

ANZCA BULLETIN

September 2012



FPM FACULTY OF PAIN MEDICINE ANZCA

Researchers behaving badly

PLUS:
A VISION FOR THE COLLEGE: ANZCA STRATEGIC PLAN 2013-2017

ANZCA CURRICULUM REVISION 2013 UPDATE

10 YEARS ON FROM THE BALI BOMBING



8 ANZCA Strategic Plan 2013-2017

The College has developed a strategic plan for the next five years.



24 The revised curriculum and you

Next year's training program will benefit all.

22 Bali bombing 10-year anniversary

October 13, 2002 started as an ordinary day at the Royal Darwin Hospital but things soon changed.



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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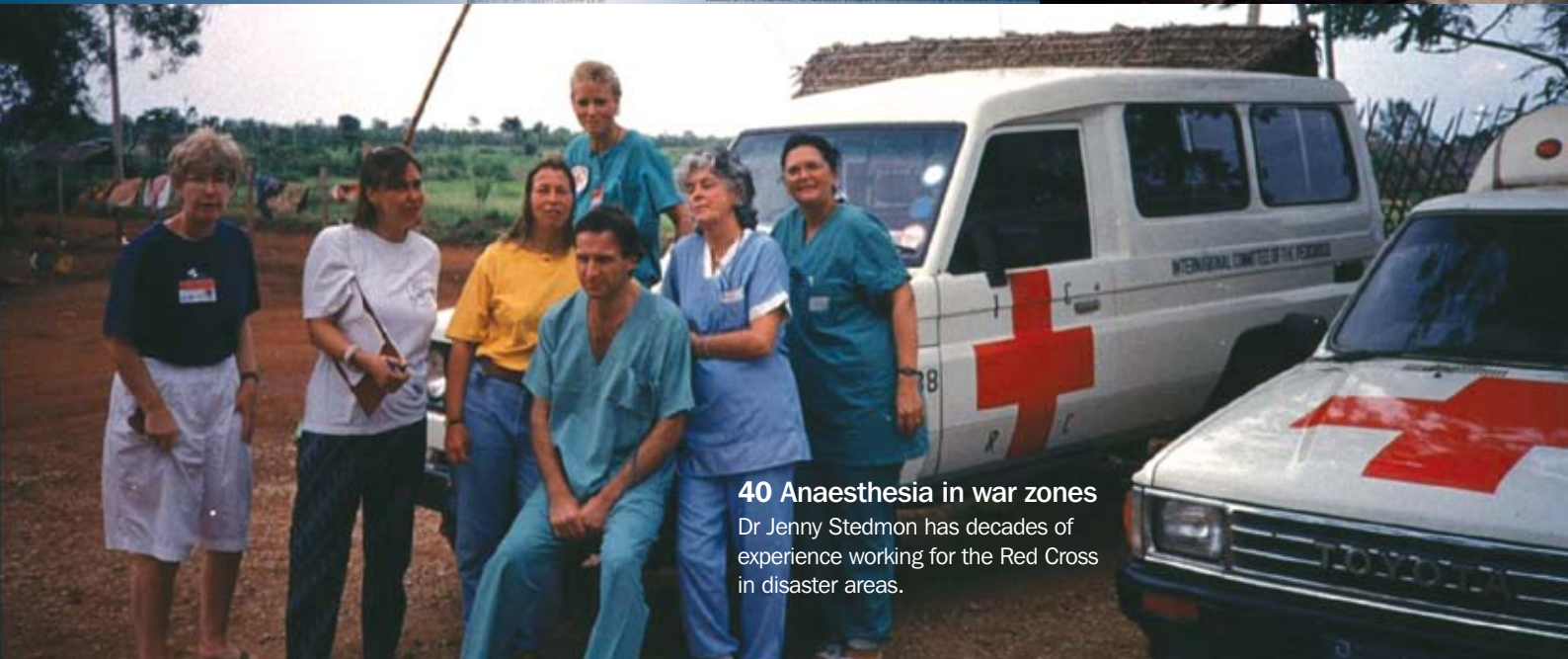
16 Researchers behaving badly

Recent cases of scientific misconduct have thrown the spotlight on anaesthesia.



78 STEPS in the West

A program in WA is helping many people with persistent pain.



40 Anaesthesia in war zones

Dr Jenny Stedmon has decades of experience working for the Red Cross in disaster areas.

Contents

4	President's message	26	How anaesthesia departments are affected by the revised curriculum	54	ANZCA Trials Group
6	Chief Executive Officer's message	28	College launches training and accreditation handbook	56	New Zealand news
7	News	29	Investing in a world-class training program	60	Australian news
8	A vision for the College by 2017	32	Anaesthetic history: Dr William Russ Pugh's eventful life	68	Special interest group events
10	ANZCA in the news	34	Propofol misuse among anaesthetists – is it a problem?	70	Faculty of Pain Medicine
11	Anaesthesia stories: People and events shaping a modern specialty	36	Overseas Aid: Central American specialists learn Essential Pain Management	76	Hypnosis research brings new awareness
11	Continuing professional development going mobile	37	Overseas Aid: Oximeter donation helps to save lives in Papua New Guinea	78	STEPS in the West for people with persistent pain
12	Three councillors farewelled	40	War zone anaesthesia	80	Library update
13	Professor of Anaesthesia – University of Melbourne	44	Quality and safety	82	ANZCA Council meeting reports
14	ANZCA and government: building relationships	50	New Fellows Conference 2013	86	Obituaries
16	Researchers behaving badly	52	Anaesthesia and Pain Medicine Foundation – a clear purpose	89	Future meetings
22	Remembering a day of terror and triumph: 10 years from the Bali bombing			91	life&leisure: Early adapting anaesthetists buzz with new technology
24	How the revised curriculum will benefit you			94	life&leisure: Visit Spain

President's message



Dr Lindy Roberts
President, ANZCA

Strategic Plan 2013-2017: What's in it for Fellows?

This month, ANZCA launches its strategic plan themed "Advancing anaesthesia, improving patient care". Developing this plan has involved extensive consultation with Fellows, along with trainees, staff and external organisations. The College is listening to its Fellows, and building services and products to assist and support them. While the plan officially commences next year, the foundation for many of the 16 objectives underpinning the four strategic priorities is already under way, as outlined below. For more information about the plan, see page 8.

Strategic priority 1: Advance standards through training, education, accreditation and research

Training for clinical supervisors

For the launch of our world-class training program in 2013, ANZCA is ensuring that all Fellows who supervise trainees have access to training for their important roles. Options include face-to-face workshops and the online Foundation Teachers Course, which runs over eight weeks. To date, more than 60 per cent of supervisors of training plus an additional 350 Fellows have attended workplace-based assessment (WBA) workshops, many led by the 25 WBA champions.

Continuing professional development and continuing medical education support

Later this year, access to the ANZCA/FPM Continuing Professional Development Program will be improved by the launch of a new mobile continuing professional development (CPD) platform, configured for smartphones. ANZCA and FPM, with the input of many Fellows and trainees, run numerous high quality continuing medical education events including the annual scientific meeting (ASM), tripartite special interest group meetings, workshops and other meetings across Australia and New Zealand. We also are providing more online resources. So far this year, we have offered 16 podcasts, nine webinars and our well-regarded ASM e-newsletter with daily updates for those unable to attend.

Quality and safety

ANZCA's professional documents set the standard for anaesthesia practice in Australia and New Zealand. Currently in development or review are documents on airway management, the expert witness, anaesthesia and echocardiography, infection control, and pain relief and end-of-life issues. Recently, ANZCA established the Anaesthetic Allergy Sub-Committee, under the leadership of Dr Michael Rose, to produce guidelines and other resources for prevention and management of anaesthesia-related allergy. Participation in web-based anaesthesia incident reporting continues to increase with more than 40 hospitals now reporting through the tripartite ANZTADC website www.anztadc.net.

Accreditation

Heads of department will be planning for the introduction of the revised curriculum and ANZCA has set up a webpage headed "Supporting departments". The release this month of the *ANZCA Handbook for Training and Accreditation and Regulation 37: Training in anaesthesia leading to FANZCA and accreditation of facilities to deliver this curriculum* will provide even more detail about requirements. ANZCA has advised all jurisdictions in Australia and New Zealand about the revised curriculum.

Evidence for our clinical practice

The ANZCA Research Committee adjudicated and the Anaesthesia and Pain Medicine Foundation allocated more than \$860,000 for research projects in 2012. The ANZCA Trials Group, led by Associate Professor Tim Short, generates internationally recognised outcomes through its involvement in large multicentre trials. Additionally, it nurtures emerging researchers and develops new ideas through its annual strategic research workshop.

Strategic priority 2: Build engagement, ownership and unity

Improved online services

Projects are under way to streamline services to Fellows through digital channels. Examples include online registration for events, mobile access to CPD through smartphones and the development of the training portfolio system.

Focus on Fellows: seeking your feedback

I am aware that time-poor Fellows are sometimes concerned about the level of service they receive when contacting the College. Under the leadership of our new chief executive officer, customer service charters for staff are being developed to ensure that Fellows and trainees are assisted quickly and efficiently. La Trobe University is undertaking a study of Fellow engagement with the College. The 2013 fellowship survey is in development. Both will inform further activities to support Fellows. I encourage you to respond to ANZCA surveys.

Our binational College

Fellows, including councillors, on both sides of “the ditch” embrace the richness and strength of our diversity in having strong representation and input from both Australia and New Zealand. The College engages externally with other colleges and organisations through the Committee of Medical Colleges in New Zealand (of which Dr Geoff Long, ANZCA NZ National Committee Chair, is a member) and in Australia, the Committee of Presidents of Medical Colleges (of which I am a member and Immediate Past-President Professor Kate Leslie is chair).

ANZCA and the Faculty of Pain Medicine working together

Associate Professor Brendan Moore, Dean of FPM and ANZCA councillor, and I welcome opportunities for collaboration, building on the work of former presidents and deans. Apart from joint documents and events, recently we have had opportunities for co-ordinated development of strategic plans as well as sharing around curricula and international medical graduate specialist assessment processes.

Publications

ANZCA seeks to continually improve its publications including the quarterly *ANZCA Bulletin*, the monthly *ANZCA E-Newsletter*, FPM’s *Synapse* and the *Training E-Newsletter*. *Australasian Anaesthesia 2011* (the “Blue Book”), edited by Associate Professor Richard Riley, and containing 26 articles written by Fellows, was promoted in electronic format for the first time with hard copies available on request. This is in response to concerns expressed by some Fellows about our environmental impact and increasing comfort with electronic formatting. I welcome your feedback.

History and heritage

The College is working to ensure access to our rich history for current and future generations. Most recently, this has resulted in the “Anaesthesia stories” series, led by Dr Christine Ball. These are short interviews with luminaries in anaesthesia and pain medicine. Watch out for the first three – Dr Duncan Campbell, Professor Tess Cramond and Dr Nerida Dilworth – on the website.

Strategic priority 3: Develop and maintain strong external relationships

Policy submissions

This year so far, ANZCA and FPM have provided more than 30 submissions to the Australian government and more than 20 in New Zealand. These have been on matters as diverse as accreditation standards for medical schools, dextropropoxyphene withdrawal, international criminal history checks and the Medical Board of Australia (MBA), proposals for prescribing by non-doctors and MBS access for training. In New Zealand, ANZCA continues to work with Health Workforce New Zealand on the development of regional training hubs and the physician assistant project. Increasingly, outside bodies are seeking ANZCA’s input to important matters that determine how healthcare is provided to our community.

The profile of anaesthetists and pain specialists

Publicising our messages about safe and high quality anaesthesia and pain medicine is enhanced by a broader public profile. A potential audience of more than 13.5 million people has been exposed to the work of ANZCA and FPM through coverage by 576 media outlets of 30 media releases and other news generated by the Communications Unit this year. ANZCA issued media releases for most regional and special interest group meetings, for publications including the *Safety of Anaesthesia report* (2006-2008), edited by Dr Neville Gibbs, and *Australasian Anaesthesia*, as well as to promote results of research by Fellows. Nine media releases were issued for the Perth annual scientific meeting, resulting in 347 media reports.

Working for the whole community

The Indigenous Health Committee is developing eight podcasts about working with indigenous communities. These will be released in coming months in the e-learning section of the website.

Overseas aid

The Overseas Aid Committee is continuing to expand the delivery of the Essential Pain Management course, recently holding it for the first time in Central America (see page 36). The teaching materials have now been translated into Spanish. Earlier this month, committee chair Dr Michael Cooper and Adelaide anaesthetist Dr Chris Acott attended the Papua New Guinea annual medical symposium. Dr Cooper delivered 93 pulse oximeters arising out of donations from Fellows and trainees at the Perth ASM.

Strategic priority 4: Ensure ANZCA is a sustainable organisation

Using our resources effectively

As a non-government, not-for-profit organisation we depend upon the resources provided through Fellows’ subscriptions as well as training and other fees, along with judicious management of our investments, to deliver core activities. The ANZCA Council, along with the chief executive officer and senior management, is aware of our responsibility to ensure that these resources are used wisely. Our new CEO, Ms Linda Sorrell, is ensuring that our staff and systems are working effectively and focusing on quality outcomes. An example of this is reflected in her *Bulletin* message (page 6) where she describes the IT roadmap.

Acknowledgement of contributions

Finally, as an organisation we are indebted to the input of numerous Fellows and trainees in the many roles that they undertake, both in and outside their places of work. Notwithstanding that as contributors we receive as well as give, it is vitally important that these contributions are acknowledged. The ANZCA Council will examine closely the results of the La Trobe study and fellowship survey to ensure its efforts are focused on appropriate recognition.

I commend the strategic plan to you – it provides a roadmap to build the strength and collegiality of our college as we support Fellows and trainees in the delivery of safe and high quality clinical care.

Chief Executive Officer's message



Ms Linda Sorrell
Chief Executive Officer, ANZCA

In recent months, the College has focused much attention on its information technology (IT) capabilities.

We are acutely aware of the need for our Fellows and trainees to be able to undertake College-related activities in different environments – at different hospitals, in different operating theatres or at home – so much of what we are developing can be used on smartphones and tablets.

One project being undertaken by the College that recognises this is CPD for mobile, the online continuing professional development (CPD) mobile application. This allows Fellows to record their CPD activities via their smartphones at a time and place that suits them. Fellows will be able to view in real-time their CPD status, enter activities on the go and email a statement or certificate to a nominated email address. See page 11.

By the end of the year, the College website will feature event registration online. This will enable Fellows to register for all ANZCA events through online facilities integrated into their ANZCA ID. This easy-to-use feature also should save time.

The website's event calendar also has been updated to provide better visibility and search capability.

One of the biggest IT projects being undertaken by the College, the establishment of the new training portfolio system (TPS), is being developed to support ANZCA's revised training program, which commences in the 2013 hospital employment year. It is a web-based system that can be accessed via computer and smartphone.

The TPS has been built by a professional software developer and is now undergoing testing.

The "cases and procedures" component of the system, which allows trainees to log their clinical experience, has been tested. So too the "training time" component, which records the time trainees spend in the program and includes hospital and rotation information.

By the end of September, the "workplace-based assessment" component testing should be completed. This key component of the training portfolio system allows trainees and their supervisors to record the different types of assessments required for progression through the training program.

Components to be tested over coming weeks (prior to the launch of the TPS in December) include "rotations and placements", which records training site information; "clinical placement review", which replaces the in-training assessment process; "core unit review", which records the progression from one training period to the next; and "courses and events", which records completion of such activities as Effective Management of Anaesthetic Crises (EMAC) and Early Management of Severe Trauma (EMST).

Finally, the "dashboard" component, which gives an overview of where a trainee is at in the training program, will be tested.

Developing online learning is also an important focus for the College. Activities include the trial of the online Foundation Teacher Course, which provides a rich environment for participants to share learning experiences and resources. Four modules have been developed covering "Doctor as educator", "Planning effective teaching and learning", "Interactive teaching and learning" and "Teaching in the anaesthesia clinical setting". Two further modules, "Teaching practical skills" and "The supervisory role" are due for completion at the end of the year.

Overseeing many of these projects is the new Strategic Project Office, a unit recently established (within existing staffing) following a review of IT that was completed this year. This review resulted in the development of a strategy around IT and information management (IM), also known as the IT/IM roadmap.

The IT/IM roadmap and the Strategic Project Office will help us to deliver the many projects we are undertaking to move the College forward.

A vision for the College by 2017

ANZCA Strategic Plan 2013-2017

In this 20th anniversary year of our College, it is exciting to reflect upon how far ANZCA has travelled since its establishment, thanks to the hard work and defining contributions of former leaders, other Fellows, trainees and our staff. These provide a solid foundation upon which to build our shared future.

The development of this strategic plan presented an important opportunity to consult with many key groups and individuals, both within and outside the College. Their responses have provided the basis upon which this strategy is crafted. The outcome is a modernised mission and a clear, achievable vision – a flexible yet robust roadmap for the next five years.

Changes, challenges and opportunities

Some things are unchanged: ANZCA's core mission, the driver for everything we do, keeps us firmly focused on the provision of safe, high quality patient care for our community. Also unwavering is the dedication and expertise of all those who work to advance standards of training and practice. However, the economic, political and social landscape in which we deliver on our mission has changed, and will continue to do so.

Curriculum Revision 2013 is a good example of how ANZCA stays true to its core purpose whilst leading innovation and improvement. Twenty years ago, our training program was entirely paper-based; now it includes an electronic portfolio system, e-learning and other internet resources. Learning will also be supported by workplace-based assessment tools and regular feedback on performance.

A strong College

Collegiality remains the foundation of our strength as an organisation. We must recognise, support and acknowledge contributions. It is critical that we work together to embrace opportunities, and be proactive in the way we collaborate with and influence others. The College should seek feedback from its members and use that wisely to further our joint aspirations. We must remain responsive to changing needs and new challenges, as well as fostering work environments that support and advance education and scholarship. Above all, we must ensure that messages about safe and high quality anaesthesia, perioperative care and pain medicine are heard, understood and acted upon.

On behalf of the ANZCA Council, I commend to you this strategic plan. It will guide decision-making and resource allocation as we work towards achieving our vision for the College by 2017. I look forward to being a part of the College's evolution during my two years as president and to witnessing, when ANZCA celebrates its 25th anniversary, just how much stronger we have become.

Dr Lindy Roberts
President, ANZCA

Mission

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

Advancing anaesthesia, improving patient care

Vision

ANZCA will be a recognised world leader in training, education, research, and in setting standards for anaesthesia and pain medicine

Strategic priorities

Advance standards through training, education, accreditation and research

Build engagement, ownership and unity

Develop and maintain strong external relationships

Ensure ANZCA is a sustainable organisation

Objectives

- Deliver a world-class training program
- Provide a professional development framework that supports ongoing development and maintenance of skills and expertise
- Promote and support research in anaesthesia and pain medicine
- Set clinical standards that reflect best practice and support safe, high quality patient care
- Enhance the delivery of services to Fellows and trainees
- Promote and demonstrate the value of ANZCA fellowship
- Strengthen connections within and between all parts of the College
- Expand and strengthen the collaborative relationship between ANZCA and the Faculty of Pain Medicine (FPM)
- Develop productive collaborative relationships
- Engage and influence government and other key stakeholders
- Raise the profile of anaesthesia, perioperative medicine and pain medicine
- Advocate for community development with a focus on indigenous health and overseas aid
- Develop and retain the best people
- Ensure ANZCA's systems and processes are focused on quality outcomes
- Acknowledge and support Fellows' and trainees' involvement with, and contributions to, the College
- Promote anaesthesia and pain medicine as professions



A potential cumulative audience of more than 2.8 million people has accessed news about ANZCA and the Faculty of Pain Medicine since June. ANZCA has issued nine media releases, generating 172 media reports to promote most regional and special interest group meetings, the publication of *Australasian Anaesthesia* (“the Blue Book”), and research conducted by Fellows.

Topics that generated the most interest included:

- Ballarat anaesthetist Dr Rob Ray’s presentation to the Rural Special Interest Group meeting on dealing with in-flight medical emergencies. Dr Ray gave 13 radio interviews on the topic, heard by more than 327,000 people, and also was reported in print and online, appearing across 45 media outlets.
- Christchurch anaesthetist, Dr Ben van der Griend’s five-year study of children undergoing anaesthesia at the Royal Children’s Hospital, where he used to work. The study, presented to the Queensland combined medical education conference, suggested there was little or no risk of death related to anaesthesia in healthy children undergoing operations. This story was read or heard by more than 337,000 people and was picked up by 13 online news outlets.

- Perth anaesthetist Dr Mary Hegarty’s landmark Australian research on the effects of anaesthesia on young children, which was published in *Pediatrics*. Nearly 750,000 people across 44 media outlets were exposed to reports about this study.
- Melbourne anaesthetist Professor Paul Myles’ work on the effects of general anaesthesia on redheads and their recovery time after surgery, which was published in *Anaesthesia and Intensive Care*. The story was covered by 45 media outlets and reached a potential cumulative audience of 1.2 million people.

Meaghan Shaw
Media Manager, ANZCA

Since June this year,
ANZCA has generated...
24 print stories
49 online stories
99 radio reports

Media releases distributed by ANZCA since June this year

- Do redheads feel more pain? (August 27)
- Landmark Australian study on anaesthesia and young children (August 21)
- New device for weight loss and diabetes control discussed (July 27)
- Better pain focus at hospital helps cut stays by nearly five days (July 26)
- New book highlights the latest innovations in anaesthesia (July 23)
- ANZCA Bulletin out now: Ventilator inventor honoured; New anaesthetic allergy group, Helping in Dili (July 11)
- Healthy children at low risk from anaesthesia-related death (July 6)
- Is there a doctor on board? Responding to in-flight emergencies (July 5)
- Old drugs offer new uses for pain relief (June 15)

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

Three councillors farewelled

A dinner was held at the College in June in honour of Dr Leona Wilson and Dr David Jones on their retirement from ANZCA Council and Dr Justin Burke who completed his term as the new Fellow representative.

Dr Wilson from Wellington is a former ANZCA president and is now the director of professional affairs (IMGS) and presented the College with representational cloak made from paua shell, which is unique to New Zealand.

Dr Jones, from Dunedin is the immediate past dean of FPM, and presented the College with a framed print of a white heron called a "Kotuku". In Maori oratory, the most telling compliment is to liken someone to Kotuku.



Clockwise from top to left: Professor Kate Leslie, Dr Lindy Roberts, Dr Genevieve Goulding and Dr Leona Wilson; Dr David Jones and Dr Lindy Roberts; Dr David Jones addresses guests; Dr Kate Leslie and Dr David Jones; Dr Justin Burke and Sally Burke; Dr Vanessa Beavis, Dr Leona Wilson and Dr Alan Merry.

Professor of Anaesthesia – University of Melbourne



Professor David Story has been appointed the inaugural Chair of Anaesthesia in the Melbourne Medical School (MMS) of the University of Melbourne.

This position is the result of two years of discussions, meetings and exchanges of ideas between representatives of the university, the president of ANZCA, directors of anaesthesia, possible applicants and the chief executive officers of the metropolitan teaching hospitals affiliated with the MMS. Associate Professor Michael Davies played a key role in driving this process and developing the concept model for the role.

Leading the process for the university were Professor James Best, head of the MMS, and Professor Glenn Bowes, Associate Dean, Advancement and

Communications, who recognised the advances anaesthesia has made in teaching and research in the past 20 years.

“They have been wonderfully supportive of this new initiative,” said Associate Professor Michael Davies, who led the process of consulting with the 10 directors of anaesthesia of the hospitals affiliated with the MMS.

A unique model for the chair emerged from these deliberations.

Professor Story will be based at the MMS, rather than in a hospital, and will develop the Centre for Anaesthesia, Perioperative and Pain Medicine.

He will have a variety of appointments at the affiliated hospitals and there will be staff at each hospital with a role at the centre. These affiliated hospitals perform about 160,000 anaesthetics per year, a great potential for teaching and research.

Professor Story will also have the opportunity to develop basic research with the MMS biomedical science departments of physiology, anatomy and pharmacology.

“The formation of this chair is potentially the most significant advance in academic anaesthesia in Melbourne in the past 30 years,” said Associate Professor Davies.

“The University of Melbourne is the highest placed Australian university in three of the four major world rankings. The MMS is ranked first in Australia and 14th in the world.

“If this chair is a success, the status of anaesthesia within the medical and wider community will be greatly enhanced.”

Professor Story completed his BMedSci in altitude physiology in 1986 and graduated in medicine from Monash University in 1989. He obtained his FANZCA in 1997. He was awarded his MD in acid-base disorders from the University of Melbourne in 2004.

His main clinical interest is perioperative care for high risk patients, including anaesthesia for cardiac surgery and liver transplantation.

His research focuses on serious postoperative adverse events and clinical chemistry. Apart from his teaching of ANZCA trainees, he has been involved with teaching medical students about perioperative medicine.

Professor Story has been a staff anaesthetist at Austin Health. He was chair of the ANZCA Trials Group from 2005 to 2011, a role that will assist him when co-coordinating research related to anaesthesia at the MMS. He is also a primary examiner in physiology.

Professor Story has a sound research background with more than 100 publications and having obtained more than 15 research grants.

ANZCA and government: building relationships

Australia

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 to:

- Health Workforce Australia on anaesthesia and pain medicine chapters for the Health Workforce 2025 report.
- Australian Medical Council (AMC) on the implication of MD programs on AMC accreditation.
- Australian Medical Council on the review of accreditation standards for medical schools.
- Medical Board of Australia's consultation on international criminal history checks.
- Department of Health and Ageing on draft guidelines and access to the Medicare Benefits Schedule.
- Australian Council of Healthcare Standards on a review of its constitution.
- Rural Doctors Association Australia on National Advanced Training Program.
- Therapeutic Goods Administration on dextropropoxyphene.

- Victorian Department of Health on the midwifery-prescribing project.
- Australian Commission of Safety and Quality in Health Care on the National Safety and Quality Healthcare Standards.

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 Government grants Specialist Training Program

ANZCA is progressing well against the aims and objectives of the Specialist Training Program. The College received nine new training positions, including three allocated to pain medicine, as part of the 2013 Specialist Training Program application round. This means the College will manage 48 positions in 2013, including 11 positions managed on behalf of the College of Intensive Care Medicine. In addition, 15 hospitals across rural and regional areas received funding from the Rural Support Loading Program to help with the costs of training specialists in rural settings for the 2012 training year. These hospitals will share in \$330,000 available from the Rural Support Loading Program.

The project manager for the Specialist Training Program, Donna Fahie, has visited Australian regions to explore opportunities to expand training capacity. Each visit includes a presentation to regional committees about the program, meetings with hospitals with existing Specialist Training Program funding, and key medical workforce units in state and territory health departments. Donna has visited South Australia and Queensland and aims to visit all regions this year. For further information, please email stp@anzca.edu.au.

Plain packaging – tobacco

The Australian Government welcomed a decision by the High Court of Australia in August to reject the legal challenge by big tobacco against Australia's world-leading plain packaging of tobacco laws.

Plain packaging, a vital preventative public health measure, will restrict tobacco industry logos, brand imagery, colours and promotional text appearing on packs. Brand and product names will be in a standard colour, position and standard font size and style.

All tobacco products sold in Australia must be in plain packaging by December 1.



New Zealand

Review of the Health Practitioner Competence Assurance Act 2003

The Health Practitioner Competence Assurance Act 2003 provides the framework for regulation of health professionals in New Zealand, with the aim of protecting the health and safety of the public. The Ministry of Health has announced that it will conduct a high-level review of the act in 2012.

The Ministry of Health will consult with stakeholders through meetings and a written document, to be released soon. Ministry representatives will discuss the review with the New Zealand National Committee at its November meeting.

Health Workforce New Zealand

ANZCA continued to work with Health Workforce New Zealand on the development of the regional training hubs, and the physician assistant project.

The hubs are a Health Workforce New Zealand initiative designed to support efficient health-professional training, looking for opportunities for cross-specialty and cross-profession training. Each hub will develop specific areas of expertise and lead in those fields. ANZCA is working with Health Workforce

New Zealand to identify how and where the College can support its trainees via the hubs, and how the hubs might also provide opportunities for Fellows outside main centres to link in with continuing medical education activities happening in other regions.

