Which is which?
Drug labelling under fire

Fasting or starving?
Spotlight on fasting guidelines

Propofol abuse:
Surveys show big rise in 30 years

Get involved!
National Anaesthesia Day – October 16
Surveys show propofol abuse rising

Three decades of substance abuse surveys show a dramatic potential rise in propofol abuse by anaesthetists.

A new era in teaching

The ANZCA Educators Program is all about learning to teach. It builds on the successes of the Foundation Teacher Course.

Clinical trials – a great history

The ANZCA Clinical Trials Network (formerly ANZCA Trials Group) has a long, successful past.

Drawn to Tasmania

Australia’s smallest state boasts a variety of clinical services, including a strong retrieval service, with spectacular surroundings nearby.

Difficult airway trolley

Patient safety has been improved through the development of difficult airway trolleys.

Fasting guidelines – time for change?

There is clear evidence that drinking clear fluids two to four hours before an anaesthetic is not dangerous, but even beneficial.

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

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ANZCA is the professional medical body in Australia and New Zealand that conducts education, training and certifying professional development of anaesthetists and specialist pain medicine physicians. ANZCA comprises about 3000 Fellows and 3500 members across Australia and New Zealand and is committed to ensuring the highest standards of patient safety.

Cover: Despite very similar labelling, ephedrine sulfate and heparin sodium have vastly different effects on patients.

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President’s message

Raising the profile of anaesthetists and enabling others to understand the scope and value of our work is an ongoing challenge for the profession.

Well over two million anaesthetics are administered in Australia and New Zealand each year. Every single one of these professional interactions provides an exceptional opportunity to demonstrate that we are specialists (or trainee specialists) not only to our patients and their carers, but also the peripeptive team.

It is likely that our behaviours will be noted and remembered just as much as our technical expertise, so these interactions are critically important to ensure we are recognised as specialists, not just technical experts.

National Anaesthesia Day on October 16 is another opportunity to interact with the general public and workers from other areas of your hospitals and clinics. I hope you are all giving some thought to how you can best use this occasion to inform, demystify, explain, impress and possibly even entertain – to promote key health messages. This year’s theme is “Obesity complicates anaesthesia.”

This is a sensitive topic to discuss with patients, however we are experiencing an obesity epidemic across all age groups, in Australia, New Zealand and neighbouring countries such as the Pacific Islands, and with it a rise in associated co-morbidities. Only one third of our populations has a healthy weight and the incidence of obesity is impacting significantly on our economies in terms of rising healthcare costs and lost productivity.

Anaesthetists represent around 1% per cent of specialist doctors, excluding GPs, according to the Australian Institute of Health and Welfare Medical Labour Force Survey, 2009.

As president of ANZCA I represent the College on the council of the Royal Australasian College of Surgeons (RACS), the board of the College of Intensive Care Medicine (CICM) and the Committee of Presidents of Medical Colleges (CPMC) which meets four times a year.

The Medical Board of Australia (MBA), the Australian Medical Council, the Chief Medical Officer, Medical Deans Australia and New Zealand, the National Health and Medical Research Council (NHMRC), the Australian Commission on Safety and Quality in Healthcare and the Australian Medical Association all report to the CPMC in person.

Government bodies also report, depending on what is topical at the time (for example, the Medical Benefits Schedule review, or workforce). A similar body, the Council of Medical Colleges (CMC) meets regularly in New Zealand.

ANZCA therefore has an ongoing opportunity to be directly informed about the relevant health issues of the day and to have direct access to representatives of these bodies.

ANZCA’s Policy unit plays an important role in advocating on behalf of our Fellows and trainees. ANZCA and FPM regularly respond with up to 50 submissions each year to government consultations on both sides of the Tasman. Some of these are confidential but many are listed on the ANZCA website – www.anzca.edu.au/communications/advocacy.

A recent success with advocacy efforts includes the announcement a few weeks ago from the Queensland government of $2.7 million over three years to fund a statewide paediatric persistent pain service, as well as evaluation of the current draft of the persistent pain management strategy for the state, with a view to its implementation into the future.

This has grown a profile in the media with the College actively promoting the work of anaesthetists and pain specialists with good results. This year alone there has been widespread media coverage based on the work of the Anaesthetists-Sub-Committee (allergies) and the Australian and New Zealand Anaesthetic Allergy Group (links between phycocidine and anaphylaxis). The FPM statement on cannabis, its call for a ban on over the counter codeine sales and the Faculty’s revised training program has received much attention in the media and more recently, the issue of perioperative fasting was in the news. Our media releases can be found on the website – www.anzca.edu.au/communications/Media.

Finally, it is important Fellows and trainees have a voice with their College. I urge you to participate in evaluations of continuing medical education meetings, and continuing professional development activities so that they continue to be relevant and of a high standard and to participate in surveys when they come your way.

A survey to develop values for ANZCA was recently launched. Trainees will be conducting an online survey later this year via their trainee committees.

Funding of the department in New Zealand has recently participated in a workforce census to obtain an accurate snapshot of department staffing, funding available and unmet demand. We hope to roll out a similar census across the Australian regions in the next financial year. The results of the census will assist in ANZCA having contemporary high quality data for our advocacy efforts in workforce deliberations (ANZCA’s Workforce Action Plan – data, advocacy and communication).

ANZCA awaits with interest two reports. The first is from the National Anaesthesia Training Advisory Network (NMTAN) which has been examining workforce data for three specialties, psychiatry, general practice and anaesthesia.

The second is the MBA, which commissioned independent overseas research into an evaluation of validation methods overseas and a recommendation for a possible model for Australia. The MBA will consider the findings and issue a report in November 2013.

Mr John Iott is ANZCA’s new chief executive officer, starting at the College on Monday September 28.

An experienced senior executive, John was the director of Finance and Corporate at the Australian Health Practitioner Regulation Agency (AHPRA) from 2009 to 2014 and played a key role in its formal establishment in 2010.

“I have worked closely with the medical profession throughout my career and without exception I have enjoyed the close working relationships that have developed,” he said.

Over the years he has formed close associations with medical professionals, including anaesthetists. “I appreciate the hard work that the leaders of the profession have contributed to the recognition it enjoys today,” he said.

ANZCA welcomes John to the College as its new CEO and is looking forward to meeting as many Fellows and trainees as possible during my time as CEO,” Dr Genevieve Goulding said. John has strong skills in leadership, change management and corporate governance and has built sound relationships with government, the health professions and other stakeholders.

“John has a strong commitment to service and quality and an open collaborative style,” she said.

“He is an experienced CEO and senior executive and has an extensive background in both the private and public health sector.”

Mr Iott is a specialist in anaesthesiology and pain management, and has held leadership roles within ANZCA and the Medical Board of Australia (MBA) in my five years at AHPRA,” John said. “I have great respect for the sensitive and professional way in which the MBA approaches complex issues.

“I look forward to forging similar relationships with the Medical Council of New Zealand and working with the president and the Policy unit in representing ANZCA.”

ANZCA President

ANZCA’s new CEO

John has led several organisations during his long, successful career, including the Victorian branch of the Pharmaceutical Society of Australia, the Victorian division of St John of God Hospital, and psychology management company Healthcare Management Services.

He said his experience in a membership-based organisation with the pharmacy profession had provided a good background in understanding the nature of ANZCA.

“My approach to the job is based firmly on the principles of consultation and stewardship,” he said.

“The best leadership I can provide is built around seeking knowledge and guidance from the members and leaders within ANZCA then turning that into strategic direction and achievement.

“Through the existing forums within ANZCA I look forward to meeting as many Fellows and trainees and attending as many committee meetings as possible during my time as CEO.”

John also has vast experience in public and private hospitals as chief executive at Wagga Wagga District Base Hospital, St Andrew’s Private Hospital (Ipswich) and the Mater Hospital (Rockhampton). More recently he has been a consultant in business development.

“I have worked closely with the medical profession throughout my career and without exception I have enjoyed the close working relationships that have developed,” he said.

The ongoing development of the Faculty of Pain Medicine also provides a wonderful synergy to extend the reach of the profession more widely into the community.”

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College should not advocate partisan political views

Along with all Fellows of ANZCA, I agree with the College’s mission to “serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine”. I respect the right of each member of the College to have their own personal, political, religious and ideological views.

However, it is wrong for the College to advocate partisan political views that are not a part of its mission and are probably very different to a substantial proportion of its membership. I refer specifically to the article “Closing the gap with constitutional reform” (ANZCA Bulletin, June 2015).

ANZCA’s newfound position of political promotion is even more disturbing in the context where the model for proposed constitutional reform is still open to debate among its advocates. The blatantly contradictory position of ANZCA is shown where its proponents write:

- “That section 188...which allows the parliament to make special laws for people of any race” be repealed).

- “That a new section 26A be inserted, recognising Australia’s first people and giving the parliament the power to make laws with respect to them.”

