

ANZCA BULLETIN



ANZCA
AUSTRALIAN AND NEW ZEALAND
COLLEGE OF ANAESTHETISTS

FPM
FACULTY OF PAIN MEDICINE
ANZCA



ANAESTHETISTS ON THE FRONT LINE

PLUS: CURRICULUM REVIEW UPDATE – THE LATEST
ON ANZCA'S TRAINING PROGRAM





30 Spotlight on Victoria

SPECIAL REPORT: Heath reform and anaesthesia developments in Victoria.

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 more than 4500 Fellows across Australia and New Zealand and serves the community by upholding the highest standards of patient safety.

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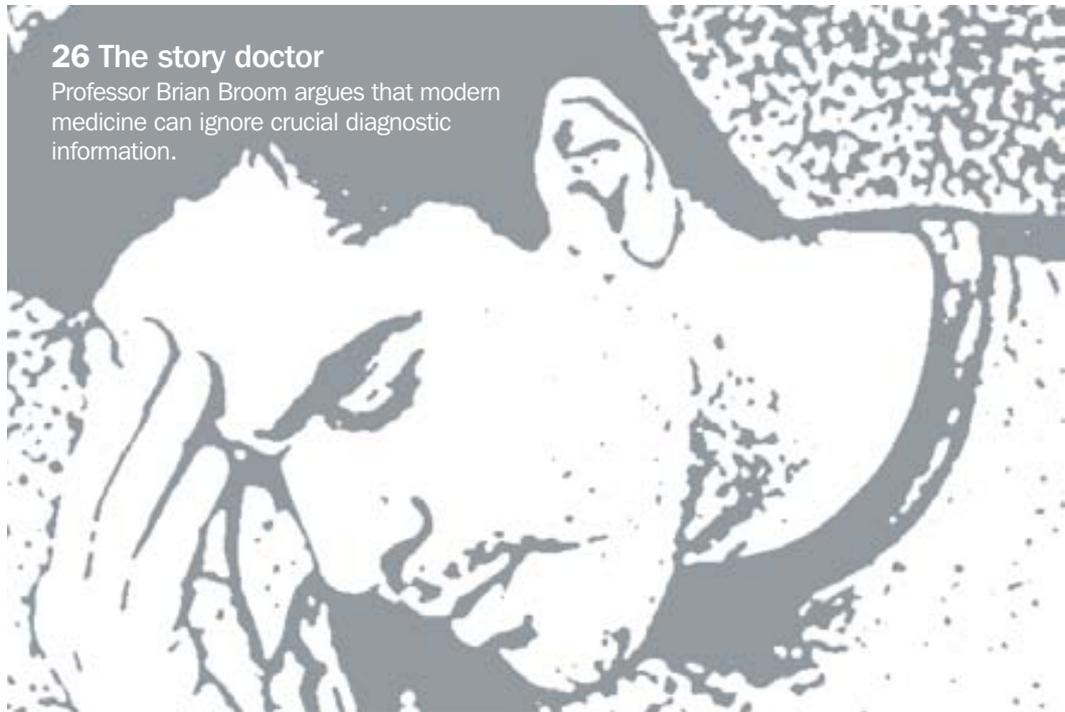
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President's message



Every ANZCA Fellow is unique. No two Fellows are exactly the same in terms of the locations in which they work, the lists they undertake, the types of patients on those lists, their preferred anaesthetic techniques and the work they do outside theatre. In addition, no two Fellows bring to their practice the same experience with anaesthetic crises, rare medical conditions or challenging team dynamics. Despite this great variation, we all have a concept of what makes a specialist anaesthetist and we use this concept every day to guide our trainees and evaluate our peers.

In this edition of the *Bulletin*, the Curriculum Redesign Steering Group reports on the work it has done creating our new ANZCA training program. The new program contains a profound articulation of core personal attributes and clinical fundamentals that make a specialist anaesthetist. These attributes and fundamentals will be woven through the study units that make up the new program in such a way that they will become embedded in practice. In this way, our new Fellows will be best equipped for the rich and varied life of an independent specialist.

The work of the Curriculum Redesign Steering Group also provides food for thought for practising specialists, so I encourage all Fellows to read on. I found it marvellous that the fundamentals of

our complex speciality could be distilled so succinctly, but was concerned that I might have developed one or two gaps in knowledge and skills over the years! The ANZCA roles and clinical fundamentals provide a great framework for reviewing your own practice and tailoring your individual continuing professional development (CPD) plan.

The ANZCA roles

During the review of the current program, the College adapted the Canadian Medical Education Directions for Specialists (CanMEDS) curriculum framework to anaesthesia. The seven ANZCA roles describe the particular key competencies and attributes of the specialist anaesthetist:

- *As medical experts*, FANZCAs apply medical knowledge, clinical skills and professional attitudes in their provision of patient-centred care.
- *As communicators*, FANZCAs facilitate the doctor-patient relationship throughout the continuum of care.
- *As collaborators*, FANZCAs effectively work within a healthcare team to achieve optimal patient care.
- *As managers*, FANZCAs are integral participants in healthcare organisations.
- *As health advocates*, FANZCAs advance the health and well-being of patients, communities and populations.
- *As scholars*, FANZCAs demonstrate a lifelong commitment to learning and the translation of medical knowledge into practice through participation in, and promotion of, research.
- *As professionals*, FANZCAs are committed to the health and well-being of themselves, individual patients and society.

The clinical fundamentals

During the redesign process, the steering group developed the ANZCA clinical fundamentals, which are a set of core clinical components underpinning all areas of clinical practice and which cannot be solely assigned to one or another study unit. The basic anaesthetic sciences underpin each of these clinical fundamentals:

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

Hitherto, our training program has been modularised according to surgical subspecialty. By weaving the ANZCA roles and clinical fundamentals across the study units in the new training program, our trainees will be encouraged to adopt a patient-focused rather than surgery-focused approach to patient care. This is particularly important in an era when surgical procedures are becoming less invasive, while our patients are becoming older and sicker. The clinical fundamentals also recognise our increasing roles outside the operating theatre and to that end clinical experience in preoperative clinics, intensive care medicine and pain medicine during training will be vital to achieving proficiency. Finally, our new training program explicitly states that safety and quality are fundamental components of our practice as specialists.

The new curriculum structure

In this issue of the *Bulletin*, you will find an article related to the Curriculum Redesign Project on page 22. This article provides you with an update on progress so far, further details of the revised structure and details of what lies ahead – including how you can keep in contact as we move towards implementing the revised program. Some key points I'd like to highlight here are:

- The revised implementation date for the new program is the 2013 hospital employment year.
- The ANZCA training program remains a five-year program that may be commenced after at least two years of practise as a junior doctor.

- The primary examination may only be undertaken during basic training (the first two years of the program) and after passing an initial workplace-based assessment.
- Detailed transition arrangements will be in place for those who commenced training before implementation of the new program.
- Our detailed communications strategy will ensure that everyone is kept up to date.

A vote of thanks

A large number of Fellows, committee chairs, trainees and staff members have contributed to the Curriculum Redesign Project so far. On behalf of Council, I would like to thank everyone for their vision and hard work. I would particularly like to acknowledge the Dean of Education and Chair of the Steering Group, Professor Barry Baker; the Director of Education, Ms Mary Lawson; Drs Damian Castanelli, Peter Gibson, Sarah Nicolson, Brian Spain and Jeneen Thatcher (Steering Group members); the curriculum project manager, Ms Claire Byrne, and EDU staff members, Ms Claire Higgins and Ms Claire Spooner. Now, the work begins on completing the detailed work and implementing the new program!

A motion of condolence

At its February 2011 meeting, the ANZCA Council approved a motion of condolence to our Fellows, trainees and staff who have suffered in the recent natural disasters of flood, cyclone and earthquake in Australia and New Zealand. Our thoughts are with these colleagues and their affected communities. Some of their stories are featured in this edition of the *Bulletin*.

Professor Kate Leslie
ANZCA President

Fellows and trainees contributing to the Curriculum Redesign Project

Curriculum Redesign Steering Group

Professor Barry Baker (Chair)
Dr Damian Castanelli
Dr Peter Gibson
Dr Sarah Nicolson
Dr Brian Spain
Dr Jeneen Thatcher
Dr Dave Law (trainee representative)
Dr Brett Segal (trainee representative)
Dr Genevieve Goulding (Chair, Education and Training Committee)
Dr Lindy Roberts (Vice-President)
Professor Kate Leslie (President)

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Dr Peter Hebbard
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Dr Geraldine Khong

Dr Brian Lewer
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Dr Nolan McDonnell
Dr Rebecca McIntyre
Dr Frances Page
Dr Andrew Pitcher
Dr Paul Sadleir
Dr David M Scott
Dr Vincent Sperando
Dr Richard Sullivan
Dr Joel Symons
Dr Su Yin Tan
Dr Michael Veltman
Dr Deborah Wilson
Dr Maggie Wong
Dr David Wybrew

Other Fellows

Associate Professor Jenny Weller (Chair, Assessment Committee)
Dr Rick Horton (Chair, Workplace-based Assessment Committee)
Associate Professor Sandy Garden (Chair, Courses Sub-committee)
Associate professor David A Scott (Chair, Examinations Committee)
Dr Craig Noonan (Chair, Primary Exam Sub-committee until 2011)
Dr Ross McPherson (Chair, Primary Exam Sub-committee from 2011)
Dr Mark Priestly (Chair, Final Exam Sub-committee until 2011)
Dr Vida Villunus (Chair, Final Exam Sub-committee from 2011)
Dr Michele Joseph (Trainee Transition project)
Dr Steuart Henderson (DPA Assessor)

Australia Day honours



Dr Walter Ross Thompson (WA), made a Member of the Order of Australia (AM), for service to medicine as a clinician in anaesthesia and intensive care, through contributions to the development of an educational framework and through executive roles within professional organisations.



Dr John Francis Oswald (Vic), awarded the Medal of the Order of Australia (OAM), for service to medicine as an anaesthetist, and to the community.



Dr John Collins (NSW), made a Member of the Order of Australia (AM), for service to medicine in the field of paediatric palliative care as a practitioner, academic and researcher, and to professional organisations.



In the past few months, an extraordinary series of natural disasters has had a devastating impact on communities in Australia and New Zealand including a cyclone in Queensland, already reeling from major flooding that also impacted on other parts of Australia, and an earthquake in Christchurch.

SUMMER OF NATURAL DISASTERS



Anaesthetists rise to the challenge

As earthquake victims flooded into Christchurch Hospital on February 22, the medical fraternity worked together, coping well under extremely difficult circumstances.

The resuscitation skills of anaesthetists deployed to the emergency department had been particularly valuable and many worked by torchlight, Christchurch anaesthetist Dr Vaughan Laurenson told the March 4 meeting of the New Zealand National Committee (NZNC).

Others were operating in theatres that had a maximum temperature of 11 degrees, said Dr Laurenson, who is an NZNC committee member and ANZCA Director of Professional Affairs (Deputy Assessor).

Ironically, within 48 hours or so, anaesthetists found themselves short of work, with no more live victims being found and all elective surgery on hold. Other non-deferrable cases, such as for cancer treatment, were outsourced to hospitals out of Christchurch. With the central business district closed, much private clinic work was also postponed. Within a few days, however, the department was planning for work to return to about half its normal level, with five theatres coming back into action for acute cases and five for elective surgery.

The Clinical Director of Anaesthesia at Christchurch Hospital, Dr Graham Roper, said the homes of about 20 of the anaesthetic staff at Christchurch Hospital – a third of the team – had been either destroyed or severely damaged in the earthquake. Other staff had lost access to homes situated in the cordoned off area. However, no staff or members of their families were harmed

and the reduction in work had enabled them to clear and store belongings and find rental accommodation.

Dr Roper said there was a lot of support within the department and throughout the hospital and that offers of help from around New Zealand and Australia had been fantastic.

Trainees probably experienced some relief that they had completed their written primary exam on the afternoon before the quake but must now focus attention on studying for their vivas at the end of the month.

Another FANZCA, Dr Maurice Lee, a consultant anaesthetist at Auckland's North Shore Hospital, was also caught up in the earthquake response. Dr Lee, who has represented ANZCA at New Zealand Ministry of Health meetings about disaster response preparedness, was in Wellington attending an emergency management conference when the earthquake struck.

He was seconded to the Ministry of Health for the next 10 days to provide clinical advice on aspects of its processes as it responded to the disaster in Christchurch. He is also likely to be involved in a review of those processes.

“THE HOMES OF ABOUT 20 OF THE ANAESTHETIC STAFF AT CHRISTCHURCH HOSPITAL – A THIRD OF THE TEAM – HAD BEEN EITHER DESTROYED OR SEVERELY DAMAGED IN THE EARTHQUAKE.”

Doctors on the front line

An aftershock shook the destroyed Pyne Gould building, as anaesthetist Dr Bryce Curran worked with a urologist and a fire officer to amputate the legs of a trapped man. He spoke to Susan Ewart about the desperate rescue.

Dr Bryce Curran, a specialist anaesthetist at Christchurch Hospital, was at home on a day off when the earthquake struck at 12.51pm on February 22. After securing the water and power supplies to his home and checking on neighbours, he headed into the hospital dressed for what he suspected could be work in the field. He was not wrong.

He was sent to the Latimer Square triage centre and was asked to assist people trapped in the collapsed Pyne Gould Corporation Building. Guided by fire officers assessing the risk, Dr Curran's first foray into the building saw him insert intravenous (IV) drips and administer morphine to three trapped people, including the widely reported case of a Brian Corker, whose legs were amputated at the site. Contrary to some early media reports, Mr Corker was fully anaesthetised when the amputation was done.

"Brian was in the stairwell, in a small space with collapsed structure all around him," Dr Curran explained.

"He was trapped by both legs crushed below the knees under

fallen masonry. After giving him the morphine, the fire officers and I left the building to assess whether Brian could be extracted any way other than by amputation at the scene.

"We were joined by visiting Australian urologists and we made a team decision that the female urologist (Dr Lydia Johns Putra of Ballarat, Victoria) and I would go in and amputate his lower limbs so he could be rescued. There was no way he could be lifted out otherwise – it was far too dangerous to try to move the concrete.

"It was a desperate situation. My attitude was to keep it very simple. In those circumstances, even putting the IV drip in was very challenging."

"There wasn't a lot of space to move around him and it was dark. We had to work by torchlight, from torches held by fire officers. Fire officers had already put bilateral tourniquets on his upper legs.

"I gave a titrated dose of ketamine and then the urologist and I amputated his legs, using a Leatherman knife and a hacksaw supplied by the fire service. A fire officer assisted to keep his airway open. It was a team effort.

"All three of us were working on adrenaline, though it was nerve-racking as there was an aftershock while we were operating. We aimed to be in and out as quickly as possible and were probably there about 15 to 20 minutes in total.

"The man was able to be lifted out and was taken to hospital, although he was desperately unwell and needed ongoing resuscitation. I was assisted in that by Dr Stuart Philip, the Brisbane

urologist who had waited with the ambulance while we operated."

The man survived, had further surgery, went to intensive care and was transferred to Waikato Hospital in the north island, where he has been making good progress.

Dr Curran emphasises that the whole procedure was a team effort and gives full credit to the fire officers, for whom he expresses huge admiration, and to the other medical personnel involved.

He describes ketamine as a very good anaesthetic in the disaster environment.

"Most anaesthetists will be familiar with it. It offers very good haemodynamic stability and tends to protect the airway reflexes."

As to working under such extreme conditions, he said: "Obviously you couldn't do the normal things like take blood pressure. You are just flying by the seat of your pants and doing what you can in that setting. You can do a lot with a very basic kit.

"If I was ever doing something like that again, the kit I would want with me is IVs that I am used to, gloves, a guedel airway, morphine and ketamine."

It would also be useful to have a head torch and hard hat (the latter was supplied).

Another difficulty in such a disaster is that communications go down or get clogged. "You can't call for help," he said. "You just have to make a decision and get on with it."

After delivering Mr Corker to Christchurch Hospital, Dr Curran returned to the site and was able to administer pain relief to others being rescued from the Pyne Gould Building.



“I GAVE A TITRATED DOSE OF KETAMINE AND THEN THE UROLOGIST AND I AMPUTATED HIS LEGS, USING A LEATHERMAN KNIFE AND A HACKSAW SUPPLIED BY THE FIRE SERVICE.”

Around 9pm that evening, he handed over his anaesthetic equipment to Dr Richard Johnson, a UK-qualified anaesthetist practising at Timaru Hospital in the south island. Dr Johnson was in Christchurch for an advanced paediatric life support course in the now-condemned Grand Chancellor Hotel. A trainee doctor working as an anaesthetic senior house officer at Christchurch Hospital, Dr Raymond Casey, was also on site to assist through the night, along with other volunteer medical specialists visiting Christchurch for conferences and courses.

Dr Curran returned in the morning but left about midday when other paramedics and external medical teams were in place.

He says that the impromptu gathering of medical personnel worked very well together despite being strangers.

Experience and training had given Dr Curran some preparation for such an event. As a young house officer at Oxford in England, he assisted at a bus crash in which the driver was trapped and required amputation at the scene.

He has also done a course in “remote site, difficult circumstances, developing countries anaesthesia”, spent a week as a locum in the Australian Defence Force Field Hospital in East Timor and helped run a primary trauma care course in Samoa shortly before that country’s devastating tsunami in 2009.

“I have always had an interest in trauma medicine and I have an evolving interest in disaster medicine,” he said.

His previous experiences helped him process the psychology of it this time. He says there are many distractions in an emergency environment.

“You just have to stay focused on what needs to be done,” he said. “I was not oblivious to the risk but once you had decided that leaving him there was not an option, then it became a job to be done.”

“IT WAS A DESPERATE SITUATION. MY ATTITUDE WAS TO KEEP IT VERY SIMPLE. IN THOSE CIRCUMSTANCES, EVEN PUTTING THE IV DRIP IN WAS VERY CHALLENGING.”

From left: The collapsed CTV building; Dr Bryce Curran in his usual operating environment.

SUMMER OF NATURAL DISASTERS

CHRISTCHURCH EARTHQUAKE

Quake hits during brain surgery

Anaesthetist Dr Vaughan Laurenson was several hours into a 10-hour neurosurgical procedure when the Christchurch earthquake hit, throwing him from his chair. He gives a personal account of what happened in the aftermath of New Zealand's horrific natural disaster.

My task for Tuesday February 22 was the neurosurgical list which had on it only one patient for excision of a base-of-skull tumour. It was scheduled to take about 10 hours. At 12.50pm all was going well. My registrar was taking a lunch break, the surgeons were nearly down to the tumour and were drilling the bone away from around the internal carotid artery using the microscope.

There was a roar, the building began to shake violently and the lights went out. I was thrown from my chair and by the light of the monitors could see the anaesthetic machine heading for the door. I grabbed it with both hands while still on my knees and struggled to hold it.

The shaking eased off and the lights came back on. The microscope was more than a metre from the patient and the stealth machine was in the middle of my anaesthetic space. It was apparent that

it was unsafe to continue to drill with more shocks expected. As we hadn't yet reached the tumour and there was no bleeding it was an easy decision to close and wake the patient. A fat graft was taken from the abdomen to close the defect, the wound closed, we woke the patient and delivered him to recovery.

I reported to the duty anaesthetist in the theatre foyer. There were already teams assigned to theatres waiting for cases, so our team (my registrar, anaesthetic technician and I) were sent to join other anaesthetic teams assisting in the emergency department (ED). At the top of the stairs we encountered a group of about 15 intensive care unit and anaesthetic staff who had just carried a large intubated ventilated patient up the stairs (the lifts were not working) and were struggling to negotiate the stretcher through the narrow doorway. The ED was busy but organised. Each available resuscitation bay had a team assigned – in our case an anaesthetist, an anaesthetic registrar, an anaesthetic technician, an ED registrar, an ED house officer and two ED nurses. Then we waited. Transport problems meant that there were major delays in patients arriving. They were triaged by ED staff at the door and assigned to a cubicle as required. Surgeons and other specialist staff assembled in the central reception area and specialist advice for the resuscitation teams was only a shout away. The workload was steady but the enhanced ED coped with it well.

This effort was occurring despite major ongoing aftershocks, intermittent loss of power (torchlight resuscitation), no CT and the lifts to other floors of the hospital only working intermittently. Many of the patients had been unconscious and had no identification which added to the confusion. Dr Bryce Curran was assigned the unenviable task of going out to the site of a damaged building to try and anaesthetise a patient for an amputation. We wished him luck as he gathered some equipment.

Meanwhile, the duty anaesthetist had sent some staff off on a break to come back for the night. I got a message that I was to go home at 7.30pm but at that time a patient arrested secondary to hyperkalaemia and the anaesthesia teams still in the department were involved in the successful resuscitation.

I left the hospital at 8pm and was amazed by the damage to the hospital surrounds, with large cracks in the roadways and large volumes of silt on the roadways and footpaths. At the parking building there was a guard on the gate. Fortunately I had arrived at work early that morning because only those parked in the lower levels were allowed to remove their cars due to damage to the upper levels. I stepped into the darkened building and nearly fell over because the floor had a large upward bulge in it.



I drove carefully home but by the time I got about four kilometres west everything looked normal and I arrived home to a house with power, water and sewerage. I felt a bit guilty.

The next morning we continued the task. Most of the early work was orthopaedics and they put a consultant surgeon in each theatre and we double staffed with a consultant and registrar where possible.

It was a trying day because of the distressed patients. Our first patient had been trapped and lost some colleagues, the second had been walking down the mall with his wife and one-month-old baby, both of whom were missing and the third patient was a critically ill intensive care unit patient for a laparotomy and bilateral mid-thigh amputations.

There were ongoing problems with a lack of water (please don't flush the toilets), and linen (the laundry has no water). As all elective surgery had been cancelled I offered to work in Christchurch hospital the next day but the department roster gurus had the situation under control and declined my offer, so I stayed out of the city.

I felt pride watching my colleagues, doctors, nurses, technicians, maintenance staff and managers managing the situation. The situation was scary and dangerous – we had to take down a ceiling panel that had come

loose above our resuscitation bay. Some of the people I was working with had lost homes, or had family they were unable to contact. They stuck to the job in a most professional courageous manner.

My heart goes out to those staff who live on the east-side of Christchurch. Having been without power and water for two days after the September 4 earthquake and experienced the months of sleep-disrupting aftershocks, I know they are in for a rough time. The next year will be stressful and they will need our support.

This is a personal account written three days after the event. It does not attempt to give an overall picture of the event or the response to it. There will obviously be a full debriefing at a later date to review what could have been done to better prepare and respond to this natural disaster.

Dr Vaughan Laurenson, FANZCA
Christchurch Hospital

“THERE WAS A ROAR, THE BUILDING BEGAN TO SHAKE VIOLENTLY AND THE LIGHTS WENT OUT. I WAS THROWN FROM MY CHAIR AND BY THE LIGHT OF THE MONITORS COULD SEE THE ANAESTHETIC MACHINE HEADING FOR THE DOOR.”



From left: Standing in a temporary triage centre are Dr Raymond Casey (back left) a trainee doctor currently working as an anaesthetic SHO at Christchurch Hospital and Dr Richard Johnson (front left), an anaesthetist from Timaru Hospital; The back of the Pyne Gould Building, where Christchurch anaesthetist Dr Bryce Curran gave pain relief to three trapped people and anaesthetised a man for an on-site amputation.

Stadium delivers more than sport

An innovative medical team converts a sports stadium to an emergency field hospital, writes Dr Peter Schuller.

I can't say I was overly enthusiastic to be invited to be the anaesthetist on-site at the emergency field hospital for the duration of Cyclone Yasi, not because I was workshy, but more due to an inner urge towards self-preservation.

Over the preceding 24 hours, we had all been following, with increasing alarm, the satellite images showing a monster of a storm heading straight for Cairns. Everyone was anxious, packing up houses, relocating to emergency shelters or flying several thousand kilometres away to escape.

The Cairns Base Hospital had been evacuated and closed, as its waterside location was considered particularly hazardous in the event of a storm surge, which had been predicted to be as high as six metres. We began preparations for an emergency field hospital at Fretwell Park Stadium, which consisted of an indoor basketball centre with changerooms and entertainment area overlooking a large football field.

A surgeon and an obstetrician were on site and there was no doubt an anaesthetist was required as well. By the time I arrived at 9am, a team of enthusiastic emergency registrars had already set up a mini emergency department comprising four stretchers with an assortment of emergency equipment organised into a trauma area – a cardiac bed, a resuscitation bed and a rudimentary labour ward.

This was one of those times when the hidden skills of staff members emerge, where “junior” registrars suddenly

admit to having worked in evacuation hospitals in Africa, and surgeons and obstetricians reveal an extensive past of developing country experience. Cairns hospital is like that – outside the realm of the super-specialised inner city hospitals, it requires and attracts staff with a varied background beyond mainstream medicine.

The plan was that we would only be operating for true life and death conditions which, furthermore, we would be able to manage post-operatively. No emergency AAAs here. To that end, I was equipped with spinal needles, local anaesthetic, an Oxylog and a pump to run Total Intra-Venous Anaesthesia (TIVA) if we needed a general anaesthetic. I also had an assortment of drugs including ketamine, propofol, muscle relaxants and opioids, and anything we might need for obstetric complications. The emergency department had already installed a blood fridge, which was well stocked with O-negative.

The obstetrician was already at work by the time I had assembled and checked my “anaesthetic room in a box”.

The first woman in labour had arrived mid-morning and proceeded to have an uncomplicated delivery. A few hours later, the second woman in labour had some bright vaginal bleeding suggesting a placental abruption and a baby was delivered via a high-ventouse procedure soon after. Some degree of privacy was provided for these women by use of a movable soccer goal which had been draped with sheets.

Several other patients, mainly with acute medical problems, were brought in by ambulance in the next few hours. They were swiftly treated and then discharged.

The next concerning patient was a four kilogram infant, who had recently undergone cardiac surgery. She had avoided transfer to Brisbane by being discharged just before the hospital evacuation, but then deteriorated after the airport had closed.

One of the paediatric specialists had taken her home hoping to be able manage her there and so avoid burdening us with a difficult clinical load, but it soon became apparent that she would require constant attention. By early evening, she seemed stable: maintaining oxygen saturation, tachycardic but resting and rousable.

The building had undergone rapid modifications during the day thanks to the hospital's building and engineering maintenance staff. They had done a slick job of installing a diesel generator system and were now building barricades to support the flimsy external doors against the expected high winds.