In the physician assistant sphere, Health Workforce New Zealand has requested ANZCA's advice on whether there is a need for the physician assistant role in the perioperative space and if so, what scope such a role could have. The New Zealand National Committee has formed a small group to provide this advice to Health Workforce New Zealand.

Submissions

Pharmac, New Zealand's drug buying agency, has been conducting ongoing consultations with stakeholders on the development of its preferred medicines list.

St John Ambulance is reviewing its clinical guidelines. The Medical Council of New Zealand is reviewing its document Good Medical Practice. The New Zealand National Committee is considering the proposed amendments.

A number of other submissions have been made to:

- The Ministry of Health on the classification of ephedrine.

- Health Workforce New Zealand on funding priorities for medical disciplines training.
- Medical Sciences Council on continuing professional development for anaesthetic technicians.
- Medical Council of New Zealand on guidelines for doctors on caring for themselves and others close to them.

AMC/MCNZ accreditation

Work continued on the College accreditation process with a preliminary meeting held in June between the ANZCA Executive, pain medicine representatives and the Australian Medical Council assessment panel. Surveys have been sent from the Australian Medical Council to Fellows, trainees and international medical graduate specialists to inform the review process, and site visits to hospitals will commence with New Zealand in September and Australia during October. The assessment panel will have further meetings with College representatives in Melbourne in October.

John Biviano
General Manager, Policy
ANZCA



Researchers behaving badly

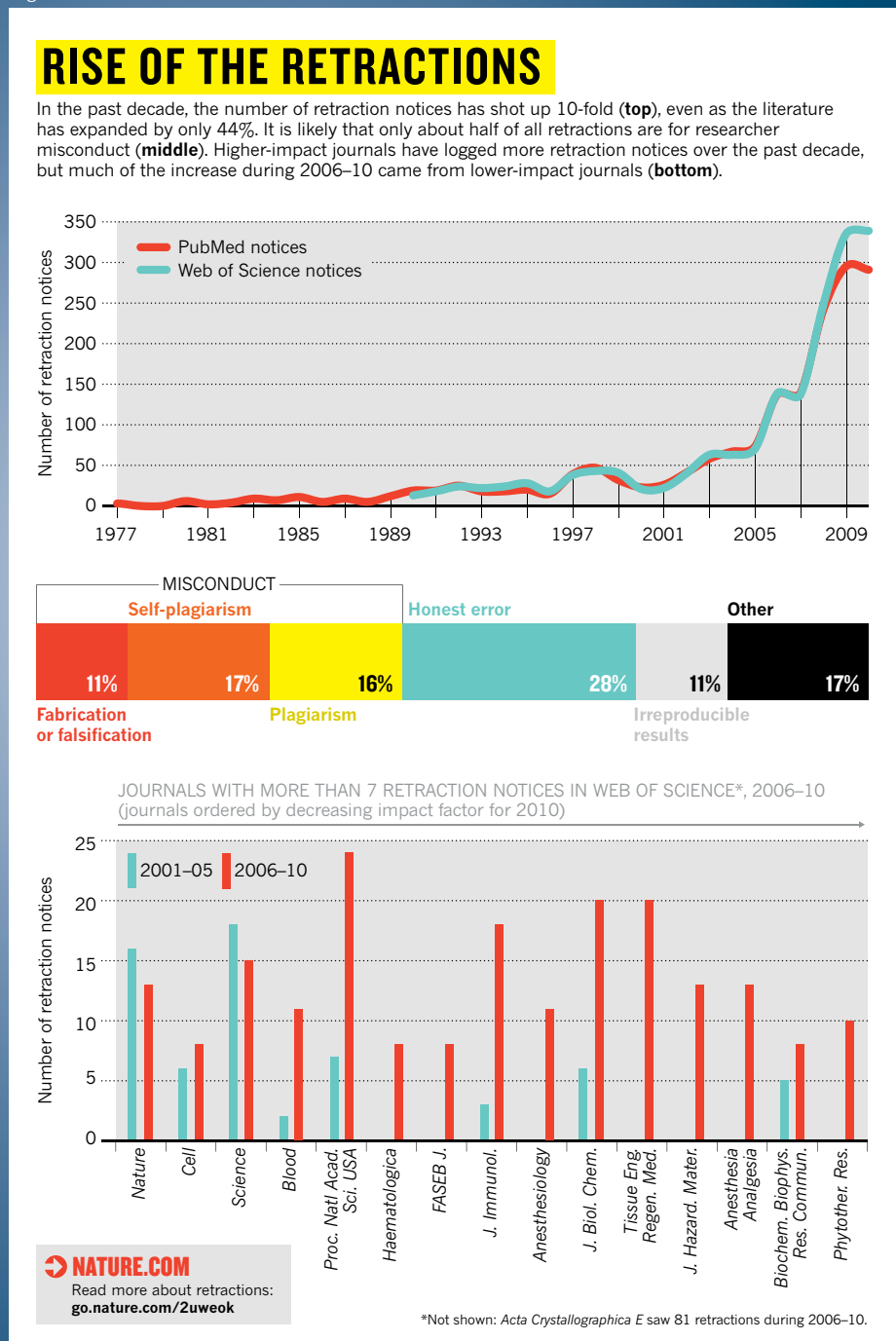
Scientific misconduct is not a subject we like to talk about, but earlier this year Japanese anaesthetist Associate Professor Yoshitaka Fujii was sacked by Toho University after serious questions were raised about his research. Investigations continue. Dr Richard Waldron explores recent examples of research fraud and what it means for anaesthetists.

There has been a dramatic increase in the number of retractions of medical papers over the past few years and anaesthesia, unfortunately, is one of the areas in the spotlight. Although about half of the retractions arise following “honest errors”, there is a disturbing increase in percentage of retractions arising from “misconduct”. Disappointingly, this 50:50 split is not reflected in the field of anaesthesia – it appears that with anaesthesia, retractions of recent years lean significantly more towards the “misconduct” end of the spectrum. There also has been a dramatic increase in retractions related to anaesthesia in the past five years.

Figure 1 is from a 2011 article by Richard Van Noorden, assistant news editor at the journal *Nature*.¹

“Historically, those who detect or reveal a fraud are not the institution of the person perpetrating the fraud, his or her colleagues or even the co-authors. Whistleblowers are usually lab technicians, statisticians and journalists.”

Figure 1.



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How do retractions resulting from research misconduct impact on anaesthetic practice? It is a delicate subject and there is little information available in peer-reviewed journals – perhaps not surprising since many peer-reviewed journals have been affected. However, journals such as *Anaesthesia*^{2,3,4}, *Anaesthesia & Analgesia*,^{5,6} the *European Journal of Anaesthesia*⁷, *BMJ*⁸, as well as the above-quoted article from *Nature* have all published editorials addressing recent research misconduct. Where possible I have attempted to use verifiable sources. Some information comes from media releases and some is web-based.

In general terms, research misconduct involves plagiarism, fabrication, falsification or alteration of data or images (including graphs). In 2009, Fanelli⁹ conducted a meta-analysis of 18 surveys of some 12,000 scientists (including medical researchers) and found that 2 per cent of these researchers admitted to fabricating, falsifying or altering their own data

(plagiarism was excluded from the study). On top of this, 15 per cent of the survey respondents indicated that they were also aware of colleagues engaging in such misconduct.

The areas of anaesthesia research misconduct covered in this paper include acute pain (Professor Scott Reuben), fluid resuscitation (Professor Joachim Boldt), post-operative nausea and vomiting (Associate Professor Yoshitaka Fujii), and perioperative management of patients with cardiac conditions (Professor Don Poldermans). There are three anaesthetists involved with a possible combined total of 284 retractions (Reuben 21, Boldt 91, Fujii 172), all within the last five years. One of them will hold the record for the most retracted medical research papers ever. The fourth person included in this article is Professor Don Poldermans, who was dismissed in November 2011¹⁰ from his position as Professor of Medicine and head of the Perioperative Cardiac Care Unit at Erasmus Medical Center, Netherlands.

Although not a trained anaesthetist, his research impacts significantly on the practice of perioperative medicine. He is also an honorary member of the Dutch Society of Anaesthesiologists.

The existence of bad research or deliberate scientific fraud should come as no surprise. The journal *Anaesthesia & Intensive Care* published an editorial on the subject in 1991¹¹. There was an editorial in the *New England Journal of Medicine*¹² in 1983 and a review article in the *BMJ* the same year¹³. One of the invited speakers at the ANZCA ASM 2011 in Hong Kong, editor-in-chief of *Anaesthesia* Dr Steve Yentis, addressed delegates on the subject of medical research fraud. The Euroanaesthesia Congress in Paris in June 2012 held a session entitled “Fraud or flawed? Which data and recommendations should we trust?”.

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Professor Scott Reuben

Professor Scott Reuben has been described by *Scientific American*, March 10, 2009 as “A Medical Madoff”³⁴, a reference to Bernie Madoff, the financial advisor who was jailed in 2009 for losing billions of investor funds in a Ponzi scheme, the largest financial fraud in US history.

Professor Reuben was a Professor of Anaesthesiology and Pain Medicine at Bayside Medical Center (Tufts University School of Medicine) Springfield, Massachusetts. He was director of Acute Pain Management. In May 2008, his hospital was conducting a research week for which he had submitted two studies. An audit found there was no ethics approval for the studies, which triggered an investigation. In March 2009 Professor Reuben admitted fabricating data, even inventing patients. He had also forged

the signatures of co-authors and had not conducted many of the 21 clinical studies that he had published in journals, including *Anesthesia & Analgesia*.

Many of the so-called studies gave favourable results to drugs produced by Pfizer, including Celecoxib (Celebrex), Valdecoxib (Bextra), Gabapentin (Neurontin). Professor Reuben was a member of the Pfizer Speaker’s Bureau and had received five research grants from Pfizer between 2002 and 2007.

Professor Reuben was also a major invited speaker at the Australian Faculty of Pain Medicine meeting in September 2008 and seven of his papers were used as references in the second edition (2005) of ANZCA publication *Acute Pain Medicine: Scientific Evidence*. All references to his papers have been removed in the third edition (2011).

In January 2010, Professor Reuben was sentenced to six months prison with a further three years supervised release and was fined \$480,000. He has 21 retracted papers (including journals such as *Anaesthesia & Analgesia*, which has run editorials on Professor Reuben’s conduct). Evidence of his falsified and fabricated research dates back to 2000. It appears that Professor Reuben’s co-authors were unaware of the fraud – in some instances Professor Reuben had forged their signatures when the articles had been submitted for publication.

Researchers behaving badly continued

Anaesthesia is not the only specialty affected. Other recent significant areas of research misconduct include psychologist Diederick Stapel (*BMJ* in 2011¹⁴), physicist Jan Hendrick Schon (16 articles retracted from *Science*, *Nature*, *Physics Review* between 2000 and 2001¹⁵), Dr Dipak Das (a 60,000-page investigation this year documented 145 counts of fabrication and falsification of data and lists 11 scientific journals affected¹⁶).

Why am I, an ordinary working anaesthetist, concerned about research misconduct? Unfortunately, the impact of research misconduct can be extensive and diverse. The type of research involved has been used in evidence-based medicine and to develop clinical guidelines. Recent retractions have led to the withdrawal of guidelines. In 2011, the British consensus guidelines on intravenous fluid therapy for adult surgical patients¹⁷ were withdrawn as a result of Boldt's retractions. The 2009 European guidelines for pre-operative cardiac risk assessment and perioperative

cardiac management in non-cardiac surgery¹⁸ are under review¹⁹ (Poldermans chaired the taskforce).

Research misconduct can adversely affect clinical practice, putting patients at risk. The perioperative use of beta-blockers and statins is being reviewed as a result of issues around Poldermans' DECREASE studies. Perhaps the greatest example is the decreasing rate of measles, mumps and rubella vaccination in the community after *The Lancet* published Dr Andrew Wakefield's paper of 1998²⁰. In 2004, 10 of the 13 authors published a "retraction of an interpretation" in *The Lancet*²¹. In 2010 *The Lancet* editors published a retraction²² after a five-member statutory General Medical Council tribunal found Wakefield guilty of "serious professional misconduct"²³. Wakefield was struck off the UK Medical Register in May 2010.

In his 2011²⁴ paper, Steen reviewed 180 primary papers retracted between 2000 to 2010 for which 9189 subjects were treated.

These 180 papers were cited a total of 5503 times bringing the total number of "at risk" treated patients to 70,501 (excluding controls).

Another example of this is the cessation or near cessation of major ongoing clinical research such as the recently completed Colloid versus Hydroxyethyl Starch Trial (CHEST)²⁵. Sudbo's fraud was uncovered just before the National Cancer Institute was about to start a 300-patient trial looking into prevention of oral cancer²⁶.

At a local level, the publication by ANZCA of the 2nd edition (2005) of *Acute Pain Management: Scientific Evidence* includes seven now-retracted Reuben papers. The 3rd edition (2010) has ceased to quote these references. A major Australian scientific meeting in 2008 had the principal author of those retracted papers as a major invited speaker (obviously prior to the retractions being announced).

How extensive is this "collateral damage" – that is, the damage to research



Professor Joachim Boldt

Professor Joachim Boldt was chief anaesthetist at Klinikum Ludwigshafen Hospital in Rhineland. His main area of research was the use of colloids, in particular hydroxyethyl starch (HES or VoluvenTM), and his papers were used as references for the British consensus guidelines in intravenous fluid therapy for adult surgical patients.

On March 4, 2011, BBC News reported on "unethical" anaesthetics research being retracted²⁵ and the *BMJ* reported the withdrawal of the intravenous fluid guidelines⁶. On February 4, 2011, the editors-in-chief of 11 medical journals, including *Anaesthesia*, *European Journal of Anaesthesia*, *British Journal of Anaesthesia*, published an open letter retracting 92 articles (out of 104 reviewed, including one that was unpublished) for lack of ethics committee approval³⁶. At the time, it was the record for the highest number of retracted papers by a single author, outstripping the previous record held by Dr John Darsee, of Harvard³⁷.

Martin Tramer's June 2011 editorial in the *European Journal of Anaesthesiology*³⁸ is also worth reading. Professor Boldt had 19 articles published in this journal alone.

The ramifications have been widespread. In February this year, the *European Journal of Anaesthesia* withdrew a further article authored by doctors working at the Klinikum Ludwigshafen after it was revealed that false ethics approval had been quoted in a paper by Ochmann C et al³⁹.

In his 2012 editorial retracting this particular paper, Tramer⁴⁰ says that Professor Boldt and a co-author submitted the original study protocol in 2003. Professor Boldt had been named as a co-author on previous drafts but had been removed on the final submission. Tramer notes that some of the authors in this paper had been co-authors on many of Professor Boldt's retracted papers.

On August 8, 2012, the Klinikum Ludwigshafen released a press statement⁴¹. It outlines the findings of a six-member investigation committee

based on the examination of 91 articles published between 1999 and 2011. In the large majority of studies, Professor Boldt failed to comply with regulations pertaining to the retention of study data. None of the studies examined had received an ethical opinion. False data was published in at least 10 of the 91 articles examined. The committee was, however, able to report that no patients had been physically harmed (the committee was able to identify 455 patients whose data had contributed to Professor Boldt's research studies).

The fallout also reached Australia and New Zealand, specifically the Crystalloid versus Hydroxyethyl Starch Trials (CHEST), a multi-centre trial sponsored by the George Institute in conjunction with the University of Sydney and the Australian and New Zealand Intensive Care Society Clinical Trials Group. An outline of what the CHEST team had to do to save the study is summarised in John Myburgh's 2011 editorial in the journal *Critical Care and Resuscitation*²⁵.

based on papers that are later retracted? The four cases mentioned have been going for many years. Fujii's papers date back some 15 years, Reuben's about 10 years years, Poldermans' at least 15 years. These papers have been cited a number of times. For example, of Poldermans' 500 papers, it appears that 16 of his studies have been cited at least 100 times and one has been cited more than 700 times. Retracted papers can "live on". Van Noorden quotes work done by John Budd. Budd examined 235 articles retracted over 30 years between 1966-96 and found they were cited more than 2000 times after their retraction (fewer than 8 per cent acknowledged the retraction).

Why does this type of fraud occur? Some would say why not? There is fraud in many fields of endeavour, including art fraud, political fraud, economic fraud, literary fraud and so on. In 2011, a vice-chancellor at the University of Queensland was dismissed for "bending the rules" to allow a family member to gain entry to

the medical school. The German defence minister, Karl-Theodor zu Guttenberg, was dismissed in March 2011 after it was suggested that his 2006 doctoral thesis had been heavily plagiarised. Dr Hwang Woo-suk was named "supreme scientist" by the South Korean government in recognition of his paper on cloned stem cells published by *Science* in 2004²⁷. In 2009 he was convicted of research fraud in South Korea. He is alleged to have embezzled \$705,000 of research funds and illegally bought human eggs for embryonic stem cell research²⁸.

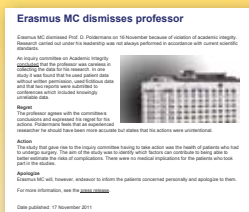
A number of factors are cited including career advancement, fame and recognition by peers, money (including research grants, the lecture circuit), work contracts that include a so-called "publish or perish" clause and others.

One factor of particular concern is learned behaviour. A 1983 *Journal of the American Medical Association* article, soon after the scandal involving Dr John Darsee²⁹, stated "studies of medical

students have revealed shockingly high rates of cheating to get into medical school or in medical school. The students cheating aren't the dumb ones. They're often the brightest". There is also a 2011 paper by Nasser et al ("Phantom publications among applicants to a colorectal surgery residency") where citations quoted by 24 per cent of applicants could not be verified³⁰.

So, as an ordinary anaesthetist working in clinical practice, how do I decide which papers to rely on to guide and improve my clinical practice? Can I rely on articles from highly reputable, peer-review journals? History would suggest no, not always. *The Lancet*, *Nature*, *Science*, *Anaesthesia & Analgesia* and *European Journal of Anaesthesia* all have retracted papers. In his editorial, Shafer asks how a peer reviewed journal like *Anesthesia & Analgesia* missed 21 fraudulent submissions by Reuben over 21 years? The answer is clearly not simple.

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Professor Don Poldermans

Professor Don Poldermans was dismissed from Erasmus Medical Centre in the Netherlands in November 2011 over "allegations that the researcher fabricated data and committed other misconduct in his studies"^{42,43}.

The Erasmus Medical Centre issued a media statement reporting that an inquiry committee concluded "that the professor was careless in collecting data for his research" and in one study "used patient data without written permission and used fictitious data" and "that two reports were submitted to conferences which included knowingly unreliable data". It said that "the professor agrees with the committee's conclusions and expressed regret for his actions"⁴⁸.

Professor Poldermans was the Professor of Medicine and Head of the Perioperative Cardiac Care Unit. He is board-certified in internal medicine, intensive care medicine, and vascular medicine. He has been an associate

editor of the *European Journal of Echocardiography* and an editorial board member of *American Journal of Cardiology*, *Heart*, *Journal of Coronary Artery Disease* and *Journal of the American College of Cardiology*. He is a Fellow of the European Society of Cardiology and had been chair of the European taskforce charged with developing guidelines for preoperative cardiac risk assessment and perioperative cardiac management in non-cardiac surgery, published in the *European Heart Journal* in 2009¹⁷. He was an honorary member of the Dutch Society of Anesthesiology.

Professor Poldermans has published more than 500 manuscripts in several peer-reviewed journals, including the *New England Journal of Medicine*, *The Lancet*, *Journal of the American Medical Association*, *Circulation* and the *Journal of the American College of Cardiology*. Of this, 16 of his studies have been cited at least 100 times and one has

been cited more than 700 times. At the time of writing (August 2012) there are no retractions of any of Professor Poldermans' papers on PubMed.

His areas of research include identification and treatment of patients at cardiovascular risk prior to, during and after surgery. In particular, he is well known for the perioperative use of beta-blockers (particularly Bisoprolol) and the Dutch Echocardiographic Cardiac Risk Evaluation Applying Stress Echocardiography Study Group (DECREASE) studies. He was involved with the DECREASE VI study at the time he was dismissed. This study has been discontinued. The primary studies that are in question are the DECREASE VI, IV, III, and II studies.

The investigation into Professor Poldermans' work appears to have been triggered by a junior researcher who felt uncomfortable with the data to be submitted for the DECREASE VI study⁴⁴.

Researchers behaving badly continued

Can I always rely on articles whose authors or co-authors include professors and department heads? Again the answer is not always. Boldt, Reuben, Poldermans, and Das were heads of departments. There is also the 1995 case involving Dr Malcolm Pearce, an assistant editor of the *British Journal of Obstetrics and Gynaecology*. In 1994, Pearce published two papers in that journal, a clinical trial and a case report³¹. Both were fabrications. His co-author for the case report was Professor Geoffrey Robertson, his head of department, also then president of the Royal College of Obstetrics and Gynaecology and the journal's editor. Robertson was unaware that the case was fraudulent. The case highlights the issue of "gift authorship", that is co-authors who have made no significant intellectual contribution to a paper. There are many cases where co-authors appear to be either unaware that they were involved in a fabricated clinical trial or even of their inclusion in the research paper.

Can I rely on articles emanating from reputable institutions? No, not always. In 1983, the *Journal of the American Medical Association* mentions Boston Medical Center, Massachusetts General Hospital, Mount Sinai School of Medicine, Yale University School of Medicine, Sloan-Kettering Memorial Cancer Center and Harvard Medical School³⁸ as institutions at which research fraud has occurred.

So, how do I, the end user of research and evidence-based medicine, find out about research fraud or misconduct? How has research misconduct been detected or uncovered in the past?

Historically, those who detect or reveal a fraud are not the institution of the person perpetrating the fraud, his or her colleagues or even the co-authors. Whistleblowers are usually lab technicians, statisticians and journalists. For example, Camilla Stoltenberg, a physician and medical researcher, picked up Jon Subdo's 2005 fraud after noticing that 250 of the 908 patients in Subdo's *The Lancet* paper shared the same birthday³².

Other examples include research scientist Phillip Vardy and medical journalist Norman Swan in the McBride Debendox case, and journalist Brian Deer in the scandal involving Andrew Wakefield.

There is a recent disturbing trend towards high-level frauds occurring over a prolonged period. This is highlighted by the cases mentioned here.

Firstly, it seems that authors with high rates of publications of clinical trials within a short period of time may be suspect. Examples include John Darsee, Jan Hendrick Schon and Robert Slutsky. In 1985, Dr Robert Slutsky of the University of California, San Diego was found to have published 12 fraudulent papers with another 48 questionable. Slutsky had published 137 articles in seven years (one paper every 10 working days³³). Schon is another, more recent example. In 2000, he had five papers published in *Science* and three in *Nature* (all as first author). In 2001, he was listed as an author on an average of one research paper every eight days.



Associate Professor Yoshitaka Fujii

Associate Professor Yoshitaka Fujii was dismissed from Toho University Faculty of Medicine in February 2012.

In a statement, Toho University said that the credibility of nine publications was "put in doubt in August 2011"⁴⁵. It appears that Associate Professor Fujii admitted to an investigating committee that the studies were done without ethics approval and Associate Professor Fujii has sent letters of retraction to the affected journals.

Associate Professor Fujii was a prolific researcher in the area of postoperative nausea and vomiting and was first author in all nine papers, published between 2008 and 2011. The Toho University investigating committee has cleared his co-author.

The discovery of this misconduct

appears to have been precipitated by an analysis of Associate Professor Fujii's paper by John Carlisle⁴⁶, which was published in *Anaesthesia*. Carlisle analysed 169 randomised controlled trials by Associate Professor Fujii (one was duplicated so only 168 were analysed), including 141 human studies and 26 canine studies between 1991 and July 2011.

A signed open letter from 23 editors-in-chief of different journals (including Neville Gibbs from *Anaesthesia & Intensive Care*) outlines the areas of concerns with an intention to retract the papers and was referred onto the relevant Japanese institutions⁴⁷. The letter also lists Associate Professor Fujii's 193 papers (including six published in *Anaesthesia & Intensive Care*). Seven Japanese institutions, as well as a special committee of the Japanese Society of

Anesthesiologists (JSA), reviewed 193 articles at risk of retraction. On June 29, 2012, a letter signed by the vice-president of the JSA (also chair of the special investigation committee) reported that the committee found that 172 papers had been fabricated.⁴⁸

This was not the first time that Associate Professor Fujii's research had been challenged. In 2000, Kranke et al published a letter in *Anesthesia & Analgesia* provocatively titled "Reported data on granisetron and postoperative nausea and vomiting by Associate Professor Fujii et al. are incredibly nice!"⁴⁹. The paper reviewed 47 articles published by Associate Professor Fujii et al between 1994 and 1999, most with Associate Professor Fujii as first author. The Retraction Watch website outlines what the authors did to notify authorities about their concerns.

Secondly, it seems that people with access to raw data are able to assist. The traditional approach of peer review, coupled with software, can usually pick up plagiarism but not data fabrication or subtle data manipulation.

Examples of this are Stoltenberg with Subdo, Vardy with McBride, lab technicians with Darsee and lab technician Walter DeNino with Eric Poehlman, who became the first US academic to be jailed for falsifying data in a grant application. Journals and/or institutions may have to conduct routine random audits of clinical and laboratory trials. A number of editors have proposed this. Interestingly, Yoshitaka Fujii's fraud was uncovered following a statistical analysis by John Carlisle of a large number of papers.

Thirdly, journals must require evidence of a co-author's involvement with a paper, not just the lead author. Some journals are already doing this. In some cases co-authors have been used without their knowledge to cover fraudulent activity. In some cases, co-authors have been complicit with the deception (Hwang, Sudbo). There should be a mechanism to verify a co-author's intellectual contribution to a paper and familiarity with the raw data. This may require the signatures of co-authors confirming their involvement and verifying the data prior to publication.

Some organisations and journals are making an effort to address this problem. One of the pleasing aspects of the Boldt and Fujii episodes is the collaborative effort by journal editors-in-chief. One of the other outcomes of this collaboration appears to be the Committee on Publications Ethics (COPE, <http://publicationethics.org>), which is a forum for editors and publishers, which was set up in 1997 soon after the affair involving Malcolm Pearce. Other institutions include the US Office of Research Integrity (<http://ori.hhs.gov>) and the UK Research Integrity Office (www.ukrio.org). There is also a website called Retraction Watch that updates regularly on potential research misconduct (<http://retractionwatch.wordpress.com>). This site was founded by Ivan Oransky, the executive editor at Reuters Health, and Adam Marcus, the managing editor at *Anesthesiology News*, in August 2010, and covered more than 200 retractions in just over a year.

Also, on the issue of retracted publications continuing to be cited or "living on", it might be worth considering some better way of notifying readers of when a publication has been retracted. In the past, retraction notices have not been well publicised; some readers may be unaware of some of the retractions mentioned here. Hopefully a system can be devised on search engines such as PubMed to notify individuals if an article they are viewing has been retracted. It may be that archived articles by respective journals could be watermarked (as done by *Anesthesia & Analgesia* for example) to highlight their retracted status.

Finally, as Steve Shafer mentioned at the 2008 Sydney ANZCA annual scientific meeting, another element in good research is the ability to reproduce results at another institution. This would be something like waiting for version 1.1 of a new software program, rather than going out to get version 1.0. It may be that as an end user, I should be more critical in my evaluation of research. And perhaps, as Van Noorden states, as we see "the rise of the retractions", we may also witness "the return of the journal club" or some other forum for rigorous debate of published medical research.

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Remembering a day of terror and triumph: 10 years on from the Bali bombing



October 13, 2002 dawned as another balmy, tropical Sunday in Darwin. The inaugural Northern Territory Anaesthesia Continuing Medical Education (CME) meeting was under way and we'd recovered from dinner the previous night.

As I awoke at 6am for the second day's proceedings, a young man was presenting to Royal Darwin Hospital (RDH) emergency department with a relatively minor burn injury. However his story, as it unfolded, was about a horrific explosion in a nightclub full of tourists. The patient had run directly from the Sari Club in Bali, got himself to Denpasar Airport and boarded a plane to Darwin in the early hours of the morning. He had come directly to the hospital. Little did

we know he was the first of many to come. Driving into the conference centre that morning, the radio had sketchy details of an explosion overnight in Bali.