My personal view is to single out any ethnic group in the Australian Constitution indicates a racist intent, which will be open to abuse. I find it abhorrent that ethnicity should override the principle that all Australians should be equal before the law. Those Australians who need assistance should be helped on the basis of need and race.

Dr David Brooks, FANZCA

Dr damplea Mitchell responds

I thank Dr Brooks and Dr Nicholas for raising a number of important issues.

While ANZCA’s mission is “... fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine”, we might ask where does our role extend in terms of “fostering”?

There is clearly more to promoting safety and high quality care than simply providing excellence in direct clinical care. The College is often called upon to contribute to broader health debates, with smoking, alcohol and government treatment of refugees being but examples of these.

Where do we as a professional health organisation see the extent of our involvement in discussions such as these? Two community health issues that the ANZCA Council has decided to give particular attention to in recent times include indigenous health and colonised populations as a whole, as reflected in the College’s Strategic Plan (www.anzca.org.au) and our position paper on our College’s Constitutional recognition.

Constitutional recognition dovetails with the broader drive for improvements in indigenous health. It is not controversial that large numbers of colonised indigenous people all around the world are in poorer health than the descendants of their first world colonisers. This is a public health problem, which falls within the College’s mission to serve the community by fostering safety and high quality patient care.

I agree the proposed changes are still very vigorously debated. The final proposed model is undecided. However, the principle of constitutional recognition enjoys support from a bipartisan parliamentary supporter. The College’s position is not party-aligned.

Section 31 currently reads: “...allows the parliament to make special laws for people of any race”. This provision has been followed for governments to pass laws that discriminate against indigenous peoples.

The suggested amendment would replace this clause with one that recognises that there may be occasions when it is appropriate to pass laws for the benefit of Aboriginal and Torres Strait Islander peoples, that is, “...to preserve the Australian Government’s ability to pass laws for the benefit of Aboriginal and Torres Strait Islander peoples”. (see www.recognition.org.au).

I acknowledge that this distinction was not made clear in the original article.

Dr Patricia Mackay

ANZCA serves includes

Delivering the highest quality perioperative care.

We endorse the ANZCA position that those supporting the Recognise movement (lavishly funded by public monies – some $15 million to date) claim this is adversely affecting the health and wellbeing of Aboriginal and Torres Strait Islander people.

I urge College members not to support the creation of a special class of Australian citizen in the constitution.

Dr Gavan J. Carroll, FANZCA

Papua New Guinea

Examiner Insights

It was interesting to read the typically insightful article by Dr Keister Brown (ANZCA Bulletin, June 2015). The examiner in this scenario was sympathetic and encouraging, but the candidate was obviously nervous that he clutched the edge of the table so tightly that his knuckles were white.

I knew that I had to ask a very straightforward and easy question to give him a chance to get started. Not all examiners can cope with nervous students and doctors may suffer, causing anxiety and hostility. There are some teachers who believe that this approach spurs the student on so that they know the answers the next time. The problem is that many students will avoid such classes.

Dr Toby Nichols, MACP FANZCA

Perth, Western Australia

Anaesthetic technicians deserve recognition

At present anaesthetic technicians are not recognised as health practitioners by the Australian Health Practitioner Regulation Agency (AHPRA). This limits their career structure, their career advancement and their pay scales.

Many enjoy recognition in other countries and most anaesthetists would agree that they play an important role in the theatre environment. Many of us often find them better trained, more experienced and more useful than their nursing counterparts. Those trained in Australia and New Zealand have often had more formal training in anaesthesia than the operating department assistants which that we are importing from the UK.

In the past, anaesthetists have supported the establishment of these roles and many of us have assisted in their training. Isn’t it about time we pushed for their recognition?

Peter McLaren, FANZCA

Southport, Queensland

Letters to the editor

Dr Patricia Mackay, OAM, who made an outstanding contribution to safety and quality in anaesthesia over more than 50 years, passed away on Tuesday, September 1, 2015. Born in New Zealand, Dr Mackay graduated from Otago University in Dunedin in 1949 and completed postgraduate training in anaesthesia in New Zealand, Australia and the UK.

She was appointed to the Department of Anaesthesia at the Royal Melbourne Hospital in 1950, and pursued outstanding career in anaesthesia, intensive care and pain medicine in Australia, including establishment of the first acute pain service in Victoria. She became Director of the Department of Anaesthesia at the Royal Melbourne Hospital in 1974 and held this position until 1990.

Dr Mackay served as chair of the Victorian Consultative Council on Anaesthetic Mortality and Morbidity from 1992 until 2005. She attended ANZCA’s inaugural Quality and Safety Committee meeting in May 2006 and remained a committee member until November 2012. She was recognised as a foundation member of the Australian Patient Safety Foundation and as a life member of the World Federation of Anaesthesiologists. In 2000 she was awarded the ANZCA Medal. In 2012 she was made a Centenary Medal of the Order of Australia and, in 2008, an OAM.


Dr Patricia Mackay

...
Awards

Anaesthetist appointed to NHMRC
Professor David Story has been appointed to the 2015-18 council of the National Health and Medical Research Council (NHMRC) of Australia.

The NHMRC is an authority established by the Australian Government to identify and support high quality research and researchers, to provide evidence-based advice on health issues to governments and the community and to uphold the highest ethical standards in healthcare and research.

Professor David Story, MBBS (Hons), MD, BMedSci (Hons), FANZCA, is the Foundation Chair of Anaesthesia at the University of Melbourne and head of the Anaesthesia, Perioperative and Pain Medicine Unit at the Melbourne Medical School.

Professor Story completed his medical education at Monash University and his anaesthesia training through the Alfred rotational training scheme. He joined the specialist staff at the Austin Hospital in 1997 with clinical interests in cardiac and liver transplant anaesthesia.

Professor Story's research interests include acid-base physiology, multi-centre clinical trials and engaging new investigators and sites in anaesthesia and pain medicine research. He is a chief investigator on NHMRC grants with funding of more than $8 million (POISE-2, RELIEF and PADDI).

He has had many roles at ANZCA including primary examiner (physiology), as a member and chair (2005-11) of the ANZCA Clinical Trials Network Executive, and as a member of the Perioperative Medicine Special Interest Group Executive, ANZCA Research Committee and ANZCA Safety and Quality Committee.

Appointment to the council of the NHMRC is an enormous personal achievement for Professor Story, but also is a very significant achievement for our specialties of anaesthesia and pain medicine, providing recognition for the high quality of our clinical care, record in safety and quality, and achievements in medical research.

It provides our speciality with an opportunity to help shape the national and international agenda in perioperative care over the next triennium.

Professor Kate Leslie Chair, ANZCA Clinical Trials Network Executive

The council of the NHMRC is appointed by the Australian minister for health and sport to provide advice to the NHMRC chief executive officer. Its work is undertaken through a network of principal committees, working committees and expert panels. Membership includes the chair, the chief medical officers of the Commonwealth, states and territories, community representatives and experts in healthcare and medical research.

Anaesthetist awarded Churchill Fellowship
Melbourne anaesthetist Dr Phoebe Mainland has been awarded a Churchill Fellowship.

Dr Mainland will explore the implementation of devices with “small bore connectors” in the US and UK next year in preparation for the introduction of these to Australia. The aim of her research is to enhance the safety of Australian patients by reducing misconnections between medical devices.

The Churchill Trust was established in April 1965, soon after Sir Winston Churchill's death in January that year. Since then, more than 4000 Australians have been awarded fellowships that have enabled them to explore a subject of merit for the benefit of Australian communities.

The Queen's birthday honour list
The Queen’s birthday honour awarded to Dr Peter Luckin was incorrectly described as the Medal of the Order of Australia. Dr Luckin received an AM (Member of the Order of Australia) for significant contributions to emergency medicine and as an authority on survivability during search and rescue operations.
Safety and quality hit the headlines

Since the June Bulletin ANZCA and FPM have generated:
• More than 35 radio reports.
• At least 25 print reports.
• More than 30 online reports.

The inappropriate use of conscious sedation and local anaesthetics for cosmetic surgery was the subject of several articles in the media over past months. ANZCA’s Safety and Quality Committee Chair Dr Phillipa Hore was interviewed by Fairfax (The Age and Sydney Morning Herald) journalists.

“ANZCA is now pushing for training in the use of local anaesthetics for cosmetic surgeons and says facilities should be licensed and audited,” the story says.

“Phillipa Hore from ANZCA’s safety and quality committee says cosmetic surgeons can provide local anaesthetic without any training.”

Dr Hore is quoted as saying: “It’s difficult to understand that in our sophisticated society with world-class medical care there is this practice going on.”

ABC Radio National’s PM program also interviewed Dr Hore on the issue and the stories that appeared online, in print and on radio reached an estimated combined cumulative audience of nearly 400,000, according to our media monitoring service iSentia.

