet the committee.

Over the next couple of months the WA office will be busy planning and preparing for next year.

Opposite page clockwise from top left: SA/NT CME Committee members Dr Gareth Lyttle and Dr Andrew Thomas; Lunch on the terrace; CME Chair Dr Nathan Davis directing panel in case study questions; Delegate lunch in the Durrell Gallery; Speaker Dr Sally Tideman; Dr Mark Buckland, Dr David Daly and Dr Nathan Davis (SA CME Chair).

Above from top: Bunker beach; Conference dinner at Wise Winery.

Victoria



Victorian Registrars' Scientific Meeting 2012

The Annual Victorian Registrars' Scientific Meeting (VRSM) was held on Friday November 16 at the College.

The meeting opened with a presentation from Associate Professor Philip Peyton from the ANZCA Trials Group and Austin Health, who also adjudicated the presentations.

The meeting consisted of two sessions chaired by Dr Mark Adams, Director of Anaesthesia at Monash Medical Centre, and Dr Shiva Malekzedah, Supervisor of Training at Austin Health.

This year we had a welcome attendance of 41 registrars representing most of the training hospitals in Melbourne.

In awarding the VRSM 2012 Prize to Dr Kristine Moser, Associate Professor Peyton praised the standard of the presentations at the meeting and wished the trainees success in their chosen craft.

Dr Richard Horton, Regional Education Officer, closed the meeting with a vote of thanks to Associate Professor Peyton, the chairs and registrars who attended.

Above from top: From left: Dr Kristine Moser, winner of the VRSM 2012 prize and presenters, Dr Ronald Cheung, Dr Jennifer Fu, Dr Vaughan Bertram, Dr Verity Sutton and Dr Tim Paterson; Dr Shiva Malekzedah (chair, session one), Dr Mark Adams (chair, session two), VRSM 2012 Prize winner Dr Kristine Moser, Associate Professor Philip Peyton (judge) and Dr Richard Horton (Regional Education Officer).

Australian news continued

New South Wales



NSW spring regional conference

The NSW spring regional conference was held on November 3-4 at the Shoal Bay Resort and Spa and included more than 140 delegates and speakers. A comprehensive lecture stream and concurrent workshops and PBLDs involved 25 speakers, including our international invited speaker, Professor Michael Beach from Dartmouth Medical School, New Hampshire, US. The program was well received by delegates. A special mention should go to the CareFlight team who ran a workshop on the beachfront on emergency procedures in the out-of-hospital setting using simulation equipment. This was a highlight of the weekend generating good feedback from delegates and interested public alike. We want to thank all the speakers for their hard work and dedication to the scientific program.

Above clockwise from left: Careflight workshop; Associate Professor Joñ Loadsman's workshop; Dr Luke Bannon's workshop; Conference dinner; Dr Simon Martel conducts a resuscitation session on the beach; Main plenary room.



Supervisors of training meeting

Thirty four eager supervisors of training from around NSW gathered at ANZCA's offices on November 16 for our second supervisor of training (SOT) meeting of the year. Most of the day focused on what SOTs need to know and be able to do to oversee implementation of the 2013 curriculum in their departments.

Oliver Jones and Joanne Dwyer joined us from Melbourne and walked us through the new training portfolio system (TPS). They provided an invaluable first look at the system and an insight into how the program will work for trainees and supervisors of training.

Nicole Phillips, Mark Priestley and Scott Fortey helped the group to run through topics from the introductory anaesthetic period, to specialised study units (SSU), clinical placement review (CPR) and core unit review (CUR) sign-off, as well as what the new scholar role will mean at a departmental level.

Olly and Joanne fielded many questions and helped us to understand the new curriculum. Evaluations from the day were very positive in terms of what attendees had learned, though many have realised how much more there is to learn!

Many thanks to Annette and her helpers in the NSW office, who helped make the day run so smoothly.

Anatomy for Anaesthetists

The annual Anatomy for Anaesthetists' Workshop was held at the Anatomy Department of Sydney University on Saturday November 24. Numbers were limited to 50 to keep the groups small and the access to the specimens was excellent as a result. These specimens had been specifically dissected for anaesthetists and gave a great perspective of nerves. We will be running this workshop again in 2013 on November 23.



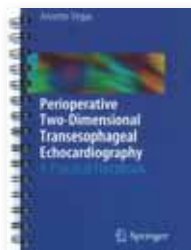
Above from left: Dr Gurdial Singh; Dr Paul Bertolino.

Library update

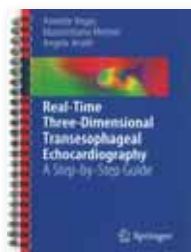
New books by ANZCA Fellows

ANZCA Fellow Dr Angela Jerath of Toronto General Hospital has donated two new books on TEE to the ANZCA Library.