By late afternoon, Cairns was shut down, with people advised by emergency services to avoid travelling outside. We were informed that once winds reached 70 knots, ambulance and other emergency vehicles would be off the road as well. At that time, we were to erect the barricades, and lock down for the duration of the cyclone. Any new patients would have to wait until the winds subsided.

Adjoining the basketball court was a corridor and a solidly constructed set of changerooms into which we placed our personal belongings and camping mattresses to sleep. While that seemed to be a secure bunker – assuming there was no storm surge flooding, the basketball court roof did seem questionable.

“BY THE TIME WE WERE BARRICADED IN, THERE WERE TWO MORE WOMEN IN ESTABLISHED LABOUR, AND THE REFEREE’S CHANGE-ROOM BECAME A SAFE BUT CRAMPED AND STUFFY DELIVERY SUITE.”



The large A-frame roof was not completely enclosed, and along the length of the building at each end there was a gap of about a metre and a half, through which cobwebs and other debris was being blown. Should the cyclone peel off a part of the roof, we feared a monstrous venturi-effect with visions of our equipment being distributed across Cairns. Once the winds picked up, we decided to relocate our equipment into the bunker part of the building for safety until the worst was over.

Staff rations apparently consisted of a few boxes of bottled water, the Fretwell Park vending machines and a large box of bananas. Several staff, including myself, had brought some provisions but we were certainly underprepared in that regard. Thankfully, the partner of one of the maintenance staff – an enterprising and capable woman – took it upon herself to cook a large pot of lamb curry, which we ate in the bar as we watched the television news coverage. By late evening it was apparent that the cyclone was tracking south and that Cairns would miss the brunt of it.

By the time we were barricaded in, there were two more women in established labour, and the referee’s change room became a safe but cramped and stuffy delivery suite. Our unwell infant was in the women’s change-room, with constant attention from a nurse and doctor. By 11pm she was irritable, required nasal CPAP and was desaturating on handling.

Most of us sought some sleep after midnight. After an hour I was woken – the obstetrician was concerned that we may need to do a caesarean section. One of her patient’s membranes had ruptured and a purulent discharge confirmed the diagnosis of chorioamnionitis. The CTG showed foetal distress and, in normal circumstances, an emergency caesarean would be indicated.

However, it seemed prudent to only embark on surgery that was absolutely necessary and the obstetrician decided

to observe the labour a little longer. Therefore, we prepared our plan should a caesarean be required urgently. The only possible venue was in the corridor outside the change rooms, next to the vending machine and the box of bananas. My plan was to do a spinal, and I prepared the drugs, set up the emergency department’s patient monitor, as well as the Oxylog and intubation equipment.

Shortly afterward, the infant deteriorated suddenly and was now poorly perfused, with mottled skin, thready pulse, and marked desaturation. Airway support with bag and mask was required to maintain sats above 90 per cent, and to make matters worse, intravenous access had been lost. Even the intraosseus route in the leg had failed – on one side there was extensive extravasation of fluid and on the other, there had been a recent deep vein thrombosis and the limb was still markedly swollen.

The situation was becoming desperate as several of us searched for veins by the light of head torches. Ultrasound showed the femoral veins were even smaller than our cannulas, but there was a very juicy right internal jugular into which I placed a standard 20g intravenous cannula, there being no paediatric central lines available. Resuscitation with fluid improved her perfusion markedly and although still unwell, she was no longer in extremis.

The wind started to calm around 4am, so we re-established the emergency department in the basketball court. The infant remained relatively stable, and after two hours the woman with chorioamnionitis had delivered, again via ventouse. By daybreak, an exhausted obstetrician delivered the last baby, relieved that she had evaded the corridor caesarean.

Around 6am, patients started appearing at the door, most by ambulance, some by themselves. A whole range of emergencies started to appear – a man with a broken femur, a boy with a severe asthma attack and another with croup had appeared.

Another woman in established labour arrived, with a history suggesting she would require caesarean as well. It looked like our four-bed hospital would be insufficient for the number of patients presenting.

Given that the worst of the cyclone had missed Cairns, and that it was unlikely that there would be any storm surge, it seemed sensible to re-establish normal emergency services at the Cairns Base Hospital as soon as possible.

Even that was not simple – communications were disrupted and we were only episodically able to make telephone calls on the mobile network. Text messages were more successful, though often delayed. Several of us, along with the labouring woman, returned to the hospital with a view to getting the operating theatres up and running again, if needed. Other doctors and nurses arrived, and gradually, the Cairns Base Hospital was functional again.

On reflection we considered ourselves fortunate at “Fretwell Emergency Hospital”. We had created a temporary facility that could offer a high standard of care, albeit for a relatively small number of patients at once.

We supported a severely ill child, had expert inpatient obstetrics care for four women, two of whom had complications that may well have ended in disaster had there not been timely intervention, as well as treating a number of other acute illnesses and orthopaedic injuries.

More than 60 patients were treated in the 24 hours that the field hospital was open, thanks to a team of multi-skilled dedicated people working together in difficult conditions.

Dr Peter Schuller, FANZCA
Cairns Base Hospital

CYCLONE YASI

A first-hand account of evacuating a major hospital

As Cyclone Yasi approached, Cairns Base Hospital underwent the biggest hospital evacuation in Australian history. Dr Sean McManus tells how everyone prepared for the storm then dealt with the aftermath, including caring for a seriously sick baby.

Monday January 31

Chat around the coffee machine in the Anaesthesia and Intensive Care Department in the Cairns Base Hospital touches on the massive low near Fiji. Most of us assume it will drift south but by that night this assumption is looking a little shaky. Yasi is now an enormous cyclone, the size of NSW, and heading our way.

Tuesday February 1

4.30am I am up and wide awake. The Bureau of Meteorology (BOM) has predicted that Yasi will be the most destructive cyclone in living memory and it is heading directly for Cairns.

6.15am First in line at Bunnings for a generator. Very happy to have got in early – they sold out an hour after the store opened. I also manage to get hold of a window repair man to fix a couple of loose windows in the house.

8am The intensive care unit (ICU) director and I start the ICU round. We have 10 patients, our staffed maximum. There is a palpable buzz in the air as news of Yasi's predicted descent on Cairns spreads. We finish the round just before 10am, an interesting patient mix – a few long-term vent weans, two necrotising fasciitis, a recovering melioidosis, a suspected leptospirosis and a quetiapine overdose among others – reminds me why I like working in ICU as well as theatre. After the round I raise the possibility of getting a couple of patients out before the cyclone so we have some room, but the director points out that trying to get even one patient out will be difficult in the time available (nearest ICU is 400 kilometres away in Townsville and non-emergency transfers tend to take a couple of days, if not a week).

10.55am Sitting impatiently in the waiting room for a kids' orthodontics appointment, feeling a little weird. There is something brewing and I need to be at work.

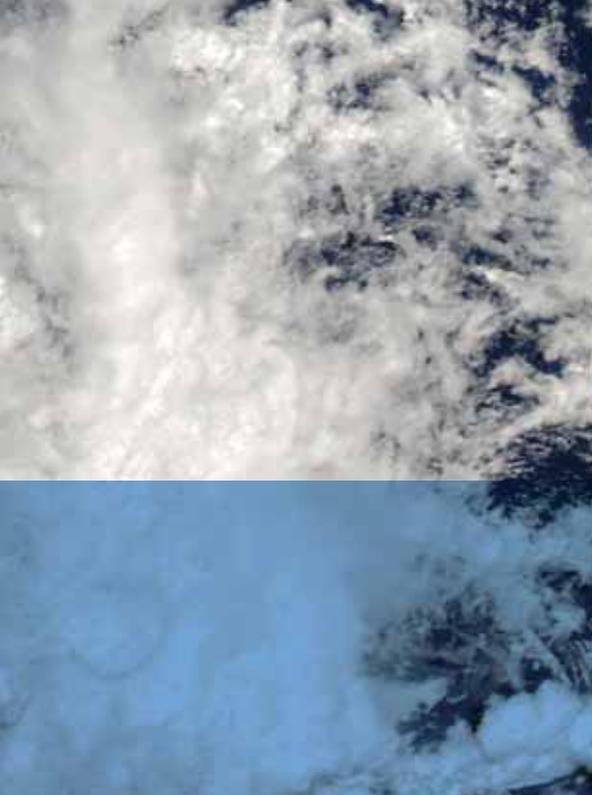
12.30pm Back to work to a scene of mild chaos. The predicted storm surge of six metres has forced the evacuation of all low lying areas, the central business district and the hospital included. The ICU director lives in a house near the beach and has gone home to evacuate his wife and three small children. I liaise with my colleagues and the senior nursing staff to prepare all 10 of our patients for transfer. Theatres have

been cancelled so we have manpower. A consultant colleague joins me in the ICU and provides quiet support throughout the day.

We assign an anaesthetic registrar to each patient to write a transfer summary and tidy up any loose ends. As they finish, those with families or living in the storm surge area are sent home along with all non-essential consultant staff. I am asked what is happening innumerable times by the ICU staff, each time I reply I don't know, we just need to focus on preparing every patient for aircraft transfer and await instructions. The mood in the ICU is apprehension and incredulity – are they really going to be able to get these 10 patients out?

2pm The emergency physician assigned as the evacuation co-ordinator of the entire hospital arrives in the unit. The two of us fill out the aeromedical summary sheet, categorise and allocate the patients for transfer. The plan is for each plane to take two patients with a nurse allocated to each and a doctor looking after both. As they are going out two by two (a flash of Noah's Ark appears in my head), we pair the sickest, most difficult patients with the stablest. Complicating this is the colonisation of four patients with VRE (hospital superbug), so they need to go together.

Throughout the hour or so it takes to do this the evacuation coordinator's mobile goes off continually and I can't help being impressed. She is a mum as



“AS ... YASI GROWS TO A CATEGORY 5, THE STRESS BUILDS IN EVERYONE, BOTH IN THOSE OF US WHO KNOW WHAT IT MEANS AND THE OTHERS WHO ARE NEW TO THE NORTH – AMAZED THAT SUCH A MONSTER WILL BE HERE TOMORROW WHEN TODAY IS SO BEAUTIFUL.”



well as a specialist – I think she is used to multi-tasking. After multiple rewrites we finally have a plan of evacuation. The next couple of hours are surreal. I feel like the captain of the Titanic. Everyone is on edge, I spend most of the time at the central monitoring station providing calm reassurance that the planes will come and the ICU staff will have enough time to get home in time to prepare their families and properties for Yasi’s onslaught.

As the BOM updates come in and Yasi grows to a category 5, the stress builds in everyone, both in those of us who know what it means and the others who are new to the north – amazed that such a monster will be here tomorrow when today is so beautiful.

6pm The first two patients have left the ICU and the next two are going at 7pm. The sense of relief is tinged with awe; this is really happening. I try to recall any other hospital of this size being evacuated in Australia and cannot. The director returned some hours ago and there are now two other consultants in

the ICU. The evacuation is proceeding smoothly so I hand over the ICU and drive home.

My wife Jennifer and I work feverishly preparing our house, the children help, but they have not really comprehended how serious the situation is. If the eye crosses we expect to lose the upper level (price paid for panoramic views in far north Queensland). We work for four hours moving everything of value from the upper level downstairs, running on adrenaline. Phones are going off continually as family and friends send messages of support and concern.

11pm Collapse into bed. Sleep is fitful – lots of “what ifs” going through my mind.

Wednesday February 2

5am BOM update comes in – Yasi’s course has deviated a little to the south. Relief is tinged with concern. Jennifer’s parents and brother and his family all live in Innisfail. The town was devastated by Cyclone Larry in 2006, the thought of them going through that again is terrible. I listen to the

authorities on the radio ask the public to be their own first responders, so I drive back to the hospital to grab some first aid and resuscitation gear.

9am Walking through the ICU and theatres is like being in a post-apocalyptic scenario. To be alone in a place that always has people is really weird. I retrieve what I think I might need (including all the kit to intubate and ventilate) and head back home.

The rest of the day passes incredibly slowly. We are feeling better as the updates come through – Yasi is almost certain to pass south of Cairns, which means the storm surge will be much lower.

10pm Yasi makes its presence felt as we lose power and the five of us go into the house cyclone shelter, a purpose-built room half underground. The house looks north, the best view to have when there is a clockwise spinning cyclone descending on you. I manage to sleep as the storm rages outside.

(continued next page)



SUMMER OF NATURAL DISASTERS

“WALKING THROUGH THE ICU AND THEATRES IS LIKE BEING IN A POST-APOCALYPTIC SCENARIO. TO BE ALONE IN A PLACE THAT ALWAYS HAS PEOPLE IS REALLY WEIRD.”

(continued)

Thursday February 3

2am I wake to find the worst of the winds have eased and check the house. There is no damage to the house but vegetation is down everywhere. I lie in bed trying to get some sleep before the morning.

6am Jennifer and I work solidly for four hours cleaning and moving everything back up to the top level. I fire up the generator and we have enough power to run the fridges, fans, computers and TV – a game changer.

11am I receive a call from the other intensivist. He is at the hospital arranging the opening of the ICU. Despite the bureaucrats saying the hospital was closed, a number of consultants took the initiative to return so emergency services can be provided. I am on call that night and my intensivist colleague is happy to arrange the return of the registrars. As we have no patients (all evacuated Tuesday) we don't think it will be too busy. He calls me at 2pm – everything is in place and he is going home to tend to his own house.

5pm I am driving around the town looking for petrol for the generator when I get a call from the ICU registrar – we have a consult. I cannot hear very well as the rain is hammering down. Fifteen minutes later I am looking at a distressed four-month-old, four kilogram Down's syndrome baby with an obvious sternotomy scar. The child is breathing up with paradoxical chest movement, unrecordable saturations on a non-rebreather oxygen mask.

Born in September, the baby underwent major cardiac surgery in December. She became unwell on the night before the cyclone and was brought to the Cairns hospital on Wednesday morning looking grey and mottled and retrieval was requested. Unfortunately the airport was closed and because the hospital was closing down, options were limited.

A paediatrician took her home and resuscitated her in her kitchen, attempting scalp veins and intraosseous access along with intermittent bag-mask ventilation while Yasi raged outside. As soon as the winds tailed off she presented at the field hospital, now peri-arrest. An extremely harrowing resuscitation followed with multiple attempts to obtain intravenous access until an anaesthetist skilled in ultrasound managed to get an internal jugular line in. We admit the baby to ICU – our first post-Yasi admission.

8pm The picture is becoming a little clearer. Severe sepsis, most likely an aspiration pneumonia. Complicating this is an incomplete cardiac repair with severe pulmonary hypertension as well as a massive fluid and sodium load from the resuscitation – she is puffy with a full fontanelle and pulmonary oedema. Saturations of the non-rebreather are in the 70s and she looks grey and mottled. The ICU staff are stressed, all of us are sleep deprived and we are not a paediatric ICU.

We prepare the equipment needed to intubate and I scan with the ultrasound looking to obtain definitive arterial and

venous access. Her vessels are tiny and this is a two-consultant job during the day, not one sleep-deprived consultant at midnight. I decide to adopt a “less is more approach” – nasal CPAP with high-flow humidified oxygen, half the feeds with free water to bring the sodium down and reduce intravenous fluids to the minimum to preserve access. I place faith in time and the physiological processes inside this four kilogram body.

11pm We seem to be making progress – the high flow oxygen is now at 50 per cent and the child looks a better colour. The rest of the night I check on the child periodically and catch some sleep. She keeps us on our toes with a few episodes of desaturation, almost to remind us how precarious a situation we are in. Eventually the morning arrives and we hand over to the Friday team. We are later relieved to hear that the baby is doing well.

Friday February 4

8am As I hand over the patient to the ICU director he goes a shade of green and agrees with the plan to call for a paediatric ICU retrieval team. Exhausted I head home to continue the post cyclone clean up and look after the kids – Jennifer has left for her second day at her new job.

Dr Sean McManus, FANZCA
Cairns Base Hospital



QUEENSLAND FLOODS

Dramatic start for new regional manager



It was the second day of work for Sandy Shaw, ANZCA's new regional manager in Queensland when West End in Brisbane – where ANZCA's offices are located – was identified as an area in immediate danger of flooding.

With the rain pouring down outside, Ms Shaw was advised that the water would need to rise to eight metres before it could enter ANZCA's Queensland offices (5.1 metres to enter the car park). However, with concerns that staff may be stranded if they stayed, means of communications with each other was established, and at midday they headed home through the chaotic traffic.

On the morning of Wednesday January 12, a team led by Dr Peter Moran from the Princess Alexandra Hospital – Drs Christopher Breen, Brendon Buzacott, Colin Brodie, Iain Salkield and Srinivas Rachakonda – gathered at the offices to move anything at risk of

flooding to higher ground. By this stage, several roads had been cut off, so a trip that may otherwise take 10 minutes took an hour.

The group removed the server, the new phone system and College gowns from the building and all movable furniture, equipment, materials and files were stacked as high as possible. An hour into the exercise the power went out.

With the water continuing to rise, it was decided that the risk of being stranded was again too great, so by midday everyone left for home.

The staff were able to keep in touch with each other via email and mobile phones, although power cuts in some areas caused communications issues. Fortunately, no ANZCA staff were personally affected by the flooding and by Friday, Ms Shaw returned to work

to find the car park had been about two metres under water but had been pumped dry and cleaned. However, power had not been restored.

By Monday, the office could be accessed safely but the power had still not been reconnected so most staff went home to work while Ms Shaw and Michelle Cordwell stayed to help restore the office to its pre-flood status with Dr Moran and a new team of helpers, Drs Pal Sivalingam, Nicholas Hogan, Paul Davies, Abe Gassiep and Glenn Jenkins.

By Wednesday morning, with the power restored, the staff returned to the office to find the air conditioning had failed and the phones were not working. While the phones came back on at 10.30am staff worked from home until Friday morning when things were back to normal.

ANZCA Curriculum Redesign Project



ANZCA's Dean of Education and chair of the Curriculum Redesign Steering Group, Professor Barry Baker, updates the Curriculum Redesign Project.

What happened as a result of the ANZCA Curriculum Review Project?

ANZCA is undertaking a comprehensive redesign of its curriculum to form a better foundation for our new Fellows for life as specialist anaesthetists in the 21st century.

The process began in August 2008 with the Curriculum Review Project.¹ The recommendations of this project were approved by Council in April 2010 and are reported on the ANZCA website.² The review resulted in the development of the ANZCA curriculum framework³ and recommendations for curriculum change.⁴

The Curriculum Redesign Steering Group (CRSG) was formed in July/August 2010 to use the framework and recommendations generated by the curriculum review to design the new curriculum.

Ten curriculum authoring groups (CAGs) each consisting of three Fellows and chaired by one of the CRSG members, were also formed to generate the curriculum content, with an initial implementation date set by Council as the 2012 hospital employment year.

The CRSG is overseeing all aspects of the redesign process and has met frequently to coordinate the authoring

process and to develop the overall structure for the revised program. The CAGs have been collaborating via an online tool to progress development of the new program, revising content in specific topic areas. A number of Fellows remain involved in this activity in 2011.

A Curriculum Project Advisory Group (CPAG) was established in mid-2010 to provide operational and administrative support for the revised training program. This group consists of the Dean of Education, Professor Barry Baker, staff directors of operational units, and the Director of Professional Affairs (Assessor), Dr Stuart Henderson. The CPAG is responsible for ensuring that the necessary infrastructure is in place within the College to ensure that the curriculum can function efficiently.

More than 40 ANZCA Fellows and trainees have been engaged in the redesign of the ANZCA training program, as detailed in the "President's message" in this issue of the *Bulletin*.⁵ They have been supported by the Education Development Unit and other senior managers at the College.

What is the latest news?

During its deliberations, the CRSG explored the implications of the recommendations for curriculum change in detail. A variety of options for the curriculum structure were considered and ultimately, the CRSG concluded that significant structural reform was required to address the issues raised in the review process.

It was determined that smaller-scale options (such as refining content within the existing modular structure) would not address these concerns. These recommendations for change were approved by Council in February 2011.

Specifically, the CRSG recommendations accepted by Council were:

- A revised curriculum structure (see diagram on page 24).
- A revised methodology to record volume of clinical practice including development of a logbook and an online learning portfolio.
- The delay in implementation of the revised curriculum until the 2013 hospital employment year.
- Expansion of workplace-based assessment throughout training, linked to the current in-training assessment (ITA) process.
- Changes to the primary examination which will only be able to be taken during training and after completion of an initial workplace-based assessment.
- Mandatory completion of an Effective Management of Anaesthetic Crises (EMAC) or equivalent course.

What are the key features of the revised curriculum structure?

Some of the key features of the revised curriculum structure are listed right and can also be found in the "President's message" on page 4.



- The establishment of ANZCA roles (medical expert, communicator, collaborator, manager, health advocate, scholar and professional). These are explained in detail on the ANZCA website³.
 - The establishment of ANZCA clinical fundamentals (general anaesthesia and sedation, airway management, regional and local anaesthesia, perioperative medicine, pain medicine, safety and quality in anaesthetic practice, and resuscitation, trauma and crisis management). These seven clinical fundamentals, each of which is underpinned by basic anaesthetic sciences, firmly orientate the new curriculum to the major clinical elements that highlight the education of an anaesthetist. They are a major move away from the traditional focus of anaesthesia training being linked to surgical specialties.
 - Length of training remains at five years.
 - o *Basic training*
Introductory anaesthetic practice approximately six months into training.
Basic anaesthetic practice approximately 24 months into training.
 - o *Advanced training*
Advanced anaesthetic practice approximately 48 months into training.
 - o *Provisional fellowship or consolidated training year* (terminology yet to be finalised).
 - Elements of training:
 - o *Core study units*
These units will contain the majority of the curriculum content, volume of practice requirements and assessments. They cover the fundamental aspects of anaesthetic practice that are broadly applicable to the care of our patients.
 - o *Specialised study units*
These units are to allow trainees to learn aspects of practice specific to a particular subspecialty area. Their size will vary with the amount of specific content but they will be much smaller than the core study units. They will not be time-based, but will have defined volume of practice and assessment requirements.
Trainees will be able to accumulate requirements in multiple specialised study units concurrently. These units cover care of patients requiring the following procedures: head and neck; ear, nose and throat (ENT) and dental; ophthalmic; neurosurgery and neuroradiology; general surgical; urological; gynaecological and endoscopic; thoracic surgery; cardiac surgery and interventional cardiology; obstetric anaesthesia and analgesia; vascular surgery and interventional radiology; orthopaedic surgery; intensive care; paediatric anaesthesia; plastic, reconstructive and burns surgery.
 - o *Consolidated study units*
These units aim to allow trainees to extend their practice and begin defining their career direction. They will include optional units to give trainees considerable choice to allow them to sub-specialise or develop particular non-clinical interests.
 - o *Clinical placements*
These placements are where a trainee undertakes supervised clinical practice in operating theatres, day surgery clinics, endoscopy units, imaging units etc to meet the requirements of the core and specialised study units.
- What does this mean for trainees, supervisors of training and heads of departments?**
Work has commenced to ensure that the transition arrangements will be as smooth as possible so that current trainees will not be disadvantaged or have their training program significantly disrupted.
Supervisors will be notified of the impact of the new curriculum on their role as this process progresses and, most importantly, the College will develop resources to assist them in their important role.
(continued next page)

Above from left: Dr Richard Horton and Dr Vincent Sperando at a workshop; the Curriculum Redesign Project Workshop in November; Dr Brian Lewer and Dr Richard Sullivan at a workshop; Curriculum Redesign Steering Group (CRSG) in February.

ANZCA Curriculum Redesign Project

continued

Communication concerning the transition arrangements will occur as soon as they are developed (which will hopefully occur following the June 2011 Council Meeting) to allow trainees, supervisors of training and heads of department to plan ahead for the new curriculum.

What are the next steps?

The CRSG will continue to coordinate all aspects of the curriculum redesign process. Further input from relevant College committees and support departments, Fellows and trainees will be sought to enable integration of the new curriculum with current educational and training activities and to assist in the smooth transition from old to new curricula.

The CPAG will develop operational and administrative systems to ensure effective and efficient implementation of the revised ANZCA training program, and phasing out of the current program.

This work will inform development of a detailed timeline for presentation to June 2011 Council by CRSG.

How can I contribute?

None of this work would be possible without the contributions of innumerable Fellows and trainees who have demonstrated their commitment to maintaining and improving the quality of anaesthetic education and training across ANZCA's training regions.

In the next stage, it is critical that we continue to receive input from Fellows and trainees who understand the diverse clinical contexts in which our future curriculum will be delivered. Please actively engage in upcoming opportunities to provide comment and feedback. For further updates visit the College website (www.anzca.edu.au/edu/projects/curriculum-redesign) or contact the Education Development Unit (email: education@anzca.edu.au; telephone: +61 3 8517 5361).