A presentation by Dr David Rowe in July, to a meeting of anaesthetists as part of the Rural Special Interest Group meeting in Tasmania on fasting before anaesthesia, struck a chord with the public and received an enormous response from media outlets across New Zealand and in every state and territory in Australia. Dr Rowe gave eight interviews and appeared in rural, regional and metropolitan publications; online and across radio including ABC, Radio NZ, 3AW, 2GB, Triple J, Fox FM and 6PR Perth. The estimated combined cumulative audience for this topic alone was close to three million.

The revised FPM curriculum was the subject of a media release which led to a lengthy live radio interview on ABC’s Afternoons radio program, where Dr Meredith Craigie spoke about the philosophy behind the revised curriculum which she explained as taking a holistic approach to the patient in pain.

Ebru Yaman
Media Manager, ANZCA

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Slash surgery fasting

Long nil by mouth period is crazy, say medics

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There are funds held by the College for this program. Staff have been working with the TMSDT project steering committee to try to reallocate some of the unspent funds. To date the proposals that have been presented to the government have been rejected. Staff will continue to work with Fellows to develop a proposal that fits with the key principals of the funding and helps to deliver better outcomes for Fellows, trainees and the local community in Tasmania.

**ANZCA and government: building relationships**

Similarly, staff have been working with Fellows in WA to try to come up with a proposal that fits with the key principals of the funding and helps to deliver better outcomes for Fellows, trainees and the local community in Tasmania.

It is anticipated that the government will agree to this proposal, and that it will fit with the key principals of the funding and help to deliver better outcomes for Fellows, trainees and the local community in Tasmania.

**New Zealand**

### Health strategy review

The Ministry of Health is leading an update of the New Zealand Health Strategy, which was published in 2000. The update intends to clarify the government’s direction for the health sector for the next three to five years. The update is being supported by two externally-led reviews on health system funding arrangements, and on the capability and capacity of the health system. These reviews will be used to provide advice to the Minister of Health, Dr Jonathan Coleman.

Following approval by the minister, the draft updated New Zealand Health Strategy will be open for public consultation later this year. The ministry hosted workshops in May and June with members of the health sector about the New Zealand Health Strategy, which ANZCA New Zealand staff attended.

Key themes that emerged during the workshops included: focus on prevention, wellness and investing in children and families; better engagement with other sectors such as education and housing; a shift towards primary care; and stronger leadership from the Ministry of Health.

### Health outcome data

The discussion of public release of health outcome data continues in New Zealand among government departments, district health boards and medical colleges. This was prompted by two media requests under the Official Information Act for surgical outcome data for individual surgeons.

### Key part of our submission...

“A key part of our submission... was a recommendation that the mandatory notification provisions in the national law be amended to exempt doctors treating impaired colleagues from reporting them to the medical board.”

The Health Quality and Safety Commission (HQCSC) and the Ministry of Health are leading the issue, with the HQSC currently developing a literature review and a statement on New Zealand’s position on the transparency of health data.

ANZCA will provide feedback to the HQSC on any position developed. In July, the ministry and HQSC facilitated a workshop to seek consumer feedback on the issue. ANZCA Executive Director of Professional Affairs Dr Leona Wilson and New Zealand staff attended the workshop.

### Stakeholder meetings

In May, Dr Nigel Robertson, immediate past chair, New Zealand National Committee (NZNC) and Heather Ann Moodie (General Manager, New Zealand National Office) attended a meeting with Health Workforce New Zealand (HWNZ) to discuss the development of a nurse endoscopy training program, including the standards, competencies and training that would be required for nurses performing endoscopy.

The issue of how sedation would be delivered in this model was raised, and ANZCA representatives reiterated that any model would need to align with PipcO Guidelines on Sedation and/or Anaesthesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures. Discussion on this issue will be ongoing.

In June, Dr Gary Hoppoep, Chair, NZNC and New Zealand staff attended the Council of Medical Colleges Board meeting. The Minister of Health attended and discussed his priorities for the health sector, including: increasing focus on early intervention in primary care to decrease pressure on secondary and tertiary care; childhood obesity; greater collaboration and reduced fragmentation across regions; and development of clinical leaders.

The minister said he was keen to have meaningful clinical engagement, including meetings with district health board heads of surgery and anesthesiology. Accident Compensation Corp services continue to provide updates on work around treatment injury and noted they were keen to engage more with medical colleges, and HWNZ discussed the sources of data they use to assess workforce demand and supply.

**Submissions**

- **Australia**
  - Medical Board of Australia – Registered medical practitioners who provide cosmetic medical and surgical procedures.
  - Medical Board of Australia – Revised Guidelines on Supervised practice for international medical graduates.
  - NSW Health – Discussion Paper: Model Scopes of Clinical Practice for Senior Medical and Dental Practitioner.
  - Department of Health and Human Services (Tas) – White Paper Delivering Safe and Sustainable Clinical Services.

- **New Zealand**
  - Ministry of Health – New Zealand and the Protocol to Eliminate Illicit Trade in Tobacco Products.
  - Ministry of Health – draft Diabetes Mellitus Elective Perioperative Pathway for Adults.
  - Health Quality and Safety Commission – review of the New Zealand Tall Man Lettering list.
  - Pharmac – proposed approach to market share procurement for hospital medical devices; the establishment of Pharmac labelling preferences.

Feedback was also provided to the Council of Medical Colleges on its paper responding to the Medical Council of New Zealand about publication of health outcome data.

**Expanded training**

Healthcare in Tasmania is undergoing substantial reform as three separate health services combine into one statewide service.

This is resulting in a change to services across the state and this is having some flow on impact regarding the delivery of the ANZCA-managed Australian government program, Training More Specialist Doctors in Tasmania (TMSDT).
ANZCA is the fourth largest of Australia’s 15 and New Zealand’s 14 medical colleges. In Australia, the 15 presidents meet four times a year as the Committee of Presidents of Medical Colleges (CPMC). The CPMC has regular interactions with the chief medical officer, the Australian Medical Council, the Department of Health, the Medical Board of Australia, the National Health and Medical Research Council, the Council of Medical Deans, the Australian Council on Safety and Quality in Healthcare and representatives of the Minister for Health and the Opposition Health Minister.

This results in a two-way flow of information between key players in health policy and the medical colleges. In New Zealand, the Committee of Medical Colleges performs a similar role.

All colleges regularly receive documents from these and other organisations for consultation and a response is always made. ANZCA also receives requests from other organisations to endorse or co-badge their documents. These requests are very carefully considered and any discussion to proceed is approved by the ANZCA Executive Committee and ANZCA Council.

In April 2015, ANZCA Council approved the development and promulgation of a new type of document for the Colleges: position statements. Position statements are a primary mechanism used by the College to provide public statements on significant issues of health policy. They are the most authoritative statement that the organisation can make on an issue.

Some may consider that making statements about certain key health issues is outside the remit of a medical college. However, health advocacy is one of ANZCA’s key roles. It is one of six ANZCA Roles in Practice embedded in the ANZCA curriculum. It is also a key part of ANZCA’s professionalism document “Supporting Anaesthetists’ Professionalism and Performance: A guide for clinicians” that is now being piloted.

The constitution also states that objectives of the College are to “advocate on any issue that affects the ability of members to meet their responsibilities to patients and to the community” and “to work with governments and other relevant organisations to ... improve health services.”

Position statements are documents that provide a short background to an issue, outline the principles that the College sees as essential to improving the issue and provides a set of actions that ANZCA will advocate. They are succinct, evidence-based and may include key references to support the stance.

All position statements will be internally consistent with existing ANZCA policy and regulations and should be no more than a page, including references.

In developing the content of a draft position statement, the ANZCA Council considers the following:

- Is the intent of this draft position statement consistent with ANZCA’s objectives and other ANZCA policies/professional documents (have other relevant ANZCA policy instruments been referenced?)?
- Is this a significant issue to the profession and is a position statement the most appropriate policy format for this issue?
- Is the information the most current and reliable, both scientifically and politically (for example, have existing strategies and plans been taken into account)?
- Is the proposed position statement actionable and will it lead to discernible outcomes that we will be able to assess/evaluate?
- Will the proposed position be relevant for the life of the position statement?

Position statements will ordinarily be approved by ANZCA Council and uploaded to the advocacy page of the website. To avoid confusion with professional documents, they will be badged as position statements.

Dr Genevieve Goulding
ANZCA President

Asylum seeker position statement

ANZCA Council has approved a position statement on the health of people seeking asylum. This document is based on one drafted by the College of Intensive Care Medicine of Australia and New Zealand and the Australian and New Zealand Intensive Care Society. The statement focuses on access to safe affordable surgery and anaesthesia when needed, including adequate pain relief.

This statement emphasises the importance of health care for asylum seekers within the framework put forward in the recent Lancet Commission Global Surgery 2030: evidence and solutions for achieving health, welfare, and economic development.