A mobile phone rang repeatedly during the morning session – plans were developing to evacuate severely injured Australians from Bali and the Australian Defence Force was activating its reservists around the country. Dr Su Winter, a staff specialist anaesthetist at Royal Darwin Hospital and the convener of our CME meeting, boarded the first C140 aircraft to Bali, along with other reservists from Royal Darwin Hospital and around the nation.

Australia had been dragged into the age of terror with a major attack on its citizens, who were holidaying in Bali.

The number and severity of injuries quickly overwhelmed the health facilities at Sanglah Hospital in Denpasar and patient survival would depend upon a time-critical evacuation to high-level healthcare in Australia. Emergency

Management Australia and government agents met in Canberra to delineate the best plan. As the critical nature of the incident evolved, they decided to bring the severely injured casualties to Darwin by military aeromedical evacuation to be stabilised at Royal Darwin Hospital before sending them on to major burns centres around Australia.

At Royal Darwin Hospital, our mass-casualty plan swung into action. By a stroke of luck, there had been a mock external disaster exercise the week before, which ironed out a few glitches. A meeting was convened with all of the hospital's senior clinicians and disaster-response personnel to inform them of the event and details as they were known. Plans were clarified for each of the clinical areas, capacity was delineated and preparations were made for management in the emergency department, intensive care, operating theatre and a combined ward area. The co-located private hospital created capacity and took patients from



“A great sense of camaraderie between all the hospital workers was palpable as everyone readied their areas for a surge of severely injured patients.”



the public hospital to free up ward beds for Bali casualties. We rang all the staff to ensure everyone was aware, and got as much rest as possible before the casualties arrived. A specialist burns surgeon and a retrieval team from the Royal Adelaide Hospital arrived to help with case management.

A great sense of camaraderie between all the hospital workers was palpable as everyone readied their areas for a surge of severely injured patients. The petty rivalries that often exist in hospitals melted away. The number and severity of injuries was unclear, but we knew that there were many and that some were very badly burnt. Extra resuscitation bays were prepared in the emergency department, outpatients was transformed into a treatment area for the less critically ill and staff busied themselves in the operating suite, opening an extra theatre on Sunday to clear the list of patients on the emergency list and preparing multiple theatres for simultaneous major trauma cases.

At 2am, 25 hours after the bombing, the first C130 Hercules landed in Darwin. Every available ambulance in the Northern Territory's Top End lined up to receive and transport patients to the hospital, 10 minutes by road. The anaesthesia department was asked to assist with meeting casualties at the airport as they arrived with the military aeromedical evacuation team. The patients were handed over by the evacuation teams and we were to assist with the ongoing management of the most

severely injured during their transport to the hospital by ambulance.

Anaesthetists provided an excellent continuity of care to these severely injured patients as they coursed from retrieval, the emergency department, intensive care, to the operating theatre and back to intensive care. Senior clinicians could stay with a single severely injured patient through this critical-care journey. Following stabilisation and emergent surgery, civilian retrieval or military aeromedical evacuation teams transported the patients to major burns centres around Australia. The volume of work was huge: jet retrieval services flew in from around the country and Darwin Airport was a who's who and what's what of retrieval organisations at the time. The local and national organisation was impressive – the first casualties were being flown onwards before the last of the victims arrived from Bali.

Over the course of the response, 66 patients were treated at Royal Darwin Hospital, 20 required intubation and ventilation, 19 had procedures in the operating theatre and many others had escharotomy in the intensive care unit or emergency department. Physicians co-ordinated the treatment and care of any patients not requiring intensive care unit care in conjunction with surgeons. It was an extraordinary 48 hours of frenetic activity across the hospital. Then suddenly it was over.

Ten years on, the hospital has transformed in many ways. There is a bigger and better equipped emergency

department, intensive care unit and operating theatre. There are more staff and a huge number of training opportunities. Royal Darwin Hospital is now the site of the National Critical Care and Trauma Response Centre (NCCTRC); this not only enhances local capacity and response, but also provides co-ordinated training in mass casualty response to anaesthetists and surgeons from Australia, New Zealand, Indonesia and the Pacific through the AusMAT (Australian Medical Assistance Teams) training courses.

Since the Bali bombing, Royal Darwin Hospital has managed several more mass tragedies including a second major bombing in Bali in 2005, a boat explosion near Ashmore Reef and police riots in East Timor. We are better equipped and organised. But a strong sense of cohesion remains among those who were working on that tragically memorable day of October 13.

Dr Brian Spain
Director of Anaesthesia,
Royal Darwin Hospital

Above panorama: The emergency department of Royal Darwin Hospital after the Bali bombings.

Opposite page from left: The first victims of the Bali bombing are unloaded at 2am in Darwin from an Australian Defence Force C130 into ambulance; Patients are unloaded from the second Australian Defence Force C130 at 7.30am. Dr Phil Blum is accompanying the patient down the ramp.

How the revised curriculum will benefit you



Greater clarity, and improved and continuous assessments, will ensure the revised curriculum benefits everyone, as Meaghan Shaw reports.

ANZCA's revised curriculum, which comes into effect next year, will be the first in the world to break the nexus between anaesthesia training and surgical procedures.

Whereas other countries' training programs are linked to surgical subspecialties, for example, anaesthesia for burns, cardiac surgery or neurosurgery, ANZCA's curriculum for the first time will be based on anaesthesia clinical fundamentals, which define an anaesthetist's scope of practice.

ANZCA's Dean of Education, Professor Barry Baker, says the establishment of the seven ANZCA Clinical Fundamentals – airway management; general anaesthesia and sedation; pain medicine; perioperative medicine; regional and local anaesthesia; resuscitation, trauma and crisis management; and safety and quality in anaesthetic practice – will set the benchmark for other countries.

"This is a world first and we are very proud of the fact that we're out in front of the bunch on this one," Professor Baker says.

The ANZCA Clinical Fundamentals isolate each part of an anaesthetist's practice and emphasise the importance of gaining skills and expertise in each area.

"Previously, things like airway management were scattered willy-nilly through all phases of surgical management and weren't gathered together as a specific anaesthetic expert area," Professor Baker says. "You might have come across difficult airway management issues in the old way of doing things but now we're focusing on it and separating it out as a specific item."

ANZCA President, Dr Lindy Roberts, says the clinical fundamentals mean that for the first time, the curriculum will define what it means to be a specialist anaesthetist, which is important not only for training but to demonstrate to others, including government agencies, other specialties and the public, what anaesthetists do.

"It's a new way of thinking about anaesthesia practice," Dr Roberts says. "By defining the scope of practice and the importance of the interactions between our different roles, we illustrate why it is that care is so safe and why it takes the amount of time it does to train a fully fledged specialist anaesthetist."

She says the revised curriculum will also ensure the College continues to produce specialists with a general scope of practice. "That means that the anaesthetist at the end of their training is able to work across a wide range of practice settings, including in rural and regional parts of Australia and New Zealand, in operating suites and outside operating suites in things like pre-admission clinics and on pain rounds, and in retrieval and trauma management," she says.

Alongside the ANZCA Clinical Fundamentals, the revised curriculum will place greater importance on the seven ANZCA Roles in Practice, which are based on the CanMEDS roles devised by the Royal College of Physicians and Surgeons of Canada, and ensure trainees have skills as medical experts, communicators, collaborators, managers, health advocates, scholars and professionals.

ANZCA Vice-President and Chair of the Education and Training Committee, Dr Genevieve Goulding, says previously the CanMEDS roles were given "lip service" in the curriculum. Now, rebadged as the ANZCA Roles in Practice, their place will be "totally overt", with the learning outcomes set for each role having a special anaesthesia emphasis.

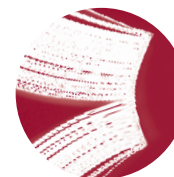
"They will emphasise that we're not just medical experts; we are team workers and we're interested in patients as humans and not just people with diseases having certain operations," Dr Goulding says. "The way it's structured enables trainees entering the program to understand from the very beginning what the art of anaesthesia is and what they're meant to achieve, and for teachers to realise it's not just about teaching skills or putting knowledge into people's heads. It's about behaviour. It's actually about how you behave with patients and with the other health professionals you deal with. It gives a breadth that I don't think has been there before."

Other features of the revised curriculum include improved and continuous assessment procedures, feedback from non-anaesthetists on each trainee's performance, clearer learning outcomes expected at each stage of training, and a return to having a compulsory provisional fellowship year to help trainees transition to being a specialist.

Ultimately, the revised curriculum is expected to provide more clarity for trainees, supervisors of training and Fellows about the training program and its outcomes, and produce more well-rounded anaesthetists.

Benefits for trainees

Trainees will receive continuous and immediate feedback on how they are progressing under the revised curriculum, and will have a greater understanding of what is expected of them through explicit learning outcomes.



Mandatory workplace-based assessments, which can take the form of a mini-clinical evaluation exercise, a direct observation of procedural skills, a case-based discussion, or multi-source feedback, will ensure trainees have a clear idea about how they are going.

Dr Goulding says trainees have confided in her that they're often told when they're not performing well, but rarely when they are. They don't know where they are on the spectrum of performance compared with other trainees, or how to improve.

"The learning objectives and the way the workplace-based assessments are structured allow trainees to see forward what they have to know and what they have to do in order to improve and they know what the standard expected is," she says.

The revised curriculum also introduces the concept of spiral learning, with the teaching of the ANZCA Clinical Fundamentals threaded throughout the curriculum. This means trainees will continually build on the knowledge they have gained.

A compulsory provisional fellowship year has been reintroduced, to allow trainees to consolidate their skills in a special practice area in preparation for their desired type of specialist practice. This final year also gives trainees the opportunity to take on greater responsibility and participate in continuing professional development to help them transition to specialist practice.

Benefits for supervisors of training

The *ANZCA Handbook on Training and Accreditation*, which will be available soon, will provide an important resource for supervisors of training, giving them more support and clarity for their role.

With clearer and more frequent workplace-based assessments, supervisors of training will be able to identify problems with trainees sooner and provide feedback on ways to improve performance.

The competency-based nature of the assessments means trainees will need to be able to show they have the skills required, rather than simply answer knowledge-based questions during exams.

Coupled with better monitoring through the new online training portfolio system, where trainees will record their training experiences and monitor their progress against training requirements, supervisors of training will be able to say with greater confidence that trainees are performing at the required level.

"From the supervisors of training point of view, it enables the progress of trainees to be better monitored and they can get on top of problems quicker because the monitoring is more regular and repeated and formalised, so it's more readily available," Professor Baker says.

Benefits for Fellows

Fellows will benefit from the tools and resources being developed as part of the revised training program.

Dr Roberts says ANZCA is developing new podcasts and other written and online resources, including for specialised study units such as ear, nose and throat anaesthesia and paediatric anaesthesia. These resources also will be available to Fellows to help them stay up-to-date with the latest practice and aid them in their continuing professional development.

"There are a lot of exciting opportunities there for us to use some of the outcomes of the curriculum to benefit specialists as well," she says.

Dr Goulding says many Fellows with a particular interest in a specialised area of anaesthesia, such as airways or pain management, will be thrilled that their area of expertise has been recognised in the ANZCA Clinical Fundamentals.

And those Fellows involved in training will have greater support and clarity about their role when interacting with trainees and greater confidence when being responsible for trainees on-call.

Benefits for the community

An increased focus on the ANZCA Roles in Practice, including the way a trainee communicates and collaborates with others, will ensure the public can continue to expect the highest standards of safety and patient care.

"This is a world first and we are very proud of the fact that we're out in front of the bunch on this one."

Dr Roberts says the introduction of multi-source feedback as a form of workplace-based assessment will mean that non-anaesthetists, including nurses and other specialists, will provide feedback on the performance of trainees and how they perform within a team.

"That will provide a lot of reassurance to the general public that the anaesthetist is actually working well as part of the whole team that looks after them when they come in for surgery or another type of procedure," she says.

ANZCA plans to continually evaluate the revised curriculum to ensure it evolves and remains up to date with changes in the delivery of healthcare.

Over the past 10 years, more of an anaesthetist's practice has moved outside the operating theatre into areas such as perioperative medicine, pre-admission clinics and post-operative pain rounds, as well as procedures in gastroenterology and radiology suites, Dr Roberts says.

"All of that makes it very important to continue to evolve our curriculum," she says.

Dr Goulding says trainees, supervisors of training and other Fellows will be encouraged to be a part of the continuous evaluation.

"We will be asking for feedback and that way we can keep the curriculum modern, alive, relevant, exciting and interesting," she says.

Meaghan Shaw
Media Manager, ANZCA

How anaesthesia departments are affected by the revised curriculum

The ANZCA fellowship training program consistently provides excellent specialists and trainees that assist us to staff anaesthesia departments throughout Australia and New Zealand.

Maintaining excellence in any area of medicine is never static and we must periodically review our training to ensure it evolves as anaesthesia and education practice also evolve.

ANZCA undertook a comprehensive review of its training program from 2008 to 2010, offering all stakeholders – including training providers, anaesthesia departments and ANZCA Fellows – a chance to provide feedback and comment.

The outcome was the ANZCA Curriculum Framework and Recommendations for Curriculum Change, both of which guided the development of the 2013 ANZCA curriculum and can be found on the ANZCA website.

The Australian Medical Council (AMC) oversees medical training in Australia from undergraduate courses to specialist training; the New Zealand Medical Council (NZMC) has the same responsibility in New Zealand. These organisations review training programs to provide accreditation and ensure that high standards are maintained. Any training program in Australia and New Zealand must meet AMC and NZMC standards respectively.

The structure, learning outcomes and assessments of the 2013 ANZCA curriculum are detailed in the curriculum document, which can be downloaded (currently password protected) from the ANZCA website:

(www.anzca.edu.au/training/2013-training-program/pdfs/anaesthesia-training-program-curriculum.pdf)

The “Training” section of the ANZCA website includes a wide range of information on aspects of the curriculum with specific sections for trainees, departments and trainers.

The structure of the revised ANZCA curriculum includes seven ANZCA Roles in Practice interwoven with seven ANZCA Clinical Fundamentals, which focus on the components that make up anaesthesia practice. These are covered over three core study units (introductory, basic and advanced) and, simultaneously, 12 specialised study units, which cover knowledge and skills in specific areas of practice. All trainees finish with 12 months of provisional fellowship training.

Changes

Specific changes have been made to the 2013 ANZCA curriculum, which will affect the way departments are managed:

- The first six months of the program, called introductory training, will focus on development and assessment of basic clinical competence.

This will ensure that trainees and trainers focus on basic clinical competence to a level of being able to handle uncomplicated cases independently. This will be assessed internally by the introductory assessment of anaesthetic competence (IAAC). Trainees will only be eligible to sit for the primary examination after completing the IAAC and introductory training. The introductory training period also will mean that when trainees have difficulty with basic clinical competencies, this will be recognised and documented early to facilitate early remediation.

- Re-introduction of a provisional-fellowship training year for all trainees as the final component of training.

After completing the requirements of advanced training, including the final examination, trainees will be eligible to commence the provisional-fellowship training period. This will allow trainees to focus on consolidating their training and a particular area of interest. Departments will have these trainees for a full 12 months (or the period of the appointment).

ANZCA Roles in Practice

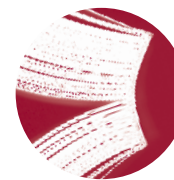
Medical expert
Communicator
Collaborator
Professional
Scholar
Manager
Health advocate

ANZCA Clinical Fundamentals

Airway management
General anaesthesia and sedation
Pain medicine
Perioperative medicine
Regional anaesthesia and local anaesthesia
Resuscitation, trauma and crisis management
Safety and quality in anaesthetic practice

Specialised Study Units

Cardiac surgery and interventional cardiology
General surgical, urological, gynaecological and endoscopic procedures
Head and neck, ear nose and throat, dental surgery and electro-convulsive therapy
Intensive care
Neurosurgery and neuroradiology
Obstetric anaesthesia and analgesia
Ophthalmic procedures
Orthopaedic surgery
Paediatric anaesthesia
Plastic, reconstructive and burns surgery
Thoracic surgery
Vascular surgery and interventional radiology



- Introduction of workplace-based assessments to provide a more formal assessment of clinical and procedural skills.

The four types of workplace-based assessments will allow comprehensive assessment of trainees throughout the training periods and ensure structured feedback occurs progressively. They are:

- Direct observation of procedural skills (DOPS).
- Mini clinical evaluation examination (MiniCEX).
- Case-based discussion (CdD).
- Multisource feedback (MSF).

Each type of workplace-based assessment will look at different aspects of trainee's performance in terms of knowledge, skills and attributes. Each one is formative and together they contribute to summative assessment of trainees at the end of each training period.

Detailed information on the workplace-based assessments is available on the ANZCA website.

Supervisory roles

To facilitate training and assessment, there has been considerable change to the supervisory roles that each department will need to have in place.

ANZCA provides guidance on how departments can transition from the current roles to new roles on the ANZCA website:

www.anzca.edu.au/training/2013-training-program/pdfs/Roles-Departments-2013.pdf

- Supervisor of training: This position remains and is pivotal to training and its co-ordination in the workplace.
- Introductory training tutor: This position will oversee trainees in the introductory training period. There will be advantages if they have an appointment as a supervisor of training. In some institutions they may be in addition to the principal supervisor of training.

- Clinical fundamental tutors (seven – see table)
- Specialised study unit supervisors (12 – see table)
- Departmental scholar role tutor: This position will co-ordinate the assessment components that relate to the scholar role. Some of these are internal and some externally assessed.

It will be important for supervisors of training to have sufficient rostered, non-clinical working time to meet with trainees for the clinical placement reviews and core unit reviews.

Other supervisor and tutor roles will also need time allocated to fulfil the duties of their roles.

Many of the specialised study unit supervisor roles are small and a single person may hold several. Similarly, one person may hold several clinical fundamental tutor roles.

Training portfolio system

The training program will have an electronic portfolio to enable easy tracking of a trainee's progress in volume of practice, assessments and reviews.

Trainees will enter data progressively as an electronic logbook of cases, as well as documenting weeks worked and all their assessments. Supervisors of training will have access to their trainees' portfolios, but other supervisors will need the trainee to sign them in so they can complete the specialised study unit reviews.

All supervising anaesthetists (FANZCAs, provisional Fellows and non-FANZCA specialists) will be able to complete workplace-based assessments – and are encouraged to do so. These can be entered directly into the training portfolio system.

People can access the training portfolio system through all devices with an internet connection, including computers, tablets and smartphones.

Departments are encouraged to facilitate wireless-internet access where possible, but otherwise ensure ready access to the internet via cabled devices.

Regulations

ANZCA has thoroughly reviewed all its regulations relating to training in anaesthesia and the ANZCA Council has approved *Regulation 37: Training in anaesthesia leading to FANZCA and accreditation of facilities to deliver this curriculum*.

The *ANZCA Handbook for Training and Accreditation* supports the training program curriculum and regulations. The handbook provides detailed information on all aspects of the training program, including requirements for hospital department accreditation, processes for remediation of trainees, where required, and detail on the implementation of regulations.

The 2013 ANZCA curriculum is poised to take training for anaesthetists into the future. The new curriculum addresses previous training problem areas and embraces clinical practice changes and education evolution to ensure we maintain the excellence of our training program.

Dr Brian Spain

Curriculum Revision Steering Group

“The ‘Training’ section of the ANZCA website includes information on aspects of the curriculum with specific sections for trainees, departments and trainers.”

College launches training and accreditation handbook

The first edition of the ANZCA Handbook for Training and Accreditation is on track for release in late September.

The handbook, which has been written to guide trainees and Fellows using the revised training program, will be available on the ANZCA website along with an updated version of the *Anaesthesia Training Program Curriculum* document and the new *Regulation 37: Training in anaesthesia leading to FANZCA and accreditation of facilities to deliver this curriculum*.

The beginnings of the handbook date back to November 2011 when a new policy model relating to the revised curriculum was approved by the ANZCA Council. The model included developing the new handbook and regulations with phasing out of the training and education (TE) professional documents.

It was agreed that regulation 37 would prescribe the training essentials and an accompanying handbook would provide additional interpretation of the regulations and expand on related processes for trainees, supervisors, heads of department and other users. This model was designed to maximise clarity, accessibility and efficiency for all.

The handbook has been informed by consultation with the Curriculum Redesign Steering Group, College committees, supervisors of training, regional/national education officers and committees, the Faculty of Pain Medicine Board, relevant special interest groups and trainees who responded to the 2011 questionnaire regarding the TE professional documents.

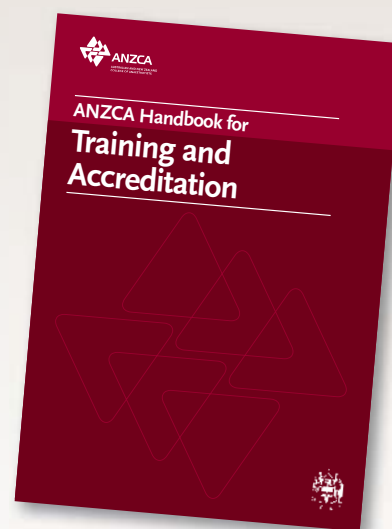
ANZCA Council approved the handbook at its August 2012 meeting, following many months of work by the TE-Document Development Group, commencing in May 2011. The chair of the working group and ANZCA President, Dr Lindy Roberts, steered the development of the document, supported by ANZCA staff, Fellows and representatives of the ANZCA Trainee Committee. ANZCA is very grateful to the Fellow participants of the group who most generously contributed their time and expertise, Dr Suzanne Bertrand, Dr Genevieve Goulding, Dr Mark Reeves and Dr Janet Smith, and trainee representatives Dr Scott Douglas, Dr Michael Lumsden-Steel and Dr Jennifer Myers.

The handbook will link closely with regulation 37 as well as other educational resources under the “Training” tab on the ANZCA website. There will be regular reviews of the handbook, on an annual basis or as required, and it is envisaged that there will be ongoing improvements to the usability of the resource, informed by feedback from Fellows, trainees and others.

The ANZCA Policy Unit co-ordinated the development of the handbook with input from the Education Development, Records Management, and Training and Assessment Units.

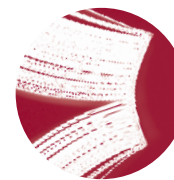
John Biviano
General Manager, Policy

“The handbook will link closely with regulation 37 as well as other educational resources under the “Training” tab on the ANZCA website”



Above: The cover of the handbook which can be found at www.anzca.edu.au/training

Investing in a world-class training program



**ANZCA
Curriculum
Revision
2013**

As most would appreciate, the College has invested heavily to develop a revised world-class training program to ensure Australia and New Zealand remain at the forefront of postgraduate medical education in anaesthesia.

More than 100 Fellows on ANZCA's education and training committees, sub-committees and working groups and all current and past members of the ANZCA Trainee Committee, as well as members of special interest groups and many others, have been involved in developing the curriculum which will commence in the 2013 hospital employment year.

Knowing how to conduct workplace-based assessments (WBA) will be an essential component of the revised curriculum. Twenty five WBA champions along with key ANZCA staff have led training sessions. To date, more than 60 per cent of supervisors of training and a further 350 Fellows have attended WBA workshops.

Over many months, the College has engaged IT experts to develop the state-of-the-art training portfolio system (TPS) which will allow information pertaining to each trainee and their progress through the curriculum to be recorded and stored for use by them and their supervisors.

More than 50 per cent of ANZCA staff throughout Australia and New Zealand, and a team of project management experts brought in specifically for this project, have also been involved in developing the revised curriculum – from organising more than 200 meetings involving Fellows, trainees and others to co-ordinating the development of the *ANZCA Handbook for Training and Accreditation* and the new *Regulation 37: Training in anaesthesia leading to FANZCA and accreditation of facilities to deliver this curriculum*. The regulation, which was approved at the August 2012 ANZCA Council meeting, will govern all aspects of the revised curriculum, including the fee structure.

The fee structure is based on the principle that the user pays – if there are high levels of costs for an activity, such as engaging the expertise of the director of professional affairs (assessor) the fee will reflect this. In keeping with this principle, Fellows' subscriptions will continue to support Fellow-related activities.

While there is no change to the structure of most fees for trainees (for example, registration, annual training, examination and examination withdrawal fees) there is a new application fee for training. The application fee is a one-off fee that covers the administration costs of applying to the College, as well as indicating an interest in joining the ANZCA training program in the future. It benefits prevocational doctors by ensuring online access to College resources (much of which is password protected) including the ANZCA Library, past exam questions, podcasts, webinars and communications including College e-newsletters.

Once the application fee has been paid, doctors will have up to three years to secure a hospital training position and enter the ANZCA training program. Until a post is secured or the applicant chooses not to pursue anaesthesia training, he or she must also pay an annual application maintenance fee that gives access to the College resources mentioned above and covers the associated administration costs.

When a hospital training position has been secured, the doctor will pay the one-off registration fee and then the annual training fee for the duration of training.

In general fees associated with training cover the many ongoing complexities of conducting the training program. As an example, the cost of examining trainees is not just about running the exam itself but involves year-round activity by College staff in the Training and Assessments unit, IT, education development, communications and so on that support the exam processes.

“The fee structure is based on the principle that the user pays – if there are high levels of costs for an activity, such as engaging the expertise of the director of professional affairs (assessor)... the fee will reflect this.”

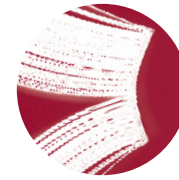
Examination costs include, but are not limited to:

- Training and Assessment unit staff costs. For example, co-ordinating the communications between, and activities of, examiners and candidates. This includes determining the availability of examiners, rostering examiners and dealing directly with candidates. Every candidate is individually assessed for their eligibility to sit each examination and this involves significant time for staff including the DPA assessors.
- Examinations committee costs. These include teleconferencing costs and face-to-face meetings that involve travel and accommodation costs.
- Examiner costs. While examiners are not paid for their time, the College must cover all air and ground travel, accommodation, catering and meal allowances.
- Venue hire, including catering, security and office equipment.
- Staff costs at venues including invigilators, support for examiners, transport and accommodation. In 2012, this included 12 venues in Australia, five in New Zealand, and three in Asia for the primary exam and seven for the final exam.
- Costs associated with patients for the final exam medical vivas at seven venues in Australia, New Zealand and Hong Kong.
- Costs associated with the oral component of the primary exam held in Melbourne and Hong Kong, and with the final examination anaesthesia vivas in Melbourne and Sydney.

(continued next page)

Investing in a world-class training program

continued



**ANZCA
Curriculum
Revision
2013**

- Exam paper printing and examiner postage costs.
- IT costs associated with the exams management system (EMS) which includes candidate lists and results, examiner rosters and performance, as well as ongoing evaluation and other quality improvement processes to ensure that the examinations meet the requirements of accrediting bodies (the Australian Medical Council and the Medical Council of New Zealand).
- Examiners training and question writing workshops in Melbourne involving travel, accommodation as well as administrative and education development costs.

There are many other training program costs. These include:

- DPA (assessor) and DPA (deputy assessor) costs. DPAs are experienced clinicians employed by the College for their expertise. The DPA (assessor) and DPA (deputy assessor) verify training documents to ensure the eligibility of candidates to sit exams and make other decisions, for example, in relation to recognition of prior learning, completion of training requirements and admission to Fellowship.
- Helping trainees experiencing difficulty including, where required, undertaking trainee performance reviews (TPRs), to assist trainees to get their training back on track.
- Hospital accreditation. There are 209 accredited hospitals in Australia, New Zealand and Asia that require regular inspections to ensure that they are able to deliver the training program to an appropriate standard. Co-ordinated by College staff, these inspections also include travel and accommodation costs for experienced Fellow inspectors. It is critical that assessments are unbiased, so this requires team members from outside the hospital's region, as well as representatives of the regional and national committees to provide a local perspective.
- Records management. This team receives queries and processes documentation on a range of training program components each year including approximately 4000 in-training assessments (about 400 in hard copy), 450 applications for registration, 3500 module completion forms, maintenance of the supervisor of training and module supervisor data base for about 800 ANZCA representatives (updated twice a year), 2000 training fees, 350 fellowship applications, 400 special requests (such as part-time training, overseas training, provisional fellowship program application and recognition of prior learning) and 300 formal projects.
- IT costs. There are many costs involved in running the systems that support training, including the online in-training assessment (ITA) system and maintaining the College database iMIS. These require not only maintenance to ensure they are kept fit for purpose, but also input from educational experts to ensure that they support educational best practice.
- Online educational resources including publication of high quality podcasts delivered by expert Fellows and delivery of interactive webinars for trainees preparing for examinations, as well as access to all library resources, such as journals and online text books.
- Support for the educational committees and working groups committed to ensuring the training program continues to improve over time.
- Support for the ANZCA Trainee Committee and the regional trainee committees to ensure that trainees have a voice in decisions made about their training, including at the ANZCA Council which is attended by the ANZCA Trainee Committee co-chair.