Professor Barry Baker,
ANZCA Dean of Education,
Chair, Curriculum Redesign Steering Group

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Curriculum structure: Overview

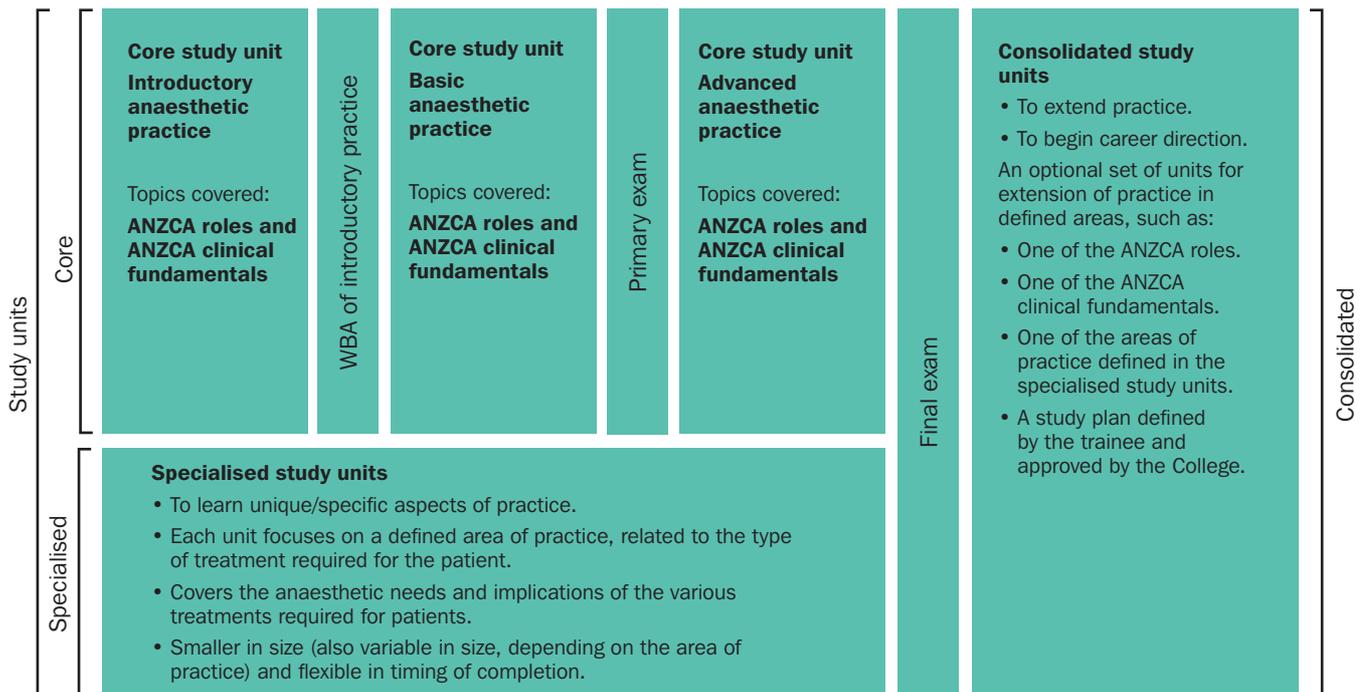
Basic training
(two years)

Advanced training
(two years)

Consolidated training
(one year)

Clinical placements

The various clinical placements, determined by individual workplaces, where a trainee undertakes supervised clinical practice. The clinical placements allow trainees to accumulate clinical experience and complete the volume of practice and workplace-based assessment (WBA) requirements of the study units.



The story doctor



Professor Brian Broom believes that to treat a person, a doctor needs to know their personal life story, not just their symptoms.

The appellation “story doctor” was bestowed on me last year, when I was a guest speaker at the Faculty of Pain Medicine conference in Newcastle. I had not seen myself that way, but while it felt odd, it was clearly oddly apt. How so?

My personal journey towards realising that, as doctors, we have become unable to see a crucial element of disease and illness, has been a long one.

My background is in academic clinical immunology and I still practise as a senior immunologist at Auckland Hospital. But in my late thirties I became disenchanted with immunology as I was practising it then – very body-focused and very laboratory test-oriented.

I wanted a more whole-person approach, but didn’t know how to achieve that within the clinical immunology setting in Christchurch Hospital.

Abandoning my consultant position, I started to train in psychiatry in an attempt to become more mind-oriented. But gradually I became aware of how intent modern psychiatry had become on biological mechanisms, diagnoses and drugs – psychiatry’s version of what I had left in immunology.

Eventually I trained as a psychotherapist and in 1987 set up practice as both an immunologist and psychotherapist. This was a pragmatic phase-of-life decision which had enormous consequences for me. I was seeing immunology referrals again for the first time in five years, but this time I was seeing them with two sets of eyes – the eyes of the immunologist and the eyes of the psychodynamically-oriented psychotherapist.

What happened next I had not foreseen. Patient after patient arrived in my clinic with a physical diagnosis, or I made a conventional physical diagnosis, but at the same time I was also hearing “stories”, life-stuff, ordinary stresses and strains, losses, rejections, failed love relations etc. Many of these “stories” appeared in close conjunction with the onset of illness, or a relapse in the illness.

Coincidence? What convinced me otherwise were the patients with “somatic metaphors” or symbolic diseases. An early one was the lady with a severe facial rash for five years who was keeping a “brave face” on her husband’s depression, and who cleared after a session with me just telling the story of her feelings, her frustration, her constant waiting around this fragile man.

Or the woman who in her seventies fell over in a car park and felt very vulnerable, went home and went “into her shell” (her words used repeatedly on first assessment) who within two weeks had developed an extraordinary thickening of the skin, diagnosed as a connective tissue disease. She started to get well a year later when a friend said to her “come out of your shell”. The steroids and immunosuppressive drugs had not worked.

I would hasten to say that not all disorders manifested symbolic material, but there were sufficient numbers to cause me to start to re-think my medical model. I have written about this in two books (*Somatic Illness and the Patient’s Other Story* 1997 and *Meaning-full Disease* 2007) and various journal articles.

We have inherited a body-first, mechanistic, physicalist model that certainly entertains a role for the psyche or the mind in certain conditions. For psychiatrists this is largely confined to the somatoform disorders, or to the effect of depression and anxiety upon “real” physical diseases.

“In our attempts to ‘heal’, we need to get near our patients. Listening to their ‘stories’, helping them make sense of the multifactorial nature of their illness.”



For many other physicians there is the bland acknowledgement that stress plays a role in otherwise medically explained (sic) conditions – but stress is really a mechanical concept borrowed from engineering. In reality, most of us have a narrow physicalist view of disease and illness. To imagine that a patient’s story of falling over in the car park could be directly related to, and make sense of, gross thickening of skin is beyond the scope of most physicians’ imagination.

The problem fundamentally is that we have the wrong model in our heads. Let’s for a moment talk about a person as having *physicality* (body, organs, physiology) and *subjectivity* (psyche, mind, story, capacity for experience). Then let’s ask the question WHEN did physicality and subjectivity start for the foetus, infant, child and adult? Did the body come first and subjectivity later? Is the mind an add-on, or was the potential for subjectivity and physicality (and all that these mean as the person develops) there right from the beginning.

I think the answer has to be that both are there, inherent, implicit, from the beginning. Another question is at what point is it reasonable to divide off physicality and subjectivity, so that we can talk about and deal with bodies and minds as separate? There is no such point. Persons are physical and subjective all at the same time. They are each aspects of the whole.

The story doctor continued

Where does this lead? Ultimately, people don't have diseases in the body that are separate from other aspects of their functioning. Even in medically authenticated diseases, physicality and subjectivity are inextricably together, entwined, contributing to one another.

This is the grave error of modern medicine; its exclusion of subjectivity, mind, story from disease. Add to that our preoccupation with abstract psychiatric and psychological diagnoses (which relate to groups of patients) rather than a close-to-the-patient understanding of their personal stories, and we can begin to see one major reason why we have so much struggle with many chronic conditions.

I am certainly not advocating a neglect of modern understandings of the biological and pathological processes occurring in disease, but rather an integrated inclusion of "story" into the same clinical time/space.

In my experience, chronic pain conditions are frequently susceptible to a "story" approach. There are two elements missing in many pain services. Firstly, there can be an undue emphasis upon the very physical elements, combined with a blindness as to the "story" elements, a blindness partly engendered by the fact there are in many patients very clear physical antecedents and components. This is a problem of not seeing that physicality and subjectivity have always lived together and always will!

Secondly, there has been in psychology and psychiatry a drift away from really knowing the patient's highly individual story to essentially general, patient-distant categories such as depression, anxiety, personality disorder etc. That is, the clinician doesn't get close enough to the story to be able make exquisite multifactorial sense of the pain with the patient.

I like the word "story" much better than say "depression", "life events" and even "narrative". In our attempts to "heal", we need to get near our patients. Listening to their "stories", helping them make sense of the multifactorial nature of their illness, empowering them on the basis that we are there to accompany them as they wrestle with the personal "demons" in their stories, and also doing what we need to do medically – this helps many people unresponsive to current forms of management.

I am reminded of a 40-year-old man with severe back pain that started as a result of a diving injury. He had been off work for 10 years, unable to sleep for more than two to three hours, was unable to have sex and in embattled relationships with his accident insurer, the local pain clinic and several orthopaedic surgeons. I contracted to work with him.

He was hugely angry. Some of this was in reaction to the way he had been treated, but some was due to rage at being the sixth child in an academic family and seeing himself as a failure. At the ninth session I told him I could not continue to work with him unless he faced the elements of his rage that were nothing to do with the insurer, the pain clinic or other clinicians. I had earned his trust. He knew I knew his story well enough to say this, and that I was right. He agreed, and by the sixteenth session he had started a yacht charter business with minimal pain commensurate with his original back injury.

In this way, I guess I am a story doctor.

Professor Brian Broom MBChB, FRACP, MSc(imm) MNZAP
Consultant physician (immunology) and psychotherapist
Department of Immunology, Auckland City Hospital
Adjunct Professor, MindBody Healthcare Post-Graduate Program
Department of Psychotherapy, Auckland University of Technology
Auckland, New Zealand

“This is the grave error
of modern medicine; its
exclusion of subjectivity,
mind, story from disease.”





ANAESTHESIA IN VICTORIA

SPECIAL REPORT: HEALTH REFORM AND ANAESTHESIA DEVELOPMENTS IN VICTORIA

In previous issues of the *ANZCA Bulletin*, we have spoken with Australian and New Zealand health ministers about the challenges facing their health systems, particularly relating to anaesthesia and pain medicine. In this issue we shift our spotlight to Victoria to look at the impact of health reform, including significant upgrading of state hospital infrastructure, pioneering programs for general practitioner anaesthetists, improvements in trainee education and continuing medical education.



VICTORIA: LEADING THE WAY ON HEALTH REFORM?



DR ANDREW BUETTNER
CHAIR, VICTORIAN REGIONAL COMMITTEE

National health reform has been through two major iterations in the past year with the most recent package announced by the Council of Australian Governments in February.

While much remains to be argued it would seem that key features will include activity-based funding and the establishment of local hospital networks.

Victoria has led the way on health reform in these areas. Governance by local hospital networks is longstanding and casemix funding was introduced in 1993. The reforms at that time were very controversial as they were accompanied by significant budget cuts but almost 18 years on they are an accepted part of the landscape and a key reason why Victorian hospitals are among the most efficient in the country.

The Victorian experience shows potential opportunities for anaesthetists as well as hazards associated with these reforms.

Casemix funding is based on the average cost of treating patients. This compares with block funding based on historical measures or population demographics. Casemix funding can promote greater efficiency as it provides incentive to treat patients at below average cost.

Activity-based funding inevitably encourages greater operating theatre throughput and Victorian anaesthetists increasingly are being involved with operating theatre management and scheduling.

Pressure to decrease length of stay promotes greater rates of day-of-surgery admissions and development of pre-anaesthetic assessment clinics. Anaesthetists are very much affected by these increasing work demands.

Casemix does not determine funding of individual clinical units within hospitals. This is determined by local hospital management. Funding allocation, though, remains very much part of the political cycle and anaesthetists can be challenged by demands to ramp up activity in response to political exigencies.

The Queensland experience showed a disconnect developing between senior doctors and hospital management when control of individual hospitals was centralised in Queensland Health. It would be pleasing to say that in Victoria, where local boards control hospitals, this has not occurred. However, it would not be entirely accurate.

Like elsewhere, while senior clinical staff remain there is frequent turnover and restructuring at a management level. Hospital management can be very much focused on financial indicators at the expense of other activities.

Casemix emphasises cost efficiency in treatment but doesn't directly address funding for quality assurance, teaching and research and anaesthetists need to be vigilant to ensure that these activities are not threatened by managers focused on short-term indicators.

In recent years there has been significant upgrading of hospital infrastructure within Victoria.

- In 2005 the Mercy Hospital for Women relocated next to the redeveloped Austin Hospital.
- In 2007 Victoria's first surgery centre was opened at The Alfred hospital to treat elective surgical patients only.
- In 2008 the Royal Women's Hospital relocated from Carlton to Parkville next to the Royal Melbourne Hospital. This followed the relocation of the Mercy hospital so that all tertiary referral obstetric centres have access to support from major adult general hospitals.

(continued next page)

Also at Parkville, a new Royal Children's Hospital is being constructed and in 2015 the Peter MacCallum Cancer Centre will relocate as a major part of the Victorian Comprehensive Cancer Centre (Victorian CCC).

This site, known as the Parkville precinct, just to the north of Melbourne's central business district, is an exciting development bringing together four major teaching hospitals, the University of Melbourne and major research institutions such as the Walter and Eliza Hall research institute (WEHI) and Bio21.

Victoria is the smallest of the mainland states but has the second-highest population. The smaller geographical barriers that we face compared to other regions allow Victorian anaesthetists greater access to educational and social opportunities. Victorian anaesthetists are well represented in the clinical, research and teaching aspects of our profession.

We are fortunate that the physical location of the College head office in Victoria helps ensure that ANZCA is not seen as a remote presence. The Victorian Regional Committee is privileged to hold its monthly meetings at Ulimaroa.

Committee members are involved in a variety of external working groups, hospital committees, College committees, the Australian Medical Association and the Australian Society of Anaesthetists, as well as active roles in continuing medical education and in pre-fellowship courses for the trainees.

Our challenge remains to engage Fellows in the activities of the committee to ensure that it remains relevant to Victorian anaesthetists into the future.

ANAESTHESIA ADVERSE EVENT REPORTING IN VICTORIA



**ASSOCIATE PROFESSOR
LARRY MCNICOL**
CHAIR, VICTORIAN CONSULTATIVE
COUNCIL ON ANAESTHETIC MORTALITY
AND MORBIDITY

There is a remarkable track record for voluntary reporting of mortality and morbidity by Victorian anaesthetists.

The Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM) was established in 1976 under section 13 of the Public Health Act 1958 and the legislative provisions have recently been updated in sections 33-42 of the Public Health and Wellbeing Act 2008. It is important to recognise that the VCCAMM is the only state anaesthesia mortality committee in Australia that also collects morbidity data.

The level of reporting has remained relatively constant over many years, due mainly to the high level of trust between practising anaesthetists and the council, particularly during the chairmanship of Dr Patricia Mackay from 1991 until 2005. This is due in no small part to

the strict adherence to the confidentiality provisions within the act, and the direct feedback from the chair of the deliberations of council to the reporting anaesthetist in the form of a confidential letter.

In addition to the confidentiality clauses within the legislative provisions, the VCCAMM imposes an additional layer of security in that only the chair and the confidential project officer are privy to the identity of the patient, hospital and reporting practitioner. All identifiable information is removed from case reports before presentation to council.

Council also has access to mortality cases referred to the Office of the State Coroner and receives in an ad hoc manner, de-identified case records of anaesthesia adverse events from quality assurance meetings held by hospital departments of anaesthesia. Dependence on voluntary reporting, however, inevitably leads to under estimation of adverse event rates.

Importantly therefore, under the legislative provisions of the new act, and effective from January 1, 2010, the chair of the council is empowered to issue a notice to all health services to provide details of anaesthesia-related adverse event cases for deliberation by the council.

This provision essentially incorporates a mechanism for mandatory notification of such events and authority to seek and be provided with specified information. It is anticipated that this will facilitate more systematic reporting of anaesthesia mortality and morbidity, without compromising confidentiality.





Left: The Alfred hospital.

However, it is also important to recognise that in 2010, the individual practising anaesthetist is likely to be confused about the expectations on them regarding incident and adverse event reporting requirements. The dilemma of parallel reporting imposes not only a burden, but the risk of non compliance.

Most hospitals in Victoria are expected to contribute to local institutional and statewide generic incident reporting systems (Riskman, VHIMS) as part of a broad clinical risk-management program. Quality and safety managers in hospitals are frequently asking for clinical departments to engage in more systematic reporting of adverse events using these programs. However, such generic systems do not easily incorporate data fields of sufficient depth to capture important clinical information of relevance to particular craft groups (for example, anaesthesia).

In Victoria, over the past five years, in the pursuit of a uniform electronic tool for anaesthesia adverse event reporting, the directors of anaesthesia and quality assurance (QA) coordinators in three major metropolitan hospitals in Melbourne (Austin, Alfred and Royal Melbourne) and one regional teaching hospital (Barwon) have collaborated with a software company (Schmik Solutions Pty Ltd) in the development of the Victorian Anaesthesia Safety (VAS) project. It has recently undergone a name change and is now referred to as the Anaesthesia Safety Project (ASP).

This is a web-based adverse event reporting system that includes a defined set of adverse event categories and in its current version is attempting to automatically collect denominator data for all patients by linking to the operating theatre data management system.

Over the past four years there has been a significant increase in interest and investment in anaesthesia incident reporting in Australia and New Zealand. The presidents and chief executive officers of each of the Australian and New Zealand College of Anaesthetists the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists have formed a committee dedicated to the reporting and collection of critical events in anaesthesia.

This committee, the Australian and New Zealand Tripartite Anaesthesia Data Committee (ANZTADC), has met regularly to develop incident/event definitions for data capture, and to establish integrated systems for collation and dissemination of outcome data to practising clinicians in these two countries. It is now actively recruiting throughout Australia and New Zealand to encourage departments of anaesthesia to sign on as registered reporting sites for its web-based system.

One of the most important foundations of quality assurance is the establishment and maintenance of a reliable adverse event reporting tool. It should have the following components:

- Ease of reporting.
- Confidentiality.
- Clinical relevance.
- Provision of a mechanism for individual feedback from a peer group.
- Contribution to a database that is used as a knowledge bank for dissemination of information.

Although there is clearly some potential for confusion by anaesthetists about where to report adverse events, there is also considerable room for optimism. I strongly believe that the current anaesthesia trainee has already developed a culture that involves the recognition of the benefits of ongoing collection of case load data for educational purposes (for example, career-long log book).

Given the rapid advances in technology to enable automatic and seamless data acquisition, it is a relatively small step to “build in” an easy-to-use anaesthesia adverse event menu, either through web-based systems and/or through the automated electronic anaesthesia record.

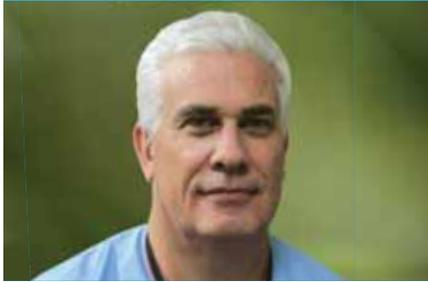
This can then be used in multiple ways, including the retention of a personal account of clinical experience, presentation to local hospital department of anaesthesia QA meetings and/or the private practice group peer review meetings. Importantly, adverse event details could also be easily transported to adverse event repositories and collection agencies such as the VCCAMM, the ASP and the ANZTADC.

“Over the past four years there has been a significant increase in interest and investment in anaesthesia incident reporting in Australia and New Zealand.”



Right: Royal Women's Hospital.

VicPROMPT



DR MICHAEL SHAW
VISITING MEDICAL OFFICER AND
ANZCA SUPERVISOR OF TRAINING,
BALLARAT HEALTH SERVICES

Practical Obstetric Multi-Professional Training (PROMPT) is a multidisciplinary team training course that covers the management of a selection of obstetric emergency scenarios.

It was developed at Southmead Hospital, Bristol more than 10 years ago and has subsequently been extended to maternity units across the United Kingdom. Following implementation in south-east England, improvements in several clinical outcomes have been clearly demonstrated. These include:

- A 51 per cent reduction in five minute APGAR scores of less than seven.
- A 50 per cent reduction in neonatal hypoxic ischaemic encephalopathy.
- A 75 per cent reduction in neonatal brachial plexus injury after shoulder dystocia.
- A 40 per cent reduction in the "decision to delivery interval" after a cord prolapse.

PROMPT has also been successfully modified for varying "local" conditions and is used in New Zealand, Fiji, Hong Kong, Singapore, Italy and the United States. In Australia, PROMPT is being run in Western Australia (called InTime) and in Victoria as (VicPROMPT).

VicPROMPT is being run as a pilot program, sponsored by the Victorian Managed Insurance Authority (VMIA), at four sites across the state. In metropolitan Melbourne, the eastern and southern health networks are involved, while in regional Victoria, the Barwon and Ballarat health services are pilot sites.

The program is overseen by the VicPROMPT Steering Committee which is made up of representatives from the VMIA, Victorian Health

Department, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), ANZCA, the Australian College of Midwives and Eastern Health (the foundation site in Victoria).

Each pilot site has run multiple courses during 2010 and will continue to do this into 2011. The course is designed to be run over a single day and involves participation of midwives, obstetricians and anaesthetists. The aim of the course is to promote safe and effective management of emergency situations in obstetric practice by revising local protocols, practising simulated emergencies and building communication, understanding and respect within a team environment. This is achieved through a series of lectures and discussions of core material presented to suit local practise and management of simulated emergencies in the local environment, by a team comprised of midwives, an obstetrician and an anaesthetist.

The program began in February 2010 at Eastern Health's Box Hill campus, where a "train the trainers" day was held. Members of the PROMPT organisation in the UK and PROMPT course organisers from Auckland ran a valuable workshop on the practicalities of planning and implementing a PROMPT course to attending medical and midwife trainers from the four pilot sites. The following day, the Eastern Health team ran the first VicPROMPT course for 2010. Since then, 27 courses have been completed across the four sites and a further 25-30 days are planned this year.

The pilot is now being evaluated with a view to a more general rollout across Victoria. The evaluation will focus on the effectiveness of the PROMPT program in Victoria, across a variety of clinical environments. Short and medium-term outcome measures will include:

- Satisfaction of participants with the training content and methods.
- Changes introduced to local policy and procedures as a result of the training.

The ease with which the PROMPT program can be used in large metropolitan hospitals as well as regional and smaller rural settings is also being monitored.

Improvement in clinical outcome data, such as that seen in the UK, may take longer to assess. The pilot program will hopefully provide sufficient data to make an initial judgement.

To that end, a formal research project has been set up to specifically investigate whether the VicPROMPT team training pilot can deliver improved clinical outcomes across a broad range of obstetric and peri-natal criteria and also improve the working environment and safety attitudes of the staff involved in the program. This is based at Eastern Health.

A report summarising the strengths and weaknesses and outcomes of the VicPROMPT pilot will be presented to the VMIA, the Victorian health department and other stakeholders by the end of the year so that a decision can be made regarding the future of the program in the state.

"A formal research project has been set up to specifically investigate whether the VicPROMPT team training pilot can deliver improved clinical outcomes ... and improve the working environment and safety attitudes of the staff involved in the program."



ULTRASOUND-GUIDED REGIONAL ANAESTHESIA



DR MICHAEL BARRINGTON
ST VINCENT'S HOSPITAL MELBOURNE

In 2005-06 it was becoming clear that regional anaesthesia was undergoing monumental changes due to ultrasound guidance.

Ultrasound-guided regional anaesthesia was being adopted around the world, providing anaesthetists with the potential to see what previously was impossible to visualise – the location of nerves, needle tip and spread of local anaesthetic.

As with all new techniques, evidence of safety, efficacy and clinical effectiveness were required to justify the outlay of significant funds for the purchase of equipment. Now it is evident that ultrasound guidance improves the success, onset and quality of peripheral regional anaesthesia, but in 2006, the clinical practice was evolving and the results of systematic reviews had not been published.

Fortunately, in late 2006, a collaboration of anaesthetists from 18 Victorian public hospitals were successful in obtaining new technology grant (NTG) funding, which can be used to deploy new technologies and clinical practices. The \$1,005,482 in funding was used to supply these hospitals with portable ultrasound machines for regional anaesthesia.

To ensure that this technology could be implemented safely, anaesthetists from each of the recipient hospitals received practical, hands-on training during a two-day course. The course content included fundamentals of ultrasound imaging, development of sonography skills and recognition of sonoanatomy on models.

In addition, hands-on needle-probe coordination and block procedures were practised in an anaesthetised pig model. Once the technology was implemented in the clinical setting, procedures performed using the NTG equipment were audited.

To provide comparative data, information on regional techniques not using ultrasound was also collected. For this purpose, an online database was developed by Dr Rowan Thomas allowing direct entry of data from multiple sites.

The outcomes resulting from the collaboration of Victorian anaesthetists and Victorian health services have been enormous. Interest in regional anaesthesia has increased and it is increasingly being used, even in hospitals that previously performed few or no regional techniques.

Funding provided three probes for each machine, so many anaesthetists in Victoria now have access to transthoracic echocardiography probes and have become proficient in basic cardiac scanning. The technology is commonly used for vascular access, adding further value to the equipment.

The Australian and New Zealand Registry of Regional Anaesthesia (AURORA) developed from the multi-centre collaborative network established by the NTG audit and now, in addition to Victoria, includes hospitals from New South Wales, Western Australia, Queensland, Tasmania, New Zealand and Malaysia. AURORA provides insight into our contemporary practice of regional anaesthesia informing the quality and safety of clinical practice and it is clear that the use of ultrasound to perform regional anaesthesia has dramatically increased over the past five years.

In summary, the NTG allowed statewide application of new technology, improving healthcare outcomes in Victoria.

“The use of ultrasound to perform regional anaesthesia has dramatically increased over the past five years.”



GENERAL PRACTICE ANAESTHESIA



DR FRED ROSEWARNE
IMGS/AON AND GP LIAISON OFFICER
VICTORIAN REGIONAL COMMITTEE

While administration of anaesthesia by general practitioner anaesthetists (GPAs) is widely practised outside metropolitan and major regional hospitals Australia-wide, the relatively shorter travelling distances in Victoria have facilitated development of some initiatives in both training and continuing education.

Following the cessation of examinations conducted under the auspices of the Joint Consultative Committee on Anaesthesia (JCCA), the supervisors of training from a group of Victorian hospitals felt that some form of examination would be worthwhile.

The aim was to provide a standardised assessment across the broad range of Victorian hospitals involved with GPA training. These hospitals ranged from outer metropolitan hospitals such as the Northern Hospital in outer metropolitan Melbourne to smaller non-ANZCA accredited hospitals such as Hamilton in western Victoria. This year Ballarat Base Hospital held the first such examination in Victoria, which was undertaken by a group of GPA trainees from across Victoria. This year, expansion of this to involve most of the Victorian GPA trainees is planned.

Another Victorian initiative are refresher programs, such as the one run by Ballarat Base Hospital, which allow GPAs from across Victoria to work under the supervision of specialist anaesthetists

in a major regional hospital to provide upskilling opportunities. These were pioneered at Ballarat more than 10 years ago by former director of anaesthesia, Dr John Oswald, OAM, and continue under his direction with a waiting list for attendees.

Joint educational meetings such as the Australian Society of Anaesthetists' Victorian Country Meeting and the Rural Special Interest Group meeting provide local and national opportunities for all anaesthetists to meet and learn, renewing old friendships and making new ones, with the common background of enjoying the benefits of rural and regional anaesthetic practice.

“Another Victorian initiative are refresher programs, such as the one run by Ballarat Base Hospital, which allow GPAs from across Victoria to work under the supervision of specialist anaesthetists in a major regional hospital.”