The Australian Society of Anaesthetists, New Zealand Society of Anaesthetists and Faculty of Pain Medicine have endorsed the document.

It can be accessed via the ANZCA website at www.anzca.edu.au/communications/advocacy.

ANZCA’s first position statement: Health of people seeking asylum

ANZCA is the fourth largest of Australia’s 15 and New Zealand’s 14 medical colleges.
ANZCA is celebrating National Anaesthesia Day on October 16, again marking the anniversary of the day ether anaesthesia was first demonstrated in 1846, in Boston, Massachusetts.

Obesity complicates anaesthesia

This year our theme, “Obesity complicates anaesthesia,” was chosen after hearing an overwhelming number of Fellows voice concern at the increasing challenges of caring for patients with excess weight.

Over the past 20 years, the rate of obesity has soared in Australia and New Zealand. In Australia, the latest report on national weight trends by the Australian National Preventive Health Agency found that in 2011-12, one in five adults was obese compared with one in five adults in 1995. The most recent figures for children under 5 years of age show one in five is obese.

In New Zealand, the prevalence of obesity has increased threefold – from 10 per cent in 1977 to 30 per cent in 2012-13. Between 2006-07 and 2011-13, the rate of obesity among two to 14-year-olds increased from 9 per cent to 12 per cent.

“Obesity complicates anaesthesia – a key message for patients”

While informing patients and their carers about the complications to anaesthesia caused by obesity, a key message for them is that there is something they can do. To start with, they should talk to their medical team, including their anaesthetist.

The risks to an obese patient having an anaesthetic are well known, with excess weight associated with:

• Health problems such as type 2 diabetes, high blood pressure and heart disease – conditions that compromise anaesthesia and make it more difficult to heal.
• Difficulties in positioning patients properly for an operation. Folding and keeping a patient in place during anaesthesia.
• The heart under extra pressure, especially under anaesthesia.
• Complicating maternity care – for example, the risks to a mother’s health, the increased risk of pre-term labour, and risk of anaesthetists not being able to accurately insert an epidural.
• Difficulties in managing pain following surgery and anaesthesia.

Your support is essential

The aim of National Anaesthesia Day is to lift the community profile of the specialty. A Community Attitudes Survey commissioned by ANZCA two years ago found that, despite 96 per cent of people reporting experience of a general anaesthetic (personally or through a close family member), only 50 per cent were aware that all anaesthetists are doctors (of these, 41 per cent know they are doctors with the same training/qualifications as other specialists).

Nearly one in 10 does not think anaesthetists are doctors and another 49 per cent are unsure. And 50 per cent don’t feel informed about anaesthesia.

The most effective way to improve the community’s understanding of anaesthesia happens every day through face-to-face interactions between anaesthetists and their patients. National Anaesthesia Day is another, more focused way to draw attention to the specialty.

In September, ANZCA will send kits to hospitals, private practices and others on its database. These will contain “Obesity complicates anaesthesia” posters and other promotional materials, including the “Who is your anaesthetist (an-ees-the-tist)?” flyer. More of these can be printed and distributed.

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• Complicating maternity care – for example, the risks to a mother’s health, the increased risk of pre-term labour, and risk of anaesthetists not being able to accurately insert an epidural.
• Difficulties in managing pain following surgery and anaesthesia.

To reduce your weight, patients are encouraged to discuss their weight with their General Practitioner (GP) and seek their anaesthetist’s advice on how best to reduce their risks during surgery.

I urge you all to embrace National Anaesthesia Day and support the ANZCA mission to “serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine”.

As we do more in the perioperative sphere, encourage your patients to talk to their medical team about what they can do to reduce their risks during surgery.

Dr Genevieve Goulding
ANZCA President

We are all affected by the obesity epidemic.

As we are only too well aware, patient obesity is affecting our profession more and more.

Some six years ago, when confidential information to maternal deaths in the UK told us of the greatly increased risks of maternal morbidity and mortality, as well as perinatal mortality in patients with a body mass index (BMI) of 35 or more, my hospital, the Royal Brisbane & Women’s Hospital, was inundated with referrals of overweight patients from smaller hospitals unwilling to take the risk with bigger maternity patients.

At the time, our maternity pre-anaesthesia clinic took on such patients with a BMI of 35 or greater for an antenatal consultation, to identify risks and develop an anaesthetic management plan for labour and delivery, but soon we weren’t coping with the number of referrals so the minimum BMI was reset at 40.

The hospital still couldn’t cope and now the clinic is only able to take in patients with a BMI of over 40, which means unless there are other serious co-morbidities, many obese patients will only receive a brochure on obesity in pregnancy and why it might be necessary to see an anaesthetist, and the patients are referred to us in labour.

The ANZCA Council has recognised this growing issue facing anaesthetists and has started to discuss establishing guidelines and/or a professional document related to managing obese patients peripersonally.

So it is timely that this year’s National Anaesthesia Day on Friday, October 16 is focusing on obesity and overweight patients are being encouraged to talk to their medical team about what they can do to reduce their risks during surgery.

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Inappropriate comments about a patient

Dr Peter Roessler, Director of Professional Affairs, Professional Documents

Interestingly, the gastroenterologist apparently did nothing to discourage the anesthesiologist’s actions and comments.

What would you do?

If faced with this situation there are a number of issues to consider in deciding on what action to take. Negative comments tend to be counterproductive and have a demoralising effect on teams and their performance. If they are frequent, repetitive, and incalculable, they can become an irritation to those subjected to such behaviour. It may be appropriate to contemplate this as the ITCH factor:

- Intent: What is the reason or the purpose for making the comment?
- Tox: Is there anything to be gained by making the comment or is it simply an inappropriate or innocent comment?
- Content: Does the comment reflect a factual observation poorly expressed or is it a deliberately twisted interpretation?
- Health or impairment issue: Is this a normal pattern for this individual that warrants significant concern?

The following resources may assist in evaluating and addressing behavioural issues. All can be found at www.anzca.edu.au/resources/professional-documents:

- Supporting Anaesthetists’ Professionalism and Performance: A guide for clinicians (pilot). See page 11 (playing an active role in clinical teams and working to prevent and resolve conflict), page 12 (examples of good behaviour) and supporting others on page 13. Also page 16 (defining ethics and probity).

The report provides a comprehensive resource that underpins the upcoming professional document PS50 Guidelines for the Management of Evolving Airway Obstruction: Transition to the Can’t Intubate Can’t Oxygenate Airway Emergency and its accompanying background paper. It also supports the next stage of the practical implementation of this decision-making process, which is the continuing professional development-based CICO component under emergency responses.

The Airway Management Working Group was convened by the ANZCA Safety and Quality Committee and includes members of the Airway Special Interest Group, who have worked hard to achieve this result. It is the first of a number of airway resources to be published by ANZCA. The next will be on airway assessment.
While many Fellows and trainees utilise the ANZCA Library and take advantage of its services, it is important that we continue to promote and communicate the specialist nature of the library and all that is on offer.

A recent library review supported greater marketing of the library and an increase in collaboration between the library and other College units. A number of initiatives are planned covering online resources and activities as well as practical initiatives designed to support information gathering and workflow.

We are working with colleagues from the education and research areas of the College to develop a one-and-a-half hour workshop on tips and tricks for using the library for research that will be held at the 2016 ASM in Auckland.

This workshop will be modified so that it can be presented at other College education events and will support the scholar role as part of the training curriculum. Remember also that the library is a constant presence at all annual scientific meetings (ASMs) and will be at the New Zealand ASM in Wellington from November 5-7, 2015. Please feel free to drop by the ANZCA stand and find out more about library services and resources.

One other area where the library is providing resources and ensuring that these are relevant and valuable to Fellows and trainees is the College’s learning management system, Networks. We are ensuring resources relating to continuing professional development (CPD), exams and the curriculum are progressively being linked and embedded in areas of learning.

Did you know that in the first six months of 2015, there have been more than 170,000 downloads from the online textbook collection? This already exceeds the number of downloads for all of 2014.

The ANZCA Library provides a specialised collection of anaesthesia and pain medicine-related resources, 24 hours a day, seven days a week, regardless of the user’s location.

Jan Sharrock
General Manager, Fellowship Affairs
ANZCA
Recognising the traditional owners of the land

The Indigenous Health Committee was also engaged in the process and, following council endorsement, undertook research to identify the Aboriginal people in each Australian state and territory for the specific area where an ANZCA office was located. Land councils, government bodies and local councils as well as indigenous Fellows were consulted as there can often be spirited debate as to which Aboriginal nation and people hold responsibility for lands. Once confirmed, the information was incorporated into the wording and design of a glass plaque installed at ANZCA head office and now at each regional office.

As well as the plaques, council confirmed that it would endorse the use of an acknowledgement of country at significant ANZCA meetings, most particularly before each council meeting and at significant meetings like the annual scientific meeting.