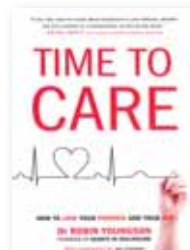
As part of the Toronto General Hospital Department of Anesthesia, the Perioperative Interactive Education (PIE) group is a team of medical artists and researchers dedicated to creating visually based aids for medical teaching. The PIE group works on multiple projects aimed at improving medical education outcomes ranging from online patient simulations to three-dimensional anatomical visualisations. Interactive resources include Virtual TEE, Fluid Management, and Control of Blood Pressure: <http://pie.med.utoronto.ca/>



Perioperative two-dimensional transesophageal echocardiography: a practical handbook
/ Vegas, Annette.
-- 1st ed -- New York: Springer, 2012.



Real-time three-dimensional transesophageal echocardiography: a step-by-step guide
/ Vegas, Annette; Meineri, Massimiliano; Jerath, Angela. -- 1st ed -- New York: Springer, 2012.



Time to care: how to love your patients and your job
/ Youngson, Robin. -- 1st ed -- Raglan, New Zealand: Rebelheart Publishers, 2012.

New Zealand Fellow and author Dr Robin Youngson also created the companion website Hearts in Healthcare: www.heartsinhealthcare.com/welcome

Hearts in Healthcare is an inspirational community of health professionals, students, patient advocates, health leaders, and many others who are champions for compassionate care. A belief in bringing like-minded people together is the first step to re-humanising healthcare around the world.

Better search results to suit you

The ANZCA Library has recently acquired onsite access to the bibliographic software EndNote, which means library staff can now send citations and references from literature searches in a format that can be downloaded straight into an EndNote library or in a format specific to your needs, such as Vancouver, Harvard or for journal publication. While the library is not able to provide Fellows and trainees access to the software, library staff will soon be on hand to provide advice and support for the basic functions of this great tool.

New ECRI publications

Health Devices, Vol. 41, No. 9, Sept 2012

- Using ECRI Institute's Health Technology Hazard Self-Assessment Tool – a case study

Health Devices, Vol. 41, No. 10, Oct 2012

- Smartphones in healthcare: the good and the bad

- Health apps and safety: views from recent sources

Operating Room Risk Management

- Blood transfusions

Latest anaesthesia and pain medicine research

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

American Association for Respiratory C, Restrepo RD, Walsh BK. *Humidification during invasive and noninvasive mechanical ventilation*. *Respir Care*. 2012 May;57(5):782-788.

Andreae MH, Andreae DA. *Local anaesthetics and regional anaesthesia for preventing chronic pain after surgery*. *Cochrane Database Syst Rev*. 2012;10:CD007105.

Cao W, Pavlinec C, Gravenstein N, Seubert CN, Martynyuk AE. *Roles of aldosterone and oxytocin in abnormalities caused by sevoflurane anesthesia in neonatal rats*. *Anesthesiology*. 2012 Oct;117(4):791-800.

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Flick RP, Davidson AJ. *The international assembly of pediatric anesthesiologists*. *Paediatr Anaesth*. 2012 Oct;22(10):943.

Garfield JM, Garfield FB, Holzman R, Mitani AA, Tsen LC. *Practice policies for older anesthesiologists in academic departments: a national survey of academic departmental chairpersons*. *J Clin Anesth*. 2012 Aug;24(5):357-363.

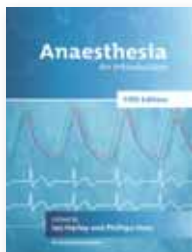
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Lang RS, Gorantla VS, Esper S, Montoya M, Losee JE, Hilmi IA, et al. *Anesthetic management in upper extremity transplantation: the Pittsburgh experience*. *Anesth Analg*. 2012 Sep;115(3):678-688.

Olivar H, Sharar SR, Stephens LS, Posner KL, Domino KB. *Similar liability for trauma and nontrauma surgical anesthesia: a closed claims analysis*. *Anesth Analg*. 2012 Nov;115(5):1196-1203.

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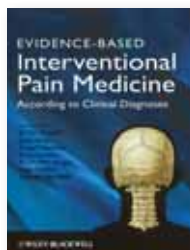
New titles



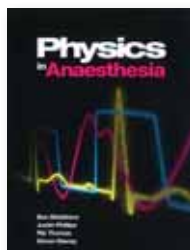
Anaesthesia: An introduction / Harley, I. [ed]; Hore, P. [ed]. -- 5th ed -- East Hawthorn, VIC: IP Communications, 2012.