Left: Royal Children's Hospital.

TRAINEE EDUCATION



DR RICK HORTON
REGIONAL EDUCATION OFFICER,
VICTORIAN REGIONAL COMMITTEE

It has been about 20 years since I was a complete novice. It's easy to forget what it's like. In Victoria, I think we do a great job at preparing our trainees for their examinations and so the next challenge has been to get the training of our novices a bit more formalised.

It's a rewarding brief. They are on the steep part of the learning curve so it's like watching a plant grow in front of your eyes a few minutes after watering. I remember when I did my final exam I thought: "Gee, I wish I had known a bit more of this practical stuff earlier on."

We held our first part 0 course in 2010 in the seaside town of Lorne on the Great Ocean Road. It was a lot of fun and the troops were pretty enthusiastic so I think it's going to be a permanent item on the fixture. We don't try and cover too much in a day. It's pretty hands on and practical – and hopefully stimulates the trainees to do a bit more personal exploration. At the end of the day, it's great to see a bunch of people come together from all the different hospitals, facing the same challenge of what can be a pretty tough year – the first year of training.

Our facilitators come from all over the place as well. It helps build relationships between the hospitals at a senior level, which is never a bad thing.

Victoria has seven different training schemes, which used to make selection a bit of a nightmare. There was little coordination so trainees and the schemes didn't know when the music had stopped and they had to grab the nearest chair. There is a lot more communication now. The schemes run a matching system that is fairer and more efficient. We don't trust computers though. It is done manually by two people who have to come up with the same answer independently or they have to repeat it. So far this has never had to be done. Perhaps all that Sudoku training...

An unusual feature of the Victorian system is our Obstetric and Paediatric Training Scheme (OPATS) year. Most Victorian trainees, after they have completed their basic training, spend their first advanced training year in the OPATS.

This scheme is coordinated by the major obstetric and paediatric training hospitals and combines trainees from all the different training schemes. Mixing trainees together helps promote a greater sense of cohesion and many registrars form their study groups for the part 2 exam at this time. It also ensures that access to training at our world-class paediatric and obstetric centres is not restricted to only a few rotational programs.

Research is a great way of engaging in our specialty and the Victorian Registrars Scientific Meeting has gone from strength to strength in recent years. It has been difficult to get trainees to present when it is not a requirement for getting their formal projects signed off. We have tried all sorts of things over the years to improve the participation rate. We have moved it to later in the year to give trainees more time to prepare, we have changed our prize to "no strings attached" cash and I think the most significant step has been involving the ANZCA Trials Group which not only makes sense in that these trainees are the researchers of the future, but also lets the trainees know that the senior people of our profession take them seriously. We had 17 presenters last year, our best year.

"Research is a great way of engaging in our specialty and the Victorian Registrars Scientific Meeting has gone from strength to strength in recent years."



CONTINUING MEDICAL EDUCATION



DR DEBRA DEVONSHIRE
HONORARY SECRETARY
VICTORIAN REGIONAL COMMITTEE



DR DAVID BRAMLEY
ASSISTANT CME OFFICER
VICTORIAN REGIONAL COMMITTEE

Like many icons, ANZCA is invaluable in numerous, diverse and remote locations. Like the iconic Phar Lap, who was foaled in New Zealand, trained in Australia and whose heart, skeleton and hide are geographically separate, the sum total of the parts builds an outstanding champion. ANZCA is a “living” incarnation of its members, unlike the equine celebrity.

Victoria is privileged to host the physical shell or hide of ANZCA in the buildings on St Kilda Road, while our active continuing medical education (CME) program contributes to feeding the body of our establishment. The architecture of ANZCA House is a combination of 18th century Victorian and 21st century high-rise. CME in Victoria over the past five years has been a similar combination of merging heritage values with contemporary trends.

Our busy CME schedule incorporates a variety of activities organised by Fellows and the Victorian Regional Committee members. Part of the challenge in coordinating these events is ensuring that a broad range of topics and meeting styles are represented that complement, rather than compete with, the many educational activities offered by hospitals and the Australian Society of Anaesthetists (ASA). The centrepiece of this collaborative program is the ASA/ANZCA Melbourne winter anaesthetic meeting in July. Cross pollination of ideas between the ASA and ANZCA Victorian representatives has been invaluable.

In the past, our diverse topics have included highlighting awareness of how anaesthetists interact within their community. The contemporary idea was that there is life outside the operating room fishbowl. Themes pushed our concepts of how we, as anaesthetists, fit into controversial social discussion on topics such as bird flu, climate challenge, bushfire response, indigenous health and reducing our carbon footprint.

We subsequently returned to more traditional themes, for example, our co-branded ASA/ANZCA “Tools of the trade”. This year the theme will be “Hot topics in a cool city” and the program promises some excellent speakers covering a range of relevant and potentially controversial topics. The meeting is typically well attended and makes for an ideal weekend in the city for the many interstate and regional delegates.

A good CME program needs to facilitate accessible opportunities for quality assurance (QA).

Our QA activities held at the College in the style of hospital morbidity and mortality meetings have been particularly successful in the past few years. A half-day program typically involves organised presentations of cases and relevant educational material followed by smaller group discussions where attendees are encouraged to bring their own case to share. These group discussions are then summarised to the larger group with feedback and open participation is encouraged.



Left: Epworth Hospital.

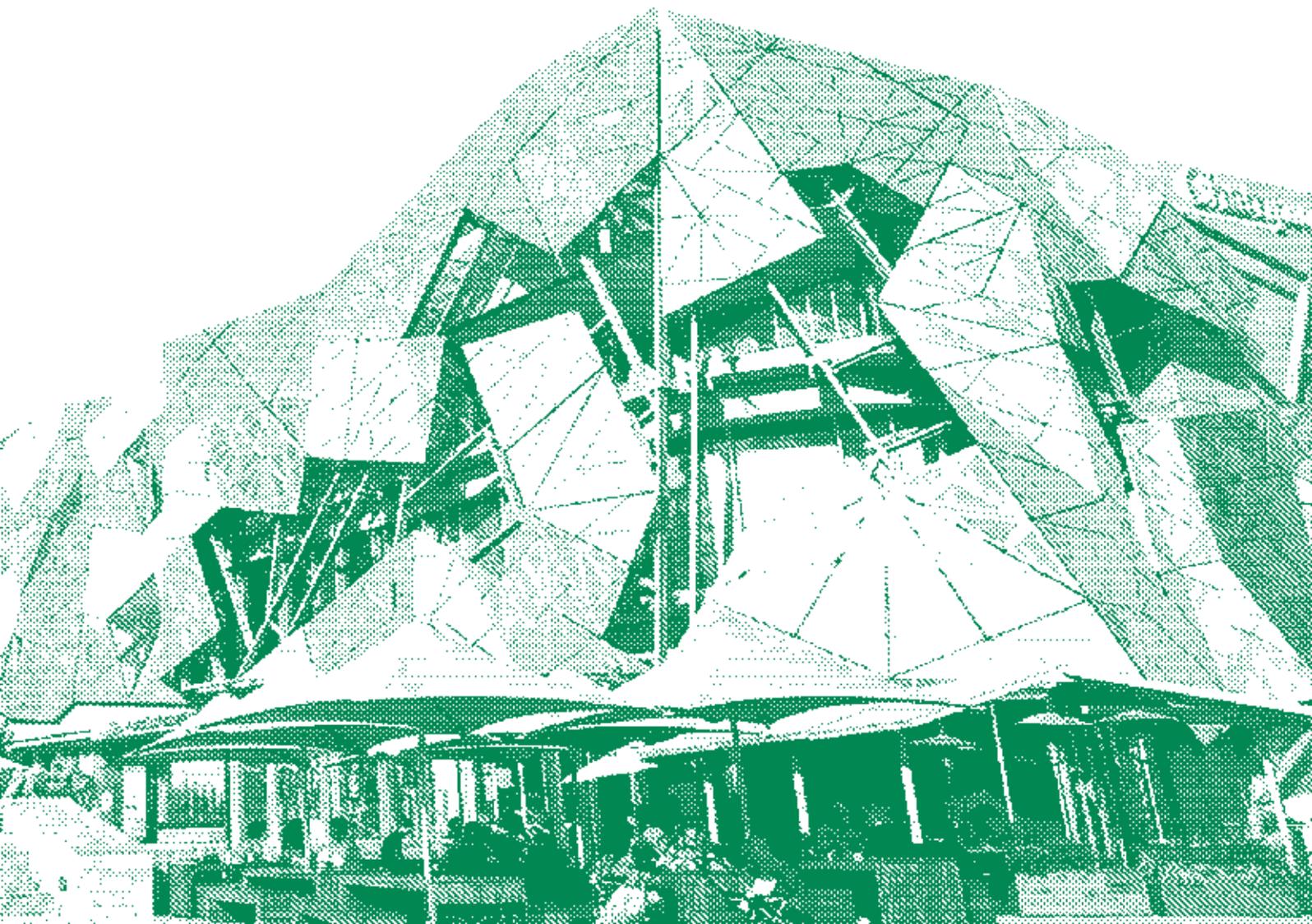
The format receives positive feedback and provides an excellent opportunity for Fellows to interact socially and professionally while working toward meeting valuable continuing professional development (CPD) requirements. Evening lectures held at the College also offer opportunities for Fellows to hear visiting speakers on a diverse range of topics.

The 2013 ANZCA Annual Scientific Meeting will be held in Melbourne with the theme "Superstition, dogma and science". The regional organising committee, with Dr Debra Devonshire as convenor and Dr Mark Hurley as deputy convenor, have preparations well advanced for what promises to be an exceptional meeting.

Dr David Bramley and Dr Rowan Thomas are creating a broad scientific program to examine the assumptions that underpin the practise of anaesthesia and pain medicine. The state-of-the-art facilities at the Melbourne Exhibition and Convention Centre have been secured for the many scientific sessions, problem

based learning discussions (PBLDs) and workshops and we look forward to creating a truly enjoyable "Melbourne experience" with the social program. Lock the dates May 4-8, 2013 in your diary!

"Themes pushed our concepts of how we, as anaesthetists, fit into controversial social discussion on topics such as bird flu, climate challenge, bushfire response, indigenous health and reducing our carbon footprint."



Eyes on Ethiopia



Royal Victorian Eye and Ear Hospital anaesthesia trainee Dr Rachna Shankar talks about her extraordinary professional and cultural experience in Ethiopia.

At the end of 2010, I had the opportunity to travel to Ethiopia with a voluntary organisation, Eyes for Africa. The aim of this organisation is to restore sight to the poor and under-privileged people of Ethiopia by performing cataract surgery. This year the hospital in the ancient cultural town of Harar was chosen. The target was to operate on 200 patients from within and around Harar in two weeks.

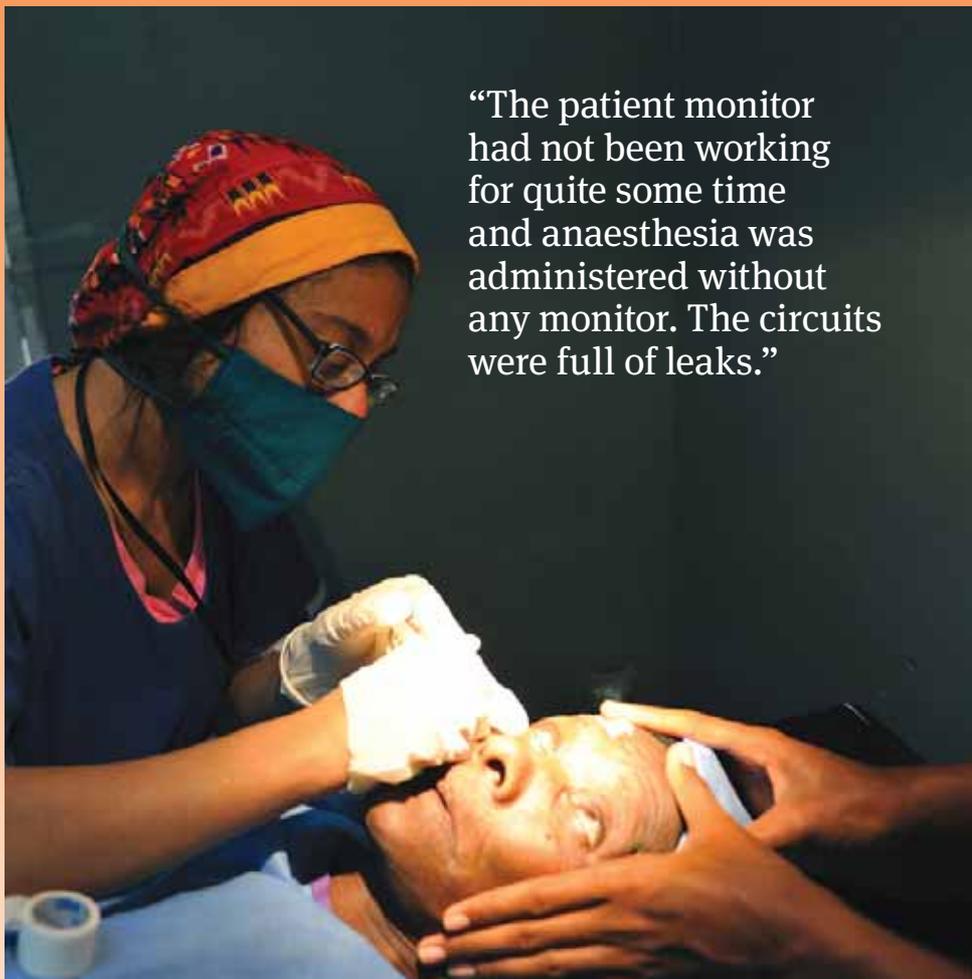
I had travelled with a team comprising experienced ophthalmology

nurses from the Royal Victorian Eye and Ear Hospital, a surgeon and a photographer. We all had similar compassion for the underprivileged. The equipment had been collected from donations and funds raised over the previous year. We were very warmly welcomed by the locals on our arrival with colourful dances and great food.

My first day in theatres was full of surprises and shocks. I saw various colours of oxygen cylinders – green, blue and black. I was relieved to hear that there was no nitrous oxide stored in cylinders, and there were no gas pipelines, as you would imagine. The anaesthesia machine was 20 years old with halothane and isoflurane vaporisers but, because of the cost, only halothane was used. The patient monitor had not been working for quite some time and anaesthesia was

administered without any monitor. The circuits were full of leaks. However I was full of praise for the people who were able to administer anaesthesia without any advanced technology and very limited resources.

After touring the facility it was time to work. We started at our usual theatre time of 8am. The patients were crowded outside the outpatient building waiting impatiently for surgery. We had two theatres going simultaneously. The local surgeon was operating in one and the other was run by our team. I didn't have the luxury of an assistant and there were no technicians. I had learnt a few local words to get me through the blocks for the cataract surgery with some help now and then. Tennis balls were used in place of Honan's balloon as a compression device!



“The patient monitor had not been working for quite some time and anaesthesia was administered without any monitor. The circuits were full of leaks.”

I had two children present with bilateral cataracts. One was five years old and the other six. After weighing the options, I chose intravenous ketamine boluses supplemented with a sub-tenon’s block by the surgeon. I was fortunate to get a small portable pulse oximeter from one of the team members. To keep an eye on breathing, I used the good old technique of pre-cordial stethoscope for respiratory and heart sounds.

Towards the end of the case with the six-year-old, who was on the table under ketamine, all was going well when the power went off! There was a complete black-out for 15 minutes during which time we managed with hand-held torches!

When not working between 8am and 5pm, we had plenty of sight-seeing

opportunities combined with local and traditional food. We were blessed many times with warm hugs, kisses and spit on the hands (it sounds disgusting but spitting is their way of blessing!)

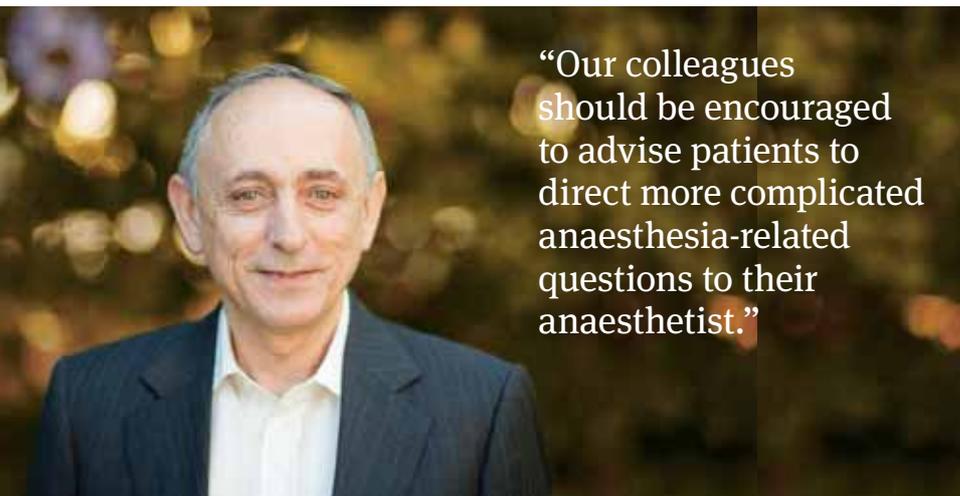
By the end of our two weeks we had completed 180 cataract surgeries including two on children.

I had the most amazing experience both professionally, enabling patients to see the world again, and culturally. This foundation does a yearly trip to an African country and anyone interested can donate via <http://eyesforafrica.org/> or contact Julie Tyers via the website.

Dr Rachna Shankar
Anaesthetic trainee
Royal Victorian Eye and Ear Hospital

Above from left: The hospital in the ancient cultural town of Harar; the ICU and recovery room at the hospital; Dr Rachna Shankar (right) with a patient; some of the machines used at the hospital; tennis balls were used in place of Honan’s balloon as a compression device; Dr Shankar at work.

Perioperative patient preparation – the importance of communication



“Our colleagues should be encouraged to advise patients to direct more complicated anaesthesia-related questions to their anaesthetist.”

“How do I prepare for surgery?” This was a question that appeared in the *Ask the Naturopath* column of Sunday News Ltd newspapers throughout Australia on February 6 and it raises a number of interesting issues.

Obviously if patients don't receive information from their relevant healthcare practitioners they will seek it from other people, most of whom not only have opinions, but also are very willing to express them without due consideration of the consequences.

In the movie *Ghostbusters* there was a team responsible for the eradication of ghosts and the theme lyrics were “... who ya gonna call? Ghostbusters!” This highlights the importance of having the right people for the job, and the right people for informing patients about anaesthesia matters are anaesthetists.

Although ANZCA can provide guidance in general terms, an anaesthetist is best equipped to deal with the specific queries that patients may have. The skill of communication, which is included in the new curriculum, is paramount in achieving this goal. Failure to adequately inform patients and the community tends to drive them to seek information from other sources, in which case it should be no surprise if they acquire distorted perceptions.

Fear of the unknown is a common and real fear. Most patients facing surgery are preparing to experience anaesthesia for the first time, or are presenting for a different surgical procedure and consequently facing the unknown in each case. This fear, which is often not divulged, can be mitigated by the patient gaining some insight or understanding. If this is not forthcoming from the anaesthetist then patients will seek it from whatever source is willing to provide it.

In the above mentioned newspaper article, the author presents reasonable general advice spanning a number of issues. However, one comment typifies the lack of understanding of anaesthesia when advising on the perioperative use of supplements. The concern is in the statement “It should not interfere with the anaesthetic, but check with your nurse or doctor”.

Underlying this advice is the erroneous assumption that anaesthesia is simple enough that any nurse or doctor has sufficient knowledge to advise on anaesthesia issues and is sufficiently expert in drug interactions. The reference to “the doctor” will invariably be interpreted as either their general practitioner or their surgeon, neither of whom may be the appropriate person to provide anaesthesia advice.

Another aspect of the preoperative preparation is the previously common practice, by our physician colleagues and sometimes the patient's general practitioner, of providing gratuitous instructions.

These instructions were typically to avoid hypoxia and hypotension, particularly in the cohort of patients who were already hypoxic and hypotensive or who had a significant predisposition to hypoxia and hypotension. Then there were the occasions where patients had been instructed that they must never have a general anaesthetic while others had been instructed that they must never have a “spinal”. But the classic of them all was the assessment of fitness for anaesthesia, resulting in the conclusion that the patient was either fit or unfit for anaesthesia, without differentiating between local anaesthesia, regional anaesthesia, general anaesthesia or sedation.

The medico-legal implications are noteworthy. The risk is that when there is more than one view, but only one can be adopted, there will be debate, and generally any view that is associated with a poor outcome will be discarded. Consider an assessment where the patient is assessed by the physician as unfit for anaesthesia; however, the anaesthetist, recognising the anaesthesia risk factors, decides that it is in the patient's best interests to proceed and administers anaesthesia.

Where the outcome is good no questions are raised about the assessment of fitness for anaesthesia. However, where the outcome is poor there is no doubt that this assessment would weigh significantly in the court's decision. Similarly, for patients in whom the instruction preoperatively was to “avoid hypoxia and hypotension” but who suffered any degree of either it could be difficult to place these into perspective.

I often used to wonder about the interpretation of the “fitness for anaesthesia” assessment. Were patients deemed unfit for anaesthesia because



I was administering anaesthesia and they had to be much fitter to tolerate my technique or were they unfit for all anaesthetics by all anaesthetists? Joking aside, the ramifications of such assessments are widespread, including the impact on the patient's state of mind and anxiety, as well as the medico-legal implications.

Are these concerns sufficient to warrant action? If so, what action?

Firstly, the ongoing education of our colleagues is essential to ensure that their advice, which is greatly appreciated, is specific, and limited to the opinion sought on basic anaesthesia-related matters. Our colleagues should be encouraged to advise patients to direct more complicated anaesthesia-related questions to their anaesthetist.

Secondly, genuine communication with our patients is imperative.

I firmly believe that communication with our patients and the community contributes to educating them and to providing them with the insight and understanding they need. This not only allays anxiety but also allows for realistic expectations, and reduces the likelihood of them gaining distorted views. Furthermore, it will reduce the incidence of patients seeking information from inappropriate sources.

Finally, it could be anticipated that these measures may lead to anaesthesia being appreciated as the truly professional medical specialty that it is, and for anaesthetists being appreciated and respected as caring health professionals exhibiting empathy and professionalism.

Dr Peter Roessler, FANZCA
Director of Professional Affairs
(Professional Documents)
Melbourne

ANZCA's work overseas



Fellows and trainees may be unaware of the contribution that ANZCA has made to anaesthesia in neighbouring developing countries. Examples include developing postgraduate anaesthesia training in Papua New Guinea and assistance with training in South-east Asia and the Pacific. Professor Garry Phillips was a driving force behind many of these projects.

ANZCA continues to make an important contribution. The Overseas Aid Committee (OAC) was formed at the Christchurch annual scientific meeting in May last year and meets by teleconference at least three times a year. The main role of the OAC is to develop, oversee and implement initiatives to assist with the development of anaesthesia and pain medicine in neighbouring countries.

Coordination of development activities is very important. To achieve this, the OAC works cooperatively with the Overseas Development and Education Committee (ODEC) of the Australian Society of Anaesthetists and the Overseas Aid Subcommittee of the NZSA.

The members of the OAC are:

- Dr Michael Cooper
- Dr Roger Goucke
- Dr Roni Krieser
- Professor Kate Leslie
- Dr Wayne Morriss (Chair)
- Dr Rob McDougall
- Dr David Pescod

The following summarises some of the activities of the OAC:

1. Papua New Guinea

Australia's closest neighbour, Papua New Guinea (PNG), has a population of over six million people and health problems on a par with the poorest countries in Africa.

The University of PNG offers a one-year postgraduate diploma in anaesthesia (DA) and a four-year masters in medicine, as well as a one-year diploma in anaesthetic science (DAS) for non-physician anaesthetists. ANZCA helps by coordinating

educational visits by Australasian teachers, including an examiner visit at the end of the year. Two visits are funded by ANZCA and the remainder are funded by AusAID.

After some lean years, the DA and MMed training programs are looking more healthy. Two MMed trainees, Lisa Akelisi-Yockopua and Greg Tokwabilula, successfully completed MMed training last year. There are six registrars doing DA training and 10 registrars doing MMed training.

ANZCA has also approved funding to provide educational materials to all hospitals in PNG. Lack of educational resources and ongoing education are major problems in PNG and parts of the Pacific. While some places have reasonable internet access, many have unreliable and slow access, and computers that have been crippled by viruses or humidity!

Dr Michael Cooper and Dr Richard Morris have put together a selection of books and CDs that cover a variety of anaesthetic topics and subspecialties. The selection includes books from TALC (Teaching Aids at Low Cost) and the World Federation of Societies of Anaesthesiologists, and Dr David Pescod's book *Developing Anaesthesia*.



2. Essential Pain Management (EPM) course

We are now part way through the Global Year Against Acute Pain. Pain may be inadequately treated in Australia and New Zealand but the situation is often worse in developing countries. There are many reasons for this, including lack of staff, inadequate knowledge and unavailability of medicines (for example, oral morphine solution).

As reported in the last *ANZCA Bulletin*, Dr Roger Goucke and Dr Wayne Morriss, with the vital support of ANZCA, have been developing an interactive course for doctors and nurses called Essential Pain Management (EPM). The course aims to improve knowledge about pain, to provide a simple framework for managing pain, and to explore ways of overcoming local pain management barriers. We have also developed a short “teach the teacher” course to allow early handover of EPM to local instructors.

EPM was piloted in Papua New Guinea in April last year. Since then, courses have been run in Mongolia, Solomon Islands, PNG and components of the course have been taught in Rwanda, using funding from a variety of sources. The course has attracted the support of the World Federation of Societies of Anaesthesiologists (WFSA)

and International Society for the Study of Pain (IASP) and we are planning courses in Fiji, Solomon Islands, Vanuatu and PNG, along with Mongolia and Tanzania.

3. ANZCA International Scholarship

This scholarship has been offered by ANZCA for a number of years. It provides support for an anaesthetist from the Pacific or South-east Asia to work in a hospital in Australia or New Zealand for up to one year.

In recent years, the scholarship has not always been filled. Dr Phone Myint from Burma was able to use part of the 2010 scholarship to get experience in cardiac anaesthesia and medical perfusion at the Royal Prince Alfred Hospital in Sydney.