New Zealand staff have discussed recognising the indigenous owners of the land where the New Zealand office is located with members of the Te Atiawa iwi (tribe), which has current mana whenua (authority) for that land. While appreciating the intent behind the plaque concept, Te Atiawa are more concerned with the wider relationship between ANZCA and Maori overall. The New Zealand National Committee (NZNC), too, recognises its responsibility to acknowledge Maori on a national basis, rather than just locally. It is more common in New Zealand to acknowledge the Treaty of Waitangi as the founding document that underpins the relationship between Maori and the Crown and, accordingly, the NZNC and New Zealand staff are exploring the concept of a document acknowledging the treaty, and perhaps Te Atiawa, in a form appropriate to Maori.

Dr Sean McManus, ANZCA Councillor and Chair of the Indigenous Health Committee
You are working in a busy theatre complex preparing for a day of anaesthesia. During the pre-operative consultation your first patient describes significant anxiety at the prospect of undergoing surgery so you offer to provide a small dose of intravenous midazolam when they arrive in the theatre induction room. Talking to your patient you reassure them that the medication you are injecting will soon take effect and will make them feel “warm and relaxed”. Moments later they tell you it feels “strange to swallow”, soon followed by “I can’t breathe...” as a look of panic comes across their face and they struggle to move in the bed. You quickly check the medication and syringe you believed had been so carefully prepared only to realise the clear glass ampoule you had selected contained the paralysing agent cisatracurium and not the anxiolytic midazolam you had intended. Recognising the error you act quickly to ensure the patient is oxygenated and general anaesthesia is induced safely. The surgery proceeds uneventfully and the patient makes a full recovery but subsequent follow up reveals they have developed a disabling post-traumatic stress disorder requiring ongoing counselling and therapy.

Some will have first-hand experience of a significant drug administration error, most will know of a local episode and all of us are aware of the persistently large number of medication errors...reported.”

The problem
Anaesthetists will immediately recognise the chilling scenario described as a frightening consequence of an error in the preparation and administration of medications commonly used in our practice. Some will have first-hand experience of a significant drug administration error, most will know of a local episode and all of us are aware of the persistently large number of medication errors, and the harm that results, reported in anaesthetic and medical literature. Medication incidents are the second most common event reported in health services with sobering estimates of patient harm and associated costs. Prospective research suggests drug errors may occur as frequently as one in every 133 anaesthetics although the true incidence is likely greater due to under-recognition and under reporting. A report from the Institute of Medicine in America identified labelling and packaging deficiencies as contributory in as many as one third of medication errors.

Why do errors occur?
Twenty-five years ago the landmark report of the committee on Quality of Health Care in America, “To err is Human”, identified that causes of error in the provision of healthcare are multifactorial and reflect system and process complexity.

With the provision of a single dose of medication to a patient in a critical care setting estimated to require between 80 and 200 individual steps from prescription to preparation and administration, the potential for errors is obvious. Environmental and situational factors such as time pressure, cognitive overload and distraction undoubtedly contribute to the likelihood of making a medication error in anaesthesia. Theorising about the fundamental causes and mechanisms of accidents, psychologist James Reason described the concept of latent errors. These preconditions can be thought of as “accidents waiting to happen”. The variable and indistinct packaging and labelling of injectable medications is a clear example of such a latent error and an obvious contributor to the type of administration error described in the above scenario.

Research suggests drug errors may occur as frequently as one in every 133 anaesthetics although the true incidence is likely greater.

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Administered intravenously these similarly packaged drugs have effects ranging from anticoagulation, decreased blood pressure and increased analgesia/sedation to increased heart rate, elevated blood pressure and reversal of analgesia/sedation.
What is being done?
Anaesthetists have long been contributors to improvements in safety in medication handling and administration. Research by Professor Bill Runciman and Professor Alan Merry, among others from Australia and New Zealand, remains some of the most widely cited work examining both the extent of medication errors and potential solutions.

User applied labelling of syringes with ISO 26825:2008 standard colours for injectable medicines was a change championed by ANZCA with the Australian Commission on Safety and Quality in Health Care (ACSQHC). This has undoubtedly been a significant step forward but continues to rely on the user correctly identifying a drug in its original ampoule. Recently documented examples of high risk medication swaps highlight the limitations of such an approach.

Time for change
A report prepared by the Departments of Anaesthesia and Pharmacy at Western Health in Melbourne documents recent medication errors with neuromuscular blocking agents and proposes that Australia adopt standardised packaging and presentation of these drugs.

The report, endorsed by ANZCA, was submitted to the Therapeutic Goods Administration earlier this year and echoes previous calls by the ACSQHC to “require distinctive labelling and packaging of neuromuscular blocking agents in labelling regulatory changes”.

Existing recommendations in Canada and the US suggest NMBDs be presented in ampoules with a redivial cap and the words “Warning: Paralyzing Agent”.

Despite the widespread adoption of this and other measures by international manufacturers, it is not yet supported by any binding standard. Should the proposals of the “Time for change” report be fully implemented as a mandatory standard, Australia would be positioned as a world leader in this area of regulatory innovation. The changes proposed are clearly only one small part of minimising look-alike and sound-alike products.

Optimising drug storage environments to facilitate clear product identification.

Making user applied labels readily available and minimising the time between drug selection and administration.

Good practice and safe behaviours are fundamentally important but anaesthetists will be familiar with the ever changing presentation of medications that require ongoing “reactive” responses.

Assuming human fallibility underpins the philosophy that further success in reducing medication errors will depend on continuing to address the latent errors in the system including the packaging and presentation of high risk medications.

The tip of the iceberg
Even where serious adverse patient outcomes do occur, institutions may keep such events confidential. As a result, the episodes reported in the medical literature, logged in incident reporting databases or appearing in the media represent only the tip of the iceberg.

Making a difference – the EZDrugID campaign
EZDrugID is a global campaign to reduce medication errors by addressing issues related to pharmaceutical packaging, with a particular emphasis on the problem of “look-alike drugs”.

The EZDrugID campaign was initiated in December 2014 and is active in Australia, New Zealand, the United Kingdom, South Africa and the US. Online petitions to the relevant regulatory authorities in each country have been established, calling for mandatory national standards which incorporate consideration of human factors principles into the design of pharmaceutical packaging so as to maximise the distinctiveness of different drug classes and high risk drugs.

Anaesthetists will already be familiar with the international standard for colours coding by drug class which comprises part of the national recommendations by ANZCA and the Australian Commission on Safety and Quality in Healthcare (ACSQHC) for user applied syringe labels. Among other strategies, EZDrugID proposes extending this colour coding system to elements of manufacturer applied pharmaceutical packaging.

The tip of the iceberg
The frequency of errors related to look-alike drugs is difficult to gauge as a lack of mandatory reporting means that many “near miss” events and errors not causing patient harm do not get captured. Even where serious adverse patient outcomes do occur, institutions may keep such events confidential. As a result, the episodes reported in the medical literature, logged in incident reporting databases or appearing in the media represent only the tip of the iceberg.

A survey conducted in conjunction with the EZDrugID campaign revealed that more than 75 per cent of participating clinicians had experienced a “near miss” which they attributed to medication packaging. Nearly 70 per cent of respondents had been involved in an actual medication error related to medication packaging, with serious patient harm being reported in about 10 per cent of these cases.

What they’re saying
In 2005, UK pilot Martin Bromiley’s wife Elaine died during routine surgery as a result of errors to which human factors made a significant contribution. He founded the Clinical Human Factors Group which brings together experts, clinicians and enthusiasts who share understanding of human factors at the heart of improving patient safety.

He is strongly supportive of the EZDrugID campaign.

“IT IS a huge advantage to the anaesthetic team and to nurses to have a drug that is readily identifiable by its packaging and presentation.”

Other comments
Following is a selection of comments from doctors and others from the Change.org website – www.change.org/p/therapeutic-goods-administration-improve-mandatory-national-standards-for-drug-packaging

“Doctors make errors that can kill. This is one way to make that better. It’s what our patients expect and deserve.”

“The potential for catastrophic events due to drug errors that could be easily avoided with better packaging is significant.”

“Medication errors are common, dangerous and unnecessary.”

“So many errors just waiting to happen, and can easily see myself making one of these errors.”

“Drug error is a major problem. Better drug labelling is an obvious and simple solution.”

“Almost every week there seems to be a change in packaging and presentation of these drugs. It makes the potential for drug error even more likely.”

“I am a nurse and have witnessed multiple near misses and medication errors.”

“It’s ridiculous how many drug packages are similar and we need to provide safer patient care.”

“We must take every effort to engineer safety to limit human error and minimise patient harm.”

“I am a nurse and none of us want to have a medication error so having different packaging would make me more comfortable and confident in drug administration.”

Good practice and safe behaviours are fundamentally important but anaesthetists will be familiar with the ever changing presentation of medications that require ongoing “reactive” responses.