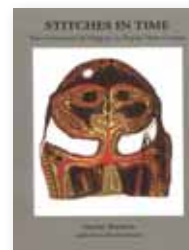
Ethical practice for health professionals / Freegard, Heather Christine [ed]; Isted, Lyn [ed]. -- 2nd ed -- South Melbourne: Cengage Learning Australia, 2012.



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New online books

Anesthesiology / Longnecker, David E [ed.]; Newman, Mark F; Brown, David L; Zapol, Warren M. -- 2nd ed -- New York: McGraw-Hill, 2012.

Benumof's and Hagberg's airway management / Hagberg, C. A. [ed]. -- 3rd ed -- Philadelphia: Elsevier/Saunders, 2012.

Essentials of trauma anesthesia / Varon, Albert J. [ed]; Smith, Charles E. [ed]. -- 1st ed -- Cambridge: Cambridge University Press, 2012.

Manual of emergency and critical care ultrasound / Noble, Vicki E.; Nelson, Bret. -- 2nd ed -- Cambridge: Cambridge University Press, 2011.

Pain comorbidities: Understanding and treating the complex patient / Giamberardino, Maria Adele [ed]; Jensen, Troels Staehelin [ed]. / International Association for the Study of Pain -- 1st ed -- Seattle: IASP, 2012.

SBA and MTF MCQs for the primary FRCA / Nickells, James.; Walton, Benjamin. -- 1st ed -- Cambridge: Cambridge University Press, 2012.

Thoracic anesthesia / Barbeito, Atilio [ed]; Shaw, Andrew D. [ed]; Grichnik, Katherine [ed]. -- 1st ed -- New York: McGraw-Hill Medical, 2012.

Understanding patient safety / Wachter, Robert. -- 2nd ed -- New York: McGraw-Hill, 2012. Online book through Access Medicine

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

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

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ANZCA Council meeting report

November 2012

Report following the ANZCA Council meeting held on November 10, 2012

Deaths of Fellows and Trainees

Council noted with regret the deaths of Dr Thomas Howard Allen (SA) FANZCA 1992, FFARACS 1961; Dr Christie Michelle Cameron (Vic) FANZCA 2004; Professor Issy Pilowsky (NSW) FPPMANZCA 1999 and Dr Nerida Frances Telec (Vic) ANZCA trainee. As a mark of respect, the president has written to their families.

Honours and Awards

Professor Michael Cousins (NSW) has been awarded an honorary doctor of science degree by McMaster University, Ontario, Canada.

Fellowship Affairs

New Fellows: The following are congratulated on their admission to ANZCA fellowship. All new Fellows will be invited to present during the College Ceremony at the 2013 Annual Scientific Meeting in Melbourne.

Jill Patricia BARKER	NZ
Kwok Fui HOR	NZ
Jennifer BENTON	NZ
Min-Qi LEE	NSW
Benjamin Martin DARVENIZA	Qld
Fiona Mary REARDON	NT
Jennifer DIXON	Vic
Cristina Cilla REVENGA	WA
Nicolas Oswald FERNANDES	WA
Jonathan Peter SAMAAN	Qld
Alison May GRAHAM	Vic
Michael SOARES	WA
Hillel David HOPE	NSW
Lloyd Antony ROBERTS	Vic

Professor Adrien Antonius Jozef van Zundert was admitted to fellowship of the College by election under regulation 6.3.

FANZA logo: ANZCA Council approved a FANZCA logo for professional use by Fellows on business cards, letterhead, slide presentations and email. This will be distributed with the 2013 subscription notice and can be downloaded from the ANZCA website.

Professionalism Guidance Working Group (PGWG):

The recommendations of this group, chaired by Dr Leona Wilson (NZ) that ANZCA develop tools to assist anaesthetists in their practice, especially in the non-medical expert roles, were approved.

Regulation 3 and terms of reference for Australian Regional Committees and the New Zealand National Committee:

Following consultation with regional and national committee chairs, other Fellows and staff, regulation 3 and the terms of reference have been amended to ensure alignment with the revised curriculum and the revised ANZCA Constitution.

Regulation 13 – Gilbert Brown Prize:

Regulation 13 has been amended so that the Gilbert Brown Prize is open to those who meet all of the following criteria – Fellows of ANZCA or FPM within eight years of admission to fellowship of ANZCA and of admission to their original fellowship and of obtaining their original specialist qualification in anaesthesia or pain medicine.

Policy on Councillor and Past Councillor Privileges:

Council approved this document for promulgation on the ANZCA website.

External Relationships

Recognition of pain medicine as a vocational scope of practice in New Zealand: the Medical Council of New Zealand has accredited pain medicine as a vocational scope of practice in New Zealand for a period of five years. This is an historical achievement and recognises the work of ANZCA and the FPM advocating for the large number of New Zealanders who suffer unremitting pain to ensure a focus on interdisciplinary care with access to highly trained pain medicine physicians.