- Support for training activities at a regional level and in New Zealand, such as running courses, meetings and workshops for supervisors of training.

The above are examples of the ongoing costs that ensure the College delivers a training program that produces anaesthetists who can deliver safe, high quality anaesthesia to the community.

The details of the training fee structure are in regulation 37 which will be released on the College website in late September 2012 with the handbook. Annual fees which are part of the ANZCA annual budgeting process are determined each October for the following calendar year.

Dr Michelle Mulligan
Treasurer, ANZCA

“Fellows’ subscriptions will continue to support Fellow-related activities.”

Anaesthetic history: Dr William Russ Pugh's eventful life



William Russ Pugh is best known for administering Australia's first general anaesthetic for a surgical operation in Launceston on June 7, 1847. His other achievements are less well known.

Born in London in 1805, William Russ Pugh was educated in Edinburgh and Dublin and qualified as a surgeon and accoucheur.

Aged 29 he made the four-month journey to Hobart, Van Diemen's Land, as ship doctor aboard the *Derwent*. Also travelling was Cornelia Kerton, single and 10 years his senior, coming to accept a legacy from her deceased brother's estate.

Arriving in Hobart on December 10, 1835, Pugh sought a position in Hobart. None was available. The *Derwent* proceeded to Sydney so Pugh tried his luck there. There were still no opportunities. He returned to Hobart on the *Derwent* and decided to walk the 200 kilometres to Launceston to seek work.

Arriving in Launceston on March 6, 1836, Pugh found Cornelia, who had travelled to Launceston by coach after disembarking from the ship. He proposed and they married on May 7. Eight months after the marriage, tragedy struck

when Cornelia gave birth to a stillborn daughter. In 1838, a second daughter, Cornelia, was born, but tragedy struck again when she died from croup at the age of seven months, two days after she was baptised. The couple had no further children.

Pugh is well known for administering the first general anaesthetic for a surgical operation in Australia in Launceston on June 7, 1847.

The late Dr Gwen Wilson established that the *Illustrated London News* of January 9, 1847, containing the news of ether use, arrived in Hobart on May 27, 1847 having left London on January 26 and reaching Launceston on Saturday May 29.

Mrs Pugh probably first claimed the papers since we know that she received several periodicals, and was eager for news from "home". On Saturday evening, under the gaslight, it is possible she said: "Look at this Pugh. I'm sure you could make one of these in your laboratory!" Nine days later he had prepared the equipment and the ether essential to successful etherisation. During that week he selected suitable patients.

A number of medical and other witnesses attended Pugh's private hospital on the morning of Monday June 7, 1847. First, a woman with two decayed molars and an abscess in her jaw breathed the ether vapour through a tube for five minutes before becoming insensible, after which the operation

was completed successfully. After a short while she declared herself pleased with the procedure and walked home. The second patient, a 60-year-old, almost-blind man, had a successful cataract operation, previously aborted twice because he was unable to tolerate the pain. After a painless procedure, he quickly recovered and walked home. The first surgical etherisation in Australia had been successful.

But his other achievements are less well known.

Pugh also assisted Count Paul Edmund Strzelecki, the Polish explorer of south-eastern Australia and Van Diemen's Land, to analyse Tasmanian coal samples by providing laboratory space and equipment. Subsequently, the Pughs lit their Launceston home with coal gas in 1844.

Pugh performed forensic analyses for coroners in poisoning cases. He advised on the safe disposal of a ship's cargo of zinc sulphide, which threatened to spontaneously ignite in Launceston's port.

In 1838 Pugh became a founding and active member of the Tasmanian Society for Natural Science, Agriculture, Statistics &c., which subsequently became the Royal Society of Tasmania. He made presentations on geology, zoology, botany and meteorology to both societies.

His interests must have contributed the knowledge and motivation to encourage him to confidently initiate ether anaesthesia. His scientific training



meant that he documented his experience in detail in the *Australian Medical Journal* on the same day.

Eleven days later, he had critically assessed his experience and wrote another report, pointing out that an uncritical use of etherisation was dangerous and potentially lethal.

Pugh was appointed Sub-Agent for Immigration and Health for Launceston and a member of the Court of Medical Examiners.

Professional jealousy was alive and well in Launceston in 1842. Following a surgical case in which he operated for hernia on a patient who died five days later, three jealous colleagues persuaded Dr Haygarth, a naive and recently arrived doctor, to accuse Pugh of manslaughter. After sitting from midday until midnight, the magistrate hearing the evidence concluded that Pugh had no case to answer.

No sooner was this over than Pugh became embroiled in a dispute with a banker over a lost invitation to a ball. The banker, who was losing money because of a depression engulfing Van Diemen's Land, sought to recover funds from Pugh after presuming he was a wealthy gentleman. After he goaded Pugh with insulting letters and attempting to expel him from the Launceston Club, Pugh – exasperated beyond reason – challenged him to a duel.

The banker refused so Pugh fixed a notice to the door of the club accusing the banker of being a coward and a liar. The banker sued for defamation in the Supreme Court, seeking £2000 in damages. The jury heard that the defamation was proven but they should decide the damages. Not being fond of the banker, the jury recommended damages of one farthing, and said that each party should pay their own costs. Pugh's tattered reputation was partially restored.

Scarcely was this case over, than Pugh charged Dr Haygarth with “malicious prosecution” seeking damages of £1000. The same judge heard this case. The jury gave a verdict in Pugh's favour, awarding damages of £250. Haygarth, unable to pay the fine and Pugh's costs was jailed in Hobart for 12 months.

A bright spot in 1844 was the award of an MD from Giessen University for his thesis on treating fractures.

Pugh continued to practise in Launceston until 1854, when, perhaps drawn by the gold-rush inspired prosperity of Melbourne, he moved to Melbourne with his wife. He practised as a surgeon and oculist from rooms at 131 Collins Street before returning to England in 1872 or 1873. Pugh died aged 91 and is buried in Brighton cemetery.

Dr John Paull, FANZCA
Launceston, Tasmania

“His interests must have contributed the knowledge and motivation to encourage him to confidently initiate ether anaesthesia. His scientific training meant that he documented his experience in detail in the *Australian Medical Journal* on the same day.”

Above from left: William Russ Pugh, portrait; Pugh's carriage and home in Collins Street, Melbourne; formerly St John's Hospital and Dispensary 1845-52 (author's photo); Cornelia Pugh, portrait, 1871.

Propofol misuse among anaesthetists – is it a problem?

Preventative campaigns and vigilance are essential to save the lives of specialists at risk, writes Lisa Zuccherelli.

Addiction is an occupational hazard for anaesthetists, who have easy access to highly addictive drugs and the requisite knowledge and skills to use them.

Current US literature reports an incidence of general substance abuse of 1 to 2 per cent among anaesthesia care providers^{1,2}.

The untimely death in 2009 of pop superstar Michael Jackson, largely thought to have resulted from a propofol overdose, triggered a resurgence of interest in propofol as a drug of abuse.

More than 80 per cent of propofol misuse is found among healthcare providers, probably because of ease of access. However, the drug is freely available for purchase without a prescription on many websites and experts fear there could be a spike in the number of non-medical personnel becoming addicted to propofol following the publicity surrounding Jackson's death.

The incidence of propofol misuse is quoted as 0.1 per cent among anaesthesia providers. In a US survey in 2007³, 18 per cent of 126 responding academic anaesthesia departments reported one or more incidents of propofol abuse or diversion in the past 10 years. This represents a fivefold increase in reporting from previous surveys.

Some experts believe this is the tip of the iceberg because many propofol misusers start with opioids or other sedatives and graduate to propofol. They also often misuse more than one drug at a time, so propofol abuse may be underreported. The survey also found that about 30 per cent of the cases present with death as the first indication of a substance abuse problem, and the vast majority of deaths occur among trainees, particularly within five years of medical school.

In an Australasian survey of substance abuse among anaesthetists published in 2005⁴, 44 substance abuse cases were reported in 100 responding programs. In 15 per cent of cases, the initial presentation was death and death was the eventual outcome in 24 per cent of cases. Induction agents were responsible for 20 per cent of cases of substance abuse (compared to only 6 per cent in a similar survey from 1993). Unfortunately, the breakdown of agents was not reported.

Opioids were responsible for 66 per cent, benzodiazepines 5 per cent, and inhalational agents 5 per cent of substance abuse cases in the 2005 survey.

There is an obvious attraction to propofol as a drug of abuse. It is short acting and allows a rapid, clear-headed recovery with no residual hangover, ideal for on-the-job use because it is less likely to signal a substance-abuse problem. The restful, refreshed quality of sleep afforded by propofol administration, often referred to as "pronapping", is attractive to insomniacs and shift workers. It imparts a strong sense of euphoria at subanaesthetic doses, secondary to enhanced dopamine release in the reward areas of the brain.

Undoubtedly ease of access plays a role in the growth of propofol misuse. The drug is unrestricted, unsecured and unregulated, and available in a wide variety of clinical settings within most medical facilities. Because it has such a short duration of action and rapid recovery, it may be self administered up to 100 times a day.

Finally, there is a lack of routine testing for propofol, and it needs to be specifically requested in drug-screening panels.

Unfortunately, the properties that make propofol so attractive as a drug of abuse are accompanied by a narrow therapeutic index, and accidental or intentional death is a real possibility. It is highly addictive and sudden withdrawal after chronic misuse gives rise to an intense craving, despite a lack of compelling evidence of a physical withdrawal syndrome.

The management of propofol abuse is described in detail in the Welfare of Anaesthetists Special Interest Group resource document 20, found on the ANZCA website.

Prevention remains the most important aspect of any management strategy, and includes raising awareness through education.

It is important that departments or group practices establish a substance abuse policy and offer a proactive program, which may include regular tutorials, compulsory e-learning and mentoring. Mentoring can be both preventative and therapeutic. A mentor may be able to identify an anaesthetist who is at risk long before a report of drug diversion. They can guide and support a return to clinical practice and assist with ongoing monitoring and rehabilitation.

One way of combatting the problem would be to introduce and easily accessible substance folder within the department. This should include details of substance abuse committee members and a designated intervention team. Substance abuse committees are integral to both the prevention and management of substance abuse, and perform an administrative, not therapeutic function. Among other duties, the committee should be responsible for education, investigating of reports of drug diversion, appointing an intervention team, monitoring of treatment and follow-up support. Only 20 per cent of Australasian anaesthesia departments surveyed had a substance abuse policy in place in 2005⁴.


Other preventative strategies include witnessed discarding of unused anaesthetic agents at the end of every case, and the regulated dispensing of propofol.

Regulated dispensing, used in many other parts of the world, is a highly controversial subject and many see it as both inconvenient and potentially dangerous – impeding ready access to propofol in an urgent or emergent procedure could be disastrous. As propofol is used in large volumes, regulated dispensing would have a significant impact in many hospital, outpatient and clinic settings, and could pose a regulatory nightmare. It also has been found to be ineffective for the determined diverter.

Nevertheless, regulated dispensing allows earlier detection of drug diversion, which may save lives. Proponents of regulated dispensing say that preventing deaths is more important than inconvenience in practise.

In the US, many hospitals use an automated anaesthesia drug-dispensing system, which provides drugs to individual anaesthetists and records usage. The database can identify abnormal usage patterns. Interestingly, fospropofol, a water-soluble prodrug of propofol introduced into clinical practice in the US in 2009, has been labelled as a schedule four drug (which requires a doctor's prescription). All programs reporting deaths from propofol abuse in the US survey occurred in centres where there was no pharmacy accounting for the drug.

Another preventative measure used in the US is mandatory, random drug testing, which also has been used successfully in the aviation, transport and military industries.



“It is highly addictive and sudden withdrawal after chronic misuse gives rise to an intense craving despite lack of compelling evidence of a physical withdrawal syndrome.”

The Boston Massachusetts General Hospital has introduced a \$US50,000 program that allows one to two urine tests per year plus pre-employment screening for approximately 80 registrars⁵. This is weighed against the cost of diagnosis and management of one substance-abusing doctor – more than \$US100 000. Issues reported include false negatives and positives, and the fact that mandatory testing may screen out substance abusers, who then apply to other academic programs.

Another controversial issue concerns the return to work of a detoxified and rehabilitated anaesthetist – in particular whether or not the specialist should return to work in anaesthesia⁶. The Medical Board of Australia determines limitations on practice, and makes recommendations regarding ongoing monitoring and testing, level of supervision and restricted working hours. There is no formal policy regarding these conditions because every case is dealt with individually.

Unfortunately, the initial relapse symptom in 15 to 25 per cent of cases is death, most commonly in the early period of recovery. Because relapse is associated with significant mortality, a period away from clinical practice after initial detoxification may reduce the rate of relapse. This may require placement

in a facility, such as a dialysis centre or primary-care facility, where exposure to propofol is unlikely.

Although many substance-abusing anaesthetists return to work, the literature suggests that fewer than half make a long-term recovery, and only 20 per cent will make a long-term recovery within the speciality of anaesthesia⁴. Sadly, successfully completing a treatment program does not guarantee a specialist won't relapse.

US literature shows propofol misuse among anaesthetists appears to be increasing³. An emphatic prevention campaign and vigilance is key to reducing the likelihood of a tragic outcome. There also needs to be ongoing discussion and debate about the issue of tighter control over propofol dispensing and whether this is feasible and/or desirable.

Dr Lisa Zuccherelli, FANZCA
Canberra Hospital, ACT

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Further doctors' welfare information, including Doctors' Health Advisory Service Hotline numbers and access to the Welfare of Anaesthetists Special Interest Group, can be found here www.anzca.edu.au/resources/doctors-welfare.

OVERSEAS AID: Central American specialists learn Essential Pain Management



Pain by the numbers

- 70 per cent of the world's cancer deaths and 99 per cent of HIV deaths occur in low and middle-income countries but only six per cent of the world's opioids are consumed in these countries.¹
- 80 per cent of the world's population lacks adequate access to pain treatment.²
- In over 150 countries, morphine is not available.³

The ground-breaking Essential Pain Management (EPM) course has been held in Central America for the first time, bringing new hope to pain sufferers in some of the poorest countries in the region.

The EPM course aims to improve pain knowledge, provide a framework for managing pain cases and address pain-management barriers.

A series of EPM workshops was run in San Pedro Sula, Honduras, in early August. A small country in Central America, Honduras has a population of about eight million and is one of the poorest countries in the region. Its health services are very unevenly distributed. San Pedro Sula is the country's second largest city and main business centre.

The president of the Honduran Society of Anaesthetists, Dr Carolina Haylock Loor, hosted the pilot series after it was discussed during meetings at the World Congress of Anaesthesiologists in Buenos Aires in March. At one of these meetings Dr Haylock Loor offered to translate the teaching materials into Spanish and host the courses in Honduras.

A vital part of the EPM course is that local instructors quickly take over responsibility for running the course. To do this, we typically run a "one-half-one" series of courses.

On day one, we run a one-day interactive workshop. On day two, participants from the first day attend a half-day instructor workshop. On day three, the newly trained instructors run one or two courses with the help of the visiting team.

In San Pedro Sula, 29 doctors attended the first one-day EPM workshop on August 2. Dr Haylock Loor had invited

anaesthesiologists from around the region and there were representatives from seven countries: Honduras, Nicaragua, Guatemala, El Salvador, Dominican Republic, Panama and Mexico. Anaesthetic societies from these countries are part of a grouping called FESACAC (Federacion de Sociedades de Anestesia de Centroamerica y del Caribe).

I was initially concerned that the EPM teaching materials would be too basic for a group of anaesthesiologists, but there was good understanding that EPM offers a "system" for managing different types of pain and also a method for teaching others.

The group attended the half-day instructor workshop on August 3 and then ran two concurrent EPM workshops on the final day. In total, 29 instructors were trained and 64 people completed the one-day course.

The workshops identified a number of pain management barriers, including problems related to staff knowledge and attitudes, absence of basic analgesics (for example, liquid morphine or an equivalent) and the absence of pain management protocols. The newly trained instructors were positive that the EPM would help them to address these barriers.

The workshop series was exceptionally well organised by Dr Haylock Loor and her colleagues at the Sociedad Hondurena de Anestesiología, Reanimación y Dolor (SHARD). This pilot was an excellent example of collaboration between three organisations – SHARD, the World Federation of Societies of Anaesthesiologists and ANZCA. Participants were asked to contribute a nominal sum and the EPM team was grateful for the support of local companies including Asopharma, Janssen, Merck, MD

Pharma, Menarini, Novartis, Pfizer and Sanofi.

The outlook for EPM in Latin America is bright. All teaching materials have been translated into Spanish and there is now a group of enthusiastic instructors who are keen to run more courses in Central and South America.

The EPM workshop was developed by Dr Wayne Morriss and Associate Professor Roger Goucke with the assistance of ANZCA to improve pain knowledge, to provide a simple framework for managing pain and to address pain-management barriers. The program was developed following discussion with Papua New Guinean anaesthetists on the lack of available training in pain medicine in PNG. Pilot courses were held in Papua New Guinea in April 2010 and workshops have been held across the Pacific, Asia, Africa and Central America.

For further information on the Essential Pain Management program please visit www.fpm.anzca.edu.au/fellows/essential-pain-management.

Dr Wayne Morriss, FANZCA

Past-Chair, Overseas Aid Committee, ANZCA

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Above from left: Carolina Haylock Loor, María Elena Mariana, Angela Enright, Claudia Alvarez, Wayne Morriss, Juan Carlos Duarte, Alex Shelton.

Oximeter donation helps to save lives in Papua New Guinea



The distribution of College-donated pulse oximeters has been a real blessing to PNG as Meghan Shaw reports.

ANZCA donated nearly 100 pulse oximeters to 40 hospitals throughout Papua New Guinea in September thanks to fundraising efforts by Fellows and trainees at this year's annual scientific meeting in Perth.

The Chair of ANZCA's Overseas Aid Committee, Dr Michael Cooper, presented 93 pulse oximeters to the PNG health department at the annual PNG Medical Symposium in Port Moresby in front of about 400 medical specialists.

The pulse oximeters were provided from the nearly \$50,000 raised by ANZCA specialists and the Overseas Aid Committee through the Lifebox project, a global initiative arising out of the World Health Organization's safe surgery checklist.

For \$US250, the Lifebox project provides a robust pulse oximeter and educational material to hospitals in developing countries.

Dr Cooper told the symposium Lifebox estimated about 77,000 operating theatres around the world did not have access to these oxygen monitors, putting at risk the lives of about 35,000 patients each year.

So far, the Lifebox project has provided about 1700 pulse oximeters to 48 countries, including efforts by Australia and New Zealand to provide five units to Tonga, 15 to the Solomon Islands, 20 to Fiji and 20 to Samoa. "As of today, will have red dot on Papua New Guinea as well," he said, to spontaneous applause from the audience.

Dr Cooper said the death rate in developed countries, such as Australia and New Zealand where pulse oximeters were standard equipment, was one in 200,000 anaesthetics administered, compared to one in 133 in Africa.

"The majority of these deaths are respiratory deaths, three-quarters of them," he said. "Aspiration, tube in the wrong place, post-operative hypoxia, overdose of drugs or they can't sort the airway out. All of these cases could have been identified by pulse oximetry."

He said pulse oximeters were able to increase the detection of hypoxia nearly 20-fold, as well as if a tube was in the wrong place or a patient not breathing properly or ventilated properly. They also decreased the frequency of myocardial ischemia and cardiac arrest, because they can pick up hypoxia earlier.

Dr Cooper said senior anaesthetists in PNG had identified a need for 320 pulse oximeters for operating theatres and recovery areas around the country, but his "gut feeling" was this was a low estimate, not taking into account other specialist wards and units.

The PNG Deputy Secretary of Health Dr Paison Dakulala, who represented the Secretary of Health Mr Pascoe Kase at the presentation, said the donation would make a huge difference to PNG's health services and the care provided to patients.

"This is a very, very important life-saving device and equipment that will go a long way to bringing life and health to our people, especially in all the theatres throughout the country, as well as in the health facilities where this is most needed," he said.

"The evidence is clear and really it goes a long way to give us the encouragement and strength to start the push to bring delivery, health and wellbeing and quality of life to many of our people who have not had access to it for many, many years."

Dr Cooper later distributed the 93 pulse oximeters to anaesthetic scientific officers at the 25th anniversary of the Society of Anaesthetists of Papua New Guinea's specialist meeting, which was attached to the symposium.

One of the recipients, anaesthetic scientific officer Mr Paul Jeff from Mt Hagen General Hospital, said he was "overwhelmed" by the donation.

"It's really a blessing to us," Mr Korowa said. "It will help improve our patient care and make our job easier."

At the specialist meeting, the Overseas Aid Committee also distributed 40 packs of 11 key medical textbooks specific to developing anaesthesia for use by hospital anaesthetic departments.

The books included Melbourne anaesthetist Dr David Pescod's *Developing Anaesthesia Textbook*, the *Oxford Handbook of Anaesthesia*, *Understanding Paediatric Anaesthesia*, *Care of the Critically Ill Patient* and the *Westmead Anaesthetic Manual*.

Above from left: PNG Chief Anaesthetist Dr Duncan Dobunaba, Adelaide anaesthetist Dr Chris Acott, President of the Society of Anaesthetists of PNG Dr Harry Aigeeleng, Australian and New Zealand College of Anaesthetists' Overseas Aid Committee Chairman Dr Michael Cooper, Deputy Secretary of Health Dr Paison Dakulala and senior PNG anaesthetist Dr Gertrude Marun; Anaesthetic scientific officer Paul Jeff, from Mt Hagen General Hospital, with the chair of the Overseas Aid Committee, Dr Michael Cooper.

War zone anaesthesia



“I haven’t really felt any extreme danger myself despite being in war zones and hearing shelling and gunfire. I’ve always had great trust that you’re there because they want you to be there and they will do their best to make sure you get out again.”

The former chair of the WA Regional Committee, Dr Jenny Stedmon, has decades of experience working for the Red Cross in disaster areas, as Meaghan Shaw reports.

As an anaesthetist working for the Red Cross, Dr Jenny Stedmon has helped to treat landmine victims on the Thai-Cambodian border, attended to casualties of a civil war in Yemen, gained experience in tropical medicine in Kenya and provided medical support in East Timor, following the withdrawal of Indonesian troops.

“You get hooked,” she says of her Red Cross experience. “You make loads of friends, and the ideals of the movement fit with your own ideals as a medic. Once you’re actually in these places, you realise how disadvantaged both the local population and healthcare workers are and you just want to stay part of the group.”

Dr Stedmon, an unpretentious UK-born consultant anaesthetist at Fremantle Hospital and Immediate Past Chair of ANZCA’s Western Australian Regional Committee, is relaxing at her home in Fremantle near the beach, an idyllic location for the Rottneest Island swim team member and medal-winning former triathlete.

Her house is filled with a fabulous art collection, which includes a Picasso lithograph and work by Mexican artist Rufino Tamayo, and loads of books. Her 11-year-old boxer, Bubbles, lolls on the couch, snoring loudly as Dr Stedmon talks about her 22-year involvement with the International Committee of the Red Cross, her work as WA Chair of the Red Cross’s International Humanitarian Law Committee, and her interest in disaster anaesthesia, planning and engagement with the Australian medical assistance team (AusMAT).

Dr Stedmon lived in Nigeria from the ages of six to 11 with her teacher parents, who were motivated to try and improve education standards in the newly independent republic during a time that coincided with Nigeria’s Biafran civil war. It was a formative experience, and influenced her involvement in the Red Cross. “I think that kind of thing does get in your blood a bit,” she admits.

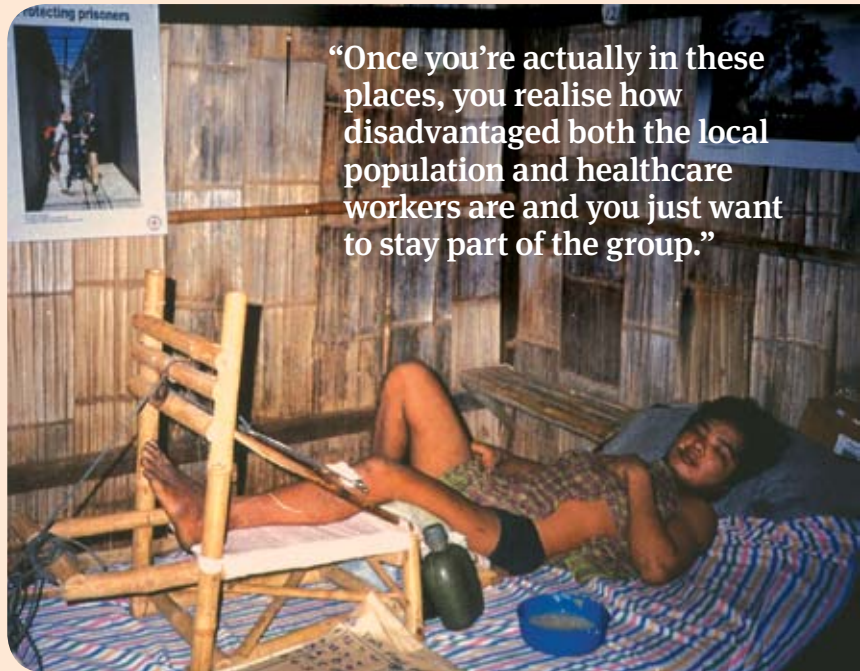
But her interest also “happened by chance”, prompted by a talk she heard as an anaesthetic registrar at St George’s Hospital in Tooting, London, from a medic who had been involved with the Orbis eye-care plane.

She applied to do the British Red Cross training course and, within a week of completing it in July 1990, received a call to go to the Khao-I-Dang refugee camp hospital on the Thai-Cambodian border.

Having just passed her fellowship, she dropped her training program – an unpopular move with her hospital – and left for three months of rudimentary anaesthesia, where the “bread and butter” surgery involved treating landmine injuries.

There she witnessed the skill of surgeons who were experienced at amputating injured limbs, cleaning and debriding the wounds, and leaving them open for about five days before performing a delayed primary closure to prevent infection. She marvelled at the adaptation of the locals, who made their own Braun Frames from bamboo, and used re-filled one-litre fluid bottles, equivalent to one kilo, to provide traction for lower limb injuries.

The trip was followed in July 1994 by a two-month stint at the Revolutionary Hospital in Taiz, the stunning intellectual capital of Yemen, in the wake of Yemen’s civil war. Once there, she helped set up a mobile field hospital, known as a “Finn Hosp”, which arrived packed in steel trunks and ready to go – complete with a set of detailed instructions written in Finnish. She created the anaesthetic department inside one of the trunks, which was filled with a “grimly small amount of drugs” including thiopentone, lignocaine, vecuronium and ketamine, but no other analgesia.



Her third assignment was at the end of 1998, after she had moved to Australia and was based in Maryborough, Queensland, when she was sent to the Lokichokio Red Cross Hospital on the northern border of Kenya and Sudan, an isolated outpost familiar to many Red Cross workers.

At the hospital, Dr Stedmon treated not only victims of the Sudanese civil war but also a varied stream of general and elective surgery cases from the over-crowded Kenyan refugee camps and surrounds, often requiring careful airway management in basic circumstances. The cases ranged from spear attacks, a snake bite and a hyena bite to a boy's face, to removing a massive goitre, dealing with tropical diseases, and anaesthetising for an operation on a Turkana woman whose neck, weakened by wearing numerous necklaces, broke when she fell while tending camels. The Turkana woman's accident again highlighted the ingenuity of Red Cross surgeons, who applied traction to her neck by making several burr holes in her skull and threading them with wires attached to a pulley contraption at the head of the bed.