Assuming human fallibility underpins the philosophy that further success in reducing medication errors will depend on continuing to address the latent errors in the system including the packaging and presentation of high risk medications.

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The changes proposed are clearly only one small part of minimising look-alike and sound-alike products.

Optimising drug storage environments to facilitate clear product identification.

Making user applied labels readily available and minimising the time between drug selection and administration.

Good practice and safe behaviours are fundamentally important but anaesthetists will be familiar with the ever changing presentation of medications that require ongoing “reactive” responses.

Assuming human fallibility underpins the philosophy that further success in reducing medication errors will depend on continuing to address the latent errors in the system including the packaging and presentation of high risk medications.

The report, endorsed by ANZCA, was submitted to the Therapeutic Goods Administration earlier this year and echoes previous calls by the ACSQHC to “require distinctive labelling and packaging of neuromuscular blocking agents in labelling regulatory changes”.

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A global healthcare issue

The issue has resonated with clinicians worldwide. Paramedics, nurses and doctors across numerous specialties have shared images of look-alikes from their clinical environments via social media. The EZDrugID campaign provides a forum for clinicians to highlight concerns, describe incidents and propose potential solutions.

The campaign has gained the support of several prominent human factors campaigners in the healthcare arena including the chair of the Clinical Human Factors Group in the United Kingdom, Martin Bromiley, as well as British anaesthetist, author and television presenter Dr Kevin Fong.

Prevention rather than cure

While hospitals attempt to deal with the issue of look-alikes internally via institutional purchasing, labeling and storage practices, these solutions are not robust enough to provide adequate protection to patients. Changes in purchasing and packaging make it too easy for look-alikes to “slip through the cracks”, to be recognised only after patient harm has occurred.

The importance of prospectively addressing the look-alike issue before drugs reach the market was recently highlighted by the near identical packaging of commonly stocked brands of glycopyrrolate and oxytocin. In the right circumstances, substitution of these drugs has the potential to cause serious foetal harm. Although oxytocin is not usually stocked on anaesthetic trolleys, it was found inadvertently mixed together with the glycopyrrolate in some Australian operating theatres.

Even though the pharmaceutical company involved worked collaboratively with regulatory bodies to address the packaging issue, the realities of the time taken to approve designs, manufacture new packaging and deplete existing stock meant that for a period of more than six months the look-alike packaging stayed in clinical areas, exposing patients to continued risk.

Dr Nicholas Chrimes, FANZCA
Monash Medical Centre, Victoria

Above: Some labels are difficult to see when they are in dark drawers.

Play your part

Healthcare professionals do their best to provide the safest possible care for their patients but despite this vigilance, errors still occur.

This risk is increased in situations of stress, distraction, time pressure or fatigue – making anaesthetists particularly vulnerable to such errors.

To learn more about the problems, potential solutions and participate in addressing this serious patient safety issue by signing the online petition, visit the website at: EZDrugID.org
"Many national guidelines have stipulated a six-hour fast for solids and a two-hour fast for clear fluids for more than a decade so it is not unreasonable to ask why "nil by mouth from midnight" is still advised by some.

Fasting – not starving – before an anaesthetic

Achieving an empty stomach

The first dogma to challenge is that a prolonged fast results in an emptier stomach than a short fast, the classic "nil by mouth from midnight" that many of us were introduced to as medical students doing our first surgery rotations. The logic that follows from Mendelson's paper is that to prevent aspiration of stomach acid the stomach should be empty at the time of inducing anaesthesia.

The 2016 European fasting guidelines' clearly state that patients should be encouraged to drink clear fluids up to two hours before the induction of anaesthesia, citing level A evidence from papers dating back to the mid 1970s.

There is clear evidence that drinking clear fluids two to four hours pre-anaesthetic (unrestricted volume) results in a smaller residual gastric volume with a higher pH (less acid) than restricting fluids for greater than four hours. Fluids dilute the acid that is continually secreted and stimulate the stomach to empty. The guidelines go on to state that patients traditionally thought to have delayed gastric emptying – the obese, diabetic, pregnant or those with reflux – can follow the same advice.

Many national guidelines have stipulated a six-hour fast for solids and a two-hour fast for clear fluids for more than a decade so it is not unreasonable to ask why "nil by mouth from midnight" is still advised by some.

Avoidance of over-fasting is not a new concept. Lest Lister, the father of modern surgery, noted in 1862 that prior to chloroform anaesthesia "it will be found very salutary to give a cup of tea or beef-tea about two hours previously."

Preoperative oral carbohydrates in practice

Carbohydrate rich drinks offer a simple alternative to prolonged fasting and the restriction of clear fluid intake to water only.

The current ANZCA fasting guidelines apply to "healthy" patients and – Results time since (hours)

Fasting in Armidale hospital, NSW

The 2011 European fasting guidelines – Results incidence of pre-operation (%)

References:

3. Levy D, Pre-operative fasting—60 years on from Mendelson’s landmark paper. Anes T 2016; 3: 84-89

Acknowledgement:

I’d like to thank Dr Bruce Burrow FANZCA, Princess Alexandra Hospital, Brisbane for his assistance in preparing this article.

An increasing body of literature supports the use of pre-operative carbohydrate rich drinks to reduce the stress response to surgery, to shorten length of hospital stay in major surgical cases and improve patient wellbeing on arrival in theatre.

Anesthesiasts need to retake ownership of the pre-anaesthetic fasting message and look to include recommendations for the use of carbohydrate rich drinks in their fasting protocols to ensure that patients arrive in theatre comfortably and in an optimal metabolic state.

The current ANZCA fasting guidelines apply to “healthy” patients and conservatively restrict fluid intake to 200ml per hour up to two hours pre-anaesthetic. In a welcome move, the College announced in the August 2015 ANZCA E-Newsletter that its Safety and Quality Committee has decided to review the current fasting guidelines found in PS 15 Recommendations for the peroperative care of patients selected for day surgery.

There needs to be a robust and thorough review to define best practice. If developed and published in time, perhaps our profession can use the 2016 National Anaesthesia Day to reclaim and redefine the fasting message to celebrate the 70th Anniversary of Mendelson’s landmark paper.
“Available, unsecured and unregulated in a variety of locations within a hospital, propofol is relatively easy to access unlike opioid medications.”

In the interim, protection of the individual and their patients is paramount, and should be overseen by an intervention team member, senior consultant anaesthetist, registrar or, in some circumstances, a senior nurse or technician. It is now mandated that the appropriate health authority be notified.

Further investigation that should be considered includes an observer report, retrospective audit(s) of escalating drug usage and prospective observation for ongoing discrepancies.

Definite evidence is required for a successful intervention so careful observation for signs and symptoms of abuse and documentation is essential. A more rapid intervention should be considered if major signs have been observed or documented, such as conclusive evidence of self-injection or intoxication.

An intervention team, including the head of department, an expert in the field such as a psychiatrist and possibly the welfare officer, should outline in advance the plan for an intervention, including the post-intervention strategy and treatment options. The intervention is best conducted early on a normal operating day when the anaesthetist in question is normally on duty.

The suspect should be informed of the intervention on arrival at work and concurrently given the opportunity to appoint an advocate. The anaesthetist should then be accompanied at all times for their protection against self-harm.

An effort should be made where possible for the chosen advocate to attend the meeting. If this is not possible, the intervention team should appoint a mentor to act on behalf of the anaesthetist under investigation.

It is the responsibility of the intervention team to ensure the safety and emotional needs of the person being investigated are met.

Depending on the situation, the intervention meeting should culminate in one of two ways to ensure the safety of the anaesthetist. If medical detoxification is considered necessary, a qualified person should accompany the anaesthetist to the prepared detoxification unit. If discharge back into the community is considered, this should only occur after a psychiatric assessment for validity risk.

Record the results of the intervention meeting and subsequent treatment plans then confidentially file this together with the other relevant records.

Three decades of substance abuse surveys indicate a dramatic potential rise in propofol abuse by anaesthetists.

Propofol is involved in 56 per cent of new cases of substance use disorder reported in anaesthetic registrars. Sadly this also seems to be associated with a high mortality rate.

Often available unsecured and unregulated in a variety of locations within a hospital, propofol is relatively easy to access unlike opioid medications. It is short acting, has a rapid clear-headed recovery and appears to have minimal hangover effects. Like most addictive drugs or activities, it enhances dopamine levels in the mesocorticolimbic reward area of the brain, which also reinforce the repeated associated behaviour of obtaining and injecting the drug. Sub-anaesthetic doses appear to provide a sense of euphoria and relief to sleep-deprived shift workers.

Substance use disorder and addiction are chronic medical conditions, and while they are treatable, they also are subject to exacerbations and relapses, especially without appropriate therapy and follow up.

Recognition and identification of an anaesthetist with substance use disorder continues to be difficult and subjective, with denial by both the addicted individual and the observer common.