Health Workforce 2025, Medical Specialities – Volume 3:

Health Workforce Australia released this report on Friday November 9 (see www.hwa.gov.au). It contains detailed supply and demand projections for the Australian medical workforce, by specialty. The College welcomes this report and awaits jurisdictional responses to the findings.

NHMRC grants: ANZCA Fellows were very successful in the recent NHMRC grants process, an acknowledgement of the high quality of research being undertaken as well as the value of ANZCA grants in developing future success in a wider forum. All successful recipients are congratulated.

ANZCA external representative:

Dr Andrew Jackson (NSW) has been nominated as the ANZCA representative to assist with the rapid review of existing Medicare Benefits Schedule perfusion services.

Essential Pain Management Subcommittee:

This group has been established to ensure appropriate governance of the Essential Pain Management program including teaching, delivery and evaluation. Regulation 2 has been amended accordingly.

Training

Australian Medical Council (AMC) and Medical Council of New Zealand accreditation visit:

The AMC in their preliminary findings commented favourably on the quality of the College and Faculty submissions and the revised ANZCA training program, including the communication and change management strategy. A final report is awaited.

Dr Ray Hader Award for Compassion:

Dr Brendan Carp has generously agreed to sponsor this award for a further five years. Criteria for the award will be amended to recognise a Fellow, nominated by trainees, who has contributed to trainee pastoral care, with the details to be determined by the Education and Training Committee.

Primary Examination Sub-Committee membership appointed:

Associate Professor Ross MacPherson (NSW, chair), Dr Andrew Gardner (WA, deputy chair), Dr Meredith Craigie (SA, chair FPM Examination Committee), Dr Peter Doran (NZ), Dr Patrick Farrell (NSW, chair of Examinations), Dr Mark Reeves (Tas), Dr Graham Roper (NZ), Professor David Story (Vic), Professor Bala Venkatesh (Qld, chair of examinations of the College of Intensive Care Medicine), Dr James Derrick (Qld, co-opted) and Dr Emma Giles (WA, co-opted).

Final Examination Sub-Committee membership appointed: Dr Mark Buckland (Vic, chair), Dr Chris Cokis (WA, deputy chair), Dr Damian Castenelli (Vic), Dr Patrick Farrell (NSW, chair of Examinations), Dr Kerry Gunn (NZ), Dr Mark Priestley (NSW), Dr Lynne Rainey (SA), Dr David Tremewen (Vic), Dr Vida Viliunas (ACT), Associate Professor Jennifer Weller (NZ), Dr Sally Wharton (NSW), Dr Chris Butler (Qld, co-opted), Dr Meredith Craigie (SA, co-opted) and Dr Roman Kluger (Vic, co-opted).

Academic dishonesty policy: Council supported the ANZCA Policy Unit developing an academic dishonesty policy applicable to trainees and Fellows.

Privacy and the training portfolio system (TPS): The following clause has been added to the Training Agreement to ensure compliance with privacy legislation in Australia and New Zealand – “I acknowledge that collecting information about patients has important privacy implications. In collecting and using any patient information it is my responsibility to ensure that all privacy obligations are met, and if necessary consent obtained. Only de-identified information should be routinely stored. If any identifying information is recorded in the TPS, or other material submitted to the College, I will ensure that my, or my hospital’s, privacy statement addresses this issue or that my patient has consented.”

International Medical Graduate Specialists

International medical graduate specialists (IMGS) and IMGS supervisor agreements: These were approved for implementation from the start of 2013. They outline the roles and responsibilities of both the College and international medical graduate specialists and IMGS supervisors, respectively.

Finance

2013 Budget, 2013 Business Plan and Information Management/Information Technology Roadmap: ANZCA approved all three of these documents, which align with the strategic priorities of the ANZCA Strategic Plan 2013-17 and were developed by the ANZCA CEO and her staff with input from committees, sub-committees and working groups.

2013 schedule of fees: Fees for 2013 are based on a user-pays principles where trainees pay for training-related activities and Fellows for Fellow-related activities. This followed extensive modelling of the costs of providing services, with those services that require more extensive input from the director of professional affairs (DPA) assessor, for example, being appropriately costed to reflect the use of resources.

The president has written to all trainees explaining that with the introduction of a world class training curriculum in 2013, the training portfolio system development, supervisor training and provision of educational resources such as podcasts and webinars, training fees have been modelled to reflect the cost of providing these services.

To align with the user-pays principle and ensure fairness and equity, the annual training fee will be pro rated (by quarter) in the year in which the trainee admitted to Fellowship. Each graduating new Fellow will receive a credit for the annual training fee on their invoice for the subscription and entrance fee. Their Fellow subscription will continue to be pro rated, as currently.