Registration requirements for overseas doctors have become more problematic recently, especially the requirement to pass the IELTS English language test. Passing this test is now a prerequisite for scholarship applicants. A number of overseas doctors have struggled with the IELTS test despite impressive language skills and it is important that potential applicants start the process early. Applications for the 2012 scholarship close in August 2011.

Dr Wayne Morriss

Chair, Overseas Aid Committee, ANZCA

Above from left: Newly trained Essential Pain Management (EPM) instructors, National Referral Hospital, Honiara, Solomon Islands; Dr Max Sarma (Royal Hobart Hospital) teaching EPM in Honiara; Dr Paul Wajon, Dr Phone Myint and Dr David Mawter.

Trainee workshop visits



Face-to-face meetings with trainees by ANZCA's Director of Training and Assessments, Alan Penny, have provided an important interface between the College and trainees.

The aim of the hospital workshop visits is to disseminate information about the training program and respond to questions from trainees.

The presentations focus upon the global view of the training program, drilling down to specific aspects that impede trainees' progression. Issues raised have included:

- Difficulties associated with the self-administration of documentation.
- How to interrupt the training program.
- What it means to be categorised under "basic training year extension" (BTYE).

Workshops have been held at the Royal Melbourne, St Vincent's and Canberra hospitals with one at The Alfred planned for April 8.

Further workshops are planned for South Australia in mid-March, NSW in early April, Queensland in June, the Australian Capital Territory in July with New Zealand and Western Australia still to be determined.

Presentations to regional committees on the online in-training assessment and new online annual training fee process are planned to coincide with the trainee workshops.

For further information about the workshops, please contact Alan Penny at apenny@anzca.edu.au or for trainees, via your supervisor of training.

Alan Penny
Director, Training and Assessments
ANZCA

International speakers a highlight of Hong Kong meeting

CSM 2011
HONG KONG
ANZCA - HKCA
14 – 17 May 2011



Dr Steve Yentis



Professor Mervyn Singer



Professor M. Catherine Bushnell



Professor Vincent Chan



Professor Homer Yang



Associate Professor David Scott



Professor You Wan



Professor Spencer Liu

It has been 10 years since the Australian and New Zealand College of Anaesthetists held a combined meeting with the Hong Kong College of Anaesthesiologists. Those who attended the 2001 meeting still talk of it fondly.

The regional organising committee for the Combined Scientific Meeting, 2011 has worked hard to develop a scientific and social program that will meet these high expectations – and they have done it!

The scientific program is outstanding. Professor Warwick Ngan Kee and his team have assembled a formidable range of international speakers. The advantage of a combined meeting is that we will have eight international visitors.

A short flight will allow you to listen to talks by some of the best speakers from the United Kingdom, North America, Australasia and South-east Asia.

From the United Kingdom, we have Dr Steve Yentis – an entertaining speaker with broad interests covering publication ethics, evidence-based medicine and obstetric anaesthesia, and Professor Mervyn Singer, who is an intensivist with interests in sepsis and haemodynamic monitoring.

We have Professor M. Catherine Bushnell from Canada, who will talk about imaging pain, Professor Vincent Chan who is an expert in the areas of regional anaesthesia and pain medicine,

and Professor Homer Yang, who will speak about perioperative myocardial infarction.

Professor Spencer Liu, from the United States, will speak about post-operative pain management and from Beijing is Professor You Wan who will speak on the use of acupuncture in pain medicine. Our Australasian Visitor is Associate Professor David Scott whose wide range of interests include regional anaesthesia, acute pain management, cardiovascular anaesthesia and the cognitive effects of anaesthesia.

What an impressive group of speakers!

The invited speakers are only part of an extensive program, with more than 200 anaesthetists and pain medicine specialists contributing to make our meeting as diverse as it is.

Looking through the registration brochure, I'm finding it hard to choose – will it be the update on ultrasound in clinical practice session or an airways workshop? What about a session on traditional Chinese medicine, an update on acute perioperative pain, or the chance to listen to Dr Yentis talk about author misconduct, or maybe some intensive care or paediatric refresher topics?

The program delivers choice for everyone. The poster sessions this year will be moderated and, with more than 130 submissions, the quality is

extremely good. The Gilbert Brown Prize session will be held as a Monday afternoon plenary session to encourage as many delegates as possible to attend. This is a chance to hear from our young researchers – and really, the future of our profession lies in the hands of these young researchers. No excuses about late nights with a 1.30pm start time!

The workshop and problem-based learning discussion programs offer a huge choice, including education-focused workshops for those with an interest in teaching and supervision.

I have focused on the scientific program because I believe everyone knows what a fabulous city Hong Kong is – and what a fabulous social program we will have to highlight this.

Don't wait another 10 years – register at www.csm2011.com for the 2011 Combined Scientific Meeting in Hong Kong and join the fun!

Dr Nicole Phillips
ASM Officer

Evaluation of PCA pumps

The ECRI Institute has identified the safety risks of overdose with PCA pumps as number seven on the top 10 technology hazards for 2011.

The institute recently published an evaluation of patient-controlled analgesic infusion pumps, both fixed and ambulatory, from four suppliers.

The pumps concerned were: CareFusion Alaris, Hospira Lifecare PCA, Hospira GemStar, Smiths Medical CADD-Solis, Moog Curlin Painsmart IOD, all of which are claimed to be marketed in Australia.

Criteria examined were displays, battery life, data logs, low flow continuity, accuracy, occlusion detection, air-in-line detection, alarm characteristics, programming functions, resistance to tampering, human factors, design and reliability and most importantly, drug error reduction systems (DERS) which was rated highly as a critical element in prevention of errors in drug administration.

Top rating went to the CareFusion Alaris for its powerful DERS and for the ability to monitor pulse oximetry and capnography without the need of separate monitors and with an interlock feature to stop the infusion. The Alaris also has an optional bar-code reader.

Hospira Lifecare PCA and Smiths Medical also rate well for safety features, including DERS. The Moog Curlin pumps have effective DERS but allow free flow if used with infusion sets without an anti-siphon valve. Lowest rating went to the Hospira GemStar which is a multi-therapy ambulatory pump that lacks any safety software.

Fellows wishing for further information should contact Laura Foley, ANZCA Librarian, who has full access to ECRI reports.

Dr Patricia Mackay

Communications and Liaison Portfolio
Quality and Safety Committee

The risk of an airway fire – update

Several years ago, the Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM) posted an alert regarding operating theatre fires, particularly noting the risk associated with tracheostomy (see www.health.vic.gov.au/vccamm/warnings_archive.htm).

The council has reviewed a recent case involving an airway fire during adenoidectomy-tonsillectomy. Fortunately the patient made a complete recovery from the airway injury and there were no long-term sequelae. However, the case highlights the need for anaesthetists, surgeons and all operating room staff to remain aware of the risk of fire when surgical procedures are performed on the airway.

The three elements necessary for the production of a fire are:

- A source of heat (surgical diathermy).
- A combustible substance (for example, patient tissue, surgical swab, airway device etc.)
- An oxidiser, usually oxygen or nitrous oxide.

In this particular case, the fire involved ignition of the laryngeal mask airway (LMA) during use of diathermy. The diathermy setting was 25. The inspired gas mixture was 40 per cent oxygen with air and sevoflurane.

Council did not attribute the fire to the use of an LMA and noted that previous published accounts of airway fires during tonsillectomy occurred during endotracheal anaesthesia.

Council therefore recommends that during any surgical procedure on the airway, strict attention must be given to minimising fire risk through:

- Use of the lowest inspired oxygen concentration to provide a safe level of oxygenation.

- Careful placement of the chosen airway device.
- Use of the lowest level of diathermy heat energy able to achieve haemostasis.
- Use of a suction device to vent any fume or smoke from the vicinity of the heat source (diathermy) as well as any excess oxygen containing gas from the operative field.

For a more detailed review it is suggested that there be reference to and consideration of the Health Care Safety Alert produced by the Massachusetts Department of Public Health in March 2002. The full document can be viewed at www.state.ma.us/dph/dhcq/pdfs/orfires.pdf. As indicated in the “acknowledgements” section of this document, most of the recommendations are those put forth by ECRI (formerly the Emergency Care Research Institute, which is an independent non-profit health services research agency) in their Health Devices Safety Reports. ECRI’s Medical Device Safety Reports can be viewed at www.mdsr.ecri.org.

Associate Professor Larry McNicol
Chairman, VCCAMM
(In conjunction with and endorsed by VCCAMM)



Profile: Dr Peter Roessler

I started out anaesthetic life as a staff anaesthetist at the Queen Victoria Medical Centre in Victoria and this offered opportunities to become involved in training registrars. In addition to this, there was an emphasis on research at the Queen Vic, which led to publications on computerisation of anaesthesia records (still in the early stages of development in the early '80s) as well as other clinical topics.

As an emerging young consultant intensely involved in teaching and research, opportunities arose for me to present at meetings. Through these activities, I began to develop in the Canadian Medical Education Directions for Specialists (CanMEDS) roles of medical expert, communicator and scholar.

During moments of reflection on teaching, it became apparent to me that this was only one element of education and that education was really the key to the advancement of anaesthesia. I started lecturing for courses run by the Victorian Regional Committee as well as becoming an examiner.

As chair of the Primary Examinations Committee, I participated on the College Education Committee. Immersion

in this environment of committed quality colleagues provided an arena for debate and for the introduction of changes to the examination process whereby a syllabus was created that formed a common ground for trainees, teachers and examiners, as opposed to examination questions forming the basis of knowledge expected from trainees.

It is interesting to note that "life" has a sense of humour. When I first started lecturing to trainees, in addition to lecturing on respiratory physiology, I was asked to lecture on the physiology of ageing. I thought that this was an odd topic to assign to a neonatal anaesthetist (a main area of practice at the time). However, after presenting the topic for more than 25 years, I can say that I was finally able to speak from personal experience!

The next stage of my ongoing development included the remaining CanMEDS roles of collaborator, manager, professional and health advocate, while serving on the Victorian Regional Committee as regional education officer. Clinically, I was also continuing to evolve by commencing part-time private practice, which became full-time over the next few years. During this time, the newly formed Hong Kong College of Anaesthesiologists extended invitations to participate as their external examiner in physiology, which exposed me to varying educational views held by my counterparts from the United Kingdom.

Despite a busy private practice and a growing family, the opportunity to retain College involvement came through an invitation to participate in the International Medical Graduate Specialist (IMGS) Committee and its evolution. This is a stimulating environment among committed colleagues and is most rewarding.

Finally, perspectives gained from my private practice and past College involvement led to my appointment as a director of professional affairs for ANZCA. I was allocated oversight of the professional documents, which were earmarked for a complete overhaul and which are closely related to standards for quality and safety. It was then a natural progression to participate in activities of the Quality and Safety Committee.

As I have progressed through my career, I have been most fortunate to have been involved with a great bunch of colleagues in clinical practice, on Council and the Quality and Safety Committee, as well as some great ANZCA staff. There is no paucity of challenges, and the stimulation provided, combined with the ability to be involved in the progress of anaesthesia and anaesthetists, is a reward in itself.

Dr Peter Roessler, FANZCA
Director of Professional Affairs
(Professional Documents)
Melbourne

Case report: Death following upper airway obstruction after surgical drainage of Ludwig's angina

This is a summary of an inquest conducted by an Australian coroner following the postoperative death of a young man due to upper airway obstruction. The purpose of this is to raise awareness of the possible catastrophic consequences of upper airway obstruction in the perioperative period. The intention is not to focus on individual errors but on the system errors that can take place. They demonstrate the "Swiss cheese" effect where a series of faults may line up to allow unfortunate results.

Patient X was a 31-year-old male who died following drainage of a dental abscess that had extended into the fascial spaces of the neck, resulting in Ludwig's angina.

The patient's previous health was good. He developed dental pain and visited a dentist for review. The dentist diagnosed a dental abscess and offered extraction of the affected tooth. The patient requested anaesthesia and waited four days until an anaesthetist was available. Antibiotics and pain relief had been prescribed during this time. Despite this medication, right-sided facial swelling from beneath the ear to the jaw had developed by the time he re-presented.

The patient's voice "sounded different". He was having difficulty swallowing but no problems with breathing. (*"The anaesthetist saw deviation of larynx from midline with retropharyngeal swelling. He later warned the hospital staff about airway risk and began intravenous antibiotics.*

He also checked the patient a few hours later" – personal communication with anaesthetist, February 2011). The tooth was extracted but there was no drainage from the abscess. The anaesthetist advised immediate transfer to a hospital by ambulance due to the risk of airway oedema and obstruction and accompanied the patient to the hospital. A maxillo-facial surgeon reviewed the patient that day and he was admitted to the intensive care unit (ICU).

The following morning, the patient was experiencing pain. He couldn't open his mouth properly and his voice was still affected. Drainage of the dental abscess and Ludwig's angina was booked under general anaesthesia. Before transfer to the operating theatre, the patient complained to his wife that he felt his tongue was swollen and he had difficulty swallowing. The anaesthetist noted that the patient's trachea was not in the midline due to the swelling.

Most of the anaesthetic history was obtained from the patient's wife because he could not speak. Consequently, the anaesthetist performed a nasal fiberoptic intubation under sedation prior to induction of general anaesthesia using a 6.5mm internal diameter nasal RAE tube. The size of the tube was chosen based on the degree of airway swelling present at the time.

The maxillo-facial surgeon drained 200 millilitres of pus and inserted two surgical drains. Bacteriology showed that the two antibiotics prescribed postoperatively provided adequate coverage for the infection.

The anaesthetist also arranged postoperative ventilation in ICU following surgery. He emphasised to ICU staff and the patient's wife the importance of securing the tracheal tube and wrote that he expected the tube to stay in-situ for several days. The possibility of a tracheostomy, if prolonged intubation was required, was also mentioned.

However the patient was extubated at 7am day one postoperatively. His wife arrived in ICU shortly afterwards to find her husband's face was still quite swollen on both sides with drains on the right hand side. His tongue was swollen and he was experiencing ongoing pain. The patient was transferred to a general ward in the afternoon of the same day and his family spent the day with him. His wife stated the patient required suction to clear his mouth because he couldn't swallow. However he was allocated an area in the ward away from the nurses station. The patient's wife left at 10.30pm that night.

The following day, the patient's neck was still swollen, especially on the right side and his voice was distorted. He still couldn't swallow and his tongue was swollen. During the early afternoon, the patient had difficulty coughing and swallowing though he did not show signs of respiratory distress and his pulse oximetry readings were normal.

His condition declined over the afternoon to a point where he was wheezing and developed difficulty in breathing at 3.30pm. There was a sudden episode of desaturation and the intensive care resident reviewed the patient. By the time the resident saw the patient, he had coughed up some sputum and his respiratory distress had settled. A diagnosis of "mucus plug" was made and nebulised saline was prescribed.

The nurse administered oxygen via a facemask. The maxillo-facial surgeon arrived at 4pm. The surgeon was concerned that there was severe airway obstruction present despite a pulse oximetry reading of 100 per cent. The patient at this time was distressed, tachypneic, sweating and using his accessory muscles for breathing. The surgeon indicated to the patient and his family that an urgent tracheotomy was required in the operating theatre under local anaesthesia. He asked the nurse to call for the intensivist. At this point the

patient indicated by sign language that he couldn't breathe. The maxillo-facial surgeon asked the patient's wife to call for the nurse.

His wife used the call button with no effect. She then went into the corridor to find the nursing staff. The intensive care resident arrived in seven to 10 minutes. Medical staff from the intensive care and emergency departments also attended. Bag-mask ventilation was instituted when the patient had a respiratory arrest. Direct laryngoscopy and intubation was unsuccessful.

Distortion of the neck anatomy made several attempts at a percutaneous tracheotomy unsuccessful. A surgical tracheotomy was also attempted but ventilation was difficult. At this point the patient had a cardiac arrest and advanced life support with defibrillation was started. Approximately one hour later the patient was declared dead.

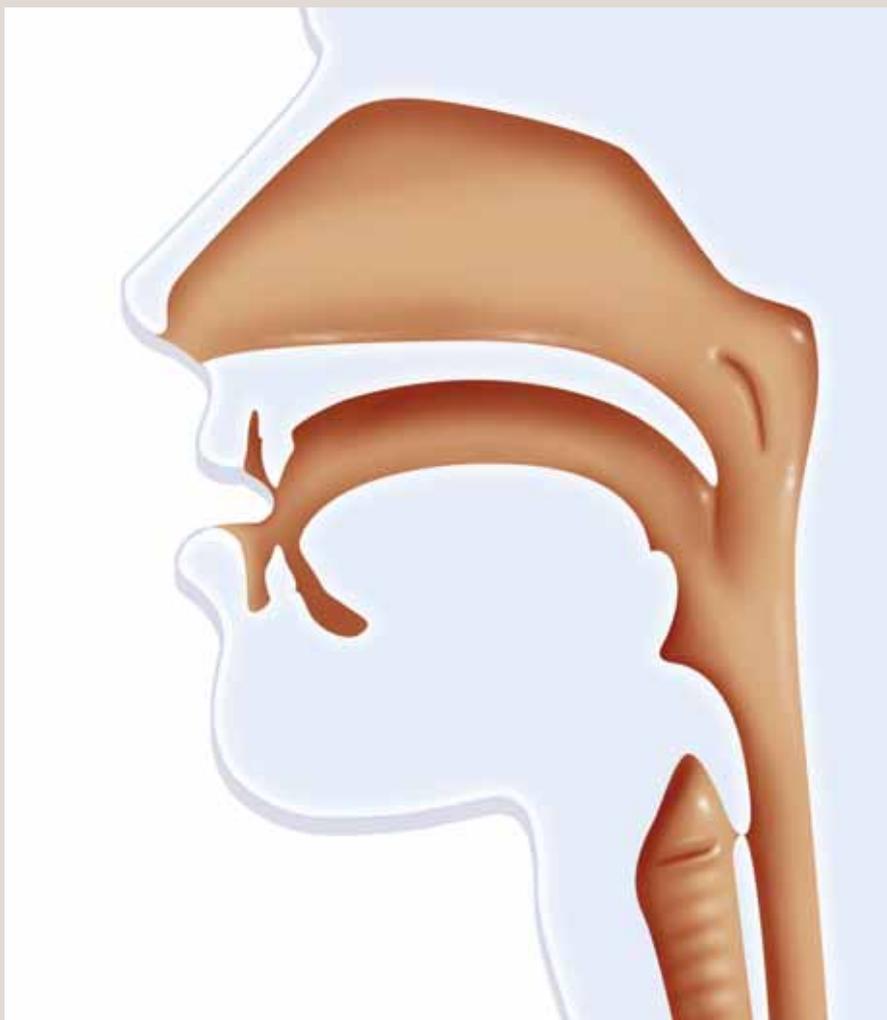
The coroner concluded that the patient died a "traumatic and frightening death" and also stated "the circumstances of his death were extremely distressing to his wife, his family and to all the medical staff who tried to save his life".

Author's comments

The purpose of this article is not to attach blame to any staff involved in this case. This scenario reflects the management of Ludwig's angina including some commonly held beliefs concerning the evolution of acute airway obstruction.

This case reinforces the fact that diagnosis of airway obstruction should be a "bedside" clinical assessment and that changes in clinical parameters such as pulse rate, blood pressure and pulse oximetry are late. Ongoing research of this and similar cases is under way with the hope of producing a clinically applicable algorithm in a peer-reviewed journal.

Finally, airway obstruction is often dynamic. Medical staff should consider possible ongoing changes as well as the



present clinical state when managing such patients. There should be a low threshold for close clinical monitoring of these patients in a high-dependency unit.

The time spent in intensive care should be equally spread so that the time spent with the patient intubated should be matched by a similar length of time following extubation. For example, a patient who is intubated overnight in ICU after surgical drainage of Ludwig's angina should be monitored for another 12 to 24 hours following extubation before transfer to the general ward.

It is likely this recommendation will meet considerable resistance in many busy ICUs.

The catastrophic outcome of these cases, however, requires their re-examination and an avoidance to trivialise their severity.

Dr Keith Greenland, FANZCA

The ANZTADC project

The mission of Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) is to improve the safety and quality of anaesthesia for patients in Australia and New Zealand by providing an enduring capability to capture, analyse and disseminate information about incidents relative to the safety and quality of anaesthesia in Australia and New Zealand.

The committee plans to release preliminary results in the *ANZCA Bulletin* and also the newsletters of the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists. Anaesthetists who are members of more than one of the tripartite organisations, may see the article containing the same results in more than one publication. Soon after publication, articles will be released on WebAIRS, the ANZTADC website.

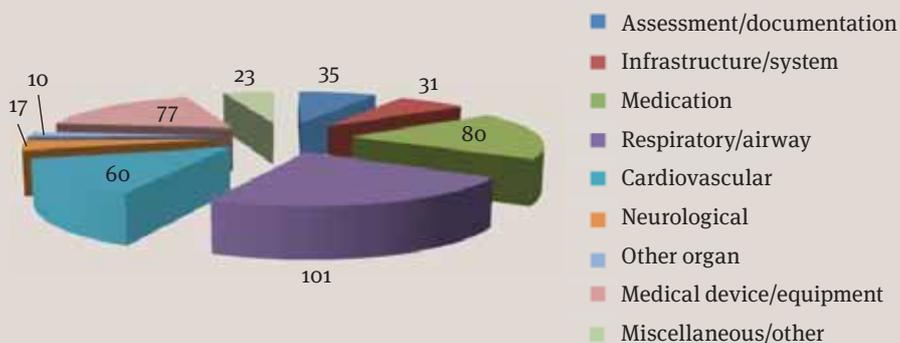


Figure: Main category coding 1/9/09 – 17/1/11

ANZTADC is a joint endeavour, funded by the ASA, ANZCA and NZSA. The figure shows the main categories for 434 incidents collected between September 1, 2009 and January 17, 2011.

The largest main categories were respiratory/airway (23.27 per cent), medication (18.43 per cent), medical devices and equipment (17.74 per cent) and cardiovascular (13.82 per cent). Each of these categories has been further subdivided. Table 1 shows a drill down analysis of cardiovascular events.

Table 1 – Drill down analysis of cardiovascular events

Sub Category	Number	Per cent
Bradycardia (sinus rhythm)	9	15%
Bradycardia (abnormal rhythm)	1	1.67%
Tachycardia (sinus rhythm)	2	3.33%
Tachycardia (sinus rhythm)	4	6.67%
Dysrhythmia (other)	1	1.67%
Myocardial ischaemia	2	3.33%
Myocardial infarction	3	5%
Cardiac arrest	7	11.67%
Hypertension	1	1.67%
Hypotension	17	28.33%
Embolism (venous)	1	1.67%
CVS trauma (unintentional surgical)	2	3.33%
Blood loss – sudden or severe	3	5%
Blood loss – more than patient blood volume	2	3.33%
Anaphylactic/Anaphylactoid reaction	1	1.67%
Other	4	6.67%
Total	60	100%

We have compared the results of the cardiac arrest subcategory with the first 2000 AIMS reports, published in 1993¹, and with a further 1000 AIMS reports, published in 2007². There were 87 cases of cardiac arrest in the first 2000 AIMS cases (4.35 per cent) and 62 in the second AIMS series (6.2 per cent). In the ANZTADC series there were seven cardiac arrests, representing 1.61 per cent of all the reported events and 11.67 per cent of the reported cardiovascular events.

This variance may reflect differences in reporting, or possibly improved management of events that may lead to cardiac arrest, such as early treatment of ischaemia, hypotension, dysrhythmias and anaphylaxis. In the first 434 incidents in the ANZTADC series there were no reports of cardiac arrest related to drug administration, hypoventilation or direct cardiac stimulation.

By contrast, in the AIMS first series of 2000 incidents there were 19 cases related to drug administration, 15 to hypoventilation, and four of direct cardiac stimulation. Vagal stimulation as a cause of asystole was seen in 57.14 per cent of the ANZTADC cases compared with 18.39 per cent in the 1993 AIMS study. A total of 28.57 per cent of the ANZTADC cases were associated with bleeding compared with 14.94 per cent of the 1993 AIMS cases.

In the ANZTADC series, there was one case of anaphylaxis, reported as a cardiovascular event but without cardiac arrest. However anaphylaxis was mentioned in the narrative in a further six cases, of which two had an increase in trypsin concentration (that is, three cases with strong evidence of

anaphylaxis and a further four with probable or possible anaphylaxis). None of these cases was associated with cardiac arrest. By contrast, in the 87 cases of cardiac arrest in the AIMS first series, six were associated with anaphylaxis. This may suggest improved early detection or improved management, and is gratifying.

Overall survival following cardiac arrest was similar, with 71 per cent of the ANZTADC series surviving, compared with 77 per cent in the first AIMS series (1993) and 71 per cent in the second (2007).

The obvious limitations of this analysis are the relatively small numbers so far. A more comprehensive analysis will be reported in due course, when more reports have been received. We expect to be able to make useful recommendations for practice at that stage.

The main purpose of this interim report is to show anaesthetists the type of information that is accumulating and to encourage them to report incidents to ANZTADC. The more reports, the more meaningful our analyses will be and the greater the chance of providing useful suggestions to improve healthcare.

If you would like to register your hospital please do so via the link on the ANZCA website or via www.anztadc.net/RegisterAccount.aspx?org=658365. The ANZTADC program is provided at no cost to Fellows of ANZCA, members of the ASA and members of NZSA.

We thank all registered sites for taking part in the ANZTADC project and for the useful feedback provided regarding the pilot.

Analysis subcommittee ANZTADC

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Continuing Professional Development

CPD tips

Dr Vincent Sperando is a consultant anaesthetist at St George and Liverpool hospitals in Sydney, where he specialises in trauma, orthopaedic and neuroanaesthesia. He has a strong interest in medical education. He regularly instructs at the Sydney Clinical Skills and Simulation Centre at Royal North Shore Hospital and is a volunteer author of the new ANZCA curriculum. He has published works of fiction.

He continues his series of articles directing Fellows, especially those in rural practice, to convenient places to collect continuing professional development (CPD) credits and offers his views on useful resources.

The aim of this third article is to direct Fellows to the resources available to collect CPD credits in Categories 3 and 4 as well as to commence the next series on general medicine. As Category 3 and 4 credits are more self explanatory and easily acquired locally, this article will briefly remind Fellows of ways of collecting credits before moving on.

Category 3 and 4 credits

As a reminder, Category 3 credits are acquired for work in practice assessment and category 4 is for educational development.