Unfortunately late signs such as direct observation or intoxication are the most frequently reported methods by which cases are identified and the more subtle signs are often missed.

What to do if you suspect a colleague

In the situation where an anaesthetist is suspected to have a substance use disorder, written evidence should be collated and any oral evidence documented. This will need confidential confirmation by an appropriate investigation.

Janet was desperate. Doing a research fellowship made access to her ‘little helper’ – the milk of amnesia 2,6-diisoprophenol – real to problematic. She knew she could try obtaining it over the internet, but that just increased the risks. She’d leave that to an act of last resort. Posing as a nurse in the accident and emergency unit she had just slipped the drug out of a drawer in the procedure room when she was confronted by the charge nurse. The rest is history.

Rehabilitation

Unfortunately rehabilitation following substance abuse is often complex and relapses and even death may occur.

The optimal management of the impaired anaesthetist is controversial. The most evidence guiding management originates from the Physicians Health Programs in the US. These programs combine multidisciplinary management with long-term professional and peer support, and involve contracts committing to rehabilitation and abstinence.

These studies shown success rates of 75–90 per cent after five years for US physicians treated through Physicians Health Programs and preliminary data from the Victorian Doctors Health Program indicates similar Australian five-year success rates.

(continued next page)

WHAT TO LOOK FOR

MAJOR SIGNS

Direct observation of suspicious behaviour.

Drugs found in non-work areas.

Injection marks.

Signs of intoxication or withdrawal.

Illegible or inaccurate records.

MINOR SIGNS

Social withdrawal, disengagement.

Mood swings, depression, euphoria.

Poor hygiene, weight loss.

Long toilet breaks, long sleeves.

Temperature sensitivity.

Anxiety, inappropriate conduct.

Volunteering for extra duties or cases.

Anaesthesia training in Australia and New Zealand could be considered a high-risk occupation due to the impact of substance abuse on the profession, according to a review of the past 30 years of data from three prospective surveys.

Eleven deaths (23 per cent) associated with substance use were identified in the survey period, with five directly identified as being related to substance abuse or overdose, and seven described as suicide.

The estimated mortality rate of 39 deaths per 100,000 anaesthetic registrars is very high, especially considering the most dangerous Australian industry, freight trucking, has a death rate of 29 deaths per 100,000.

The overall incidence of substance abuse was 1.7 cases per 1000 registrar years, or potentially as many as one in every 133 registrars entering training.

“LITTLE HELPER” POSES PROBLEMS

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TRAINES AT RISK

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The overall incidence of substance abuse was 1.7 cases per 1000 registrar years, or potentially as many as one in every 133 registrars entering training. The recent 10-year survey indicates that trainee suicide may be three times that of specialists and that propofol has become their most common drug of abuse for registrars (56 per cent), with opioids falling to 44 per cent.

Lewis Fry
Medical student

References:


It is essential we are aware of the signs of substance abuse and that departments have access to the expertise to deal with these issues to best assist impaired anaesthetists.

ANZCA has a number of strategies to address this issue including continually updated doctors welfare resources on the ANZCA website (see www.anzca.edu.au/resources/doctors-welfare), devoting sessions to welfare at most conferences, supporting the establishment of departmental welfare officers and working with the Royal Australasian College of Psychiatrists to improve the diagnosis and treatment of at-risk individuals.

Dr Rob Fry, FANZCA
Special Interest Group

References:
Evolution of an adult difficult airway trolley

A difficult airway trolley (DAT) is essential in all operating theatre complexes. Adverse events involving the airway continue to account for a significant proportion of morbidity reports. At Melbourne’s The Alfred hospital (2008-2010), airway-related adverse events were consistently the second most reported (figure 1) and featured highly in morbidity meetings. It is a major cause of reported morbidity in Victoria and continues to represent significant risks for morbidity and mortality. Coupled to this, the number of devices to assist in difficult intubation has expanded exponentially. This increases the complexity and range of anaesthetic technical skills required but makes it difficult to prioritise which equipment to use.

Recent evidence recognises and supports the need for ongoing simulated practice to improve the preparedness of anaesthetists and intensive care specialists to manage can’t intubate can’t oxygenate (CICO) events.1,2

Figure 1: The pattern of adverse events reported to The Alfred Anaesthesia Safety Project 2010 (with permission from Schmik solutions Pty Ltd.)

In 2009, we redeveloped difficult airway trolleys at The Alfred. The primary principles and goals of the project were to:

- Limit the number of devices available at the point of care.
- Standardise the equipment across the entire Alfred Health network.
- Support an ongoing education program surrounding difficult airway management.
- Develop a systematic approach to improve preparedness to manage CICO events.
- Incorporate human factors into the airway trolley layout.

Limiting equipment was justified, as too much equipment on the difficult airway trolley makes finding the required equipment difficult in an emergency. We aimed to modify the temptation to “try every device” instead of developing a well-reasoned sequence of actions in advance.

Every staff member involved in airway management should be familiar with the use of every component on the trolley. We designed an integrated shared model for difficult airway management that paralleled education and, above all, simplified and improved the abilities of the clinical team to act collectively and respond appropriately.

We incorporated information from the 2009 BJA CICO paper,3 airway experts’ feedback and allied health staff to ensure we had an optimised difficult airway trolley. A CICO pack was provided that could be deployed rapidly in all theatres and be used to provide percutaneous emergency oxygenation during a CICO crisis. The education model separated plan A (intubation) from plan B (supraglottic oxygenation) and plan D (infraglottic oxygenation). Importantly oxygenation was central to the model and forms part of the pre-induction planning. Plan C ( wake up) represented the final aim and although it didn’t require specific equipment, it is critical to the underlying education program that surrounded the management of failed intubation and CICO events (figure 2).

The model supported clear pre-induction planning and recognised the interaction between plan A, plan B and plan C. Educationally these processes represent everyday practice and the trolley was designed with that in mind. The difficult airway trolley was designed around the model to include seven colour-coded drawers (figure 3). Plan A drawers are colour coded blue, plan B are colour coded yellow and plan D, red or black. In addition, there is a cognitive aid, fibrescope and a range of bougies and catheters on each trolley. The colour coding provides the user of the trolley with instant visual feedback as to which drawers are required for plans A, B and D in a systematic stepwise process and assists those involved in any scenario knowing where they may be in the model.

Central to the deployment of the difficult airway trolley was an orientation package that included a cognitive aid, talks and simulated practice program.

(continued next page)
Evolution of an adult difficult airway trolley (continued)

Ultimately we hope this reduces the consequences of oxygen desaturation associated with difficult airway management by incorporating a standardised trolley to improve the interaction between healthcare teams, the equipment and skill sets.

Over the period of time The Alfred difficult airway trolley was used, it became apparent certain aspects could be improved upon, in particular additional papers reviewed and the ANZCA PS56 Guidelines on Equipment to Manage a Difficult Airway during Anaesthesia. It was concluded that some products were not as effective as perceived.

These changes allowed for a narrower trolley with smaller dimensions to be used so it was lighter, more mobile and easier to store. It was especially designed to be able to fit a seven-drawer distinctive red colour configuration to allow easy recognition. The trolleys were relocated in a central storage area for use in the more elective setting. Sugammadex (2000mg) was added. A policy for its use was developed given its relatively high cost.

Conclusions

Figure 3: The Alfred and Epworth difficult airway trolleys.

Our goal in developing a mobile difficult airway trolley and learning package was to reduce the variability and complexity of factors in high-risk airway situations, standardise the equipment available across many different organisations, campuses and environments in Victoria and allow for the easy deployment of the trolley in remote anaesthetising locations. The trolley and its cognitive aid are designed to facilitate the smooth progression between the different airway plans.