Quality and Safety

Medication Safety Notice Standardised User-applied Labelling for Injectable Medicines:

ANZCA agreed to co-badge this document with the Australian Commission on Safety and Quality in Health Care (ACSQHC) informing both label manufacturers and hospital administrations.

PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures:

The council approved the latest draft of the professional document and the accompanying background paper for circulation to the endorsing external organisations (colleges and societies).

PS16 Statement on the Standards of Practice of a Specialist Anaesthetist and TE06 Guidelines on the Duties of an Anaesthetist (reclassified as PS57 Statement on the Duties of Specialist Anaesthetists): Council approved professional document PS57 and the accompanying background paper to be circulated to the regional and national committees, the FPM Board, the ANZCA Trainee Committee and relevant special interest groups for comment. PS16 Statement on the Standards of Practice of a Specialist Anaesthetist will be withdrawn upon promulgation of a revised ANZCA code of conduct.

PS39 Minimum Standards for Intrahospital Transport of Critically Ill Patients and PS52 Minimum Standards for Transport of Critically Ill Patients:

Council approved the attached draft of PS52 and accompanying background paper, to be circulated to the ANZCA regional and national committees, the FPM Board and regional committees, the ANZCA Trainee Committee and relevant special interest groups for comment.

PS03 Guidelines for the Management of Major Regional Analgesia: This professional document and the accompanying background paper were approved by the council and will be promulgated on the ANZCA website.

Dr Lindy Roberts
President

Dr Genevieve Goulding
Vice President

The 2013 schedule of fees can be found on the ANZCA website.

ANZCA Council meeting report

October 2012

Report following the ANZCA Council meeting held on October 13, 2012.

Faculty of Pain Medicine Strategic Plan: Council endorsed the FPM Strategic Plan for 2013-2017 (see www.fpm.anzca.edu.au).

Fellowship Affairs

New Fellows: The following are congratulated on their admission to ANZCA fellowship:

Melissa Wendy Faith MCDUGALL (Vic)

Sajidah Ilyas MOHAMMAD ILYAS (Malaysia)

Sarah PREISSLER (NZ)

Ian RICHARDSON (Vic)

Paul James SUTER (Qld)

James Jonathan TUCKETT (NZ)

ANZCA graduate outcome survey:

Fellows at the completion of their first year in specialist anaesthesia practice will be asked to complete an ANZCA survey to assist with graduate outcomes. The Australian Medical Council recommends that all medical Colleges collect such data.

Professionalism Guidance Working Group:

The working group has been set up with the following membership: Leona Wilson (NZ, chair), Vanessa Beavis (NZ), Peter Gibson (NSW), Richard Halliwell (NSW), Linda Sorrell (Vic), Annette Turley (Qld) and Gabe Snyder (new Fellow councillor, Vic). The group will make recommendations about the development of tools to assist Fellows in professional aspects of their practice.

Position statement on specialist, non-specialist and non-medical providers of anaesthesia:

ANZCA makes many submissions on workforce issues concerning alternative providers and extended scopes of practice. It is envisaged that this position statement will promote the College's position about the provision of anaesthesia.

Annual scientific meetings:

2015 ASM Adelaide: Dr Nathan Davis has been appointed the scientific co-convenor.

2016 ASM Auckland: Dr Michael Kluger has been appointed convenor and Associate Professor Tim Short has been appointed scientific convenor.

New Zealand hospital visits: Linda Sorrell, ANZCA CEO, and Dr Geoff Long, Chair New Zealand National Committee, were commended for their recent meetings across the country attended by approximately 155 Fellows and trainees to address issues such as the revised curriculum and services for Fellows.

Education and Training

Regulation 37: Council approved further amendments to regulation 37, in relation to the following:

- The eligibility for the primary exam (PEX) has changed from having to have completed the initial assessment of anaesthetic competence (IAAC) prior to application for the exam to having to be in basic training by the date of the written component of the primary exam.
- A clarification that Australasian candidates who are sitting the 'old' primary exam in early 2013 must have a partial pass, that is, excluding candidates who have failed previous attempts or never attempted the primary exam.
- That advanced trainees who have completed 104 weeks of advanced training but who have not yet passed the final examination (FEX) may pass into ATY3 of the 2004 curriculum for the 2013 hospital employment year; however those who have passed the final examination but have other outstanding requirement such as module 11, will transition into the revised curriculum as advance training and thence provisional fellowship training.
- That trainees transitioning into advanced training at the start of the 2013 year with unmet subspecialty volume of practice requirements which cannot be realistically met due to clinical placements in 2013, will have those requirements waived.