Practice assessment

Practice assessment can easily be achieved locally, even at small hospitals. Fellows can evaluate their own practice or care not related to their practice. Besides simple gatherings to discuss cases and have peer reviews, Fellows can perform audits of a part of their practice or send out patient satisfaction questionnaires.

Fellows can also use the CPD section of the College website to write reflections on interesting cases, which both acquires and documents credits.

Attending skills and simulation courses is another way of gaining points easily, but often requires Fellows to travel.

Educational development

Educational development credits are not required, but teaching and research always accrue CPD credits. Teaching credits can be accrued for giving lectures and presentations as well as for work spent as an examiner. If work-based assessment is brought in with the new curriculum, this will also accrue credits.

Any research, publication or review of manuscripts for publication also accrues credits in Category 4.

General medicine CPD articles of interest – management of essential hypertension

If you are like me, you may find it difficult to remain current with the medical treatment of the common diseases seen in our ever-ageing population.

Coincidentally, medicine was also considered to be under-represented in the ANZCA training program according to the recent ANZCA curriculum survey of Fellows.

The aim of this section and future articles is to direct Fellows to best practice guidelines in medicine where there have been significant changes and advances in the management.

For those of you not aware, the *British Medical Journal* has a website dedicated to best practice guidelines and can be found at www.bestpractice.bmj.com. From this website, you can access references for best practice guidelines for most medical conditions. Virtually all of these articles can then be accessed for free via the College's online journal resource.

The management of essential hypertension

The most recent guidelines were published in the *European Heart Journal*¹. The article, "2007 Guidelines for the management of arterial hypertension", is accredited for two hours of continuing medical education (CME) work by the European Board of Cardiology and considered to meet the quality and standards of the European Accreditation Council of CME. With such backing, reading it should easily qualify for CPD credits in Australia.

To spark your interest, I will highlight some of the recent updates and major points of the article. In no way do I suggest that this summary would be sufficient for CPD points in itself.

Definitions and classifications of hypertension have been updated in the article. Emphasis on both systolic and diastolic hypertension has been recommended and evidence is presented to support that both were similarly

predictive of stroke and coronary mortality. For middle-aged and elderly patients, pulse pressure showed a strong predictive value for cardiac risk.¹ There is also the introduction of isolated systolic hypertension as a unique entity with its unique risk, especially in the elderly.

Searching for subclinical organ damage continues to be emphasised, in particular microalbuminuria and left ventricular hypertrophy. Retrospective analyses of prospective trials have shown that treatment-induced reductions in proteinuria and left ventricular hypertrophy are accompanied by reduced incidence of cardiovascular events.¹

The decision to treat hypertension would appear straightforward as it translates into significant reduction of cardiovascular morbidity and mortality.¹ These benefits are across ethnic groups and gender. More intense blood pressure lowering may be of benefit for some subgroups, in particular diabetic patients. Other benefits are also discussed in the article.

Still, the decision to initiate medical treatment is complex. The decision takes into account risk factors, blood pressure readings and special circumstances such as diabetes and metabolic syndromes. Lifestyle changes are always part of any management and include smoking cessation, weight reduction, reduction of excessive alcohol intake, exercise, reduction of salt intake, increased fruit and vegetable intake and decreased saturated and total fat intake.¹

The choice of antihypertensive drug is an important factor to maximise benefits.¹ Several articles are referenced to justify the authors' recommendations. Less emphasis has been given in the article to the first choice of drug, as most

patients requiring medical management will require more than one drug. The avoidance of classes of drugs with certain diseases remains important.

Key suggestions for consideration are:

- A previous favourable/unfavourable past experience with a drug.
- The effect of the drugs on cardiovascular risk factors in relation to the cardiovascular risk profile of the individual patient.
- The presence of subclinical organ damage/cardiovascular or renal disease/diabetes.
- The presence of pregnancy or diseases such as asthma or heart block, may limit choice.
- The possibility of drug interactions for those being treated for other diseases.
- The cost of the drug.

Some common diseases, previous events and various conditions with the preferred drug treatments are as follows:

- Left ventricular failure – angiotensin converting enzyme inhibitors (ACEI), calcium antagonist (CA), angiotensin receptor blockers (ARB).
- Renal dysfunction and microalbuminuria – ACEI, ARB.
- Previous myocardial infarction (MI) – beta-blockers (BB), ACEI, ARB.
- Heart failure – diuretics, BB, ACEI, ARB.

Some drugs to avoid with certain diseases are as follows:

- Gout – thiazides.
- Asthma/atrioventricular block – beta-blockers.
- Atrioventricular block/heart failure – calcium antagonist (verapamil/diltiazem).

- Pregnancy/hyperkalaemia/angioneurotic oedema/ bilateral renal artery stenosis – ACEI.
- Pregnancy/hyperkalaemia/ bilateral renal artery stenosis – ARB.
- Renal failure/hyperkalaemia – diuretics (antialdosterone).

Understanding the medical management of patients when they are out in the community should make it easier for us to continue their treatment during the peri-operative period and hopefully maximise the benefits these drugs have to offer.

I hope I have sparked your interest with a hint of the complexity of the treatment of essential hypertension. I would encourage all Fellows interested in medicine to read this quarter's highlighted article.

Dr Vincent Sperando, FANZCA
New South Wales

Reference

1. Guidelines for the management of arterial hypertension. *European Heart Journal* 2007;28: 1462-1536.

The Medical Board of Australia requirements for continuing professional development

The ANZCA Council was fortunate to be addressed by Dr Joanna Flynn, President of the Medical Board of Australia (MBA), at the February Council Meeting. She reiterated the MBA's expectation that all medical practitioners registered as specialists will meet the standard of continuing professional development (CPD) as set by the relevant Australian Medical Council (AMC) accredited College. ANZCA mandated CPD for all Fellows in January 2009.

The MBA deems ANZCA responsible for defining the standard of CPD expected of specialist anaesthetists. Specialist anaesthetists may complete programs other than ANZCA's (including individually tailored programs) but, if audited by the MBA, will be expected to demonstrate that those programs comply with the standard set by ANZCA.

The MBA will automatically audit the CPD of any specialist practitioner

who is the subject of notification to the board. Otherwise, the MBA will only audit practitioners as part of a regular, random audit process. Practitioners who have indicated that they are completing an appropriate level of CPD but are unable to demonstrate this during an MBA audit face the prospect of disciplinary action by the MBA. ANZCA will continue to monitor the CPD compliance status of its Fellows but is not required to notify the MBA of non-compliant Fellows.

The MBA has stated that anaesthetists who have commenced purely non-clinical practice (for example, teaching or administration) but wish to remain registered as specialists will be expected to complete the same CPD requirements as other specialists. Otherwise, the MBA CPD requirements for anaesthetists moving from clinical to non-clinical practice are still being clarified (the current ANZCA CPD program does address the requirements of this latter group of practitioners).

Further information regarding the MBA CPD requirements can be found at www.medicalboard.gov.au. The ANZCA CPD department can be contacted on + 61 3 8517 5323.

Dr Rodney Mitchell
CPD Officer
Chair, CPD Committee

New year online access difficulties

Fellows attempting to access their 2008-10 triennium continuing professional development (CPD) online portfolio in January were unable to do so.

Participants are granted a "grace" period in the year following the end of the triennium during which they can complete data entry. The grace period now extends until March 31 of each year.

However, because 2008-10 was the inaugural triennium of the new CPD program, the program did not allow retrospective access once the new triennium had commenced.

The situation has been addressed and retrospective access has been enabled. The CPD department recognises that many Fellows experienced considerable angst during this period and apologises for this.

For further information, please contact the CPD unit on + 61 3 8517 5323.

Dr Rodney Mitchell
CPD Officer
Chair, CPD Committee



The involvement of anaesthetist, Dr Bryce Curran, in the heroic on-site double amputation of a man trapped in the Pyne Gould building in Christchurch following the February earthquake attracted several media reports.

Dr Curran was interviewed by the *Sunday Star Times*, the *Dominion Post*, the *New Zealand Herald* (with reports picked up by *The Australian* and *Weekend Australian*), TV3 and by Dr Sally Cockburn on 3AW's "Talking Health" program following the distribution of a media release by Susan Ewart, ANZCA's Communications Manager, New Zealand.

The main subject of the two-hour "Talking Health" program was Dr Malcolm Hogg, the head of Pain Services for Melbourne Health, who was interviewed at length by Dr Cockburn on Sunday February 27, 2011.

The remarkable story of Adelaide anaesthetist Dr Waleed Alkharajy, which was featured in the December *Bulletin*, also attracted much media attention, due in part to a sad coincidence in timing.

The media release describing Dr Alkharajy's arrival in Australia on a wooden fishing boat after fleeing Iraq 15 years ago was distributed the day after the Christmas Island tragedy in which more than 30 people seeking asylum in Australia died when their wooden boat smashed on rocks.

Dr Alkharajy was interviewed on radio 2UE in Sydney, the Channel 10 news shown throughout Australia and on the drive programs of ABC News Radio and 3AW in Melbourne. He was also interviewed for online news site The Punch.

As a result of the same media release, Dr Morne Terblanche was interviewed on ABC Radio National's "Life Matters" program about how Bundaberg Base Hospital has recovered and rebuilt following the Jayant Patel scandal.

More recently, the "Anaesthesia – too much of a good thing" meeting in Hobart from February 18-20 attracted widespread media coverage. Following the distribution of a media release, Associate Professor David Story was interviewed about the REASON study, Dr Mark Alcock about a Launceston General Hospital audit and Dr Nico Terblanche about ultrasound-guided epidurals.

A report on ABC TV in Hobart was also picked up on ABC TV in Sydney, Melbourne and Perth and then the next day on ABC radio in Perth (twice) and three times during the day in New Zealand on TVNZ. There were also reports from the meeting in Hobart's *Mercury* and *The Examiner* in Launceston.

The media releases and media coverage can be seen on the ANZCA website at <http://www.anzca.edu.au/news/media-centre/> under "Media activity – 2010".

Inaugural ANZCA Media Award

Earlier this year, the Communications Unit launched the inaugural ANZCA Media Award. A prize of \$5000 will be awarded for the best news story or feature about anaesthesia or pain medicine that appears in print, on radio, on television or online in Australia or New Zealand in 2011.

The aim of the award is to raise community awareness of the vital role played by anaesthetists and pain specialists. Media kits with conditions of entry details, an entry form, a poster and the *About ANZCA* booklet have been mailed to health and medical journalists, news rooms and program directors throughout Australia and New Zealand.

Clea Hincks

General Manager, Communications

Amputating as earth shook

THE DOCTOR who amputated a man's leg inside the remains of the Pyne Gould Corporation building had to operate in an anaesthetist's clinic the structure around him.

Christchurch Hospital specialist anaesthetist Dr Bryce Curran spoke out yesterday, revealing the procedure was done in the dark, lit only by torches held by firefighters.

"There wasn't a lot of space to move around him, and it was dark. We had to work by torches held by the officers," he said.

He was on a day off when the quake struck, but rushed into work and was sent to the collapsed PCC building.

Curran and Australian otolaryngologist Dr Lynda Johns Patra – in Christchurch for a conference –

went in with firefighters and found the man pinned under concrete. "A team decision was made to go in and amputate his lower limb so he could be rescued. There was no way he could be lifted out other wise – it was far too dangerous to try to move the concrete."

"I was able to administer an anaesthetic drug until the man was unconscious and then the web team and I amputated his leg using a Leatherman knife and a hacksaw supplied by the Fire Service. It was a team effort. All three of us were working on adrenaline, though it was nerve-racking because there was an afterlock while we were operating. I was assisted in that by Dr Stuart Philip, a Brisbane surgeon who had

worked with the ambulances," Curran said.

The man – known only as Brian – survived, had further surgery and was transferred to Waikato Hospital, where he is doing well.

His wife said: "We don't care about the legs. He is alive, we will carry on."



Hero doc: Bryce Curran



Media releases distributed by ANZCA (since mid-December)

"Christchurch earthquake – anaesthetists story"

(Saturday February 26, 2011)

"Tasmanian doctors discuss childbirth pain relief and research on elderly"

(Friday February 18, 2011)

"ANZCA *Bulletin* out today (Asylum seeker anaesthetist; Bundaberg post-Patel; opioid controversy)" (Thursday December 16, 2010)

Since mid-December, ANZCA has generated...

31 print and online stories

5 radio interviews

2 radio news stories

15 television reports



Single medical college

The concept of a single medical college for New Zealand, with different disciplines such as anaesthesia and faculties within it, is gaining traction with officialdom. The Executive Chair of Health Workforce New Zealand (HWNZ), Professor Des Gorman, raised the concept at the end of last year, both in comments and in an article in the December 2010 issue of *Medical Council News*.

ANZCA's New Zealand National Committee (NZNC) will not finalise its position until HWNZ produces a formal consultation paper defining the problem to which it sees a single medical college as a solution. However, NZNC members did consider the concept in general terms ahead of the Council of Medical Colleges (CMC) February meeting and its own meeting on March 4 and the general view is that ANZCA New Zealand gets very good value out of its association with its Australian colleagues and would struggle to provide the same level of service and training on its own.

Professor Gorman has called on the medical profession to debate the matter and New Zealand's Minister of Health, Mr Tony Ryall, also raised it when he met with ANZCA's NZNC Chair, Dr Vanessa Beavis and ANZCA councillor Dr Leona Wilson on February 15.

In his December article, Professor Gorman said that "the nexus we have with Australia through the Australasian colleges largely serves an Australian purpose". He called for debate of a unified New Zealand college, with distinct disciplinary academies managing the training and continuing education of the "various medical tribes", though with some continuing access to the scholarship and programs of the Australasian colleges.

The general stance at the CMC meeting, most of whose constituents are trans-Tasman colleges, was to adopt a "wait and see" approach pending a formal proposal from HWNZ.

Roadshow

With her visit on March 2 to Grey Base Hospital, NZNC Chair Dr Vanessa Beavis completed the ANZCA New Zealand 2010-2011 roadshow – a sterling effort of 26 visits to hospitals throughout New Zealand between October 2010 and March 2011. In February, she made four visits within a week – to hospitals in Nelson, Blenheim, Hastings and Gisborne.

In her presentations, Dr Beavis spoke about the College, its work, recent changes and the political climate within which it has to operate. At each meeting, she also invited questions and discussion of the issues those attending saw as important. Dr Beavis emphasised how anaesthetists can assist with building a better understanding of their work during their everyday encounters with patients and their families.

Where possible, questions were answered at the time or followed-up after each meeting. However, general themes emerged including the new in-training assessment (ITA) and workplace-based assessment (WBA) processes for trainees; the need to ensure

medical students get more exposure to anaesthesia; the need for the College to lobby against anaesthesia being devolved to far less qualified alternative providers and to promote better understanding of the extent of the anaesthetist's role; the need for better understanding of the path to vocational registration and fellowship for IMGs; the need to better promote the benefits of gaining and maintaining fellowship; and the desire for more co-operation between rural and urban hospitals to help overcome educational and staffing shortages in rural hospitals.

The NZNC is looking at how it can respond to these needs.

The roadshow stemmed from a NZNC decision in March last year that there should be a countrywide tour of hospitals across New Zealand. It also gave expression to ANZCA's key initiative in its 2010-12 strategy of increasing engagement with the College's members.

Above from top: Dr Vanessa Beavis at Hawke's Bay Hospital in Hastings; attendees at a roadshow in Gisborne.

NZ's °rst national perioperative mortality review

New Zealand's new Perioperative Mortality Review Committee (POMRC) is working towards its inaugural report, due to be released in July. The report will provide the first truly national snapshot of perioperative mortality in New Zealand.

POMRC was established in mid-2010 but recent legislative changes have placed it within New Zealand's Health Quality and Safety Commission, which is chaired by ANZCA councillor Professor Alan Merry. New Zealand's other ANZCA councillor, Dr Leona Wilson, is the POMRC's deputy chair.

The committee is responsible for reviewing deaths following any invasive procedure and deaths that have occurred following anaesthesia. Specifically, perioperative mortality deaths include deaths after an operative procedure within 30 days, or after 30 days but before discharge from hospital to home or a rehabilitation facility, or while under the care of a surgeon in hospital even though an operation was not undertaken.

An "operative procedure" is defined as any procedure requiring anaesthesia (local, regional or general) or sedation. Gastrosopies, colonoscopies, and cardiac or vascular angiographic procedures (diagnostic or therapeutic) are included in this definition.

Once the data has been collected and analysed, the committee will make national recommendations on how perioperative mortality rates can be understood and reduced, taking a whole-of-system approach. Developing strategic plans and methodologies to reduce mortality and morbidity is a key role of the committee.

POMRC's first report will look at the approximately 2900 deaths in 2009, with a focus on the 400 or so deaths associated with elective surgery. The reports will be available publicly, and will contain collated, non-identifiable data on the deaths. Each year's report will contain an overview of all perioperative deaths, with a detailed analysis of a particular category of deaths.

Specific legislation protects the privacy of individual cases and Dr Wilson says health providers should be comfortable with the extent of the protection of information and those who provide it.

NZNC strategy and lobbying

At its March 4 meeting, the New Zealand National Committee (NZNC) voted to develop a strategic communications and lobbying plan to advance its position on key issues facing New Zealand's anaesthetic community. Most issues are workforce related, with a major threat being government pressure to "do more with less", most probably through less-qualified providers.

The NZNC position is that anaesthesia is a medical speciality and, for the safety of the public and quality of delivery, it is essential that it remain the preserve of doctors fully trained and qualified in the practice of anaesthesia. Underlying messages relate to the role of ANZCA in setting and maintaining standards of practice and the role of the anaesthetist in the wider perioperative setting.

The committee voted to instigate a strategy and lobbying campaign to ensure that anaesthesia remains a medical specialty and to maintain and improve its current high standards of quality and safety. It will establish a small working group to spearhead work on the campaign and will commission specialist advice to help develop and implement its plan.



Ministerial meeting

A wide range of issues was discussed when NZ National Committee Chair, Dr Vanessa Beavis, ANZCA councillor, Dr Leona Wilson, and ANZCA NZ's Executive Officer, Ms Heather Ann Moodie met with New Zealand's Minister of Health, Mr Tony Ryall, pictured, on February 15.

The minister was particularly interested in hearing about the roadshow initiative, where Dr Beavis has addressed anaesthesia departments throughout the country, and the issues it raised. Also discussed were ways in which larger district health boards can support the smaller boards and ways in which the College can provide smaller centres with continuing medical education.

Other topics were supply and demand for anaesthesia services, quality and safety matters, HWNZ initiatives and their impact on training, the need for general medical training to include exposure to anaesthesia and the single medical college concept. On the matter of alternative providers, Dr Beavis reinforced the principle that the delivery of anaesthesia must remain a medical task.

Advanced Trainee Scheme (ATS)

Anaesthesia is one of the specialties for which Health Workforce New Zealand (HWNZ) is seeking candidates under its Advanced Trainee Scheme, which has now been rolled out nationally. HWNZ accepts applications on an ongoing basis, with a maximum of 25 new trainees each year.

The scheme provides a scholarship to assist advanced medical trainees to study overseas in a medical specialty for which there is a shortage of specialists. It guarantees the trainees a job back in New Zealand, to which they are bonded for a period.

To be eligible, trainees require a career plan and a commitment from their medical college and district health board or employer with a specified guaranteed job on return. They must be willing to work in an identified regional area of workforce need.

The aim is to ensure that trainees with excellent potential have the opportunity to benefit from overseas experience, while the New Zealand health sector has the opportunity to benefit from that experience.

For further information, see <http://healthworkforce.govt.nz/working-in-health/medical-workforce/advanced-trainee-scheme>.

BWT Ritchie Anaesthesia Scholarship 2011

Nominations for the BWT Ritchie Anaesthesia Scholarship 2011 close on June 30. The scholarship is open to New Zealand-based ANZCA, CICM and FPM trainees and Fellows who have passed their final examinations for fellowship and who are eligible to proceed to training year five, or wish to take a further year of study outside New Zealand in the year following completion of their fellowship. The 2011 scholarship is valued up to \$25,000. Candidates must be nominated and supported by their training department. For an information pack, email Rose Chadwick (nzaec@anaesthesia.org.nz) or download it from the NZAEC website at www.anaesthesia.org.nz/nzaec.



Two visiting lectureships in 2011

The NZ Anaesthetic Education Committee (a joint ANZCA-NZSA committee) has awarded two visiting lectureships for 2011 – to Dr Francois Stapelberg of Auckland (above) and Dr Chris Jephcott of Hamilton (above right).

The doctors will each present their nominated lectures to two regional hospitals. The lectureships are intended to promote sharing of knowledge and experience through outstanding presentations among anaesthetic departments and practices.

Dr Stapelberg was nominated by Dr Alan McLintic for “his enthusiastic drive throughout the years to temper our blasé attitude to the potential for anaesthetic toxicity in brain tissue”. Dr McLintic notes that Dr Stapelberg presents his research in a clear and entertaining way, providing insight into the intricacies

and myths connected with anaesthesia, post-operative cognitive function and the topical subject of Alzheimer’s disease. Dr Stapelberg’s lecture is entitled “Anaesthetics are toxic to vulnerable young and old animal brains. What does that mean to your patients?”

Dr Chris Jephcott was nominated by Dr Cameron Buchanan for his presentation on the topic of “Novel strategies for ward-based procedural sedation”. In his lecture, Dr Jephcott describes how he and his team have introduced techniques related to the management of safe and effective analgesia for painful procedures outside the operating theatre. Dr Buchanan notes that implementing these strategies has led to significant resource saving, improvements in efficiency and, most importantly, to significant improvements to managing, in a safe and effective way, ward-based patients requiring painful procedures.



Preliminary competence inquiry (PCI) pilot

On February 1, the Medical Council of New Zealand (MCNZ) began a 12-month pilot of a preliminary competence inquiry (PCI) process.

A PCI is used when concern is raised about a doctor's competence but there is insufficient information on which the MCNZ could base a decision. The PCI will involve an interview of the doctor by a member of the council's Performance Assessment Committee. The interviewer will report to the complaints triage team on the doctor's areas of strength and weakness but not make recommendations. If concerns remain, the PCI report will go to a council meeting, together with any written response from the doctor concerned, and the council will decide whether a performance assessment is required.

At the end of the pilot, the complaints triage team and the council members will evaluate the PCI based on their experience and on the data collected from the interviewers and doctors during the pilot. The main questions that the pilot will be seeking to answer are whether a PCI is a worthwhile step in the performance process and whether the information obtained through the PCI better enables the council to decide whether a doctor should undergo a performance assessment.

MCNZ registration policy

The Medical Council of New Zealand (MCNZ) is reviewing its policy on registration within a special purpose (postgraduate training) scope of practice, which provides registration for doctors wishing to train in New Zealand to obtain knowledge and skills to take back to their own country (or the country sponsoring them).

The council is concerned that sometimes this registration pathway is used for purposes other than those intended, causing difficulty for trainees, their employers and the MCNZ. It notes that the scope of practice is not intended as a pathway to permanent registration, or to be used primarily for service provision, or to allow registrants to undertake a vocational training program.

MCNZ is proposing changes to clarify the purpose of the pathway.

In line with the changes, the MCNZ is proposing to add to the admission criteria for IMG postgraduate trainees applying to undertake the NZREX clinical exam, that the doctor must not already hold registration within the special purpose (postgraduate training) scope.

New South Wales



Supervisors of training meeting

The first NSW supervisors of training meeting for 2011 was held in the NSW College offices in Crows Nest on February 25.

The meeting covered issues such as the curriculum review, trainee issues and the online in-training assessment process.

Following the meeting, the NSW regional education officer, Dr Natalie Smith, facilitated a workshop on standard setting and the use of educational standards in assessment.

Supervisors of training described and diagnosed various trainee problems using a variety of tools. The steps involved in making a decision about the standards of trainees were explored in detail, as were expectations of the different training years.

The meeting also discussed the difficulties in making these decisions and setting over-arching acceptable standards.

Above from top: Dr Natalie Smith, NSW REO, facilitating a workshop; Dr Phil Byth, Dr Natalie Rogoff, Dr Alan Rubinstein and Dr Sacha Muller Botti.

Part 2 refresher course

The NSW Regional Committee conducted a successful part 2 refresher course in anaesthesia at Royal Prince Alfred Hospital from February 21 to March 4. The course enabled candidates sitting for the final fellowship examinations a greater understanding of anaesthesia. The course included seminars, panel sessions, demonstrations, lectures and informal tutorials. A highlight on the last day was the anatomical workshop held at Department of Anatomy and Histology of the University of Sydney, which enlisted the help of seven lecturers in a hands-on workshop. A special thanks to all the speakers who devoted their time and effort in assisting the candidates to prepare for their final examinations, especially Dr Tim McCulloch and Associate Professor Gregory Knoblanche.

Above: Participants at the part 2 refresher course in anaesthesia.

South Australia and Northern Territory



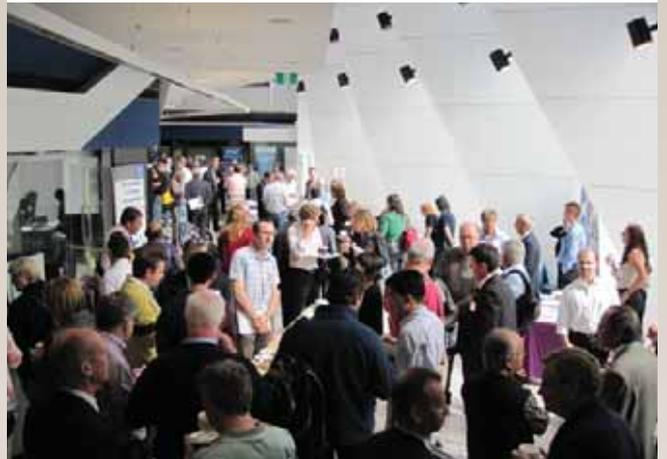
Part 0 induction course

On January 29, a part 0 induction course was held at the ANZCA's South Australia and Northern Territory office for trainees commencing the ANZCA rotational training scheme in February. The course covered topics such as the roles of ANZCA, the Australian Society of Anaesthetists and the Group of Australian Society of Anaesthetists Clinical Trainees (GASACT), trainee welfare, the role of supervisors of training, ANZCA-accredited hospitals, training modules, formal projects, examinations, the part 1 long course and in-training assessments. The course is facilitated by the SA and NT Trainee Committee and receives excellent feedback from new trainees. It was wonderful to have the ANZCA formal projects officer Dr Simon Jenkins, rotational trainee deputy supervisor Dr Kenneth Chin and trainee welfare officer Dr Marion Andrew on hand to present and answer questions.