This trip was followed in 2000 by a month at Dili General Hospital in East Timor. The most modern and well equipped of all the Red Cross hospitals

Dr Stedmon visited, the hospital had some sophisticated monitoring equipment, but the one donated ventilator was kept in the cleaning cupboard because no one knew how to use it. A defibrillator lay idle for the same reason.

Future lengthy trips were put on hold in 2001 after Dr Stedmon married and "inherited a 12-year-old son", and she wanted to be around to watch him grow up. However, she was on stand-by to go to Georgia in 2008 following the unrest there, and remains on the Red Cross's "active" list for short-term assignments.

The constants throughout her deployments have been the rudimentary nature of the facilities, the lack of sophisticated equipment and the paucity of anaesthetic drugs.

"I used almost entirely ketamine and some local and regional techniques," she explains, outlining ketamine's profound analgesic effect, good use as an induction agent, and ability to protect airways relatively well.

She says the experience made her a better anaesthetist, requiring hands-on interaction with the patient, and not the over-reliance on anaesthetic machines and gadgets, which she believes has become the norm.

(continued next page)

"Once you're actually in these places, you realise how disadvantaged both the local population and healthcare workers are and you just want to stay part of the group."

Above left to right: Dr Jenny Stedmon; Dr Stedmon and Red Cross colleagues in Khao-I-Dang; the Khao-I-Dang hospital; a locally-made Braun Frame at Khao-I-Dang.

War zone anaesthesia continued



“I’m a bit old fashioned,” she says. “Give me some ketamine and a patient who really needs some help, with no machine and no oxygen, and I can give them a safe anaesthetic with my fingers and my ears and my stethoscope. And I take my stethoscope everywhere.”

Dr Stedmon is also on the books for AusMAT deployments to provide medical help following disasters: “I suppose because I believe that I can do a reasonably good job in an austere environment with limited equipment,” she says.

Her AusMAT work has involved helping after the devastation of Cyclone George in Port Hedland, WA, in 2007, participating in simulation training exercises in Karratha, regular AusMAT training, as well as committee work. She ruefully points out that she was mobilised in the wake of the Indian Ocean tsunami in 2004 but never left Australia, instead sitting in Sydney’s Darling Harbour for three days watching others head off. A call to action following the 2006 Yogyakarta earthquake also failed to eventuate.

A spin-off from Dr Stedmon’s overseas and disaster work has been her interest in the Red Cross’s International Humanitarian Law Committee and her work as the chair of the committee’s Western Australian branch.

She passionately believes all countries – rich and poor – should follow the body of established international humanitarian law, including a ban on weapons, such as landmines, that are designed to maim, not kill.

“I don’t think cluster bombs or landmines are a very good idea,” she says. “I’ve worked among the effects of them and I don’t think when they make them they realise the after-impact. There are landmines all over Cambodia and they haven’t removed them all and it’s the civilians who are always affected after the conflict ends.”

There is also a personal link. Flying out of Geneva on her first mission to Khao-I-Dang, Dr Stedmon met New Zealand nurse and long-time Red Cross worker, Sheryl Thayer. The pair worked together, became friends and holidayed together. In December 1996, Ms Thayer was one of six Red Cross delegates assassinated in a brutal attack by gunmen at the Red Cross hospital in Novi Atagi in Chechnya. No one has ever claimed responsibility and the murders were never solved.

“I was really shocked when Sheryl got killed,” Dr Stedmon says. “At the time, it was seen as a one-off (attack). But it seems to be a bit of a pattern nowadays. Doctors, nurses and healthcare workers are an easy target.”

To raise awareness of the dangers health workers face, Dr Stedmon has been involved in the Red Cross’s Healthcare in Danger project, which aims to ensure safe access to effective and impartial healthcare during armed conflict and other situations of violence.

She has only felt in danger once, while working in Yemen, where the small team was forced to follow a curfew and

needed an escort to go to the hospital out of hours. Following the civil war, there was religious sensitivity because the Red Cross hospital accommodated patients of both sexes in some wards due to the small number of staff. The team was extracted quickly from the country.

But Dr Stedmon says Red Cross workers are trained to psychologically cope with the possibility they may be attacked, ambushed or taken hostage, and are usually debriefed in Geneva when their work is over.

“I haven’t really felt any extreme danger myself despite being in war zones and hearing shelling and gunfire,” she says. “I’ve always had great trust that you’re there because they want you to be there and they will do their best to make sure you get out again.”

Ultimately, she says, the work is about helping those in need. “You’re actually just following your Hippocratic Oath: one, do no harm and, two, treat the patient in front of you. You’re not interested in their politics. I suppose that’s why I’ve become really interested in international humanitarian law, because it is fair. It’s actually about fairness.”

Above left to right: A hospital ward at Lokichokio; Turkana women waiting at Lokichokio hospital; a Turkana woman in improvised traction.

The New Zealand Perioperative Mortality Review Committee

Inaugural report

The New Zealand Perioperative Mortality Review Committee (POMRC) released its inaugural report in February. The report showed that same and next day all-cause mortality after an admission requiring general anaesthesia was approximately 0.02 per cent (elective) and 0.38 per cent (acute); cumulatively 0.1 per cent. More than half of those patients died of cardiac or cardiovascular-related causes.

Download the full report at: www.hqsc.govt.nz/assets/POMRC/Publications/POMRC-2011-Report-Lkd.pdf

The New Zealand Perioperative Mortality Review Committee differs from the Australian profession-based mortality reviews in that it takes a national, whole-of-system approach to understanding and thus reducing perioperative mortality. To do this it cumulatively collects accurate data on the epidemiology of perioperative deaths (who dies) and peer review of targeted cases (why they die). Having multi-disciplinary membership, including nursing, allows all aspects of care to be analysed, rather than taking one profession's perspective. For example, for the same case, anaesthesia review may find inadequate pre-assessment and/or preparation, surgical review may find delay in performance of the operation, and nursing review may find inadequate recognition of worsening clinical status and inadequate staffing levels. While each of these factors has some remedies, they are far more effective if an integrated whole is considered. In taking this whole-of-system approach, the committee is cognisant of the dangers of losing the advantages of the profession-based approach.

2011 report: Other headlines

An epidemiological approach to data collection and analysis will provide accurate information on anticipated mortality resulting from common procedures. These data will be a valuable tool in the informed consent process. From the first report, the 30-day mortality for patients in NZ from 2005 to 2009 was:

	Acute admission %	Elective admission %
Colo-rectal resection	9.8	2.1
Hip joint replacement	7.3	0.24
Knee joint replacement	n/a	0.21
Cataract extraction	n/a	0.2

Older age and higher ASA scores are always risk factors for mortality, variable and lower value risk factors are male gender, non NZ European/pakeha ethnicity and lower socio-economic status. While the overall rate for acute colo-rectal resection was 9.8 per cent, for those aged 80 years or over 19 per cent died. Similarly, for those with ASA status of four, 26 per cent died within 30 days of the procedure.

While these data could enable benchmarking and longitudinal tracking, care needs to be taken with use of the data. Of note, unlike deaths after other procedures, the deaths after cataract extraction do not show any temporal relationship with the procedure. This would support the thesis that the "cataract rate" shows the underlying death rate of the population having such a procedure.

As far as the committee could tell, the mortality rates are comparable with those in comparable countries.

History

The NZ Perioperative Mortality Review Committee was established in April 2010, under the New Zealand Public Health and Disability Act 2000 and rose from the ashes of the Anaesthesia Mortality Assessment Committee, which was set up in 1981. The Anaesthesia Mortality Assessment Committee, which was similar to the Australian state anaesthesia mortality committees, operated successfully for about 10 years until the police obtained a report to it as part of their investigation into a charge of manslaughter against an anaesthetist. This led to consternation among reporting anaesthetists, and reports to the committee dried up.

Despite this, there was a commitment to continuing mortality review once a system was established to ensure confidentiality for all participants. The medical community had been committed to mortality reviews; the initial one in

New Zealand was the Maternal Deaths Assessment Committee, set up in 1962, and in Australia the first committee was the NSW-based Special Committee Investigating Deaths Under Anaesthesia, set up in 1960. At the same time, there was increasing interest in the medical community critically reviewing healthcare, reflecting on it and improving both individual practice and healthcare systems.

New Zealand anaesthetists had identified that there was a problem with anaesthetists (and other healthcare professionals) being convicted of manslaughter, when there was not necessarily an element of gross negligence or recklessness. Alan Merry led the successful pan-professional campaign to have the law changed (this occurred in 1997). As part of the lobbying, we assured the then minister of health that if the law regarding manslaughter was changed, we would be committed to continuing mortality review.

The 1990s were spent concurrently working on this campaign and developing new models for mortality review. The profession agreed that it would be better to have all those involved in the care of the patient involved in mortality review, and hence the NZ Perioperative Deaths Working Party was born, involving anaesthetists, surgeons, obstetricians and gynaecologists as core members. Progress was slow. There was considerable change in the Ministry of Health. The Maternal Deaths Assessment Committee met a similar fate to the Anaesthesia Mortality Assessment Committee, despite considerable effort being put into lobbying for the reinstatement of mortality review by the College, the New Zealand Society of Anaesthetists and individual anaesthetists.

Discussions with several governments resulted in mortality review committees being set up within the new New Zealand Public Health and Disability Act 2000. The first to be set up was the Child and Youth Mortality Review Committee (2002), followed by the Perinatal and Maternal Mortality Review Committee (2005), Family Violence Deaths Review Committee (2008), and finally the Perioperative Mortality Review Committee in 2010. The committees initially reported directly to the minister, but with the establishment of the Health Quality and Safety Commission, chaired by Alan Merry, the mortality review committees came under its auspices.

Composition

Perioperative Mortality Review Committee is multidisciplinary; it has two anaesthetists (Leona Wilson and Michal Kluger), three surgeons (Cathy Ferguson, Jonathan Koea and Jean-Claude Theis), one obstetrician and gynaecologist (Digby Ngan Kee), one intensivist (Tony Williams), two nurses (Rosaleen Robertson and Teena Robinson) and one epidemiologist (Phil Hider). It was initially led by Iain Martin, who resigned at the end of last year. The epidemiological analysis for the first report was performed by Liz Craig and her team from Otago University.

Terms of reference

Perioperative Mortality Review Committee is to review and report on deaths within its scope in order to reduce the number of such deaths and promote quality assurance program, to advise on matters related to mortality as asked by the Health Quality & Safety Commission, and to develop plans and methodologies to reduce morbidity and mortality, relevant to the committee's functions. These functions are set out in s59e of the New Zealand Public Health and Disability Act 2000.

The scope of deaths includes: within 30 days of a procedure or before discharge, whichever is the longer, or under the care of a surgeon even if no death occurred. An operative/invasive procedure is one that requires anaesthesia (general, local or regional), and specifically includes endoscopy and angiography, including those occurring in endoscopy or radiology rooms. It was decided to defer "deaths under the care of a surgeon where no procedure occurred" until the initial stages of the committee have been completed.

Legal protection

The committee and all its agents have statutory protection of the data and indemnity for their actions (New Zealand Public Health and Disability Act 2000 schedule 5). This places strict limits on how and when the committee can disclose data and the penalties (which include a fine of up to \$NZ10,000) for illegal disclosure of information. The committee is able to obtain the data it needs for its purposes from a wide range of sources, as long as it is relevant to its needs.

2011 report: Data collections

The report covered both the quantitative data on selected procedures (above), as well as information on the potential data sources, and proposals for analysis of data.

Existing data collections include the National Minimum Dataset and the National Mortality Collection. These data sets can be matched, allowing identification of deaths after healthcare procedures, whether in the first hospital, a second hospital, or in the community. The National Minimum Dataset has nearly complete information on publicly funded procedures, and both have relatively complete demographic information. However, there is limited coverage of privately funded procedures in private facilities. The reason for a perioperative death is sometimes hard to ascertain from the coded data because of the coding rules. For example, many of the patients dying after having a total hip replacement have their death ascribed to a fall. While this is probably the cause of their injury, and need for a procedure, it does not indicate why the patient died after their procedure. These data also provide few insights into the circumstances surrounding the death, or any systems issues involved in their deaths.

Recommendations for improved data collection

The following recommendations focus on enabling more complete data collection of healthcare procedures.

1. All places that provide healthcare procedures should be certified as healthcare facilities under the Health and Disability Services (Safety) Act 2001. This would bring in day-stay facilities that don't offer 24-hour care, and would require a change to the legislation.
2. All healthcare facilities should submit data to the National Minimum Dataset. Some private providers do not submit data, and thus the data is incomplete. This would be best achieved by legislative change.
3. The death certificate should contain a 'tick-box' to indicate that the death was within 30 days of a procedure of interest to the Perioperative Mortality Review Committee. This would be best achieved by legislative change.

The Perioperative Mortality Review Committee is working with the appropriate bodies to propose these changes. The recommendation "identifying existing conditions from those acquired during that admission" in the National Minimum Dataset is due to be implemented from January 2013.

Future directions

In response to the consultation questions within the 2011 report, there was broad support for the proposed direction, with many emphasising their desire for the qualitative component to be added in to help understand the preventable causes of death.

Work is now underway to develop a standardised mortality review form that will be common to all facilities and practitioners, and the processes to consider deaths at multiple levels (national, regional, within facility).

The 2013 report will explore the additional information contained within the coronial database, provide information on progress with development of processes, and information on specific classes of deaths.

Summary

The 2011 report finally arrived after more than 15 years of lobbying for a replacement for the Anaesthesia Mortality Assessment Committee. The NZ Perioperative Mortality Review Committee has taken a national, whole-of-system approach to perioperative mortality review. No other jurisdictions have been found that take the same approach, so the committee is developing its processes. Current national administrative datasets are being used as a basis for data collection, with additional data collection (expert, peer-reviewed opinion) to aid consideration of the practitioner and systems factors underlying those deaths. The aim is to develop recommendations that focus on improving health quality and safety.

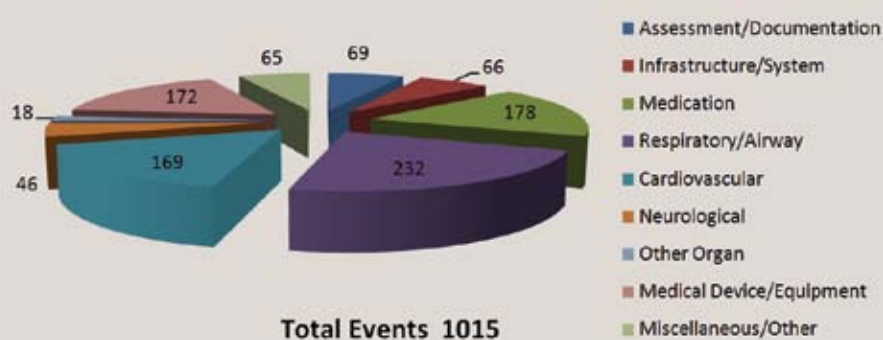
Acknowledgements

The Perioperative Mortality Review Committee would like to acknowledge the leadership of the inaugural chair, Iain Martin, the support of Health Quality & Safety Commission New Zealand, especially the chair, Alan Merry, and all of those who have worked tirelessly for many years to develop national perioperative mortality review.

Dr Leona Wilson, FANZCA
Chair, New Zealand Perioperative
Mortality Review Committee

webAIRS from ANZTADC

Main Category coding - May 2012



Incident analysis

The Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) has been collecting data using the webAIRS (Web-based Anaesthetic Incident Recording System) program since September 1, 2009. This figure shows the main categories for the 1015 incidents collected and analysed up to May 11 this year. The results were presented during the Safety in Anaesthesia session at the ANZCA Annual Scientific Meeting in Perth on May 13. There will be a further session with updated data at the Australian Society of Anaesthetists' 71st National Scientific Congress in Hobart on October 2. A paper also will be presented during the Human Factors session of the New Zealand Anaesthesia Annual Scientific Meeting combined with the 13th International Congress of Cardiothoracic and Vascular Anesthesia on November 17, titled "Fix it twice – using this methodology to reduce medical error".

Of the incidents reported, the largest main categories were respiratory/airway (22.86 per cent), medication (17.54 per cent), medical devices and equipment (16.95 per cent) and cardiovascular (16.65 per cent).

In this issue, the ANZTADC Analysis Sub-Committee presents its analysis of respiratory incidents, which accounted for 232 of the 1015 incidents (22.85 per cent). We have further drilled down to 27 incidents involving regurgitation with or without aspiration. This represents 11.6 per cent of all respiratory incidents and 2.66 per cent of all incidents reported. Fourteen cases involved probable aspiration or confirmed aspiration and these were classed as aspiration events. Thirteen cases involved regurgitation without suspected or confirmed aspiration. Of the cases classed as aspiration, five cases (38.46 per cent) were managed by intermittent positive pressure ventilation (IPPV) in an intensive care unit and one was managed by continuous positive airway pressure (CPAP) in a high dependency unit. The remaining seven cases of aspiration (53.84 per cent) were managed without admission to an intensive care unit or high dependency unit. Although temporary harm occurred in 11 of the 27 cases (40.7 per cent) in these two categories, no cases were reported as fatal or resulting in serious harm. However, other studies have noted the incidence of fatal complications to be

12.4 per cent (Warner et al¹) and 4 per cent (Kluger et al²). Several fatal cases of aspiration also were reported by Victoria Consultative Council on Anaesthetic Morbidity and Mortality in the 2007 annual report³.

In this series, 14 cases were associated with a supraglottic airway but temporary harm only occurred in three, and none were admitted to an intensive care unit or high dependency unit. Endotracheal tubes were associated with six instances of temporary harm, four of which required IPPV in an intensive care unit and one required CPAP in high dependency unit. Finally, five cases were associated with a facemask or Hudson mask and one of these required IPPV in an intensive care unit. The number of airway devices used exceeds the total number of cases; this is because in some instances of airway difficulty, multiple devices were used. Also some cases aspirated either immediately prior to intubation during management with a facemask or post-extubation.

Interim recommendations, in keeping with the literature, are that although regurgitation and/or aspiration are events with the potential for serious morbidity or death, most published cases may be managed conservatively in the absence of significant respiratory consequences or signs in the first two hours post-operatively^{1,2}. This is supported by the webAIRS data collected so far. In cases where there is doubt, close post-operative monitoring is recommended. If there are signs of respiratory deterioration, consider respiratory support (for example CPAP, Bi-phasic Positive Airway Pressure or IPPV) in an intensive care unit or high dependency unit. ANZTADC plans to publish a full report in the form of a peer-reviewed article when enough cases have been reported.

At the Australian Society of Anaesthetists' National Scientific Congress in Hobart, Dr Antonio Grossi will present management strategies

for managing respiratory incidents, including updated methods for dealing with hypoxia during anaesthesia and regurgitation with or without aspiration. Come along to the session and give your opinion on the best way to manage these types of incidents. He will also discuss the role of various airway devices in the management of respiratory incidents.

More than 40 hospitals report to ANZTADC using the webAIRS software and we wish to thank all the registered sites for taking part in the ANZTADC project and for all the useful feedback. If you would like to register your hospital please do so via the link on the ANZCA website or www.anztadc.net/RegisterAccount.aspx?org=658365. The secure ANZTADC program is free of charge to ANZCA Fellows, members of the Australian Society of Anaesthetists, and members of New Zealand Society of Anaesthetists. If you need help with ethics or other approvals at your hospital, ANZTADC will assist with the relevant applications.

Professor Martin Culwick, Dr Antonio Grossi, Mrs Heather Reynolds and Professor Alan Merry
ANZTADC Analysis Sub-Committee members

References:

1. Clinical Significance of Pulmonary Aspiration during the Perioperative Period. Mark A. Warner, Mary Ellen Warner and Joseph G. Weber. *Anesthesiology* 78: 56-62 1993.
2. Crisis management during anaesthesia: regurgitation, vomiting, and aspiration. M T Kluger, T Visvanathan, J A Myburgh, R N Westhorpe. *Qual Saf Health Care* 2005;14:e4 <http://qualitysafety.bmj.com/content/14/3/e4.full.html>
3. Victoria Consultative Council on Anaesthetic Morbidity and Mortality (VCCAMM) annual reports <http://www.health.vic.gov.au/vccamm/vccamm-reports.htm>

ECRI alerts

The ECRI Institute is a non-profit organisation that issues alerts from four sources: the ECRI International Problem Reporting System, product manufacturers, government agencies including the US Food and Drug Administration (FDA) and agencies in Australasia, Europe and the UK, as well as reports from client hospitals.

Some alerts may only involve single or small numbers of cases, there is no denominator to provide incidence and there is not always certainty about the regions where the equipment is supplied.

This section highlights some of the alerts that may be relevant. Hospitals should follow up with the manufacturer's representatives if they have not already been contacted.

CareFusion Alaris Pump Modules (Model 8100)

Two problems have been reported with the 8100 Alaris pump modules:

1. Motors of the pump modules may stall intermittently, particularly at high infusion rates (>900ml/hr). There will be a visual error code and an audible alarm followed by termination of infusion. This may result in patient morbidity if the infused medication is critical.
2. The keypad overlay in the door assembly of the pump module may delaminate potentially allowing fluid ingress, which may lead to keypad malfunction or termination of infusion. Carefusion has notified customers of affected serial numbers and these pumps should be individually examined.

Shiley Size 8 Reusable Cannula Cuffed Tracheostomy Tube: leakage or disconnection

Covidien, the manufacturer of these tracheostomy tubes, has received several reports. These reports have entailed volume leakage and/or disconnection between inner and outer cannulae, usually during mechanical ventilation. It is possible that the tube may need immediate replacement. An urgent device recall has been initiated.

Timesco Laryngoscope Handles: loose contact disks

The contact disks of these laryngoscope handles may become loose after autoclaving potentially causing flickering or failure to function. This confirms the importance of checking the blade before case commencement and having a second functioning laryngoscope available for every case.

MAQUET HL30 Heart-Lung machines: arterial pump shut down due to electrostatic discharge

Maquet has received reports of unexpected cessation of the arterial pump during bypass. Investigation has revealed that this is due to electrostatic discharge (ESD) at the pump control panel, most likely occurring when a static electricity charge builds up on an individual, who then adjusts the pump controls. In all cases, the perfusionists used the hand crank while the pump was replaced with an emergency back-up pump.

Maquet claims that immediate restart of the pump should be possible but can also provide an ESD upgrade kit on request.

Dr Phillipa Hore

Communications and Liaison Portfolio
Quality and Safety Committee

Anaesthesia and Pain Medicine Foundation – a clear purpose



The ANZCA Council has approved a new statement that clarifies the purpose of the Anaesthesia and Pain Medicine Foundation. The new statement affirms the foundation's role in supporting research and education projects conducted by ANZCA Fellows and ANZCA and integrates the previous objectives and purpose statements:

To raise funds for medical research and education in Australia, New Zealand and internationally, to:

- Increase the safety and comfort of patients undergoing anaesthesia and sedation.
- Improve outcomes for critically ill patients following surgery or trauma.
- Improve the treatment of acute pain, cancer pain and persistent non-cancer pain.

Research grants 2013 update

The Anaesthesia and Pain Medicine Foundation has received 38 applications for grants in 2013, including project, simulation/education, academic enhancement and novice investigator grants, and the Douglas Joseph Professorship.

The number of high-quality applications from Fellows continues to increase each year, underscoring the urgent need to increase donations to maximise funding and research outcomes. The foundation greatly appreciates contributions from Fellows, trusts, corporate sponsors and philanthropic donors, who are vital to the foundation's capacity to fund important, life-saving work.

The ANZCA application process is modelled on the process used by the National Health and Medical Research Council. Three reviewers with relevant expertise assess each application. In mid-September the ANZCA Research Committee examined all applications and reviews, and will make funding recommendations to the ANZCA Council for 2013 grants. Successful applicants will be notified and listed in the December *ANZCA Bulletin*.

Renewed healthcare industry support

The five-year sponsorship terms of our founding sponsors, Mundipharma, Pfizer Australia and St Jude Medical, expired in 2011. The foundation is delighted that Mundipharma has since advised that it will continue its sponsorship, and positive discussions are in progress with St Jude Medical.

The foundation is contacting a range of other companies in the sector regarding the potential to sponsor the foundation to help maintain and increase the support for research and education in pain medicine and anaesthesia.

Philanthropic grantmakers

The foundation has made several contacts and lodged expressions of interest with philanthropic trusts and foundations as part of a strategy to access new funding from this sector.

Overseas aid

The foundation is working with the ANZCA Overseas Aid Committee to develop a plan to increase resources for Fellows' efforts to bring better pain management and anaesthesia knowledge and skills to people in less developed communities, including the successful Essential Pain Management course. Donations – or requests for information – can be directed to the foundation.

Thank you to all those generous Fellows and donors who support the Anaesthesia and Pain Medicine Foundation. Donations or inquiries related to any of its activities are welcome and can be made by calling Rob Packer, General Manager, Anaesthesia and Pain Medicine Foundation on +61 3 8517 5306, or emailing rpacker@anzca.edu.au.

Robert Packer
General Manager,
Anaesthesia and Pain Medicine
Foundation, ANZCA

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

ANZCA Trials Group strategic research workshop in Palm Cove,



The ANZCA Trials Group held its fourth strategic research workshop in the warm environs of Palm Cove, Queensland from August 10-12. This is the second time the workshop was held at Palm Cove.

About 60 participants including three guest speakers attended a full program that brought together experienced and emerging researchers from Australia, New Zealand, Hong Kong, the US, the Netherlands and the UK. The primary aim of these meetings is to present, mentor and encourage new ideas for multicentre research in anaesthesia, perioperative medicine and pain medicine. Another aim is to update existing research activity and encourage participants to engage in current multi-centre trials.

This year there were two invited speakers, including a biostatistician who was invited back to the meeting following delegate feedback in 2011 for an ongoing statistical component in the program. Dr Katherine Lee from the Murdoch Children's Research Institute (Royal Children's Hospital, Melbourne) gave a presentation on intention to treat

analysis, followed the next day by a presentation on cluster randomisation within individually randomised trials. Her presentations were coupled with talks from the current chair of the Australian and New Zealand Intensive Care Society-Clinical Trials Group (ANZICS-CTG), Professor Steve Webb. Professor Webb spoke on the need for clinical trial groups to focus their strategic research planning on programs rather than individual projects. His second talk examined evidence for clinical intervention: what is it, and what should be done with it?

The quality of new proposals presented at the workshop was high. There were 14 proposals that covered topics such as cardio-pulmonary exercise testing; ketamine infusion to avoid chronic pain post surgery; high-dose dexamethasone and major surgery; tranexamic acid in lower limb arthroplasty; a perioperative model of care; oxytocin infusion for elective caesarean section; anaesthesia and cognitive decline; oxygen levels during cardiopulmonary bypass; fluid rationalisation after cardiac surgery; videolaryngoscopy use; intravenous iron intraoperatively; pharmacokinetics and pharmacodynamics of sevoflurane; cerebral oximetry to reduce perioperative morbidity; and, readability of research patient information forms for patients.

Associate Professor David Story presented a pilot grant application on behalf of Dr Dean Cowie (Vic): "Cerebral oximetry to reduce peri-operative morbidity". This research project was later approved to receive a pilot grant award for 2012.

Current multicentre research updates were given by Professor Paul Myles on Aspirin and Tranexamic Acid for Coronary Artery Surgery (ATACAS) and Nitrous Oxide Anaesthesia and Cardiac Morbidity after Major Surgery-2 (ENIGMA II). ATACAS continues to seek greater surgeon participation as well as new centres internationally, while ENIGMA II is on track for completion in 2013. Other multicentre research updates were the REstrictive versus LIBeral Fluid Therapy in Major Abdominal Surgery – The RELIEF Study (Myles); the Balanced Study by Associate Professor Tim Short; and Professor Matthew Chan spoke on two pain studies that are underway; persistent pain after surgery and the chronic pain sub-study of the ENIGMA II trial. Professor Chan also presented updates on the vascular events in non cardiac surgery patients' cohort evaluation studies (NeuroVISION and cardiac computed tomography angiography (CTA) Vision Studies). Associate Professor Tomas Corcoran's presented his work



on dexamethasone and peri-operative infection risk as well as tranexamic acid in burns surgery.