Regulation 23: Recognition as a specialist in anaesthesia for international medical graduate specialists and admission to fellowship by assessment for international medical graduate specialists: This regulation has been revised, with an updated version on the website.

Education officer, supervisor of training and rotational supervisor agreements:

Council supported agreements for education officers, supervisors of training and rotational supervisors. The agreements outline ANZCA's obligations and responsibilities to the supervisors as well as the supervisors' obligations and responsibilities. It is envisaged that an appointment period of three years would commence from the date of each agreement being signed.

ANZCA Training Agreement: An additional clause (#17) has been added to the ANZCA Training Agreement emphasising the values of honesty and integrity, the codes of professional conduct pertaining to all registered medical practitioners and ANZCA's intolerance of academic misconduct.

Provisional Fellowship Program

Assessment Panel: From 2013, provisional fellowship positions and programs will be approved by the Provisional Fellowship Assessment Panel, reporting to Education and Training Committee. Membership is: Dr Patrick Farrell (deputy chair Education and Training Committee and panel chair), Associate Professor Jenny Weller (chair Assessments Committee), a trainee (to be nominated by the ANZCA Trainee Committee and who has completed 52 weeks of advanced training) and three Fellows: Dr Gary Hopgood (NZ), Dr Craig Noonan (Vic) and Dr Emily Wilcox (NSW).

Clinical Teacher Development Working Group (CTDWG):

The Clinical Teacher Development Working Group has been reformed with the following members: Associate Professor Kersi Taraporewalla (chair, Qld), Dr Vanessa Beavis (NZ), Dr David Koskuba, Dr Irina Kurowski (WA), Dr Andrew Potter, Dr Phil Russell (WA), Dr Navdeep Sidhu, Dr Rodney Tayler (Tas), Dr Michael Tsiripillis, Associate Professor Deborah Wilson (Tas), Dr Caroline Zhou, Mr Olly Jones, General Manager Education Development, and Mr Maurice Hennessy, Manager, Education Development and Training.

GP Anaesthesia Working Group

(GPWG): ANZCA has been involved in GP anaesthesia training for 20 years through the Joint Consultative Committee on Anaesthesia (JCCA), a tripartite group with the Royal Australian College of General Practitioners and Australian College of Rural and Remote Medicine. The GPWG has been formed to review ANZCA's role in GP anaesthesia training. Membership includes Kate Leslie (Vic, chair) Vanessa Beavis (NZ), John Biviano, General Manager Policy, Mark Gibbs (Qld), Olly Jones, General Manager Education Development, Andrew Michael (SA), Craig Mitchell, chair Rural SIG (Vic), Rod Mitchell (SA), Frank Moloney (NSW), Lindy Roberts, ANZCA President (WA), Fred Rosewarne (Vic), Linda Sorrell, ANZCA CEO, Brian Spain (NT), Juliette Whittington, Operations Manager, Training and Assessments Unit and Deborah Wilson (Tas).

Quality and Safety

PS42 Statement on Staffing of

Departments of Anaesthesia: Council approved this revised professional document and the accompanying background paper to be circulated to the regional and national committees, the Faculty of Pain Medicine Board, the ANZCA Trainee Committee and relevant special interest groups for feedback.

Standards Australia Committee:

Dr Glenn Hawkins (NSW) has been appointed the ANZCA representative for the Standards Australia Committee SF-046 – Non Diving Work in Compressed Air Hyperbaric Treatment Facilities.

The ANZCA Anaesthesia and Pain Medicine Foundation

The research applications for 2013 were of high quality and successful applicants are congratulated on their achievement.

2013 Project Grants and Research

Awards: Council approved several ANZCA grants and research awards for 2013. See page 42 for full details.

Dr Lindy Roberts

President

Dr Genevieve Goulding

Vice President

Tom Allen

1923 – 2012



Tom Howard Allen was born on May 9, 1923. He died peacefully after a short illness on August 10, at Summertown, South Australia, surrounded by his family.

Tom's passing allows us to reflect and honour the memory of a pioneer of paediatric anaesthesia and intensive care whose legacy we see every day in clinical practice. Tom was one of the first full-time directors of paediatric anaesthesia and he was pivotal in establishing modern clinical practices and training. With his colleague Dr Ian Steven, he demonstrated in the 1960s that it was safe to secure the compromised airway in infants and children with endotracheal intubation via the nasal route using a poly vinyl chloride tube during an inhalation general anaesthetic with halothane. The established practice all over the world was to perform an emergency tracheostomy, often by inexperienced clinicians in suboptimal conditions with mortality rates up to 30 per cent. This innovation paved the way for paediatric intensive care as we know it today.