Above: The new trainee group from left: Dr Rick Champion, Dr Scott Graham, Dr Sam Lumb, Dr Alexandra Bull, Dr Jim London, Dr Eddie Khoo, Dr Melissa Jusaitis, Dr Div Kumar, Dr Rachelle Augustes, Dr Jennifer Lim and Dr Marnie Calvert.

Above right from top: Morning tea at the Art of Anaesthesia meeting; Dr Michael Fong presents at the meeting.

Australian Capital Territory



Meetings update

The Art of Anaesthesia meeting was held on the first weekend of March and was chaired and organised by Professor Thomas Bruessel. Entitled "Pushing the limits of day surgery and operating room efficiency", the meeting was opened by the presidents of ANZCA and the Australian Society of Anaesthetists, Professor Kate Leslie and Dr Andrew Mulcahy. It contained the usual provocative elements with talks from international and local speakers that were very well received. Registrants numbers were pleasing and feedback was positive. Thanks to Alison Inglis, the ACT Regional Coordinator, for her efforts.

A registrar workshop with Dr Annie Bartlett was held at the ACT regional office on February 11. Having covered viva technique and preparation last year, the focus this year was on more general approaches to examinations and coping with the fallout in the event of failure. The attendance was excellent, reflecting the value of such sessions.

Western Australia



New roles in WA

Western Australia has a new regional education officer (REO), Dr Jodi Graham, from Sir Charles Gairdner Hospital (SCGH) and a new deputy REO, Dr Jay Bruce from Fremantle Hospital. Dr Steve Myles from SCGH is staying on as the rotational supervisor. Thank you to the outgoing REO, Dr Suzanne Bertrand, and deputy REO, Dr Soo-Im Lim who have done an exceptional job over the past few years coordinating the WA Rotational Training Scheme.

The Group of Australian Society of Anaesthetists Clinical Trainees (GASACT) part 0 course for new trainees was held at the WA office on February 3. Topics included the welfare of trainees, the training program and modules, the role of ANZCA and its Trainee Committee, the role of the ASA and the GASACT Committee, College paperwork and the part 1 exams and beyond. Fifteen trainees and their partners attended the evening. The course convenor was the WA GASACT Senior Chair, Dr Kevin Hartley. Thank you to the presenters, who included Dr Graham, Dr Irina Kurowski, the welfare officer from SCGH, Dr Prani Shrivastava, and advanced trainees, Dr Vanessa Percival and Dr Hartley. Thank you also to Dr Myles and Dr Bruce.

Advanced trainees who are about to sit their final exams were given the opportunity to attend a "Stress less" course on January 29 and February 5. This course was organised by the ASA and was presented by Dr Dennis Hayward. The feedback from the participants was overwhelmingly positive. Thank you to Dr Hayward.

The WA Autumn Scientific Meeting will be held on Saturday March 19. The meeting will be held at the University Club of Western Australia and is entitled "Anaesthetic disasters – cause and prevention". The meeting convenor is Dr Angela Palumbo from SCGH. The plenary speaker is Professor Jan Davies from Canada and her presentation is entitled "Disasters in anaesthesia – a human factors approach".

Above from left: Dr Jay Bruce; Dr Jodi Graham.

Tasmania



Tasmanian meeting

The annual Tasmanian combined ANZCA/Australian Society of Anaesthetists (ASA) meeting was held in Hobart from February 18-20. The theme was "Too much of a good thing".

Our invited speakers, Professor Kate Leslie and Associate Professor David Story, spoke on perioperative mortality, as well as the effects of over-anaesthetising patients. We had five registrar talks, with Dr John Carney being awarded the \$500 ASA registrar talk prize for his presentation on "Paediatric TAP blocks".

We also enjoyed media coverage from ABC television, as well as the local newspapers who were particularly interested in Dr Nico Terblanche's talk "The use of ultrasound for epidural insertion".

The meeting attracted 70 registrants and 19 trade exhibitors, with two major sponsors. We were pleased to have Fellows from interstate and New Zealand attending the meeting.

The meeting for 2012 will be held in Launceston in February as the ASA National Conference will be held in September in Hobart.

Dr David Brown
Convenor

Above from top: Associate Professor Marcus Skinner and Dr Mark Alcock; delegates at the meeting.

Victoria



Orientation to anaesthesia

The annual Victorian Orientation to Training seminar was held at the College on March 4. Trainees new to the specialty came to meet College staff, rotational supervisors and other trainees.

Topics covered included educational and other resources available through the College library and website, tips on preparing for the primary exam, making the most of the first year of training, the museum and welfare issues.

Feedback from the trainees was very positive and special thanks to Daphne Eler, Minh Lam, Laura Foley and Ian Collens from the College, Drs Rod Westhorpe, Abhay Umraniyar, Jamie Smart, Brad Hockey, Roman Kluger, Richard Barnes, Andrew Jones, Tony Leaver and Amanda Young (Fellows) and the trainee representatives, Drs Michelle Spencer, Kushlani Stevenson, Kym Saunders, Samantha Bigg, Michelle Gerstman, Jun Keat Chan, Ravi Ramadas.

Dr Richard Horton

Convenor and regional education officer

Victorian part 0 course

The Victorian part 0 course was held at ANZCA House on Saturday March 5. The course was designed to help prepare first-year trainees to move beyond level-one supervision.

Topics covered included a guide to planning cases, equipment disasters, an approach to managing unexpected difficult airway problems, an introduction to epidural anaesthesia and welfare issues.

The event was a great success and plans are under way to enhance the course next year.

Special thanks to Daphne Eler and Minh Lam from the Victorian Regional Committee and the doctors who gave their time on a Saturday to provide their expertise – Dr Ainslie Murdoch, Dr Amutha Samual, Dr Nick Chrimes, Dr Jane Anderson, Dr Amar Singh-Jangi, Dr Amanda Young, Dr Michelle Spencer, Dr Dean Dimovski, Dr Maggie Wong and Dr James Griffiths.

Dr Richard Horton and Dr Amar Singh-Jangi

Convenors

Above from left: Victorian rotational supervisors panel for the Orientation to Anaesthesia; Facilitators of the part 0 course from left, Dr Amanda Young, Dr Michelle Spencer, Dr Richard Horton, Dr Nick Chrimes, Dr Amar Singh-Jangi and Dr Jane Anderson.

ANZCA Council meeting report

February 2010

Council approved a motion of condolence to the Fellows, trainees and staff who have suffered in the recent disasters in Australia and New Zealand. Council's thoughts are with these colleagues and their affected communities.

Deaths of Fellows and trainees

Council noted with regret the deaths of the following Fellows:

- Dr Allan Metcalfe Hall (Vic), FANZCA 1992, FFARACS 1959
- Dr Roland John Wilson (NZ), FANZCA 1992, FFARACS 1986
- Dr Geoffrey Perkins, (QLD), FANZCA 1992, FFARACS 1986

College awards and election

- Dr Walter Ross Thompson (WA) was awarded membership of the Order of Australia (AM) in the general division, Australia Day Honours.
- Dr John Francis Oswald (VIC) was awarded the Medal of the Order of Australia (OAM) in the general division, Australia Day Honours.
- Admission to fellowship by election via application (regulation 6.3) was awarded to Dr Britta Sylvia Regli-von Ungern-Sternberg.
- Professor Kate Leslie was re-elected as president of ANZCA for the period May 2011 to May 2012, and was elected chair-elect of the Committee of Presidents of Medical Colleges (CPMC) commencing November 2011 for two years.

Quality and safety

The College formally endorsed the Australian Commission on Safety and Quality in Health Care publication *National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines* and related resources, which are to be promulgated on the ANZCA website and in the *Bulletin*.

Education and training Curriculum Redesign Steering Group – progress report

Council was provided with a series of recommendations from the Curriculum Design Working Group and the Education and Training Committee about the curriculum redesign. Recommendations for a new curriculum structure and revised timeline were approved.

Council agreed that the College will work towards implementing the new curriculum from the start of the 2013 training year, with transition arrangements for those already in the training program to be determined soon to ensure adequate notice for trainees and supervisors.

The next stages of the project will include consultation with key committees, as well as the staff units within the College, which will be responsible for developing the resources and infrastructure required for the new curriculum. Regular updates will be provided to Council and to Fellows and trainees in the *ANZCA Bulletin* and *ANZCA e-Newsletter*, as well as on the website.

Internal affairs

ANZCA Council – terms of reference (TOR)

Council approved terms of reference for the following committees that report directly to council: the Executive Committee, Education and Training Committee (ETC), Training Accreditation Committee (TAC), Continuing Professional Development (CPD) Committee, Fellowship Affairs Committee (FAC), Quality and Safety (Q&S) Committee, Research Committee, New Programs Committee, Internal Medical Graduate Specialist (IMGS) Committee, Finance, Audit and Risk Management (FARM) Committee and ANZCA Trainee Committee.

The aim is to streamline both council and committee work by clarifying the purpose of and arrangements for committees, particularly to define which functions are delegated to committees (and report through to council) and which require council approval.

The TOR will function as working documents for committee chairs, committee members and staff to assist with day-to-day running of committee business and to ensure standardisation of processes such as voting.

The TOR have been placed on the ANZCA website and are to be reviewed every three years, with amendments brought to council for approval.

Fellowship affairs

Council approved the nomination made by the regional organising committee to appoint Associate Professor Kelvin M Kong as the orator for the College Ceremony at the 2012 Perth ASM.

Professional documents

Guidelines for the selection of trainees

The “Guidelines for the selection of trainees” is to be developed into a professional document according to the process outlined in ADP1. Dr Patrick Farrell (NSW) has been appointed to chair the Document Development Group (DDG), with the membership to be determined by council on advice from the ETC.

PS40 Policy for the Relationship Between Fellows, Trainees and the Healthcare Industry and T3 Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice

These were approved by Council and are on the ANZCA website.

PS28 Guidelines on Infection Control in Anaesthesia

Council has endorsed the establishment of a document development group, comprising Dr Margie Cowling (SA), Professor Paul Myles (Vic), Dr Mark Reeves (Tas) and Dr Peter Roessler (Vic), to review this document.

TE22 Policy on Simulation Centres Offering the Effective Management of Anaesthetic Crisis (EMAC) Course and PS53 Statement on the Handover Responsibilities of the Anaesthetist

These have been approved by Council and will be circulated to regional/national committees and relevant special interest groups for comment.

PS31 Recommendations on Checking Anaesthesia Delivery Systems

Council endorsed the establishment of a document development group comprising Dr P Farrell, Ms N Benfell, Dr G Merridew, Dr P Roessler, Dr A Sharples, Mr A Smith and Mr S Threlfo, to review this document.

New appointments

Research

Council approved the appointment of Associate Professor Tomas Corcoran (WA) to the Clinical Trials Group Executive Committee.

Training and accreditation

Council approved the appointment of Dr Vanessa Beavis (NZ) to the Training Accreditation Committee. The contribution of Dr Alastair McGeorge (NZ), outgoing committee member, was acknowledged.

Professor Kate Leslie
President

Dr Lindy Roberts
Vice-President

Dean's message



For this first message in 2011, I would like to extend our thoughts to all those affected by the catastrophic events of flood, fire, cyclones and earthquake affecting our two countries recently, and where appropriate encourage members to consider what direct help they can offer to those struggling to cope with these awful events. I am aware many of you have gone the extra mile to help in these circumstances.

As attention to pain is our business, I draw your attention to a headline in the *New Zealand Herald* (February 24, page A6) which reads "Immediate pain carries spectre of long-term loss". This simple headline embodies all of complexity within our understanding of the biopsychosocial model of pain.

The spot prevalence estimate of one in five (in the Australian population) suffering persistent/chronic pain¹ will undoubtedly be exceeded in communities such as Christchurch following its devastating earthquake. There are not only large numbers with serious injury and all that goes with their survival, including much acute pain, but also the problems to come, like post-amputation (with "long-term loss" as in the headline) and postsurgical pain conditions, added to which will be the expected post-traumatic stress disorder (PTSD) complications impeding recovery.

From understanding the neurobiology of pain, it should also be evident that it is not even necessary to have received direct trauma in order to later experience several types of chronic pain conditions. With the enormous stress, tension and sleep loss in even the uninjured it will not be long before natural pain inhibition falls short for many, leading to development of widespread pain at many body sites.

I deliberately stop short of using labelling terms for these conditions, as anyone understanding the controversy surrounding this (especially in the NZ Accident Compensation Corporation legal environment) will understand how the words/labels can themselves be "damaging" by the way they can get used to discredit sufferers.

Generally these people have a hard time, most believing there should not be anything wrong without direct physical trauma. They will nevertheless add to the "silent epidemic" of persistent/chronic pain. Prospective engagement – via information that anticipates and educates about these in an objective way – might help.

Continuing the theme of environment and lifestyle effects on the size of the population who will have pain, an item in the *The Sunday Age* (February 27, page 18) "Why we want to know the truth about our daily bread" refers to "food-related disorders – obesity, diabetes and heart disease", stating that one in four Australians are obese. We know all these conditions are connected both directly and indirectly with an increased incidence of persistent/chronic pain conditions. The pain epidemic may well increase.

It is therefore in no way too soon for the new body painaustralia to be settling its foundations and gearing up for the much needed advocacy role as part of last year's National Pain Summit and the National Pain Strategy. As a Kiwi, I am unconcerned with that title only naming "Australia". Although we have not become Australia's newest state, trans-Tasman collaboration and influence is wider than national boundaries, illustrated by the help in both directions following the Pike River mine disaster, cyclones in Australia and the recent Christchurch earthquake, to name but a few outside our professional spheres. Professionally we work towards the same goals.

As for influence and leading the way, modelled closely on the Australian-driven² "pain relief as a basic human right"³ theme³, carried on in ANZCA's PS45⁴ and the National Pain Summit, we now have the "Declaration of Montreal" resulting from the International Pain Summit in September 2010. This statement underscores the continuing low importance placed on pain and its management in most parts of

the world – always in contrast to other more "sexy" or dramatic areas of health and healthcare⁵. You are invited to sign for your support of the statement as individuals at: www.iasp-pain.org/Content/NavigationMenu/InternationalPainSummit/DeclarationofMontr233a/default.htm#sign

The Faculty is now better informed about the position regarding FPM Fellows continuing professional development (CPD) requirements under the new national registration by MBA, especially as many of you will have been wondering how to approach this from the common dual-registered vocational specialty situation. This is on the immediate board agenda.

Meanwhile, I can encourage you (in Australia, because this is not settled yet in NZ) to use the protected title – namely "specialist pain medicine physician", one which only those with FPPMANZCA will be permitted to use. It will take some getting used to, but get used to it we must if we are to move forward as a separate identified vocational specialty.

The next time we meet is likely to be at the CSM in Hong Kong, where a brilliant program awaits us in both pain medicine and anaesthesia. I look forward to seeing and hearing from you there.

Meanwhile take care of yourselves and those around you and safe travels.

Dr David Jones
Dean
Faculty of Pain Medicine

Reference

1. The high price of pain: the economic impact of persistent pain in Australia. Access Economics [Internet]. 2007. From: <http://www.accesseconomics.com.au/publicationsreports/showreport.php?id=142&searchfor=2007&searchby=year>.
2. Dan and Frank, I didn't forget your co-authorship – please forgive the down under patriotism!
3. Cousins MJ, Brennan F, Carr DB. Pain relief: a universal human right. *Pain* 2004;112:1–4.
4. ANZCA. PS45 Statement on patients' rights to pain management and associated responsibilities – updated 2010 [Internet]. 2010. From: <http://www.anzca.edu.au/resources/professional-documents/ps45.html>.
5. From: <http://www.iasp-pain.org/PainSummit/DeclarationOfMontreal.pdf>
6. From: <http://www.ahpra.gov.au/Legislation-and-Publications/AHPRA-FAQ-and-Fact-Sheets.aspx> (see appendix one).

Fellowship training and examination dates for 2011

Examination dates

November 25-27, 2011

The Royal Brisbane and Women's Hospital, Brisbane, Queensland

Closing date for registration:

October 7, 2011

Pre-exam short course

The date and venue for the pre-exam short course is to be confirmed.

Admissions to fellowship of the Faculty of Pain Medicine

By training and examination:

Dr Matthew Bryant,
FANZCA
Queensland

Dr Chee Yong Choo,
FANZCA
Singapore

Dr Jing-Chen Jason Chou,
FANZCA
Victoria

Dr Andrew C Wilkinson,
AFRM RACP
South Australia

By election:

Dr Ross Drake,
FRACP, FACHPM
New Zealand

Board election

Dr Frank New, FRANZCP (Qld) has been re-elected unopposed to the FPM Board. A postal ballot will now be conducted, there being four nominations for the three remaining places. Ballot forms have been circulated to the fellowship.

International Pain Summit – Declaration of Montreal

The Declaration of Montreal, resulting from the International Pain Summit in Montreal, which states that access to pain management is a fundamental human right, has been signed by the Dean on behalf of the Faculty. We anticipate a document on the desirable characteristics of national pain strategies shortly.

Submission for GP education

The Faculty and the Royal Australian College of General Practitioners recently submitted a joint application for funding to the BUPA Foundation for development of an online modular educational program for primary healthcare professionals to address pain management. We anticipate a response in April.

Specialist registration in Australia

Legal advice has confirmed that the term “specialist pain medicine physician” is a protected term and may only be used by those so registered under the national specialist registration scheme. Fellows are encouraged to use this term, rather than “pain specialist”.



2014 ASM Sydney

Dr Lewis Holford has been appointed FPM Scientific Convenor to the 2014 ASM in Sydney.

Telehealth Advisory Group

“Connecting health services with the future: Modernising Medicare by providing rebates for on-line consultation” telehealth initiative. Following a request from the Department of Health and Ageing for a nomination to join the MBS Telehealth Advisory Group to work on the introduction of MBS items and incentives to support the use of telehealth services, there has been FPM/ANZCA representation at both the initial meeting and a subsequent meeting in Canberra. The College has also made a submission strongly in support of telehealth consultations for pain patients. The implementation date for this initiative is July 1.

Training unit accreditation

The Kowloon East Cluster Pain Management Centre (Hong Kong) and the Nepean Hospital (NSW) have been accredited for pain medicine training. This takes the number of Faculty-accredited units to 25.

FACULTY OF PAIN MEDICINE
AUSTRALIAN AND NEW ZEALAND
COLLEGE OF ANAESTHETISTS



PAIN MANAGEMENT: GETTING CLOSER TO THE DRAGON PEARL

**REFRESHER COURSE DAY AND FACULTY DINNER
HONG KONG CONVENTION CENTRE, HONG KONG
FRIDAY, MAY 13, 2011**

The program is headlined by international guests, Professors M. Catherine Bushnell, You Wan and Spencer Liu, and complemented by national leaders in opioid management and outcomes in pain medicine.

The meeting will be of value for Fellows, trainees and other practitioners who have an interest in pain medicine and will precede the ANZCA/HKCA Combined Scientific Meeting.

KEYNOTE SPEAKERS:

Professor M. Catherine Bushnell of McGill University, Montreal, Canada.

Professor You Wan of Peking University, Beijing, China.

Professor Spencer Liu of the Hospital for Special Surgery, New York, United States.

PROVISIONAL PROGRAM:

Session 1: Neurobiology

Session 2: Challenges in opioid therapy

Session 3: Outcomes in pain management

Session 4: Eastern influences

FPM ANNUAL DINNER:

Dragon Court, Jumbo Kingdom, Aberdeen, Hong Kong.

REGISTRATION:

Registration brochures are available for download from www.anzca.edu.au/fpm or contact the Faculty office:

E: painmed@anzca.edu.au

T: +61 3 8517 5377

FPM board meeting report

February 2010

Faculty Board

The board meeting began by expressing deep condolences to all those affected by the recent natural disasters in both Australia and New Zealand.

At the February board meeting of the Faculty, Dr David Jones was re-elected unopposed to the position of Dean-Elect.

The board noted with pleasure that the following were recognised in the Australia Day Honours list in recognition of distinguished contributions to their disciplines:

Dr John J Collins, FRACP, FPPMANZCA (NSW)

Dr Walter R Thompson, FANZCA, FCICM (WA)

Dr Bruce Foster, FRACS (SA)

Ms Clea Hincks, ANZCA's General Manager, Communications, met with the board and gave a comprehensive overview of the Communications Unit and its plans to develop a perception of ANZCA and FPM as the most modern, innovative and professional specialist medical organisations in Australia and New Zealand. (Subsequently the board has congratulated her on being appointed General Manager, Communications).

Relationships Portfolio Regulations

Associate Fellows

Since the previous board meeting, the board resolved by electronic vote that associate Fellows would:

- Be eligible to present for formal admission during the College Ceremony at the annual scientific meeting.
- Be presented separately to those presenting for full fellowship, with an explanation of the difference in their introduction.
- Be eligible to present again for formal admission upon conferral of full fellowship.

Relationships

BUPA submission for general practice education

The board discussed a recent joint FPM/Royal Australian College of General Practitioners (RACGP) application for funding submitted to the BUPA Foundation. This is for the development of an online modular educational program for primary healthcare professionals to address pain management.

Should the application be successful, funds would come directly to the Faculty as an untagged educational grant with complete content and editorial control by FPM and the RACGP. GPs will be consulted on the top 10 topics they want.

It is intended that completed modules be independently assessed for accreditation, to avoid bias. A response from BUPA is expected in April.

Liaison with pain societies

Following an invitation from the Australian Pain Society (APS) to nominate a Faculty representative to their newly formed Relationship and Communications Committee, Dr Penny Briscoe was confirmed as our nominee.

In working toward joint endorsement of position papers, the APS has supported, with one small amendment, the Faculty Professional Document PM1 (2010): Principles regarding the use of opioid analgesics in patients with chronic non-cancer pain. We await the decision of the New Zealand Pain Society (NZPS) regarding endorsement.

Corporate Affairs

Regional Committees Queensland

The board supported a request from the FPM Queensland Regional Committee for professional development in the area of committee governance. Appropriate courses are to be explored by ANZCA, with inclusion of FPM regional committee office bearers.

Board members who are ex-officio on the regional committee reported on progress of the Statewide Persistent Pain Health Services Strategy and advised that Mr Geoff Wilson had taken over from Mr Paul Lucas as Queensland Minister for Health.

The aim is to establish a hub-and-spoke pain management network underpinned by consultation-liaison services. Five pain clinics are proposed: Brisbane, Nambour, Gold Coast, Sunshine Coast and Harvey Bay. Director positions for the new clinics will be advertised shortly.

South Australia

The board congratulated South Australian Fellows on the formation, in November, of the FPM SA Regional Committee. Membership of the interim committee, chaired by Dr Graham Wright, includes broad multidisciplinary membership.

National Pain Strategy

The board noted that the constitution and board composition for painaustralia has now been finalised with James Strong, AO, as inaugural chairman and Associate Professor Milton Cohen, past dean of the Faculty, as the ANZCA/FPM nomination to the board. Professor Stephen Gibson is the APS nomination to the painaustralia board.

Dr Cohen reported on the first board meeting held on February 1. The main points arising included confirmation of the board of directors, adoption of principles for appointment of community (consumer) directors and appointment of the interim chief executive officer. Member letters and application forms are being circulated. A business plan will be drawn up to focus on priority areas of the National Pain Strategy aiming to avoid duplication of work already being done effectively by its members.

International Pain Summit – Declaration of Montreal

As directed by the FPM executive, the dean has signed the Declaration of Montreal on behalf of the Faculty.

ANZCA Quality and Safety Committee

Following the resignation of the Faculty's representative to this committee, the board continues to seek a replacement with a quality and safety interest who could speak with authority on behalf of FPM.

FPM board meeting report continued

Board election

Dr Frank New, FRANZCP (Qld) has been re-elected unopposed. A postal ballot will now be conducted, there being four nominations for the three remaining places on the board.

Trainee Affairs Portfolio

International medical graduates

With regard to non-FANZCA specialist anaesthetists registration in Australia and New Zealand (and a corresponding situation for other specialties) the board resolved that, in line with FPM regulations, fellowship of the Faculty would not be awarded until conferral of fellowship of a medical college in Australia or New Zealand acceptable to the board.

Education

The position description for a medical educator has now been finalised and expressions of interest will be called for. The 0.2 full-time equivalent position is for 12 months to progress the Faculty's blueprinting and curriculum review project.

Examination

As the Royal Adelaide Hospital is unable to host the 2011 pre-examination short course, an alternative venue is being sought.

Training unit accreditation

The Kowloon East Cluster Pain Management Centre (Hong Kong) and the Nepean Hospital (NSW) were accredited for pain medicine training. The Auckland Regional Pain Service was re-accredited for pain medicine training. A large number of onsite reviews are scheduled throughout 2011.

Fellowship Affairs Portfolio

Fellowship

New admissions

Since the October board meeting, Dr Matthew Bryant (Qld), Dr Jason Chou (Vic), Dr Chee Yong Choo (Singapore) and Dr Andrew Wilkinson (SA) have been admitted to fellowship by training and examination.

Dr Ross Drake, FRACP (New Zealand) was elected to fellowship of the Faculty. This takes the total number of admissions to 297.

Continuing education and

quality assurance

Scientific meetings

2011 CSM – Hong Kong

The board noted that the registration brochure has been circulated and is available for download from the FPM website. Registrations have commenced and an exciting program is anticipated. The FPM Scientific Meeting Awards Committee is selecting papers for the FPM Dean's Prize/free paper session.

2011 Spring Meeting

It is anticipated that registration brochures for this meeting, to be held at the Park Hyatt Hotel, Canberra from October 28-30, will be circulated with the June *Bulletin*. The meeting theme is "An exploration of the pain/musculoskeletal polemics – policies, procedures and pragmatics".

2012 ASM – Perth

The local FPM organising committee is now well advanced with a preliminary refresher course day and annual scientific meeting program.

2013 ASM – Melbourne

The FPM scientific convenor has suggested a number of potential speakers and, with the support of the Continuing Education and Quality Assurance Committee, is making informal enquiries about availability.

2014 ASM – Sydney

Following a recommendation from the FPM NSW Regional Committee, Dr Lewis Holford was appointed FPM scientific convenor to the 2014 ASM.

Research committee

National pain outcomes initiative

The board noted the momentum of the Statewide Persistent Pain Health Services Strategy in Queensland and the Agency for Clinical Innovation in NSW, and discussed potential opportunities for funding of a national outcomes initiative.