The Balanced Study, the NeuroVision Study and RELIEF study were recipients of the ANZCA Pilot Grant Scheme in 2010, 2011 and 2011 respectively. The Balanced study has also been awarded the highest grant awarded to anaesthesia research in New Zealand of \$NZ1.2 million.

The Peri-operative Ischemic Evaluation-2 Trial: POISE-2 Trial is well under way in Australia and New Zealand, and Palm Cove was the setting for another POISE-2 investigators meeting chaired by the National Coordinator for POISE 2, Professor Kate Leslie.

Professor Leslie updated 34 investigators and research coordinators on the study progress. There are 11 active sites, 18 in progress. Sixty seven patients have been recruited to date; 29 of these from Royal Adelaide Hospital; two from the Royal Hobart Hospital; eight from the Royal Melbourne Hospital; seven from Geelong Hospital; six from Dandenong Hospital; three from The Alfred hospital; and, two from Western Hospital. The rest of the meeting was open to each centre to report on their progress with recruitment and difficulties that they have encountered during the trial.

Breakout sessions for the large number of research coordinators who attend the workshop were first planned in 2011. This year two breakout sessions were arranged and the group had their own guest speaker. Rachel Parke, chair of ANZICS-CTG Research Coordinators Special Interest Group, attended the meeting from New Zealand, where she is based at Auckland City Hospital. She spoke to the group about her work with the ANZICS-CTG, and how the anaesthesia research co-ordinators might learn from her experience. Sofia Sidiropoulos is the chair of the anaesthesia research co-ordinators group. She spoke on consent issues and organised other members to speak on research audit and serious adverse event reporting. She also attends the trials group executive committee meetings as a non-voting member.

The ANZCA Trials Group Executive Committee takes the opportunity at the ANZCA Annual Scientific Meetings and the research workshops to meet in person rather than conduct its meetings by teleconference. This year ANZCA President Dr Lindy Roberts attended the meeting as a guest. Dr Roberts had earlier addressed the workshop about the College strategic plan for 2013 to 2017, and how

the trials group and research fits into this. The ANZCA Trials Group Executive Committee moved to appoint Professor Leslie as deputy chair.

Conference delegates enjoyed welcome drinks and a buffet meal on a balmy terrace at Sea Temple Resort on Friday night, while Saturday evening was a little cooler for the conference dinner. Nonetheless it was the perfect tropical setting to think about research and escape wintery weather!

The trials group executive would like to thank Dr Shiva Malekzadeh (Vic) for being our "in-house" photographer.

Stephanie Poustie
ANZCA Trials Group
Research Fellow and Co-ordinator

Opposite page clockwise from top left: Sea Temple Resort and Spa, Palm Cove; Professor Stephan Schug (WA), ANZCA President Dr Lindy Roberts (WA) and Dr Britta Regli-Von Ungern (WA); Palm Cove; Davina McAllister (NZ) presenting at the breakout session; Sofia Sidiropoulos (Vic) and Anisa Abu Baker (WA).

This page clockwise from left: Palm Cove signage; Rochelle Cotter (Vic), Professor Kate Leslie (Vic) and Joana Amorim (Vic); Delegates at Saturday's session; Associate Professor David Story (Vic) and Professor Paul Myles (Vic); Professor Tomas Bruessel, Dr David Bramley (Vic) and Dr Stefan Dieleman (the Netherlands).



2012 NZ Anaesthesia ASM

Although the early-bird registration has closed, there is still time to register for this year's NZ Anaesthesia Annual Scientific Meeting being held in Auckland on November 14-17 with pre-conference workshops on November 12-13.

By combining with the International Congress of Cardiothoracic and Vascular Anesthesia, this conference has attracted the best ever line-up of speakers for a New Zealand anaesthesia meeting.

The combined meeting offers a superb general stream, a specialist cardiac stream and a third stream that crosses the divide between those two so there is plenty to appeal to everyone. Registrants are not limited to a particular stream but can choose sessions from across the whole program. There is a huge range of workshops as well as an extensive choice of plenary sessions. To read the program and to register, go to www.iccva2012.com.

The New Zealand medical workforce in 2011

New Zealand's medical workforce continues to increase and its age cohort reflects New Zealand's general demographic, according to the Medical Council of New Zealand's (MCNZ) 2011 medical workforce survey, released in August.

The survey shows that the number of active doctors increased by 3.2 per cent, from 13,883 in 2010 to 14,333 in 2011. This compares with increases of 3.5 per cent in 2009 and 2010.

In 2000-03, the largest group of doctors (almost 20 per cent) was in the 40-44 year age group. By 2009, the largest group was aged 45-49 and in 2011, the largest group was aged 50-54.

The younger age groups of doctors have more females than males: 45 per cent of females in the workforce are under the age of 40, compared with 27 per cent of males. Only five per cent of females are over the age of 60, compared with 18 per cent of males.

While the overall proportion of females in the workforce remained at 40 per cent, females continued to outnumber men in house officer roles, making up 57 per cent of this category.

The proportion of females increased in accident and medical practice from 34 per cent to 44 per cent but decreased in obstetrics and gynaecology (from 54 per cent to 41 per cent) and paediatrics (from

53 per cent to 45 per cent). Females were significantly under-represented in the surgical scopes. Only eight per cent of doctors working in surgical scopes were female, down from 13 per cent in 2010.

The proportion of doctors who identified themselves as Māori dropped to 2.8 per cent while the proportion of Pacific doctors increased from 1.3 per cent to 1.6 per cent – both far less than their proportion of the population.

International medical graduates now make up 41.5 percent of the medical workforce – with 43 percent of GPs being an international medical graduate.

For all active doctors, the average number of hours worked was 43.7 per week with the data showing that doctors aged in their twenties worked the most hours (52.8 hours) each week on average.

The survey shows that, on average, 84 per cent of graduates are retained in the New Zealand medical workforce two years after graduation. By the third year, 78 per cent are retained, rising to 79 per cent five years after graduation. Retention rates level out to between 61 and 67 per cent in years eight to 14 years after graduation.

However, fewer than 53 per cent of international medical graduates are retained in the year immediately after initial registration, with doctors who held their primary qualification for between 11 and 20 years when they came to New Zealand having the highest retention rate. Doctors from the UK and the Americas have the lowest retention rates.

The full report is available at www.mcnz.org.nz/assets/News-and-Publications/Workforce-Surveys/2011.pdf



Christchurch citation

The ANZCA Council has awarded an ANZCA Citation to the Christchurch Hospital Department of Anaesthesia in recognition of the work its staff undertook in extreme circumstances during and after the February 22, 2011 earthquake and its numerous aftershocks.

Departmental staff performed magnificently both in the hospital and out in the field as casualties streamed in to a hospital that was without power and water at times. They continued this work despite many of their homes being ruined, damaged or inaccessible and concern about their family members. The citation will be presented during the NZ Anaesthesia Annual Scientific Meeting in Auckland in November.

Major research grant for anaesthetist

An international team led by Dr Tim Short, a specialist consultant at Auckland City Hospital, has been awarded \$NZ1.2 million to fund a major project looking at the influence of anaesthetic depth on outcome.

Dr Short is also the Director of Anaesthetic Research and Chair of the Auckland District Health Board Research Review Committee, the clinical associate professor in the department of anaesthesia at the Auckland University School of Health Sciences and an ANZCA examiner.

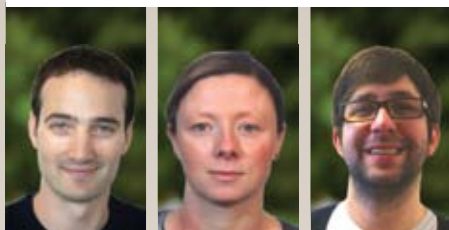
The money was awarded in the 2012 Health Research Council funding round. It will help fund a large-scale randomised trial of 6600 patients to definitively answer the question of whether anaesthetic depth alters surgical outcome.

The rationale for the project is that the optimal depth at which anaesthetics should be given is unknown. Recent observational studies have shown a 20 per cent increase in mortality in patients undergoing major surgery, who receive relatively deep anaesthesia.

Dr Short says that in particular his trial will look at the death rate at one year and also whether there are differences in other complications of surgery and anaesthesia, including wound infection, cardiovascular and neurological complications, pain and awareness.

He says the study will have important implications for how anaesthetists should run anaesthetics with findings that can be easily translated into daily practice.

Various centres around New Zealand are assisting with the trial. Others interested in participating may contact Dr Short at tims@adhb.govt.nz.



Three BWT Ritchie Scholarships awarded

The NZ Anaesthesia Education Committee has awarded BWT Ritchie Scholarships to Dr Matt Levine, Dr Nicholas Lightfoot and Dr Sheila Barnett to support them in overseas fellowships in 2013.

Each of the three candidates was highly recommended by their department and has secured an overseas fellowships that will contribute to the development of their skills, knowledge and experience, and bring benefits to anaesthesia in New Zealand when they return.

Dr Levine's fellowship at New York's St Luke's Roosevelt Hospital Centre and Dr Lightfoot's fellowship at Toronto General Hospital both begin in July 2013, while Dr Barnett begins her fellowship at Royal Children's Hospital in Melbourne in February 2013.

Dr Levine is currently chief resident and a provisional fellow in the Department of Anaesthesia and Pain Management at Wellington Regional Hospital. When nominating Dr Levine, Professor Sandy Garden commented on his high degree of clinical competence with a commonsense approach to clinical anaesthesia, his academic achievements and his leadership skills. Dr Levine is an enthusiastic teacher on Wellington-based crisis management courses and the FANZCA final exam course. He is a member of the ANZCA New Zealand Trainee Committee, an experience he says has given him a broader insight into the issues that face anaesthesia trainees, and the inner workings of the College.

Dr Levine's fellowship will enable him to expand his skills in his special interest of regional anaesthesia. St Luke's Roosevelt Hospital Centre operates the New York School of Regional Anaesthesia, and is considered one of the world's premier regional anaesthesia centres. Dr Levine looks forward to learning regional anaesthesia from world experts and bringing that information back to New Zealand to share with colleagues.

Dr Lightfoot is a provisional fellow at Middlemore Hospital in Auckland and has impressed Dr Helen Frith, who nominated him, with his conscientiousness, willingness to learn and work, and his commitment to keeping the welfare of the patient in mind at all times. He has been enhancing his ultrasound guided regional anaesthesia skills and developing an interest in transthoracic echocardiographic techniques as well as pursuing research interests in cardiac outcomes of non-cardiac surgery. Dr Lightfoot has been involved in teaching and supervising anaesthesia trainees and technicians and has recently joined the NZ Society of Anaesthetists' executive as deputy trainee representative.

Dr Lightfoot's fellowship at Toronto General Hospital will focus on anaesthesia for hepatobiliary surgery, surgical oncology and intra-abdominal transplantation. He believes that his experience at Toronto will offer a good mix of cutting-edge clinical experience where he will be challenged to learn new skills, along with more routine call work that will build and further develop skills obtained through his New Zealand training. Dr Lightfoot anticipates returning to New Zealand with a blend of skills learned during New Zealand-based training and in the North American setting, which will allow him to confidently anaesthetise patients with a diverse range of clinical and pathological conditions.

Dr Barnett is an anaesthesia trainee with the South Island anaesthesia training program, most recently in Dunedin, where Dr Jason Henwood states in his nomination that she "worked tirelessly to facilitate the educational needs of fellow registrars". Dr Henwood commented on Dr Barnett's high standard of academic and clinical achievement. She enjoys teaching and presenting, won the Ritchie Prize for her formal project and recently published in *Anaesthesia & Intensive Care*. Dr Barnett is Chair of ANZCA's New Zealand Trainee Committee.

Dr Barnett's fellowship at the Royal Children's Hospital in Melbourne will comprise nine months in anaesthesia and three months in neonatal intensive care (NICU). Dr Barnett says that the anaesthesia experience will provide regular involvement on major craniofacial cases, and complex cardiac and transplant cases. She expects her time at the NICU to be extremely valuable and fascinating, as the unit receives babies with complex conditions transferred from other tertiary centres. The Royal Children's Hospital performs more than 18,000 anaesthetics a year as well as running the Children's Pain Management Service, which sees around 8000 consultations a year. Dr Barnett believes that working in a centre so proficient in research and pain management will give her experience and ideas that will be useful on her return to the South Island. This will be particularly relevant since Christchurch expects to have a dedicated children's hospital within the 10 years.

From top left: Dr Matt Levine, Dr Sheila Barnett and Dr Nicholas Lightfoot.

Queensland



Obstetrics, paediatrics and law: little gems all anaesthetists should know

The 36th annual Queensland ANZCA/Australian Society of Anaesthetists Combined Continuing Medical Education Conference was held at the Brisbane Convention & Exhibition Centre in July.

The event focused on obstetric and paediatric anaesthesia, as well as medico-legal principles relevant for anaesthetists. The day comprised a series of lectures and a panel discussion, followed by an ultrasound workshop, a paediatric resuscitation workshop and problem-based learning discussions in the afternoon.

The program began with a presentation by solicitor Justine Beirne on the subject of 'Consent: no one size fits all'. Dr Peter Waterhouse of the Royal Children's Hospital then gave a presentation on 'Avoiding Brutane: an approach to the reluctant paediatric patient'. The keynote speaker was Dr Ben Van der Griend, of Christchurch, who spoke on 'Is it safe to anaesthetise children?'

Conference convenor Dr David McCormack said the standard of education delivered was very high in both content and form with the successful implementation of a tripartite theme. The use of a new venue also led to a high level of delegate, sponsor and committee satisfaction, he said.

The Queensland Regional Committee Chair, Dr Mark Young, congratulated Dr McCormack and the Continuing Medical Education Committee Chair, Dr Chris Breen, on the outstanding success of this conference.

Above from top left: Guest speakers Dr Ben van der Griend, Justine Beirne and Dr Peter Waterhouse; Delegates mixing with healthcare industry representatives during morning tea.



New office bearers

Office bearers were appointed at the first meeting of the 2012-2014 Queensland Regional Committee, held on May 30. The new office bearers are:

Chair:	Dr Mark Young
Deputy Chair:	Dr Sean McManus
Secretary/treasurer:	Dr Charmaine Barrett
Regional education officer:	Dr Jeneen Thatcher
Formal project officer:	Dr Kerstin Wyssusek
ANZCA/ASA CME Chair:	Dr Chris Breen
Quality and safety officer:	Dr Charles Willmott
New Fellows representative:	Dr Dale Kerr

The committee welcomes new members Dr Joe Williams and Dr Brian Lewer and sincerely thanks outgoing members, Dr Emile Kurukchi and Dr Pal Sivalingam for their contribution during the life of the previous committee.

The Queensland Regional Committee also acknowledges the significant achievements of Dr Sean McManus, the previous chair, and Dr Michael Steyn, the previous deputy chair, both of whom will serve on the new committee.

Above from left: Dr Brian Lewer, Dr Kerry Brandis, Dr Paul Nicholas, Dr Mark Gibbs, Dr Charmaine Barrett, Dr Chris Breen, Dr Mark Young, Dr James Hosking, Dr Kerstin Wyssusek, Dr Jeneen Thatcher, Dr Sean McManus, Dr Genevieve Goulding, Dr Dale Kerr.

Absent: Professor Michael Steyn, Associate Professor Kersi Taraporewalla, Dr Joe Williams, Dr Charles Willmott and Dr Peter Duff.



2012 Queensland primary viva practice course

A residential viva course was held over the weekend of August 18-19 at the Sheraton Noosa Resort in Queensland. Twenty trainees travelled from as far as Tasmania and Darwin, Orange and Cairns to participate in this intensive viva weekend. The co-ordinator, Dr Guy Godsall, of Nambour Hospital, together with 20 of his peers from the local area, worked with the trainees to further develop their skills. This popular training opportunity is limited by the number of available examiners, so places are allocated first to trainees from regional areas who are preparing for the next viva sitting.



College citation

ANZCA President Dr Lindy Roberts presented Dr Kerry Brandis an ANZCA Council Citation on September 12 at the Queensland Regional Committee meeting. The ANZCA Council Citation was established in 2000 and is made at the discretion of the ANZCA Council in recognition of significant contributions to College activities.

Dr Brandis has had a career in anaesthesia spanning 26 years during which time he has made significant contributions to advancing the profession in Queensland, and nationally, with particular achievements in education and training and service on the ANZCA Council and committees.

Australian Capital Territory



Difficult airways workshop

The ACT regional committee recently held a difficult airways workshop at the Hyatt Hotel in Canberra on August 4. Convened by Dr Stephen Brazenor the workshop had a wide variety of equipment for review by the delegates. Dr Ian McKenzie, the Director of Anaesthesia and Pain Management at the Royal Children's Hospital was a guest speaker on our Panel of Experts along with various local Fellows. There was a revisiting of the Difficult Airway Algorithm by Dr Stephen Brazenor. Videolaryngoscopy and approach to fibre optic intubation techniques were reviewed by Dr Simon Robertson. The interesting presentations combined with the hands-on aspect of the workshop combined to make the day a large success. In other news the ACT regional committee will be holding their AGM in November with the date to be confirmed.

Above from top: Dr Stephen Brazenor and the panel of experts discussing assessment of the airway; Delegates participating in the hands-on workshop.

South Australia and Northern Territory



Registrar's Scientific Meeting 2012

The 2012 Registrar's Scientific Meeting was held at the Women's and Children's Hospital on August 8.

The guest speaker, Professor Guy Ludbrook from Royal Adelaide Hospital, spoke about research being undertaken at the Royal Adelaide Hospital and ANZCA's commitment through the Anaesthesia and Pain Medicine Foundation, which contributes more than \$600,000 a year to research in Australia. He also highlighted the work of the ANZCA Trials Group, which was founded in 2005 to improve the evidence base of anaesthesia by developing and conducting high quality, multicentre randomised controlled trials and related research.

The winning registrar was Dr Rowan Ousley for her research project titled "Block height assessment for satisfactory spinal anaesthesia during caesarean section". Presentations by Dr Simon Roberts and Dr Andrew Thomas were highly commended.

This continuing medical education (CME) event is an important part of the CME calendar for encouraging trainees to demonstrate their knowledge and fostering scientific enquiry among others.

Above clockwise from top left: Business Development Manager South Australia and Northern Territory Michael Lardner, winning Registrar Dr Rowan Ousley, SA and NT CME Committee Chair Dr Nathan Davis; Registrar Dr Andrew Thomas; CME Committee Member Dr Bill Wilson and guest speaker Professor Guy Ludbrook; Registrar Dr Simon Roberts.



Education meeting hears about indigenous experiences

On June 27, the South Australia and Northern Territory Continuing Medical Education Committee held their evening continuing medical education meeting at the Women's & Children's Hospital on the subject of "indigenous health and anaesthesia".

Dr Janelle Trees, a GP anaesthetist, addressed the meeting via videoconference from Uluru-Kata Tjuta National Park, in the Northern Territory.

An indigenous Australian, Dr Trees works in a closed Aboriginal community in Mutijulu, near Alice Springs, and provided an insightful and personal talk on indigenous spiritual beliefs, "spirit in and out". Her talk highlighted the importance of trust between the anaesthetist and an indigenous patient as indigenous patients believe the spirit leaves the body during a procedure and that the anaesthetist is the doctor that guides the spirit back into the body before they wake.

The meeting was video-linked to 14 consultants and trainees at the Royal Darwin Hospital and six at Alice Springs Hospital.

Dr Phil Blum, an anaesthetist at the Royal Darwin Hospital for 13 years, spoke about issues of consent and communication and told interesting stories about how communication breakdown can lead to unpredictable outcomes. He also pointed out that a junior patient was rarely accompanied by a "natural parent" and doctors were sometimes required to take a flexible approach with consensual protocol. It was fantastic to hear about the Royal Darwin hospital and its outstanding work within the community, of which 20 per cent is indigenous.

Finally, an anaesthetist at the Royal Adelaide Hospital, Dr Tony Pearce, spoke on "my indigenous family", telling how he came to have "eight mothers-in-laws" and how he and his wife, a midwife, came to be adopted by the people of a Katherine indigenous community.

Above from left: SA and NT CME Chair Dr Nathan Davis acknowledging the Kaurna people and their lands; Video conferencing to The Royal Darwin and Alice Springs Hospital and the Uluru-Kata Tjuta National Park.



Part 0 Induction Course

On August 5, the South Australia and Northern Territory regional office held the Part 0 Induction Course for new trainees joining the SA and NT Rotational Anaesthesia Training Scheme. The chair of the SA and NT Trainee Committee, Vicki Cohen, facilitated the course. Topics included GASACT, the new ANZCA curriculum, Part 1 Course and trainee welfare. We wish to thank consultants Dr Margaret Wiese, Dr Thien LeCong, Dr Christine Hildyard, Dr Elizabeth Chye and Dr Ken Chin for presenting at the course.

Above from left: Mei Quinn (Quinnie) Tan, Richard (Branden) Emmerson, Danielle Carlson, Tim Donaldson, Johan Smit, Brigid Brown.

Australian news continued

New South Wales



New Challenges in Anaesthesia meeting at the Sydney Hilton

On June 16 the New South Wales Continuing Medical Education Committee held their major continuing medical education meeting at the Sydney Hilton on "New Challenges In Anaesthesia" with more than 340 attendees enjoying this day. The workshops and PBLDs continue to be very well subscribed, attended and well received. These included workshops on new airway devices, new pacemakers and implantable and benchtop defibrillators and anaesthetic ventilators. There were 24 workshops and PBLDs conducted throughout the day. For the first time we included a session with registrar scientific presentations and this was well attended by Fellows and trainees. Dr Jennifer Reilly was the recipient of the award.

Above clockwise from top left: Dr Tony Padley workshop; Delegates at the meeting; Dr Chris Thompson; Dr David Postie and Dr Phil Melksham; Dr Nicole Smith, Dr Michael Bennett and Dr Catherine Downs; Dr Jane Brown, Dr Vivian Walsh and Dr Anne Rasmussen.



Spinal surgery and pain – current directions in spinal surgery for pain

On Thursday June 7, NSW Faculty of Pain Medicine Fellows, trainees and allied health and Fellows from the Chapters of Addiction and Palliative Care Medicine from Sydney and the surrounding area gathered for the NSW Regional Committee's Continuing Medical Education (CME) dinner meeting.

The CME meeting was a successful mind-stimulating event on spinal surgical pain management by Dr Jonathon Ball. It was complementary to the holistic concepts given by the physicians last year. The wonderful neurosurgical presentation was held at the College office followed by Brazilian cuisine at a stylish cosy restaurant. This South American tastings provided a warm friendly atmosphere to complete a fantastic social event. We thank Mundipharma and Janssen for the joint sponsorship.

Above from top: Invited guest speaker, Dr Jonathon Ball, specialist spine surgeon and neurosurgeon, Royal North Shore Hospital; Dr Martine Holford and Dr Milton Cohen.

Tasmania



2013 Combined ANZCA/ASA Annual Scientific Meeting

The joint meeting of the ANZCA and the Australian Society of Anaesthetists will be held at The Tramsheds in Launceston from February 22-24, 2013. It is anticipated the meeting will have a perioperative theme.

A Part 0 course, along with an update on the new curriculum and an airway/advanced life support (ALS) session for all registrars will be held on the Friday prior to the meeting.

Western Australia



Office news

The Western Australian regional office has had a change in crew since the last *ANZCA Bulletin* with Melanie Roberts joining ANZCA as the regional co-ordinator and Louise Burgess appointed to the role of regional administrator. The WA office farewelled Sandra Box at a dinner following the committee meeting in July and also farewelled Bree Toussaint, wishing them well in their new endeavours.

The Bunker Bay Updates in Anaesthesia conference will be held from October 12 to 14, and is convened by King Edward Memorial Hospital and led by Dr Celine Baber. "Hectic obstetrics and frenetic anaesthetics" is the final conference of the year for WA and registrations are filling quickly. Professor Warwick Ngan Kee from Hong Kong is the keynote speaker for this conference and will be a highlight for those with an interest in intensive care obstetrics. Professor Ngan Kee was born and educated in New Zealand. He is Professor and Director of Obstetric Anaesthesia in the Department of Anaesthesia and Intensive Care at the Chinese University of Hong Kong. He is an editor of the *International Journal of Obstetric Anesthesia*, an editorial board member of *Obstetric Anesthesia Digest*, executive member of the Obstetric Anaesthesia Society of Asia and Oceania and co-editor of the forthcoming edition of Chestnut's *Obstetric Anesthesia*.

The Surgical Careers Expo is scheduled for the September 26 at the University of Western Australia and will be attended by David Hoppe and Marlene Johnson. The expo aims to provide information on vocational training and career pathways regarding the anaesthetic training program in WA.

Oliver Jones and Allan Meers presented to the Western Australian Regional Committee and the Supervisors of Training Committee to communicate important updates for the new curriculum in 2013. Thank you Oliver and Allan.

The primary and final exams are done and dusted for the year, but Part 2 tutorials will continue to run for the rest of the year. Trainees are encouraged to attend if they plan to sit the exams next year.

Victoria



33rd ANZCA/ASA Combined Continuing Medical Education meeting

The 33rd Annual ANZCA/Australian Society of Anaesthetists Combined Continuing Medical Education meeting was held at the Sofitel Melbourne on Collins on Saturday July 28. The meeting was called “the ultra meeting”, and was well supported by Victorian and interstate registrants, including the trade.

The sessions included topics such as: the bariatric patient with a multidisciplinary approach including the surgical, anaesthetic and intensive care aspects; resuscitation, focusing on the adult patient, the obstetric setting and anaphylaxis; and ultrasound use in regional anaesthesia, invasive line insertion and echocardiography in non-cardiac surgery.

A lively and entertaining debate concluded the formal proceedings, which were followed by drinks and dinner.

Above clockwise from top left: Dr Peter Seal, Convenor/CME Officer ASA Victoria, Dr Mark Suss, Chair ASA Victoria, Dr Craig Noonan, Chair VRC, Dr Mark Hurley, Co-Convenor, CME Officer, VRC; Dr Craig Noonan, Chair VRC presenting a SOT Certificate of Recognition to Dr Peter Howe; Dr Andrew Schneider and Dr Andrew Buettner; Dr Craig Noonan, Chair VRC presenting a SOT Certificate of Recognition to Dr Rob Dawson.

Special interest group events

Obstetric Anaesthesia Special Interest Group meeting



The 3rd Quadrennial Obstetric Anaesthesia Special Interest Group meeting was held at the Quay West Resort, Bunker Bay, following the ANZCA Annual Scientific Meeting (ASM) in May. The location was on the edge of the renowned Margaret River wine region and gave the delegates the opportunity to unwind after the ASM.

The theme of the meeting was “High risk obstetric anaesthesia” and the speakers included a number of well-known anaesthetists from Australia and New Zealand. In addition, the invited speakers included intensivists Dr Luke Torre, haematologist Dr Nicole Staples, lawyer and anaesthetist Dr Andrew Miller and gynaecologist Professor Yee Leung. The program included a number of interactive sessions, workshops and problem-based learning discussions with a large number of practical tips and tricks for the delegates.

The social program included a welcome reception at the resort, a wine tour visiting well-known vineyards in the Margaret River region and a conference dinner at the Wise Vineyard. During the meeting, delegates raised over \$1000 for the Lifebox project through raffles supported by sponsors, adding to the success of this initiative from the Perth annual scientific meeting.

The meeting attracted 120 delegates and six healthcare industry representatives, all of whom took away new ideas, friends and colleagues. Thank you to all the delegates, speakers and workshop and problem-based learning discussion facilitators for attending and contributing to the success of the meeting, a number of whom travelled a long way. A special thank you to the conference secretariat, Kirsty O'Connor from ANZCA, for all her help with organising the meeting.

Dr Nolan McDonnell
Convener

Perioperative Medicine/Acute Pain Special Interest Group meeting



“When worlds collide: perioperative medicine – the new specialty on the block?” was the title of the inaugural meeting of the new Perioperative Medicine Special Interest Group, which was held in conjunction with the Acute Pain Special Interest Group.

The program, which was highly practical, comprised guest speakers from diverse areas of medicine such as liver transplantation and fluid management to the role of perioperative psychiatry.

Expert panels examined controversial questions facing this potential new specialty. The two big questions to arise from the conference were: Which kind of doctor is best suited to practice perioperative medicine and how should a perioperative medicine service work?