Tom spent most of his early childhood in India, where his father was a missionary, returning in 1936 to begin his secondary education at Prince Alfred College in Adelaide. He matriculated in 1940.

In 1941, aged 18, Tom enlisted in the Royal Australian Air Force and trained as a pilot. He was seconded to the Royal Air Force in England and was posted to the Middle East where he completed his operational training in Egypt. Tom served with distinction as a Spitfire pilot in 43 Squadron (known as the Fighting Cocks) throughout 1944 and 1945. The Italian campaign included the provision of air cover based on Corsica for the invasion of the south of France on August 15 and, some six weeks thereafter, in France itself.

In 2011, Tom attended the Duxford Air Show where incidentally his old squadron was holding a book launch about the history of the Fighting Cocks. Tom was welcomed with acclaim and was besieged by autograph hunters as one of the few surviving ex-airmen present.

After the war, Tom studied medicine at Adelaide University with the aid of a returned serviceman's Commonwealth Scholarship. While at university he met Elizabeth Miriam Shepherd, who graduated as a teacher, and they married in 1948. Elizabeth worked at

Woodlands School and supported Tom, while they lived with her parents who assisted with the care of their young family.

Tom was very athletic and won his Club Letters in athletics and a hockey Blue. In 1946, he was a member of the South Australian state hockey team at the first post-war interstate hockey carnival in Melbourne.

After two years of resident training at the Royal Adelaide Hospital and Adelaide Children's Hospital respectively, Tom spent three years in Fiji where his ability to speak Hindi was a very useful attribute as a general practitioner.

He returned to the Royal Adelaide Hospital in 1958 as a registrar in anaesthetics. Early in 1962, he gained his fellowship and later that year was appointed as the director to the Department of Anaesthesia and Resuscitation at the Adelaide Children's Hospital.

Tom retired in 1982, having presided over 20 years of anaesthesia innovation, establishing the paediatric intensive care unit in the mid 1970s and paediatric retrieval services as far afield as Alice Springs and Darwin. He is credited with the first South Australian Air Retrieval. The Department of Anaesthesia and Intensive Care had become a respected and popular centre for paediatric anaesthesia training with a deserved national and international reputation. It was due to Tom's influence that all Adelaide anaesthesia trainees spent up to six months acquiring paediatric skills.

From 1960 onwards Tom's concern for children with epiglottitis, severe croup and other respiratory problems led him to manage the compromised-airway first with tracheostomy by a trained surgeon under endotracheal anaesthesia. Prior to this, the tracheostomy would be performed under sub optimal conditions in the ward with local anaesthesia only.

Subsequently, from 1962 he and Dr Ian Steven developed prolonged endotracheal intubation as an alternative to surgery. In this, Tom and Ian were greatly encouraged by Bernard Brandstater of the American University of Beirut, who was applying the same technique to a different group of patients – neonates with tetanus – in an effort to simplify intermittent positive pressure ventilation. This work led to Tom and Ian's initial paper in the *British Journal of Anaesthesia (BJA)* in 1965 [Allen TH and Steven IM. Prolonged endotracheal intubation in infants and children *BJA* 1965;37: 566-573]. This was followed up with a study in 1972 documenting their successful experience with 330 children below five years [Allen TH and Steven IM. Prolonged endotracheal intubation in infants and children *BJA* 1972; 44: 835-840]. In 1998, the *BJA* marked its 75th anniversary with a search for the 50 most cited publications from 1945. It is significant that from this list, their 1965 paper was one of 12 citation classics chosen for re-publication. It is worth quoting in full the final paragraph of the accompanying commentary from Professor David Hatch [Hatch DJ *BJA* 1998; 81:473].

"Nasotracheal intubation now has a fundamental place in paediatric intensive care. It is salutary to remember that in the early 1960s, tracheostomy was so well established under the care of the surgeon that it must have taken remarkable courage and persuasion by these two anaesthetists to bring about this radical change in management, which spread so rapidly around the world. The introduction of this technique, with the acceptance that responsibility for maintaining the airway lay with the anaesthetist, was a major force in securing the central role of the anaesthetist in paediatric intensive care medicine."

More recently Tom Allen and Ian Steven were listed with Bernard Brandstater (Beirut), Alan Conn (Toronto), John Stocks and Ian McDonald (both Melbourne) as the pioneers of paediatric intensive care (Brown TCK, *Pediatric Anaesthesia* 2012; 22: 405-407).

Tom was involved in many humanitarian missions and he eagerly embraced the opportunity to join a South Australian civilian surgical team to work among civilians in war-torn Vietnam and to teach three anaesthetic nurse trainees on the job.