The board agreed that this strategic initiative should be pursued with some urgency. The chair of the FPM Research Committee was asked to champion this initiative and to convene a working party to develop a provisional costed business plan for consideration at the May board meeting. Seeking funding will follow, with a view to a national launch of data collection in 2012.

Professional

Specialist registration in Australia

Following the board's concern that anyone could call themselves "pain specialist", legal advice was sought from the College solicitor and it was confirmed that the term "specialist pain medicine physician" is a protected term and may only be used by those so registered under the national scheme.

However, it was advised that all existing persons registered as "specialists" had been transferred to the Medical Board of Australia (MBA) specialist register and accordingly there may be some who do not hold fellowship of the Faculty of Pain Medicine. Any new additions to the specialist register must go through the processes of the MBA, which recognises FFPMANZCA as the qualification to be registered as "specialist pain medicine physician".

The board agreed that Fellows be encouraged to refer to themselves formally as "specialist pain medicine physicians" rather than as "pain specialists".

Medical Board of Australia (MBA) continuing professional development requirements

For ongoing registration with the MBA, satisfactory compliance with a continuing professional development (CPD) program is mandatory.

This has been the standard in place in New Zealand for some years. The board were advised that the MBA stipulates: "Medical practitioners with more than one qualification may have specialist registration in more than one speciality. They are expected to comply with the continuing professional development requirements of every speciality in which they hold specialist registration."

The MBA accepts that CPD undertaken to fulfil the requirements of one college may also fulfil the requirements of other colleges. Whatever else is decided, it is recommended that Fellows maintain skills relevant to their scopes of practice, and therefore carry out CPD activities relevant to what they do in practice.

At a recent presentation to the ANZCA Council by Dr Joanna Flynn, Chair of the MBA, it was confirmed that this did not mean that specialists would not be required to complete two programs, and that it was up to the colleges to determine what recognition they gave to programs of another college.

Following further discussion, it was agreed that ANZCA and the FPM would each define their standard to be met for CPD. The board nominated Dr Penny Briscoe to the ANZCA CPD Committee.

Telehealth advisory group

“Connecting health services with the future: Modernising Medicare by providing rebates for online consultations”.

The director of professional affairs (DPA) reported to the board that FPM/ANZCA had made a submission strongly in support of telehealth consultations for pain patients, especially chronic pain, although the potential to contribute to the management of post-operative pain in remote hospitals was also identified.

There had been FPM/ANZCA representation at both the initial meeting and a subsequent meeting in Canberra. Major challenges are not the content of telehealth, but how it is to be implemented and integrated with other e-health programs.

At this stage, telehealth will be restricted to non-hospital initial and follow-up consultations that are “discussion-based” (as opposed to “examination-based” or procedural). There is strong political pressure to implement this program on July 1. The next meeting is in early May. The most recent development is a request from the Department of Health and Ageing for a teleconference with ANZCA/FPM.

New Zealand application for specialty recognition

It was reported that the application fee for stage two of the process has been paid. Additional information being sought includes an account of how the Faculty deals with cultural competence. A cultural competency document is being developed.

Other information requested relates to adequate infrastructure for training and CPD programs. The deadline for submission is June 30. Before then, the Medical Council of New Zealand (MCNZ) is required to gazette and consult widely in accord with the HPCAA Act (20).

Submissions

The DPA reported on the Faculty’s contribution to a growing number of ANZCA/FPM submissions including:

- The Australian Commission on Safety and Quality in Health Care’s Clinical Handover Pilot Program.
- The Australian Commission on Safety and Quality in Health Care’s Patient-centred Care: Improving Quality and Safety by Focusing Care on Patients and Consumers.
- The Australian Commission on Safety and Quality in Health Care’s Consultation Paper on the Draft National Safety and Quality Healthcare Standards.
- Health Quality and Complaints Commission: Risk Profiling and Doctors with Multiple Complaints.
- A National Framework for Advance Care Directives Consultation Draft.

Australian guidelines: Selection for neurostimulation in chronic pain

It was reported that an article entitled “Selection of patients for neurostimulation” had been accepted for the *Journal of Clinical Neuroscience*. The Faculty’s DPA has commenced work on an FPM professional document for submission to the May board meeting.

Professional parity with physicans

An argument is being pursued on behalf of specialist pain medicine physicians that there be professional parity with other physicians.

End of life policy

Anticipating that euthanasia was likely to be a prominent, controversial topic in 2011, it was noted that the College has a good statement in Professional Document PS38: Statement Relating to the Relief of Pain and Suffering and End of Life Decisions – 2010. Fellows’ attention is drawn to that statement:

www.anzca.edu.au/resources/professional-documents/ps38.html and to the Palliative Care Australia document, Voluntary Euthanasia and Physician Assisted Suicide at www.palliativecare.org.au under “Position statements” heading under the “Policy” tab.

Better outcomes in pain management

The board considered a discussion document from a Fellow which focused on the urgent need for education and training to enhance the clinical ability of primary healthcare to achieve better outcomes in pain management.

There was recognition that this issue is juxtaposed to the development of a national outcome initiative and also the aim of the application to the BUPA Foundation. It was agreed that the author of the discussion paper be invited to participate in the Faculty’s working group.

Finance

The management reports to December 31 were accepted and the positive result against budget was noted.

2011 calendar

Dates for future 2011 board meetings are:

May 12 (Hong Kong)
May 15 (new board – Hong Kong)
August 22 (Melbourne)
October 10 (Melbourne)

The Anaesthesia and Pain Medicine Foundation



Bequest program – the John Snow Society

The foundation has established a bequest program, the John Snow Society, to honour Dr John Snow, one of the forefathers of anaesthesia and a world-renowned figure in the medical profession for his work in anaesthesia, clinical pharmacology, public health and epidemiology.

To join the bequest program and become a member of the John Snow Society, a notified bequest can be made in your will to ANZCA.

Your support

The foundation is extremely grateful for the continued support of Fellows who have made donations as part of their annual subscription, have become patrons or have pledged a bequest.

This financial support goes in its entirety towards medical research and education projects that are conducted in leading hospitals and universities. Medical research is crucial in continuing to make important discoveries and improvements for patient safety.

Patrons Program

The Patrons Program has been established to encourage and recognise those who wish to support medical research and education.

Donations can be made via a one-off contribution of the full amount or they can be made over a five-year period.

The various levels of the program are:

- **Patron:** A five-year membership to the Patrons Program is \$5000. Patrons are recognised by the foundation with a listing in the *ANZCA Annual Report* and the December edition of the *ANZCA Bulletin*.
- **Life Patron:** A donation of \$25,000 will result in recognition of the contributor as a Life Patron. In addition to a listing in the *ANZCA Annual Report* and *ANZCA Bulletin*, Life Patrons will have their names recorded in perpetuity on an honour board at the College.
- **Governor:** A donation of \$100,000 will result in recognition of the contributor as a Governor of the Foundation. In addition to the recognition afforded a Life Patron, Governors may have a research grant awarded by the College in their honour. Such an award will be made each year for four years.

Membership of the Patrons Program has continued to grow since its inception in 2009 and we are honoured to have one Governor and two Life Patrons already in the program.

To make a donation, bequest or to become a patron or for any other inquiries please contact:

Susan Collins

Acting Director, the Anaesthesia and Pain Medicine Foundation

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Melbourne VIC 3004
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Library update

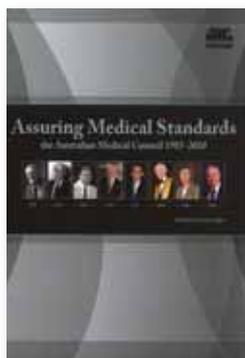
New titles

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

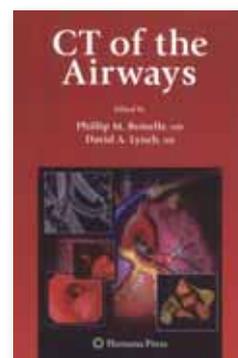
ANZCA members are entitled to borrow a maximum of five books at one time from the College library. Loans are for three weeks and can be renewed on request. Members can also reserve items that are out on loan.

Melbourne-based members are encouraged to visit the ANZCA Library to collect requested books. Items will be sent to other library users within Australia. When requesting an item from the catalogue, please remember to include your name, ID number and postal address to ensure prompt delivery.

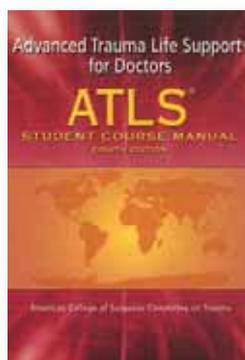
A core collection of the anaesthetic syllabus textbooks is available for loan from the New Zealand office of the College. A list of the New Zealand books can be accessed by selecting "New Zealand" from the "Location" drop-down box of the catalogue.



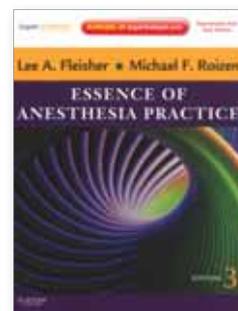
Assuring medical standards: the Australian Medical Council 1985-2010/Geffen, Laurence [ed]. – 1st limited ed – Kingston, ACT: Australian Medical Council Limited, 2010.



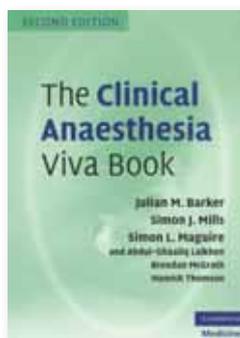
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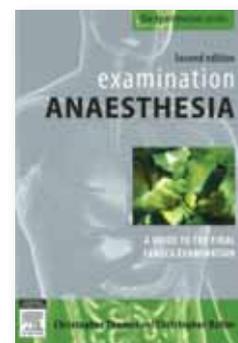
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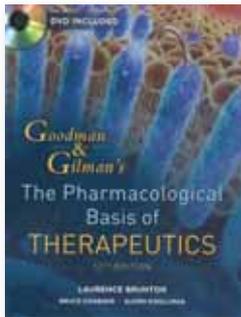
Essence of anesthesia practice/Fleisher, Lee A. [ed]; Roizen, Michael F. [ed]. – 3rd ed – Philadelphia, PA: Elsevier Saunders, 2011.
Kindly donated by Dr John Russell



The Clinical anaesthesia viva book/Barker, Julian M; Mills, Simon J; Maguire, Simon L. – 2nd ed – Cambridge: Cambridge University Press, 2009.



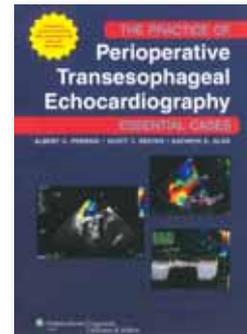
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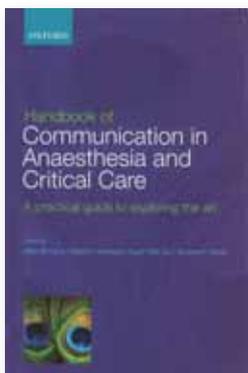
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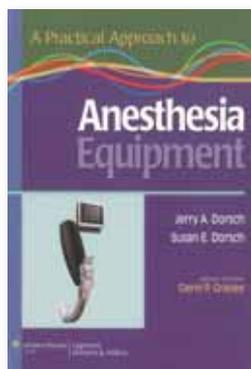
Patient safety/Vincent, Charles. – 2nd ed – Chichester, West Sussex: Wiley-Blackwell, 2010.



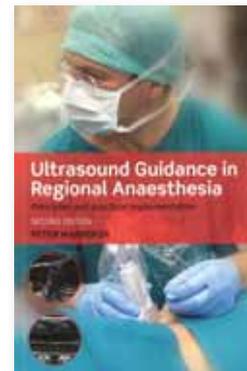
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Handbook of communication in anaesthesia and critical care: a practical guide to exploring the art/Cyna, Allan M [ed]; Andrew, Marion I [ed]; Tan, Suyin G M [ed]; Smith, Andrew F [ed]. – Oxford: Oxford University Press, 2011.



A practical approach to anesthesia equipment/Dorsch, Jerry A; Dorsch, Susan E; Gravlee, Glenn P [ed]. – Philadelphia; Sydney: Wolters Kluwer – Lippincott Williams and Wilkins, 2011.



Ultrasound guidance in regional anaesthesia: principles and practical implementation/Marhofer, Peter. – 2nd ed – Oxford: Oxford University Press, 2010.

ANZCA Library – new journals for 2011

The ANZCA Library has added three new medical education journals to the online subscriptions: *Clinical Teacher*, *Medical Education* and *Medical Teacher*.



Another new title, *Journal of Pain Research*, is an international, peer-reviewed, open access, online journal that welcomes laboratory and clinical findings in the fields of pain research and the prevention and management of pain.

The library has also commenced a new subscription to the *Undersea and Hyperbaric Medicine Journal*. Articles are available through the journal list from 2011, while articles before 2008 from this journal and other hyperbaric medicine journals are available via the Rubicon website.

All ANZCA Library online journals can be accessed at: www.anzca.edu.au/resources/library/online-journals.html (College identification log-in required).

Health and safety alerts – ECRI Institute notices



The ANZCA Library subscribes to ECRI publications on operating room risk management and health device alerts and information. Check this space regularly for updates on the latest information produced by ECRI.

Health Devices, Vol. 39, No. 11, November 2010
– Top 10 technology hazards for 2011

1. Radiation overdose.
2. Alarm hazards.

3. Cross-contamination from flexible endoscopes.
4. High radiation dose of CT scans.
5. Data loss, system incompatibilities and other health information technology complications.
6. Luer misconnections.
7. Oversedation during use of PCA infusion pumps.
8. Needlestick and other sharps injuries.
9. Surgical fires.
10. Defibrillator failures in emergency resuscitation attempts.

Operating Room Device Alerts – Anesthesia unit carbon dioxide absorbents

Evidence-based practice corner

Log-in to the ANZCA Library website to access these journal articles and guidelines.

Webliography of resources for evidence-based healthcare

Created by The Cochrane Collaboration, this webliography presents an overview of the most important print and online resources for evidence-based healthcare and medicine. It includes books, articles and online resources; databases; journals; medical news reviews; patient resources; tutorials and tools; and Web 2.0 (social media) resources to stay informed.

www.cochrane.org/about-us/evidence-based-health-care/webliography

Nitrous oxide and long-term morbidity and mortality in the ENIGMA trial

Leslie K, Myles PS, Chan MT, Forbes A, Paech MJ, Peyton P, Silbert BS, Williamson E. *Anesthesia and Analgesia*. 2011 Feb;112(2):387-93.

Heated CO₂ with or without humidification for minimally invasive abdominal surgery.

Birch DW, Manouchehri N, Shi X, Hadi G, Karmali S. *Cochrane Database of Systematic Reviews* 2011, Issue 1. Art. No.: CD007821.

Perioperative transversus abdominis plane (TAP) blocks for analgesia after abdominal surgery.

Charlton S, Cyna AM, Middleton P, Griffiths JD. *Cochrane Database of Systematic Reviews* 2010, Issue 12. Art. No.: CD007705.

Adjusting the pH of lidocaine for reducing pain on injection.

Cepeda MS, Tzortzopoulou A, Thackrey M, Hudcova J, Arora Gandhi P, Schumann R. *Cochrane Database of Systematic Reviews* 2010, Issue 12. Art. No.: CD006581.

Blood transfusion and the anaesthetist: management of massive haemorrhage

Association of Anaesthetists of Great Britain and Ireland
www.aagbi.org/publications/guidelines/docs/massive_haemorrhage_2010.pdf

Society for Ambulatory Anesthesia consensus statement on perioperative blood glucose management in diabetic patients undergoing ambulatory surgery.

Joshi GP, Chung F, Vann MA, Ahmad S, Gan TJ, Goulson DT, Merrill DG, Twersky R; Society for Ambulatory Anesthesia. *Anesthesia and Analgesia*. 2010 Dec;111(6):1378-87.

Interagency guideline on opioid dosing for chronic non-cancer pain: an educational aid to improve care and safety with opioid treatment.

Washington State Agency Medical Directors' Group. Olympia (WA): Washington State Department of Labor and Industries; 2010:55.

Overview of progress in patient safety

Pronovost PJ, Holzmueller CG, Ennen CS, Fox HE. *American Journal of Obstetrics & Gynecology*, 2011 Jan; 204(1): 5-10.

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Dr Eva Ruth Seelye 1929 – 2010



Eva Ruth Hersch escaped Nazi-occupied Vienna in late 1938. Her father, from a distinguished medical family, had been taken underground by patients and Eva and her mother made their perilous escape aided by her uncle's contacts.

The family was reunited in Dubrovnik and with the assistance of the Myer family was granted a permit to enter New Zealand. Her father, Hans, re-trained at Otago Medical School and German-speaking Eva entered a convent school in Dunedin. Her schooling was very much that of "teach yourself" and, having been given a copy of Dickens and a German/English dictionary, she sat at the back of the class.

Following his graduation, her father set up a general practice in Herne Bay. Appropriate schooling was again difficult for the intelligent Eva and she spent much of her time reading in the Auckland Public Library. She matriculated at the age of 15 after attending correspondence school and at the age of 16 was offered a place at Otago Medical School. Her wise father decided she was far too young and she enrolled at Auckland University graduating with a Bachelor of Arts in 1948 before proceeding to Dunedin to graduate MB ChB in 1953. While at Auckland University she met Ralph Seelye, a lecturer in the chemistry department, and they married in 1954.

Her father died the same year and, following her house surgeon years, she worked in her father's general practice. This she did not find to her liking and left to become an anaesthetic registrar in the Auckland hospital. With her husband, Ralph, she travelled to Oxford University where he completed his doctorate and she gained her FFARCS in 1961. Following their return to Auckland, Eve became a specialist anaesthetist with the Auckland Hospital Board, based at Green Lane Hospital. She was granted her FFARCS in 1968 and became a FANZCA in 1992.

Eve was to spend the rest of her career at Green Lane Hospital, spending most of her time working with the Cardiothoracic Surgical Unit (CTSU). She and her close friend, the late Dr Marie Simpson, provided most of the anaesthesia for that unit and they were heavily involved in the intensive care room, catheter laboratory and with cardiac perfusion.

These were the early days of cardiac surgery in New Zealand and Eve was engaged in a considerable body of research, co-authoring 26 papers from 1962. These covered anaesthesia, hypothermia, cardiopulmonary bypass and physiology with papers being published in the *British Journal of Anaesthesia* (eight), the *New Zealand Medical Journal* (four), *Clinical Science and Molecular Medicine* (five) and others in cardiothoracic journals.

Eve was also a co-author of and contributor to three books. Despite her aversion to administration, Eve was a very competent chair of the Department of Anaesthesia at Green Lane Hospital from 1978 until her retirement in 1985.

Eve was an excellent teacher, lecturing to the CTSU nurses, involved in anaesthetic technician training and was a practical instructor for all, in theatre, intensive care and on the wards. She was an examiner for the final FFARACS examinations, a role she enjoyed and filled with distinction.

Eve took early retirement to spend more time with her beloved Ralph and they spent "15 blissful years" exploring New Zealand – tramping and enjoying

the company of their many friends before his death in 2002.

Eve was a delightful companion with a quick wit and a great sense of humour although she did not tolerate fools gladly. She gave of her best and expected others to do the same. Sadly, after Ralph's death her own health deteriorated and despite constant pain, she managed to keep up with her reading, maintained a keen interest in all things medical and her enquiring mind was with her until the end.

Eve and Ralph were grateful for their own education and were keen to provide educational and learning opportunities for others. Having no children of their own, they established the Ralph and Eve Seelye Trust, which provides funding for undergraduate and postgraduate students, visiting lecturer fellowships at the University of Auckland and a doctorate scholarship in anaesthesia.

Recipients come from varied specialities and Eve enjoyed reading through the resumes and deciding who would receive funding. A wider public benefited from visits from early childhood educators, architects, marine biologists, lawyers and others as well as medical educators.

Eve always had a sense of gratitude towards New Zealand for taking her and her family in but it is we who have – and will continue to – benefit from the contribution she made to anaesthesia and the legacy she and Ralph have left.

Dr Basil Hutchinson FANZCA (retired)
Auckland

Dr Kaye Ottaway, FANZCA
Auckland

Dr Genevieve Anderson

1947 – 2010



Dr Genevieve Anderson, who died in September after a long illness, typified the best qualities of an anaesthetist.

In an era which increasingly measures success by published papers, grants and research projects she represented another path – that of quiet service to her patients rooted in well-rounded training and practice.

Genevieve was born and brought up for her early years in Waikerie, South Australia, and she remained, in many ways, a country girl.

After the family moved to Adelaide she completed her education at Brighton High School where she excelled academically, entering the Adelaide Medical School in 1965.

Attractive, intelligent and tremendously good fun, she was a popular student.

After graduating she worked in Adelaide and Alice Springs before beginning her anaesthetic training in 1974.

From this distance it is hard to believe how much the medical world has changed. Our seniors were largely working in an honorary capacity, many of them were considered pioneers of modern anaesthesia and the links with intensive care were very close.

As registrars we were given a great deal of responsibility. Genevieve found this atmosphere stimulating and developed rapidly into a competent anaesthetist. Trainees in the department of anaesthesia and intensive care were exposed to extended periods in the intensive care unit (ICU) and Genevieve always kept her interest in acute medicine and brought this to her anaesthetic practice. Looking back, it seems that work was always great fun and Genevieve was an enthusiastic participant in the social life which was so much a part of the hospital experience.

Her career after achieving her FFARACS in 1978 was spent in Adelaide, at various hospitals. Initially she worked at the Repatriation General Hospital where she met her husband Peter, a psychiatrist. Later she developed an interest in obstetric anaesthesia and practised at the Queen Victoria and later the Women's and Children's hospitals before returning to the Repatriation hospital at Daw Park where she was able to rekindle her interest in intensive care as well as general anaesthesia.

Her health began to fail in 2001 and she was diagnosed with mitochondrial neuropathy. She was forced to give up anaesthetic practice but recovered enough to enrol in and complete a diploma of visual arts – long an interest in which she had never before had the time to indulge.

She was a bird watcher of some note and, with her husband, worked on an ambitious project rehabilitating an old onion farm on the Murray River. Their tree-planting project saw the reforestation of a degraded site that was truly impressive.

Unfortunately her deterioration over the past two years was inexorable, but she bore her incapacity with courage and determination founded on her fierce independence and helped immeasurably by her husband. She died at home on September 27.

Genevieve was my close friend and admired colleague for 45 years and she will be sadly missed. She is survived by Peter, her siblings and numerous, greatly loved nieces and nephews.

Dr Helen Bidstrup, FANZCA
New South Wales

Colonel Dr (Roland) John Wilson 1948 – 2010



On January 5, people from throughout New Zealand and overseas gathered to farewell Dunedin anaesthetist and assistant director of medical services for the New Zealand Defence Forces, Colonel Dr Roland John Wilson (known as John), who died on December 28. In particular, there was very strong representation from both the NZ Army and New Zealand's anaesthetic community, reflecting their huge respect for the contribution Dr Wilson had made to both.

Born in New Plymouth on the north island to a medical family, John Wilson grew up in Dunedin on the south island. After leaving Otago Boys' High School as *proxime accessit*, he followed in his father's footsteps by attending Otago University's medical school (1968-72) and joining the military, having already moved through the cadet ranks while at secondary school.

In 1968, while still at university, John joined the Otago Medical Company with the hope of serving in Vietnam. He rapidly reached the rank of captain and was seconded to the First NZ Services Medical Team in Vietnam, where he virtually performed the duties of a doctor despite still not being qualified. After four months' service, he returned to Dunedin and finished medical school.

A love of flying and an interest in high altitude pathophysiology saw him join the Royal New Zealand Air Force Active Reserve, through which he participated in search and rescue operations. After finishing his medical registrar year, a commanding officer's suggestion saw Dr Wilson serving as a Volunteer Service Abroad doctor for two years at one of Sir Edmund Hillary's hospitals in Nepal. Here he was able to indulge his love of mountains and he developed an interest in long distance and endurance running.

On his return to Dunedin, Dr Wilson worked as a general practitioner but could not see himself spending the rest of his life as a physician and in late 1978 he went to the New Zealand Forces Hospital in Singapore, treating servicemen and their families. He helped develop adventure training exercises for army personnel, extending them far beyond their normal physical limits.

Dr Wilson planned to undertake several courses in the United Kingdom that would lead to work in developing countries but a change in rules meant he could not afford to do so. Instead, he applied for and was accepted into a job in York at a highly regarded hospital with the highest pass rate in anaesthesia for the whole of the UK. The very supportive, and competitive, learning environment there saw Dr Wilson rapidly gain fellowship of the Royal College of Anaesthetists in 1984.

On returning to New Zealand, he undertook the Australasian exams to gain his FANZCA in 1992 and then worked as a specialist anaesthetist in Dunedin in both its public hospital and at the private Mercy Hospital. He was also a clinical lecturer in anaesthesia at Otago University's medical school. Dr Wilson had been on the executive of the NZ Society of Anaesthetists for 10 years and prior to that had served the society as part of its Economic Advisory Group.

In 2000, Major John Wilson reactivated his military work, undertaking two tours in East Timor and later serving also in Afghanistan and with a NZ Army Pacific Aid team in Rarotonga.

Dr Wilson's passion for adventure, endurance running and fitness regularly took him into the mountains of New Zealand and around the world. He loved the high country and had considerable knowledge of the flora and fauna of New Zealand.

He also had great love for his four sons, and in 2008 took them to Nepal for a hospital reunion.

The Dunedin anaesthetic community knew John as an excellent clinician and teacher, with a drive to get on with the job, someone not too fond of red tape, with a strong sense of justice and a keenness to help others. A close colleague in the private sector described him as always unflappable, dependable, helpful and supportive with irrepressible energy.

His passing at only 62 was a shock to all. That he was enrolled to run the 50 kilometre Motatapu Icebreaker in March is indicative of his unstoppable energy to get up and go.

Our thoughts are extended to all Dr Wilson's family, especially his mother to whom he was devoted, his sisters and four boys. We all miss greatly that tall, energetic and deeply compassionate man who was at his best when helping others.

Compiled from notes supplied by the Dean of the Faculty of Pain Medicine, Dr David Jones, who worked with Dr Wilson in Dunedin and from information published in a profile of Major Dr John Wilson in Fight Times, December 2002.