The conference was held at the beautiful Byron at Byron Resort and Spa in NSW, on the same weekend that 20,000 people descended on Byron Bay for a music festival! The meeting was limited to 150 delegates and no sponsorship was required. A welcome reception and dinner facilitated discussion and collaboration of perioperative enthusiasts from throughout Australasia.

I thank the members of the Perioperative Medicine SIG for their contributions, our entertaining speakers, and of course Kirsty O'Connor from ANZCA for making this conference such a great success.

Dr Dick Ongley
Convener

2012 Rural Special Interest Group meeting

The Rural Special Interest Group (SIG) held its annual meeting at the Peppers Resort, Torquay, on Victoria's Great Ocean Road from July 6 to 8. The conference, now in its fifth year, returned to the theme of the original meeting with the title "Staying afloat on the shipwreck coast: The return of the accidental intensivist". The meeting was well supported by more than 80 delegates, including many GP anaesthetists and large number of trade displays.

The meeting covered a variety of topics more usually associated with the intensive care unit that country-based anaesthetists might find themselves dealing with.

"Shipwreck tales" covered a challenging paediatric case report along with how to deal with a major incident in a small town and responding to in-flight emergencies. "A treasure chest" covered all aspects of chest trauma before "Raising the respiratory wrecks" discussed ventilation all the way from non-invasive strategies to ECMO. The final morning sessions included "Avoiding the CVS capsise", which took us through ECHOs, cardiac output monitors and inotropes, before a thought-provoking final session entitled "When to man the lifeboats". This session introduced the ethics of intensive care unit treatment, some thoughts about when to say yes or no to admissions and finally a discussion about respecting patients' end-of-life decisions.

The meeting again hosted workshops with a continuation of the education theme from 2011, and offered module 3 from the 'Teaching on the Run' program. Dr Craig Mitchell and colleagues from Ballarat ran an ultrasound workshop and Dr Nick Jansen and colleagues from the Royal Melbourne Hospital ran an ALS update.

This year's meeting also held a poster prize for the first time and offered prizes courtesy of a grant from Rural Health Continuing Education – stream 1. The quality of posters was very high with the Fellow's prize going to Dr Pat Coleman of Western Australia and the registrar's prize going to Dr Rosie Zacher from Queensland. We will run a poster competition again next year and posters may be on any topic that is relevant to rural anaesthesia.

We were blessed with sunny weather on the Great Ocean Road, which enabled delegates to enjoy the golf course and the coastal walkways when not in lectures. The social events were well attended with delegates able to network at a drinks reception on the first evening and over dinner at Truffleduck at Balmoral on the Saturday evening.

The meeting was a great success and I would like to mention the contribution of the Rural SIG Chair and co-convenor, Dr Craig Mitchell, and the sterling work of Ms Hannah Burnell who, in her role as SIG co-ordinator, assisted in planning and hosting the meeting as well as all the speakers, whose high quality presentations ensured the meeting was a great success.

The final business of the meeting was the Rural SIG annual general meeting, where plans for next year's meeting were discussed. The meeting will be held at the Millennium Hotel, Rotorua, New Zealand, from July 12 to 14, and the theme will be "Obstetric anaesthesia in the bush".



Above clockwise from top: Golf course, Peppers the Sands, Torquay; Ultrasound workshop demonstration by Dr Rob Ray; Dr Pat Coleman presenting in the poster symposium; Dr Nick Jansen presenting; Dr Craig Mitchell demonstrating at the ultrasound workshop.

David Rowe
Co-convenor

Dean's message



We have recently witnessed that four-yearly event, so mesmerising for many, the Olympic Games. It is an event that symbolises so many of our aspirations as a society. Where extremes of hard work and dedication by athletes are put to the measure against the best in the world. For a small minority, the ultimate goal of “gold” is achievable. For others, one hundredth of a second can be the agonising difference in falling short. Australia and New Zealand have again performed and achieved success far beyond our comparatively meagre populations would warrant. It is inherent in the character of our two nations to unapologetically step up, to be counted and lead on the world stage.

So it is in the field of pain medicine. Our proud history of leadership in both opinion setting and structural organisation is evident. Our Faculty, our recognition of us as a medical specialty, our advocacy through contributions to government collaborations, the National Pain Summit and National Pain Strategy attest to the energy and vision that thrives in our fraternity.

As one Olympiad ends, the athletes of the future, our would-be heroes in Rio de Janeiro in four years' time, map out their training strategy for the next four years to deliver their dreams. That planning now is essential for success.

Like our future Olympians, as a specialty and Faculty we have been looking towards the future. Our mission, our vision, our strategic goals and a business plan to take us there. During the first half of this year, we have had our ongoing strategic review process in parallel with the complementary initiative of ANZCA, to finalise our strategic plan for the next five years.

The release of the details of this strategic plan is imminent. Like our athletes, we have the foundations in place to direct our growth and strength as a Faculty over the next five years, which, like our Olympians, will keep us firmly on the “leaders’ board” nationally and internationally in the years ahead.

The recent announcement by the NSW government of \$26 million of funding for pain services in NSW is reason for celebration. Tireless contributions by our NSW Fellows over many years to documenting and quantifying pain and its costs and to, most recently, planning solution via contributions to the Agency for Clinical Innovation as well as advocacy by Pain Australia. Money has been allocated to increased numbers of training positions, educational initiatives and for the electronic Persistent Pain Outcome Collaboration (ePPOC). Congratulations to all contributors and to the NSW government on this much-needed commitment.

The NSW funding announcement adds to the momentum of previous commitments to funding by governments in Queensland and Victoria and by the federal government to fund \$5 million in February 2012 for an online, electronic, controlled-drugs monitoring system. We must maintain our representations to government and advocacy initiatives to see these projects to fruition and to maintain this momentum in the future.

The significant and onerous undertaking that is the Australian Medical Council reaccreditation process in Australia is ongoing. The Faculty has benefited immensely from the experience and contributions of ANZCA in support of our reaccreditation process, as well as the tireless, invaluable contributions of our Director of Professional Affairs, Associate Professor Milton Cohen, General Manager, Helen Morris and our dedicated Faculty staff. On behalf of our Faculty, I offer a sincere thank you.

The process of assessment by the New Zealand Medical Council for recognition of pain medicine as an independent specialty in New Zealand continues. This remains one of the highest priorities for us as a Faculty. As would be expected, the process is necessarily extensive and thorough. We are nearing the finalisation of this process and have presented our cause well. We hope for a decision from the Medical Council of New Zealand this year.

Once again on the Olympic theme, the Paralympics holds special significance for us as a Faculty. So much of our management of pain requires assessment and management of disability. Convincing and inspiring patients to be the best they can be, to focus on what can be done and not what cannot, to live a full life despite pain and disability rather than to let their pain defeat them. To find that source of control and confidence within themselves, to be the master of their pain rather than believing the solutions are beyond their control.

The Paralympic Games are full of athletes who have conquered these enemies. Each has mastered their disability and often pain and has lived their dream of competing at the highest level. Each can be an example and provide hope to our patients.

Our challenge as specialist pain medicine physicians is to help our patients find the confidence and inspiration to master their pain and reach their own full potential in life.

Our challenge as a Faculty and fraternity is to keep Australia and New Zealand on the worldwide leader board when it comes to advancing the standard of care for our patients and lifting the complacency surrounding the silent epidemic of pain sufferers in our midst.

In our strategic plan for the next five years we have a map for our own success.

Bring on the new Olympiad!!

Associate Professor Brendan Moore
Dean, Faculty of Pain Medicine



Faculty of Pain Medicine Board 2012

Back Row: Dr Chris Hayes, Dr Frank New, Associate Professor Andrew Zcest, Dr Dilip Kapur, Associate Professor Ray Garrick, Ms Helen Morris (General Manager).

Front Row: Dr Kieran Davis, Dr Michael Vagg, Professor Ted Shipton (Vice-Dean), Associate Professor Brendan Moore (Dean), Associate Professor David Scott, Dr Meredith Craigie, Professor Stephan Schug.

Admission to fellowship of the Faculty of Pain Medicine

By examination:

June 6, 2012

Dr Pieter Carel Le Roux, FACEM (Qld)

Dr Duncan Morris Wood, FANZCA (NZ)

Dr Jordan Gardiner Wood, FANZCA (NSW)

Training unit accreditation

The Melbourne Pain Group and the Peter MacCallum Cancer Centre have been accredited as the Faculty's first tier two units for pain medicine training following successful initial reviews. This takes to 30 the number of accredited pain units.

Examination dates

November 23-25, 2012 (Friday to Sunday)

Auckland City Hospital, Auckland NZ

Closing date for registration:

October 5, 2012

FPM Board meeting report

August 13, 2012

Faculty Board

ANZCA Council's representative to the Faculty of Pain Medicine Board, Associate Professor David Scott, was welcomed to the board. ANZCA President Dr Lindy Roberts also attended the meeting and was welcomed. The Faculty Board will next meet in Melbourne on October 29.

Honours and awards

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

- Dr Genevieve Goulding has been appointed Vice-President ANZCA.
- Dr Leona Wilson has been appointed Director of Professional Affairs (IMGS) ANZCA.
- Associate Professor Victor Callanan has been awarded the ANZCA Medal.

FPM international medical graduate specialists (IMGS) process

ANZCA's Director of Professional Affairs (IMGS), Dr Dick Willis, and Manager ANZCA IMGS and Accreditation Renee McNamara presented a proposal for a process for the assessment of Faculty IMGS applicants. The process will be only for applicants intending to practice in Australia, pending accreditation of pain medicine as a specialty by the Medical Council of New Zealand. The board resolved that the FPM IMGS Working Group, including representation from the ANZCA IMGS Committee, will continue to develop the assessment process in alignment with ANZCA's.

Relationships

Australian Pain Society

The board nominated Dr Chris Hayes as the FPM Board representative to the Australian Pain Society's Relationship and Communications Committee, replacing Dr Penny Briscoe, who retired from the board in May.

Royal Australian College of General Practitioners

The Royal Australian College of General Practitioners/FPM GP online learning initiative is in the final stages of development and remains on track for a launch at the FPM Spring Meeting in Coolum on September 29. As part of this initiative, a library of complimentary

PowerPoint presentations has been developed for Fellows to use as teaching aids. This library of presentations endorsed by the Faculty and including high quality animations and effects will be available for download from the resources section of the Faculty website. A demonstration stand will take Fellows through accessing the GP Active Learning Module and how to download the PowerPoint presentations developed for their use. The full online Active Learning Module will be launched at the GP12 meeting on October 26.

Australian Rheumatology Association

The President of the Australian Rheumatology Association (ARA), Associate Professor Sue Piper, met with the Faculty Board in August to discuss opportunities for collaboration between the organisations. Both parties agreed that the National Pain Strategy would be greatly strengthened by the support of the ARA, which has not yet endorsed it. The Faculty's Spring Meeting in Coolum will include a session on the profile of new medications in rheumatology. Opportunities will be explored for collaboration on a future spring meeting.

Corporate Affairs

FPM Strategic Plan

The board approved the FPM Strategic Plan for 2013-2017. The structure of the Faculty's strategic plan is defined by its mission (shared with ANZCA), its vision and its strategic priorities and objectives. Strategic priorities are to:

- Build fellowship and the Faculty.
- Build the curriculum and knowledge.
- Build advocacy and access.

Activities to put the plan into action will be contained in the Faculty's Business Plan, developed annually. A business plan is being developed for the 2013 calendar year and will inform the budget process for that year.

Board handbook

The board approved a handbook for use as an orientation resource for new board members. The handbook provides an introduction to the governance arrangements and various duties, responsibilities and workings of the board and its relationships, both within the FPM and in other jurisdictions.

FPM terms of reference

The board approved terms of reference for the roles of:

- Dean.
- Board members.
- Treasurer.
- Training unit accreditation reviewer.

Committee appointments

Committee appointments were approved for 2012-13. It was agreed to include representation from New Zealand on the Research Committee.

Professional

NSW pain management plan

On July 18, the NSW Minister for Health and Medical Research, Jillian Skinner, announced a significant funding increase for pain management services in NSW. The plan, which incorporated extensive input from both a ministerial taskforce and the Agency for Clinical Innovation (ACI) Pain Network, commits an additional \$26 million over four years to support the development of new pain management services in regional areas, enhance existing teaching hospital services, and support research into chronic pain.

Electronic Persistent Pain Outcomes Collaboration

As part of the funding package announced by the NSW Government, \$300,000 of annual recurrent funding has been allocated to support benchmarking of outcomes across NSW through the Electronic Persistent Pain Outcomes Collaboration. There will be an emphasis on moving towards implementation in NSW and also on planning the national benchmarking process, working collaboratively with FPM, Australian Pain Society and New Zealand Pain Society.

NSW Government approval for pain medicine early recruitment 2012

The board noted that the NSW Government had approved the advertising of funded pain medicine provisional Fellow positions for the 2013 clinical year in May 2012, two months earlier than the annual recruitment period.

(continued next page)

FPM Board meeting report continued

Recognition of pain medicine as a specialty – New Zealand

Faculty representatives participated in a teleconference with members of the Medical Council of New Zealand's Accreditation Committee and responded to queries, including the Faculty's continuing professional development requirements. New Zealand Fellows are to be reminded of the Medical Council of New Zealand continuing professional development requirements.

Submissions

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

- Health Workforce Australia – Health Professionals Prescribing Pathway (HPPP) Australia – May 2012.
- AMC review of the approved Accreditation Standards for medical schools – August 2012.

The Faculty also responded to:

- Pharmaceutical Benefits Scheme – a review of current listings of opioids – August 2012.
- Health Workforce Australia – Pain Medicine Chapter, July 2012.
- Therapeutic Goods Administration – proposed withdrawal of products containing dextropropoxyphene (DPP) – August 2012.
- AMC accreditation assessment RANZCP and RACMA – July 2012.
- Pharmaceutical Benefits Advisory Committee – PBS access to gabapentin – August 2012.

Communications

It was agreed that the Synapse e-newsletter will be opened to paid advertising in line with ANZCA practice. Rates and publication dates will be published on the Faculty website.

Trainee Affairs

IMGS trainees

In May, the board resolved to revise the earlier decision to restrict fellowship of FPMANZCA to those holding a fellowship of an Australian and New Zealand specialist college. It was agreed that in future, the training and assessment criteria to be met by those applying

for FFPMANZCA may be supported by a specialist qualification from an international jurisdiction. Regulation 3.1.1.6 has been amended to remove reference to a requirement for an Australian or New Zealand specialist qualification acceptable to the board. The board will now undertake a process of evaluating relevant international specialist qualifications to determine those that are acceptable for this purpose. Consideration of any application is assessed based on the formal structure of examination and training required for their primary specialist qualification.

Following the decision of the board to consider specialist qualifications of international medical graduate trainees as acceptable pre-requisite specialist qualifications for FFPMANZCA, the qualification Associate Fellowship of FPMANZCA became redundant, as the only differentiating criterion was whether the applicant held a fellowship of an Australian and New Zealand specialty. Thus, the decision was also made to rescind FPM Regulation 3.5: Admission to Associate Fellowship by Training and Examination.

A separate issue is the decision of quantifying any retrospective credit of prior training and experience that is relevant to pain medicine. This decision depends on the individual's actual prior experience rather than the formal structure of their primary specialist qualification. Applications for fellowship from international medical graduate specialists applying for FPM training will be assessed on a case-by-case basis to determine the quantum of recognition of prior learning to be credited towards the Faculty's training time requirements.

Current trainees with international qualifications will not be disadvantaged by these decisions.

A list of specialist fellowships, international as well as those of Australian and New Zealand, which are acceptable to the board as satisfactory pre-requisite qualifications for fellowship, is being developed and will be generally available.

Training agreement

The board accepted a revised training agreement, which will be circulated to current trainees and all new trainees with registration documentation.

Fellowship

Three new Fellows were admitted in June, taking the total number of admissions to 331.

Education

FPM curriculum revision

The board was advised about key changes being proposed by the Curriculum Revision Sub-Committee and the critical issues in relation to these changes. The board resolved that:

- The two-year program will be restructured.
- There will be entry-level knowledge required for the structured year of training; these may take the form of pre-requisite courses.
- A range of new teaching/learning approaches will be used.
- Trainees will complete three examinations throughout the year, along with some other hurdle summative assessments.
- A budget will be created to cater for the initial high-level processes for design of the program.

Supervisor of supervisors of training appointment

Board approved the appointment of Dr Faizur Noore, FRANZCP, FFPMANZCA as the FPM supervisor of supervisors of training.

Training unit accreditation

The Melbourne Pain Group and Peter MacCallum Cancer Centre have been accredited as Tier 2 units, for up to six months full-time equivalent of structured training.

Continuing professional development

Upcoming FPM events include:

- 2012 Spring Meeting – September 28-30 – Palmer Coolum Resort, Sunshine Coast
- 2013 Annual Scientific Meeting and FPM Refresher Course Day – May 3 and May 4-8 – Melbourne

Finance

At the end of July, the Faculty remained in a positive position against the budget.

Hypnosis research brings new awareness

Hypnotherapy is increasingly used to replace or supplement pharmacological anaesthesia, with surprising results, write Dr Allan Cyna and Dr Marion Andrew. This article is reprinted with permission from *The Conversation*.

In one form or another, hypnosis has been around for thousands of years, but until recently, evidence to support its biological and clinically powerful effects has been lacking. Today clinicians around the world use hypnosis to help manage pain, childbirth, phobia and anxiety – particularly in children.

What is hypnosis?

Hypnosis is thought to be a state of conscious awareness, which most people experience transiently many times each day. Hypnotic experiences and responses tend to involve:

- Absorption or a state of focused concentration or attention.
- Dissociation, where the patient's perception of the external environment diminishes.
- Suggestibility (the ability of an individual to respond, in a non-volitional way, to a verbal or non-verbal communication).

People describe the hypnotic mindset in different ways such as, "being beside oneself", "out of body experiences", "daydreaming", "tuning out" or a meditative state.

Until the 19th century, hypnosis was the only means of having surgery comfortably. James Braid, a Scottish surgeon working in Bengal in the 1840s, operated on several hundred patients using hypnosis and his success received widespread acclaim.

Over the years, clinicians have reported dissociation from pain, decreased bleeding and reduced infection, suggesting an evolutionary basis for why we have the ability to enter a hypnotic, trance-like state when under extreme stress.

Following the establishment of pharmacological anaesthesia – with its greater effectiveness and reliability – the practice of hypnosis languished for decades, becoming little more than a parlour trick. It was almost forgotten until relatively recently.

Unfortunately, the term hypnosis has many negative connotations and its use by stage hypnotists as entertainment has probably contributed to many doctors not taking the clinical use of hypnosis seriously.

How it works

Contrary to popular belief, hypnosis is not sleep; hypnotic responses can be elicited in minutes or less; and a conscious belief that it will be effective is not required to achieve a benefit. Patients experiencing hypnosis can hear what's happening around them and can halt the process at any stage if they wish.

The success of hypnosis in a clinical setting requires trust between doctor and patient to go along with the process. But a borderline, and sometimes frank, hypnotic state frequently occurs spontaneously in hospital patients where the overwhelming stress of the external environment – or the thought of painful procedures, or feelings of being a victim to illness – can facilitate an internal focus of attention.

This can make patients highly responsive to suggestions, positive or negative. And it means that when a doctor says, before a potentially painful procedure, "this is going to sting", the communication can function as a hypnotic suggestion and is likely to increase pain. In contrast, the positive suggestion, "the local anaesthetic will numb the area and allow us to perform the procedure more comfortably" is likely to decrease pain of local anaesthetic injection.

What does the research say?

Advances in brain-function imaging using functional magnetic resonance imaging (fMRI) and positron emission tomography (PET) scanning techniques have allowed us to see that hypnosis modulates

activity in the anterior cingulate cortex, which links the limbic (emotions) and sensory cortical areas of the brain during hypnotic pain relief. This appears to allow sensations that would normally be experienced as painful to no longer have the suffering or negative emotions that would normally be associated with them.

A labour contraction, for example, can be felt as either the most terrifying and painful of sensations or a wonderfully fulfilling experience that tells the mother she is getting closer to her baby. These very different perceptions may be experienced despite the intensity of uterine contractions being identical.

Anaesthetists in Belgium have successfully used hypnosis to help thousands of patients minimise their need for general anaesthesia during thyroidectomy (surgical removal of the thyroid gland), mastectomy (removal of the breast) and plastic surgery.

Meanwhile, US researchers are investigating the effectiveness of hypnosis and suggestion in the management of chronic and procedural pain, including burns.

Our own institution is researching the effectiveness of hypnosis in managing childbirth pain, along with investigators in Denmark, the United Kingdom and the University of Tasmania.

How is it used?

Hypnosis in the formal sense – where a patient receives an induction, treatment and an alerting procedure – is more commonly practiced by clinical psychologists and not widely used in hospitals. Although a number of hospitals around the world use hypnotic techniques, the main clinical application is to use suggestions to supplement anaesthesia drugs and techniques as part of a multimodal approach to patient care.

Hypnosis has been used at Adelaide's Women's and Children's Hospital for more than 30 years, since Dr Graham Wicks, a medical hypnotherapist at the hospital, pioneered its use. Over the years, hypnosis has been used to treat thousands of children with problems as



diverse as bedwetting, pain, and helping children comfortably use hypnotic anaesthesia with needles and renal dialysis.

Today, several paediatricians and anaesthetists at our institution are trained in hypnosis and use it to supplement patient care where indicated.

As anaesthetists, we use hypnotic techniques to help patients feel more in control and to supplement and enhance their anaesthesia experience. Common examples include assisting children and adults with their induction of anaesthesia, burns dressings, treatment of needle phobia, assistance with childbirth pain and preparation of patients for surgery.

It's very rare for procedures to be performed entirely using hypnosis.

The main value of hypnosis as a technique is to assist patients to have drips and needles inserted more comfortably and to supplement a less-than-perfect local anaesthetic. The belief that the patient can do more than he or she thinks (and more than the doctor believes is possible) is likely to generate surprising therapeutic responses.

Further reading: *Handbook of Communication in Anaesthesia & Critical Care: A Practical Guide to Exploring the Art.*

Dr Allan Cyna
Anaesthetist and researcher at SA Health

Dr Marion Andrew
Anaesthetist and researcher at SA Health

THE CONVERSATION

From the curious to the serious

<http://theconversation.edu.au>

STEPS in the West for people with persistent pain

People with persistent pain face many challenges.

While it may be true that healthcare professionals can't independently change societal views of illness and disability, or move people's beliefs towards outcomes evidence-based practice, what happens when individuals and the system work together to support a system change so evidence-based care can occur at the "coalface"?

In 2007, the Western Australian Department of Health started to offer annual translational research grants. The key drivers for funding were translating evidence into practice and reducing the cost to the WA health department.

The two-day Self Educative Pain Sessions, followed by patient-initiated assessments, aimed to reduce some of the healthcare barriers. The program, known as STEPS, offers patients knowledge and skills from clinical psychologists, occupational therapists, physiotherapists and pain medicine physicians to emphasise a whole-person integrated approach to managing persistent pain. The patient is involved in each step of their care in the evidence-based management of pain. A maximum of 12 patients are booked per program, with partners or carers also invited to attend.

Opportunity met crisis at the Fremantle Hospital and Health Service where newly referred patients had to wait more than two years to attend the Pain Medicine Unit and referrals for more than 600 people with pain were nested in eight lever-arch files. The system had to change to allow more effective triage of patients.

An opportunity to address the crisis arose when the State Health Research Advisory Council and Fremantle Hospital funded an assessment of the effects of pre-clinic group education sessions (STEPS) on tertiary pain medicine units and patient outcomes.

At the time of their referral, patients were asked to complete a seven-page patient triage questionnaire, including

questions on demographics, their pain story, PainDETECT, HADS (now DASS21), life events, red, yellow and disease "flags" and pain-management strategies.

Over the next 18 months, assessors tracked the progress of 204 patients who attended STEPS and found that 52 per cent of patients didn't organise further individual appointments at the tertiary pain medicine unit. Patient surveys indicated that these patients were happy to self manage or to receive healthcare in their local community.

STEPS also resulted in reduced costs, with the cost per new patient falling from \$A1805 to \$881. Of this, \$541 was the cost of running the program. Wait times for group and clinic appointments also fell, dropping from two years to four months at one pain unit and seven months to 3.75 months at the second¹. The patients reported an increase in the use of active pain-management strategies and patient satisfaction.

In the 21 months from October 2007 to the end of 2009, 1075 patients booked to attend the two-day STEPS program at Fremantle Hospital and Health Service, of which 854 attended and 221 (20 per cent) were "no shows"; 667 patients (78 per cent) attended all five sessions. A further 1000 patients had booked to attend STEPS to August 2012.

STEPS provides up-to-date information and advice about how to effectively manage persistent pain, including medications and procedures, movement and exercise, pacing everyday activities and approaches to pain. It helps patients to understand the complex puzzle of pain, and appreciate discussions about neuroplasticity, the immune system and the multimodal range of options that work together.

The program is a resource for co-care (that is co-ordinated or combined care) for people with persistent pain, their carers, families and health professionals. It supports **wHOLE Person Engagement** – the "HOPE model of care".

Patients, their families and carers can access STEPS in Western Australia through referral by a health professional to:

- The Fremantle Hospital and Health Service Pain Medicine Unit (funded by the WA Department of Health). There is a six-week waiting time for STEPS and a two to three month wait for patient-initiated assessments (including Telehealth) by either the pain team or a single doctor. There is no charge to the patient and more than 750 new patients access the service each year.
- Perth North Metro Medical Local, 137 Main St, Osborne Park (funded by the federal Department of Health and Ageing). Perth North Metro Medical Local has had 137 referrals and 87 people have attended STEPS to date. There is a two-week waiting time for STEPS and the pain team assesses all patients four weeks after they have completed the two-day group program. The service is free to patients and includes a lunch of gourmet sandwiches.

The pain team includes a medical pain consultant, a clinical psychologist and a physiotherapist. The team encourages the use of local health resources to ensure best patient outcomes and connects the patient with local healthcare professionals and resources if required.

Fremantle Hospital and Health Service and Perth North Metro Medical both offer opportunities for healthcare professionals to attend STEPS as a learning experience (bookings are required with a maximum of two professionals per group).

The WA Department of Health also worked with the Fremantle Division of GPs (now Fremantle Medicare Local) and Osborne Park GP Division (now Perth North Metro Medicare Local) in 2008 and 2009 to deliver general practitioner-focused one-day inter-professional pain-education programs. The health department funded the five programs and research via the State Health



Research Advisory Council. The research demonstrated strong clinically important and statistical evidence for encouraging GPs to adopt more self-reported evidence-based attitudes, beliefs and clinical behaviours in their management of patients with non-specific low back pain².

An exciting partnership between WA Department of Health, Arthritis Foundation (WA), Curtin University and RuralHealthWest co-ordinated “rural roadshows” in 2010-11 for the STEPS team to deliver a modified version of the general practitioner-focused programs to other healthcare professionals. Called hPEP: Health Care Professional Pain Education Program, the workshops were delivered on a Saturday to 60 healthcare professionals. A modified STEPS program followed on Sunday and was attended by more than 80 people, including carers, in three remote and rural locations in Kununurra, Kalgoorlie, and Albany³.

Translating evidence into best practice care is enhanced when the patient is firmly in the driver’s seat with a skilled healthcare professional alongside them!

**Adjunct Associate Professor
Stephanie Davies**

Associate Professor Helen Slater

Mrs Kylie Birkinshaw

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Above: STEPS being conducted as part of the Rural Roadshow in Albany, Western Australia.

Library update

New online textbooks

The ANZCA Library has recently added two new collections of e-books - the OVID Anesthesiology and Pain collection and the Lange Basic Science Collection through Access Medicine.