Three months in 1967 and later, six months in 1970, confirmed his admiration for the EMO Inhaler as an excellent substitute for an anaesthetic machine when supplies of gas and oxygen are irregular or non-existent. Tom acquired one for the Adelaide Children's Hospital and happily used it to teach any interested registrars. He was later amused when an anaesthetist for one of the first plastic surgical teams to visit Indonesia borrowed the Adelaide Children's Hospital EMO to good effect.

Tom retired in 1982 and, aged 59, had time to pursue his other interests. His passions in retirement included land care on his property at Summertown, golf, photography, woodworking, jam making, his regular lunches with "the dinosaurs" (a group of congenial retired anaesthetists) and involvement with his children and grandchildren.

Some years after the death of his wife, Elizabeth, a friendship with one of her closest friends, Ione Banner, resulted in a happy relationship, which saw them spend Australian summers together in Australia and Australian winters in England.

Tom will be remembered as a kind and caring man, a wonderful clinician and teacher, adored by his children, their partners and his grandchildren and great grandson and remembered fondly by friends and colleagues.

It was fitting that Tom's family chose as the epitaph for his memorial service: "A life well lived".

Tom Allen is survived by his children Jenny, Katrina, Kim and Diwani, six grandchildren and one great-grandson.

By Dr Johan Van Der Walt
and Dr Margaret Wiese

Christie Cameron

1973 – 2012



Christie Cameron, much-loved doctor, anaesthetist, wife, mother and friend died just over a year after being diagnosed with small bowel cancer, leaving a huge hole in the lives of her family, colleagues and social communities.

Christie grew up in a loving family with father Justin, mother Susan, and siblings Ainslie and Lachlan. As an adult she was particularly close to her sister Ainslie, who describes moving often as a child, with Christie attending multiple primary schools in three states.

“Maybe that’s why as an adult she couldn’t be fagged with small talk. If you weren’t genuine, or if you were full of it, she’d let you know and move on,” Ainslie says.

The Cameron family stayed put in Melbourne for Christie’s high school years and she attended Genazzano College for years 11 and 12, where she was dux. She completed medical training with honours at Monash University, matriculating in 1996. During her final years at medical school, Christie met a tall hippy called Greg Moore, who entered her year after deferring to backpack the world. Their study group friendship progressed to romance, and they married in 2001.

As a Victorian trainee on the Monash and St Vincent’s anaesthesia training schemes, Christie was honest, organised and decisive, flying through exams, and was a founding member of ANZCA’s Victorian Trainee Committee in 2003-04.

Confident, vibrant and attractive, Christie was also honest, organised and decisive as an anaesthetic consultant, starting consultant life at St Vincent’s, Melbourne, in 2005, and dropping to part-time with the birth of her first child, Grace. Over the next few years Christie built up an enviable private practice as a sole practitioner. She moved her public work to Monash Medical Centre in 2007 where, as a visiting medical officer, she had a strong departmental presence – facilitating “Twilight Tutes” – the ANZCA part II preparation for Monash trainees. She was a sought-after mentor and played an integral role as part of the department’s social committee. In 2010 Christie began lecturing in the Victorian section of ANZCA’s week-long Second Part Course.

When asked to describe Christie in one word, many people simply said “forthright”.

This was not perceived in a harsh way, but in an open and honest way. She was a woman with no time for faint or false praise. If she knew a better way, she would tell you.

It is sometimes easy to define someone entirely by their working life, but this was a small portion of Christie. Motherhood was the most important thing in Christie’s life and Grace, 7, Lily, 5, and Edward, 3, were her centre. Her relationship with Greg and her family life was paramount.

Christie was a steadfast and loyal friend, and had a vast social circle that encompassed old school and university friends, mothers’ group, book club, the Carey school community, and colleagues. Her interests were varied – horticulture, fine dining, reading and she was a domestic goddess par excellence – her baking was extraordinary and she had strong views on cleanliness, and even how to purchase, label and open Tupperware!

Christie let everyone know of her 2011 diagnosis with small bowel adenocarcinoma in an infamous “BROADCAST ANNOUNCEMENT – I’VE GOT CANCER” email to inform, educate and manage the expectations of all who knew her. Her metastatic disease at diagnosis meant 15 months of alternating chemo and radiotherapy, and cruelly, both her disease and treatment robbed her of many of the things that gave her pleasure.

Anaesthetists have to get on with things. We look for danger, minimise the risks, make a plan and get on with it. Christie loved a good plan. She negotiated to continue chemotherapy with determination, so that she was doing something other than waiting to die – trying to get the most out of every day, eking out as many days with her children as she could.

On the night she died, when breathing became more difficult, she calmly told the doctors, “I think you should intubate me now”.

Forthright, to the end.

We will miss you, Christie.

**Dr Kim Rees, Craig Noonan
and Dr Greg Moore**