The packages provide access to a combined total of over 65 titles including books on ultrasound-guided regional anaesthesia, airway management, pain and intensive care medicine. Some titles of interest are:



- **Anesthesiologist's manual of surgical procedures** / Jaffe, Richard A [ed.]; Samuels, Stanley I [ed.]. -- 4th ed -- Philadelphia, PA: Wolters Kluwer/Lippincott Williams and Wilkins, 2009.
 - **Cousins & Bridenbaugh's neural blockade : in clinical anesthesia and pain medicine** / Cousins, Michael J [ed.]; Carr, Daniel B [ed.]; Horlocker, Terese T [ed.]; Bridenbaugh, Phillip O [ed.]. -- 4th ed -- Philadelphia: Wolters Kluwer / Lippincott Williams & Wilkins, 2009.
 - **Bonica's management of pain** / Fishman, Scott M. [ed.]; Ballantyne, Jane C. [ed.]; Rathmell, James P. [ed.]. -- 4th ed -- Baltimore, MD: Lippincott Williams and Wilkins, 2010.
 - the **'Practical Approach to ... Anesthesia'** series.
- The Lange Basic Sciences package is specifically suited to trainee examination preparation including four books from the Primary Exam recommended reading list:
- **Basic and clinical biostatistics** / Dawson, Beth; Trapp, Robert G. -- 4th ed -- New York: Lange Medical Books/McGraw-Hill, 2004.

- **Basic and clinical pharmacology** / Katzung, Bertram G [ed.]; Masters, Susan B. [ed.]; Trevor, Anthony J. [ed.]. -- 12th ed -- New York: McGraw-Hill, 2012.
- **Ganong's review of medical physiology** / Barrett, Kim E. [ed.]; Barman, Susan M. [ed.]; Boitano, Scott [ed.]; Brooks, Heddwen L. [ed.]; Ganong, W. F. -- 23rd ed -- New York: McGraw-Hill Medical, 2010.
- **Vander's renal physiology** / Eaton, Douglas C; Pooler, John P. -- 7th ed -- New York: McGraw-Hill, 2009.

Reminder: All material provided by the Library is for the benefit of financial Fellows, trainees and IMGS of the College and Faculty. Material is for authorised users only and should not be shared with non-ANZCA members. When using online resources, members are agreeing to abide by the terms of use for the resource.

Access the OVID e-books, the Basic Sciences e-books and many more online textbooks through the ANZCA Library Online Textbooks list or library catalogue: www.anzca.edu.au/resources/library/online-textbooks

New journal – Perioperative Medicine

Perioperative Medicine is an open access peer-reviewed journal that publishes highly topical clinical research relating to the perioperative care of surgical patients. Its essence is the distillation, examination and application of clinical evidence to improve surgical outcome. Modern perioperative medicine is a true multidisciplinary speciality and the journal welcomes research in all areas relevant to perioperative medicine from any healthcare professional.

Recent articles include:

Perioperative fluid management: Consensus statement from the enhanced recovery partnership. Mythen MG, et al. *Perioperative Medicine* 2012, 1:2 (June 27, 2012)

Access through the ANZCA Library online journal list: www.anzca.edu.au/resources/library/journals/online-journals.html

New ECRI publications

Health Devices, Vol. 41, No.6, June 2012

- The Big Picture – a focus on medical video equipment needs

Health Devices, Vol. 41, No.7, July 2012

- Saving on CT, CT Test Criteria and Safety Matters

Health Devices, Vol. 41, No.8, August 2012

Operating Room Risk Management

- Anesthesia Information Management Systems – this analysis focuses on quality improvement, patient safety, risk management, and compliance implications of anesthesia information management system use.

Evidence-based practice corner – recent reviews

American Society of Anesthesiologists Task Force on Perioperative Visual Loss. *Practice advisory for perioperative visual loss associated with spine surgery: an updated report by the American Society of Anesthesiologists Task Force on Perioperative Visual Loss.* *Anesthesiology* 2012;116(2):274-85.

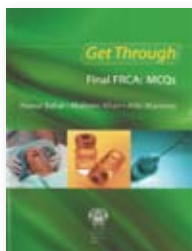
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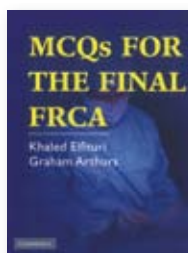
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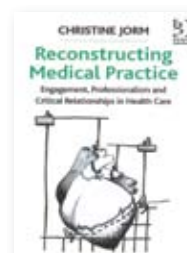
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Email: library@anzca.edu.au

ANZCA Council meeting report

August 2012

Report following the meeting Council of the Australian and New Zealand College of Anaesthetists held on August 18.

Death of Fellows and trainees

Council noted with regret the deaths of Fellows Dr Alan Marshall Barr (UK), Dr Peter Gartrell (SA), Dr John Patrick Keneally (NSW) and Dr Hilton David Swan (WA), and trainee Dr Van Tu Bui (NSW). As a mark of respect, the president has written to their families.

Honours and awards

Professor David Story (Vic) has been appointed Chair of the Centre for Anaesthesia, Perioperative Medicine and Pain Medicine, School of Medicine, University of Melbourne.

Dr Leona Wilson (NZ) has been awarded the Robert Orton Medal for distinguished service to Anaesthesia.

ANZCA Strategic Plan 2013-17

Council endorsed the strategic plan, which will be launched shortly and will allow prioritisation of decision-making, activities and resource allocation over the next five years. The plan arose out of broad consultation and the council acknowledges those contributions.

Fellowship affairs

Admissions to fellowship: To ensure timely admission of new Fellows, ANZCA Council has delegated admissions to fellowship (under regulation 6.4 and 6.5) to the ANZCA Executive Committee.

New Fellows: The following are congratulated on their admission to ANZCA fellowship:

Adly Ariff ABAS (WA)

Nada ALRAWI (Vic)

Gerry ANDERSON (Tas)

Nicola BEAUCHAMP (Qld)

Jennifer Elizabeth BENEDICT (Qld)

Anton Willis Gerard BOOTH (Qld)

Daniel Edward BOYD (NZ)

Silke BRINKMANN (Canada)

Eoin David CASEY (Vic)

Rani CHAHAL (Vic)

Richard John CHURCH (SA)

Peter John CLARKE (Vic)

Timothy James Hannam CRICHTON (SA)

Nicholas Patrick CRIMMINS (Qld)

Allan Michael CYNA (SA)

Andrew FOSTER (SA)

Matthew Lee GEALL (NSW)

Tiffany Sheryn GLASS (SA)

Christopher GORRINGE (NSW)

Jagdeep GREWAL (NSW)

Maryam HEZAR (NSW)

Christine Louise HILDYARD (SA)

Zoe KEON-COHEN (Vic)

Huey Ling KOH (Qld)

Rebecca Anne LEWICKI (Vic)

Siv Eing LIM (NSW)

Nina LOUGHMAN (NSW)

LUI Frances (HK)

Fousia MANTHODI KULANGARA (Qld)

Kameel Yousif MARCUS (Vic)

Andrew John MARRIOTT (Vic)

Steven James MITCHELL (NZ)

Premala NADARAJAH (Qld)

Ruta NERLEKAR (Vic)

William Chuk Kit NG (HK)

James John OLSON (NZ)

Desmond Niall O'REGAN (NZ)

Anand PARAMESWARAN (Qld)

Namita Jhamb RAKHEJA (NSW)

Thimali RAJAPAKSA (NZ)

Gauri Sangeeta RESCH (Vic)

Paul Andrew ROSS (NSW)

Elitza Vaneva SARDAREVA (NZ)

Timothy Theodore SCHOLZ (NSW)

Allanah Catherine SCOTT (Vic)

Raymond SINNADURAI (WA)

Scott Anthony SMITH (Qld)

Tamsin Melissa SUPPLE (Vic)

Eric Jiong-Chang TAI (WA)

Li Yen Lena TAN (NZ)

TANG Pui Yan (HK)

Andrew Gethyn THOMAS (SA)

TSE Yee Wah (HK)

Andrew Robert WALLACE (SA)

YAU Wing Sze (HK)

Annual scientific meetings:

The 2019 ANZCA Annual Scientific Meeting will be held in Kuala Lumpur, Malaysia (May 3-8).

The 2020 ANZCA Annual Scientific Meeting will be held in Melbourne, Australia (May 1-6).

All future College ceremonies held in Australia and New Zealand will include an acknowledgement of the traditional owners of the land.

ASM meeting of ANZCA Council and regional and national committee chairs to cease:

With the engagement between councillors and the regions increasing, regular teleconferences with the president and vice-president, and declining attendance due to competing commitments, the annual face-to-face ASM meeting of ANZCA Council with regional and national committee chairs will no longer be held.

Terms of reference: Terms of reference have been approved for the Anaesthesia and Pain Medicine Foundation Board, the ANZCA Trials Group executive, the honorary and assistant curators, the honorary archivist, the ANZCA medical editor (*ANZCA Bulletin*, e-newsletters etc) and ANZCA/FPM representatives to external organisations. These will be available on the website soon.

Role Terms of Reference Working Group:

Council acknowledge the efforts of this working group in developing terms of terms of reference for all the roles held by ANZCA/FPM Fellows and trainees and the group was disbanded.

Quality and safety (see ANZCA website)

Patient Blood Management Guidelines: Module 2 – Perioperative

ANZCA Council formally endorsed this National Blood Authority publication.

PS54: Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice (previously T03)

The change in code reflects the ANZCA Council's recent decision to abolish the technical (T) category of professional documents and relabel them professional standards (PS). A definitive version of PS54 will be presented to ANZCA Council for approval in October 2012, with an accompanying background paper.

PS40: Statement on the Relationship Between Fellows, Trainees and the Healthcare Industry

This document and its background paper were approved.

PS46: Guidelines on Training and Practice of Perioperative Cardiac Ultrasound in Adults

Council approved a major rewrite of this document and a newly developed background paper. These will be circulated to the regional and national committees, the Faculty of Pain Medicine Board, the ANZCA Trainee Committee and relevant special interest groups for consultation.

A01: Policy for the Development and Review of Professional Documents

Minor amendments were made to this professional document and the accompanying background paper.

Training program

Regulation 37 – Training in anaesthesia leading to FANZCA and accreditation of facilities to deliver this curriculum:

Council approved further amendments to regulation 37, including the fee structure for the revised curriculum. This will be available on the College website in late September and will be implemented from the beginning of the 2013 hospital employment year.

ANZCA Handbook for Training and Accreditation:

This was approved subject to further editing of flow and style, and will be released on the website in late September.

ANZCA scholar role: The 2013 training program will require trainees to complete a range of scholarly activities overseen by the Scholar Role Panel (Australia and NZ-wide) and scholar role tutors (departments). Council approved an approach to option B exemptions for trainees with prior research publications or relevant university qualifications. Decisions about such exemptions will be made by the chair of the Scholar Role Panel (or nominee) and will usually be for work undertaken in the previous five years. More detail is in the handbook.

Provisional Fellowship Assessment Panel: This will be established to approve provisional fellowship training in the revised curriculum.

Supervisors of training and education officer agreements:

Council supported, in principle, a proposal to develop education officer and supervisor of training agreements outlining the responsibilities both of the College and of the education officer/supervisor of training. The ANZCA Council will consider a detailed proposal in October.

Trainees experiencing difficulty

process: ANZCA Council approved a process to allow additional training time as part of the remediation process for trainees experiencing difficulty. This will provide an interim step between the 'trainees experiencing difficulty' process and the high-level 'trainee performance review' process. Decision-making will involve the supervisor of training, the relevant education officer and the director of professional affairs assessor. More detail is in regulation 37 and the handbook.

Regulation 33 – Trainee Performance

Review: ANZCA Council approved amendments to more explicitly 'close the loop' in the trainee performance review process. A report will go to the Education and Training Committee and ANZCA Council about whether the trainee has achieved the required outcomes of the process, allowing a decision about the future of the trainee in the training program. Further information is available on the ANZCA website.

Asian transition arrangements:

The Asian Transition Working Group is communicating regularly with representatives in Asia and the following recommendations were approved:

1. A dedicated regulation for ANZCA training in Asia, regulation 38, along with an explanatory handbook will be developed.
2. ANZCA training in Asia will cease at the end of the 2018 hospital employment year (that is mid-2019).
3. In Asia, ANZCA-registered trainees who have not accumulated any approved training time at the beginning of the 2013 hospital employment year will lose their trainee status.
4. Capping of examination attempts for trainees in Asia will commence from the beginning of the 2013 hospital employment year.

Internal affairs

Whistleblowers' Policy: Council approved this policy, which is available on the ANZCA website.

2013 calendar: Council approved the calendar for 2013. A copy of the calendar is attached to the report.

Dr Lindy Roberts
President

Dr Genevieve Goulding
Vice President

ANZCA Council meeting report

June 2012

Report following the meeting Council of the Australian and New Zealand College of Anaesthetists held on June 16.

Death of Fellow

Council noted with regret the death of Dr Sally Liza Barlow (NZ) FANZCA 2010. As a mark of respect, the president has written to Dr Barlow's family.

College honours and awards

Sir Roderick Deane (NZ), a member of the Anaesthesia and Pain Medicine Foundation Board, has been awarded the Knight Companion of the New Zealand Order of Merit in the 2012 Queen's Birthday and Diamond Jubilee Honours List (New Zealand).

The following Fellows were recognised in the 2012 Queen's Birthday Honours List (Australia): Dr David Henry McConnel (Qld), awarded the OAM for service to anaesthesia; Associate Professor Drew Cecil James Wenck (Qld), awarded the OAM for service to intensive care medicine; and Dr Malcolm Wright (Qld), awarded the AM for service to intensive care medicine.

New councillors

The president welcomed councillors Dr Vanessa Beavis, Associate Professor Brendan Moore (FPM Dean) and Dr Gabriel Snyder (New Fellow Councillor) as new members of the ANZCA Council.

Admissions to fellowship

The following are congratulated on their admission to fellowship of ANZCA:

Andrew James CLUER (NSW)

Edward Michael DEBENHAM (WA)

Samuel Patrick FROST (Vic)

Martin William Arthur GRAVES (NSW)

Long Ha LE (NSW)

LEE Meng Li (Malaysia)

Janet Ellen LOUGHRAN (Ireland)

Kirsten Naomi MATHESON (NZ)

Heather Alicia MATTHEWS (UK)

Glenn Andrew MULHOLLAND (NZ)

Christopher James POYNTER (NZ)

Brett Elliott Fabian SEGAL (Qld)

Jonathan Ying Tang TRINH (NSW)

Carolyn Maree WILLS (Qld)

Yoke Mooi WONG (WA)

Jordan Gardiner WOOD (NSW)

Lilian Eva YUAN (NSW)

Helen ZOIS (NSW)

Arnold Russel BEETON (Vic)

Caroline COLLARD (Qld)

Florence Tsitsi CHIKWANHA (Vic)

David FINDLOW (NZ)

Mahesh GANJI (NT)

Saira HUSSAIN (Qld)

Tilo Willy KLINGER (Tas)

Jesco KOMPARDT (WA)

Andreas Rassamy MANOPAS (WA)

Timothy William PARRIS-PIPER (NZ)

Ivan Lyle RAPCHUK (Qld)

Eric McKenzie ROBINSON (Tas)

Kumari SANTHI (Vic)

Christopher Elwyn THOMAS (Qld)

Victoria Louise UPSHON (NZ)

Education and training

ANZCA Handbook for Training and Accreditation: Council has approved, in principle, a further draft of the ANZCA Handbook for Training and Accreditation prior to wider consultation including with regional and national committees. Feedback is welcomed.

ANZCA training program in Asia and formation of the Asian Transition Working Group:

Council approved a series of recommendations about the ANZCA training program in Hong Kong, Malaysia and Singapore, which will be made available on the website. Council also supported formation of the Asian Transition Working Group, chaired by Dr Genevieve Goulding, to undertake policy development, monitoring, and consultation with the regional training committees and trainee representatives in the three countries.

Trainee Committee: To improve continuity of the ANZCA Trainee Committee membership and retain corporate knowledge, regulation 16 and the committee terms of reference have been amended to increase the number of annual face-to-face meetings from one to two, to include the General Manager of Training and Assessments as a committee member and to allow a junior observer from each regional and national trainee committee to participate in teleconferences.

ANZCA Education Framework Review: Council approved a review of the College's educational governance structure to ensure that the curriculum remains contemporary by robust evaluation, innovation, clear decision-making and reporting processes. A consultation and communication plan will seek feedback from key Fellows, trainees and staff involved in college educational activities to identify priority areas and inform the development of a revised ANZCA education and training governance structure for the future. The project will report to the February 2013 council meeting.

The Courses Working Group has been changed to the EMAC Course Subcommittee to be chaired by Professor Sandy Garden from New Zealand.

Two-stage trainee registration process: Council gave in-principle approval for the implementation of a two-stage registration process for ANZCA trainees, effective August 31, 2012, to more clearly separate employer and College responsibilities. Those ANZCA trainees who have not accumulated training time on this date will be transitioned to the new pre-registration and login access category. Further detail will be provided in due course.

Fellowship affairs

2014 ANZCA ASM: Dr Philip (PJ) Deveraux will be the 2014 ANZCA ASM Visitor.

NZ Anaesthesia Workforce Study: The results of the study have provided an opportunity to engage with a number of stakeholders including the New Zealand Minister of Health.

The NZ ASM will be held in conjunction with the 13th ICCVA in November 2012, which will include both a cardiac anaesthesia stream as well as more general streams including workshops.

Appointment to external organisations: Council approved the following appointments: Dr John Moloney as the ANZCA representative on the RACS Disaster Preparedness Committee and Dr Ross Wallace as the ANZCA representative on the group to Review Medicare-Funded Pulmonary Artery Catheterisation.

Indigenous Health Committee: Dr Rodney Mitchell has been appointed the chair of this committee.

Quality and safety

PS09: Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures: This professional document and accompanying background paper have been approved by the council and will be circulated to regional and national committees, FPM, ANZCA Trainee Committee and relevant special interest groups for comment.

TE04: Policy on Duties of Regional Education Officers in Anaesthesia and TE05: Policy for Supervisors of Training in Anaesthesia: The council has approved minor amendments to these professional documents.

Airway Management and Algorithm professional document: Council has approved the membership and terms of reference for the expert group to develop this professional document.

College awards

- The Department of Anaesthesia of Christchurch Hospital has been awarded the ANZCA Council Citation to acknowledge their exemplary contribution to the community during the earthquake in February 2011.
- Dr Kerry Brandis had been awarded the ANZCA Council Citation in recognition of his contribution to the College.
- Professor Ian Victor Callanan has been awarded the ANZCA Medal in recognition of major service to anaesthesia, pain medicine and intensive care medicine.

Dr Lindy Roberts
President

Dr Genevieve Goulding
Vice President

Dr John Patrick Keneally AM 1943 – 2012



John Keneally was a doyen of Australian paediatric anaesthetic practice, but with true modesty he would have been the last to have accepted this. Nevertheless, JK – as he was lovingly known – touched the lives and careers of many hundreds of anaesthetic trainees, as they passed through the Royal Alexandra Hospital for Children (RAHC), and thousands of anaesthetists through his contributions to anaesthetic literature and journalism.

John completed his medical studies at the University of Sydney before undertaking his intern and resident years at St Vincent's Hospital, where he met his future wife, Jane. This was the start of a wonderful loving partnership, which lasted 40-odd years and formed the foundation on which he built an exceptional career. John was drawn early to anaesthesia and began his anaesthetic training at Royal Prince Alfred Hospital with a subsequent rotation in 1971 to RAHC, then at Camperdown. He had a brief senior appointment at the children's hospital before seeking further paediatric experience in the UK at the Alder Hey Hospital, Liverpool, and Great Ormond Street Hospital, London. He returned to Sydney and the children's hospital in 1974 where he remained on the staff until his retirement in 2006.

John contributed at a number of levels to the subspecialty of paediatric anaesthesia, and to the broader anaesthetic community. He was a

thoughtful, caring clinician with a genuine interest in his patients and their families. He was a wonderful teacher and mentor to the many trainees that passed through the children's hospital, a knowledgeable colleague who was always more than ready to offer practical help and advice. John was involved in many areas of hospital management and was the immediate past head of the anaesthetic department, after being deputy head for many years. He oversaw much of the planning for the operating suite of the new hospital at Westmead, requiring skill, thoughtfulness, foresight and equanimity, especially when dealing with officialdom. Perhaps sometimes the equanimity was not always there!

John made an enormous contribution to the wider anaesthetic profession as well. He was the federal secretary of the Australian Society of Anaesthetists from 1976-80, and assistant secretary from 1981-83. He was a founding committee member of the Society for Pediatric Anaesthesia in New Zealand and Australia, vice president from 1999 to 2002, and president until 2004. He was also a board member of the pediatric anaesthesia standing committee of the World Federation of Societies of Anaesthesiologists. As a 15-year member of the NSW Special Committee Investigating Deaths Under Anaesthesia, he provided a wealth of knowledge and real-world experience from which the committee could draw.

I think John thought of himself as the brother of a famous Australian author, although we at the children's hospital saw him as the famous brother of an Australian author! Whatever the arrangement, literary talent in the Keneally family must have a genetic basis as John used his evident editorial skills on the boards of *Anaesthesia and Intensive Care* (1990-2001) and *Pediatric Anaesthesia* (1991-2011), as well as editing the highly-regarded "Blue Book" – *Australasian Anaesthesia* – from 1996-2005. He was widely published, especially in the area of paediatric pain management, an interest close to his heart.

John's huge contribution to the specialty was recognised this year when he was appointed as a member in the

general division of the Order of Australia in the Australia Day honours. It was typical of John's humble nature that he was almost embarrassed by the award, but I know that he was proud to share the award with his family to whom he was devoted. John was a passionate republican, as befitted his Irish Catholic background, and it was a relief to me that his award was announced on Australia Day and not on the Queen's birthday!

John was a gentle, kind-hearted man who always looked for the good in people. He had an encyclopaedic knowledge and took great pleasure in discussing all sorts of things with all sorts of people. He had a genuine interest in everyone and treated all with respect and consideration. The huge attendance at his funeral, and the messages from the large number of friends and colleagues who could not attend, attests to the esteem in which he was, and is held.

It was unfortunate that John's latter years were something of a battle with the progression of prostate cancer, although he managed to make use of this time by visiting places previously he had not previously explored, including a wonderful trip to Antarctica. He undertook a challenging labour of love, transcribing Jane's grandfather's World War I diaries and researching the events and people mentioned in the writing. This was also a time to spend with Jane, his children Ben, Tim, Kate, Josie and Patrick, and their partners and his grandchildren, to whom we extend our sincerest condolences. He passed away peacefully surrounded by his family whom he so loved and of whom he was so proud.

Although we will all miss JK, we can take comfort in the legacy he left behind – that of an honest, caring and committed clinician, loving and loved husband, father, grandfather, knowledgeable colleague, supportive mentor and giving friend. His commitment to his family, the hospital and the wider anaesthetic and general community will stand as an example for others in years to come. Rest peacefully, JK.

Associate Professor David Baines
Childrens Hospital at Westmead

Dr Sally Liza Barlow

1974 – 2012



Born and educated in Dunedin, New Zealand, Sally Barlow spent a great deal of her childhood in the outdoors and developed a lifetime bond with the beauty of the South Island, graduating from the University of Otago Medical School with Distinction in 1997.

Sally was a high achiever and before graduating she had won the John Russell Ritchie Prize in Anaesthesia in 1996. Other awards were the University of Otago Prize for First Year Geography (1992), University of Otago Federation of Women's Prize in Biology (1992), Senior Scholarship in Medicine (1994) and Sir Gordon Bell Prize for Clinical Surgery (1997).

House officer and senior house officer jobs from Tauranga to London gave Sally an opportunity to travel and develop her interest in anaesthesia. She joined the Auckland anaesthesia training scheme in 2003, achieved FANZCA in 2007 and a postgraduate diploma in perioperative and critical care echocardiography in 2009.

She did a fellowship in cardiothoracic and ORL and cardiothoracic and vascular intensive care before taking on a specialist job in Seattle at the University of Washington Medical Centre. There, Sally so impressed her colleagues that they have established an annual award to be called the Barlow Prize for Simulation Research. In 2011, she returned to the Greenlane Department of Cardiothoracic, Vascular and ORL Anaesthesia at Auckland City Hospital.

Sally had struggled with depression for many years but at work you would never have known of her inner struggle. She bounced into work with a grin from ear to ear and visible enthusiasm for her job as specialist cardiac anaesthetist.

She was an excellent anaesthetist who was highly regarded by her colleagues. Her expertise was impressive and the cardiac surgeons with whom she worked, often through demanding, intense and very complex cases, described Sally as "an exemplar in her commitment, expertise, mentoring and enthusiasm".

Sally was a vibrant, glamorous and beautiful woman, but she was also an adventurer. She loved a challenge and was an accomplished skier, a passionate runner and excellent cyclist. Everything she did, she took on with energy and joy and she loved to be out in nature, hiking and camping and being with her friends. She travelled the world both in her work and just purely to do the many things she enjoyed. At home, she loved to cook and she shared her talent by hosting many a wonderful dinner.

Sally loved people and was always gentle and kind and supportive. As supervisor of training for anaesthesia, she encouraged young anaesthetists and was a role model for our speciality. Her departure from anaesthesia is a sad loss for all. In her personal and work life, Sally had many, many friends whose lives she touched and influenced.

Sally had been unwell for some time and despite her best efforts, on May 9 she gave up her struggle. We need to respect Sally's decision to leave when she did and not let that define her wonderful, although short, life. In just 38 years she packed in a lot of living and achieved much, left her footprints in our lives and memories in our hearts.

Sally's parents, John and Marilyn, and her sister, Emily, were an integral part of her life and she was a proud aunt to Emily's daughter, Isla.

In farewell, with apologies to Emily Bronte:

*We bid you farewell our friend, but not
farewell to our fondest thoughts of you
You will dwell in our hearts and that
will be our comfort*

*Our lives are sweeter because you lived
Nothing that you gave is lost
Nothing that you did is destroyed.*

May she rest in peace.

Dr Marian Hussey, FANZCA
Specialist Anaesthetist
Greenlane Department of Cardiothoracic
and ORL Anaesthesia, Auckland

Doctors welfare

If you are concerned about yourself or a colleague, contact the Doctors' Health Advisory Service Hotline nearest to you.

Australia:

New South Wales/Northern Territory +61 2 9437 6552

Australian Capital Territory +61 407 265 414

Queensland +61 7 3833 4352

Victoria +61 3 9495 6011

Western Australia +61 8 9321 3098

Tasmania 1300 853 338

South Australia +61 8 8273 4111

New Zealand: 0800 471 2654

Information about the Welfare of Anaesthetists
Special Interest Group can be found at:
www.anzca.edu.au/resources/doctors-welfare

Dr Hilton David Swan

1964 – 2012



Hilton was a popular and skilled member of the anaesthetic community in Perth, taken from us aged just 48 years after a three-year dogged battle with cancer.

He and Michelle MacDonald have two children, Anneka, 13, and Aedan, 10, and he is survived by his mother Sue Harvey, and siblings Alan, Anne-Marie, Dean and Brandon.

Having started his schooling in Cape Town, South Africa, Hilton moved to Perth in 1980 with his family and within a year had completed year 12 and gained entry to the University of Western Australia medical school. He was a true all rounder with high level academic and sporting achievement, the latter in rugby at a state level and marathons over many years. A relaxed and popular student he was a magnetic figure who had that rare ability to befriend all comers from across the university and wider spectrum.

A talented paediatric and adult anaesthetist, Hilton won the Cecil Gray Prize for the second part ANZCA exam in 1995. He was appointed to the role of chief fellow at the Hospital for Sick Children in Toronto and remained on staff at Princess Margaret Hospital for Children in Perth throughout his career, while also building a highly regarded private practice.

He was obsessive yet passionate and a little shambolic, a loveable figure who somehow reconciled a disdain for the mundane (such as opening his mail or parking in any marked bay) with sustained clinical excellence. His focus was on the patients and their families; they adored him because he cared for them as kindly and carefully as he would his own children, before, during and after their operations. His colleagues regarded him as a clinical leader. He had an apparently effortless grasp not just of anaesthesia but medicine more broadly, which he gleaned from wide experience, unrestricted reading and marvellous recall.

He faced his treatment bravely, with determination and good humour. He underwent repeated rounds of chemotherapy and radical surgery yet bounced back with a disarming ability and determination to enjoy every day in spite of it all.

He loved being an anaesthetist and looked forward to (almost) every list. His greatest regret in contemplating an early death was that his time with his children was not to be longer. Family, friends and colleagues alike will miss Swanny very much – now and always.

Dr Andrew Miller
Perth, WA