Drawer 1

- Topicalisation
  - 1 x opioid/anaesthetic spray
  - 1 x short nuzzle
  - 1 x long nuzzle
  - 1 x xylocaine 1% spray
  - 1 x medicine cup
  - 1 x xylocaine 10% pump spray
  - 1 x xylocaine 3% ointment
  - 1 x lignocaine 3% ml syringe
  - 1 x tube lubricant
  - 1 x Devilbiss atomiser
  - 1 x epidual kit

Drawer 2

- Airway
  - Nebuliser/tracheotomy mask/Ovassapan
  - 1 x Ovassapan airway
  - 1 x nebuliser mask
  - 1 x AICE spacer
  - 1 x salbutamol inhalers
  - 1 x nebuliser tee
  - 1 x endotracheal mask
  - 1 x tracheotomy mask
  - 1 x bivalved/ivivana
  - 2 x salbutamol nebuliser

Drawer 3

- VGO and VPR
  - Oxygen tank holder 145 x 125 x 40mm with side rail mount
  - 1 x IV pole, adjustable height, bolt on - chrome
  - 1 x bodai/swivel Y

Drawer 4

- Laryngoscopes
  - 1 x short handle
  - 1 x normal handle
  - 1 x Kessel blade size 3
  - 1 x Kessel blade size 4
  - 1 x McCoy blade size 3
  - 1 x McCoy blade size 4
  - 1 x Miller blade size 2
  - 1 x Miller blade size 3
  - 1 x Miller blade size 4
  - 2 x batteries
  - 2 x trachy tape

Drawer 5

- Intubation – ETT/stylet
  - 1 x ETT sizes 5.5, 6.5, 7, 7.5, 8
  - 1 x MLT sizes 4.5
  - 1 x Fastrach ETT sizes 6, 7, 8
  - 1 x Parker Flexa-tip sizes 6, 7, 8
  - 1 x Stylet
  - 1 x Magills forceps

Drawer 6

- Supraglottic oxygenation – LMA
  - 1 x Supreme LMA sizes 3.5, 4.5
  - 1 x Classic LMA sizes 3.5, 4.5
  - 1 x Fastrach LMA sizes 3.5, 4.5
  - 1 x Fastrach ETT sizes 6, 7, 8

Drawer 7

- InfraGlottic oxygenation – Cricothyrotomy
  - 1 x Manujet
  - 1 x Manujet connecting tube
  - 1 x Me病人 cuffed cricothyrotomy set

Drawer 8

1 x nasopharynx 5.5, 6, 6.5, 7, 7.5

Drawer 9

Nebulisers/tracheotomy mask/Inhale

Drawer 10

1 x short handle

Drawer 11

1 x short handle

Drawer 12

1 x short handle

Drawer 13

1 x short handle

Drawer 14

1 x short handle
Given that there were approximately three times more females than males having this operation, this would mean that, for a New Zealand resident population, there would be one death expected, and the excess is two deaths, which would be within normal variability limits. The implication of this is that bariatric surgery is very safe, which, given the risks and co-morbidities involved, is an excellent result.

This was the first report that demonstrated a significantly increased risk for Maori having coronary artery bypass grafts (CABGs). The Maori caucus of the joint mortality review committees commented on this result, noting that there are multiple potential causes such as the higher prevalence of diabetes, hypertension and smoking.

The type of vascular disease may differ from that in other ethnicities, in that it is generally more diffuse and involves smaller vessels. The issues of access to treatment continue to be investigated and improvements made.

POMRC is a statutory committee comprising anaesthetists, surgeons, an intensivist, an obstetrician and gynaecologist, nurses and an epidemiologist to provide a whole-of-care perspective. It is part of the mortality group within the Health Quality & Safety Commission.

New Zealand’s Perioperative Mortality Review Committee (POMRC) presented its fourth report at a workshop held in Auckland in June.

The report outlines the rate of dying within 30 days of an operation and/or anesthesia, providing information so that prospective patients and clinicians can factor the risk of dying into their informed choice and consent.

The information also looks at other available international mortality rates to inform the public on how New Zealand’s healthcare compares with that in other countries. The full report can be found on the Health Quality & Safety Commission website www.hqsc.govt.nz/assets/POMRC/Publications/POMRC-fourth-report-Jun-2015.pdf.

The data used in producing the report covers almost all acutely admitted patients and the majority of electively admitted patients, thus providing an excellent picture of actual perioperative mortality in New Zealand.

It comes from the National Minimum Dataset (NMDS), which contains the coded healthcare data from all public hospitals and some private hospitals. This is then matched with the data from the National Mortality Collection (NMC) in that patients who died within 30 days of a procedure (either in hospital or after discharge including transfer to a second hospital) are identified and mortality rates calculated.

The procedures chosen for full analysis are those that are more common, have an increased mortality rate, or have been the focus of increased attention because of changes in healthcare or problems that have arisen.

Specific mortality rates are presented in table 1, which show the mortality for all patients undergoing the specific procedure, or having the specific postoperative complication, or with the specified ASA status.

The rates vary considerably between procedures, hence giving specific rates. While this doesn’t give guidance about other procedures, it can help give an indication for similar procedures.

The outcomes are then analysed to look for independent effects of acute or elective admission, ASA status, age, sex, ethnicity, and socioeconomic status (NZDep, the New Zealand Index of Deprivation, a 0 to 10 scale measuring socioeconomic deprivation). The mode of admission, ASA status and age have very significant effects as demonstrated, using patients who develop severe sepsis post-operatively (table 2), while that of sex, socioeconomic status and ethnicity have limited effect apart from in a few specific procedures, such as worse Maori elective CABG mortality (OR 3.96) and female acute CABG mortality (OR 2.44).

To help with separating out the effect of underlying mortality, POMRC has the proportion of the New Zealand resident population who die within 30 days broken down by age. This is particularly important for low mortality procedures, such as bariatric surgery (table 3). Patients having this procedure had an age range of 15-75 years of age, with the peak at 45-49 and 75 per cent within 35-75.

Table 1: 30-day all-cause mortality rates for specific ASA status, procedures, or post-operative complications.

<table>
<thead>
<tr>
<th>Procedure that patients underwent/ complication experienced/ condition of patients</th>
<th>Acutely admitted patients</th>
<th>Electively admitted patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>CABG</td>
<td>6.7%</td>
<td>1.6%</td>
</tr>
<tr>
<td>PTA</td>
<td>2.3%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td>2.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Severe post-operative sepsis</td>
<td>22.7%</td>
<td>10.5%</td>
</tr>
<tr>
<td>ASA 4</td>
<td>0.2%</td>
<td>0.4%</td>
</tr>
<tr>
<td>ASA 5</td>
<td>0.6%</td>
<td>0.4%</td>
</tr>
<tr>
<td>All types of cholecystectomy</td>
<td>0.8%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Open cholecystectomy</td>
<td>0.4%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Laparoscopic cholecystectomy converted to open</td>
<td>0.9%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Knee TJR</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Hip TJR</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Colorectal resection (first report)</td>
<td>3.8%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Pulmonary embolus</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>General anaesthesia (day of only)</td>
<td>0.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>ASA 1 or 2 (not measured)</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Table 2: Effect of increasing ASA status or age: 30-day all-cause mortality.

<table>
<thead>
<tr>
<th>ASA status / age</th>
<th>Severe sepsis – acute admission</th>
<th>Severe sepsis – elective admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA 1</td>
<td>1.6%</td>
<td>1.3%</td>
</tr>
<tr>
<td>ASA 2</td>
<td>3.1%</td>
<td>3.3%</td>
</tr>
<tr>
<td>ASA 3</td>
<td>9.5%</td>
<td>9.4%</td>
</tr>
<tr>
<td>ASA 4</td>
<td>15%</td>
<td>14%</td>
</tr>
<tr>
<td>ASA 5</td>
<td>3.1%</td>
<td>3.0%</td>
</tr>
<tr>
<td>ASA 6</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

Table 3: Deaths after elective bariatric surgery, compared with the deaths in the NZ resident population for the same number of people.

<table>
<thead>
<tr>
<th>Deaths (494 people)</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bariatric surgery</td>
<td>3</td>
</tr>
</tbody>
</table>

NZ residents

<table>
<thead>
<tr>
<th>Age of patient</th>
<th>Deaths</th>
<th>Death rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-39 years</td>
<td>8</td>
<td>0.008%</td>
</tr>
<tr>
<td>40-49 years</td>
<td>17</td>
<td>0.037%</td>
</tr>
<tr>
<td>50-59 years</td>
<td>25</td>
<td>0.059%</td>
</tr>
<tr>
<td>60-69 years</td>
<td>35</td>
<td>0.072%</td>
</tr>
<tr>
<td>70-79 years</td>
<td>43</td>
<td>0.088%</td>
</tr>
</tbody>
</table>

*85+ age group was inserted to indicate the increase in number of expected deaths with increasing age.

Dr Leona Wilson
Chair, Perioperative Mortality Review Committee

New high-risk medicine resources available in New Zealand

An abbreviation here, a back slash there – it doesn’t take much to cause confusion that can lead to a prescribing error. New Zealand’s Health Quality & Safety Commission (HQSC) is encouraging doctors to make full use of new resources to help reduce harm from high-risk medicines.

Common confusions with prescriptions are included in a series of “One step for medication safety” fact and activity sheets available as downloadable PDFs from the HQSC’s Open for better care national patient safety campaign website (www.open.hqsc.govt.nz).

Examples, in a one step on insulin prescribing, include the case of:

- U as the abbreviation for units – U read as 0 can lead to a 10 times overdose (for example, 80 units given instead of 8 units). U has also been mistaken for 4 and 6.
- Use of a / to separate doses. For example, 10/5, units, meaning 10 units in the morning and 5 units in the evening, can be interpreted as 15 units or even 105 units.
- IU as an abbreviation for insulin unit can result in I being read as 1. For example, 41 units given instead of 4 units when prescribed as 4IU.
- IU as an abbreviation for insulin unit can result in I being read as 1. For example, 41 units given instead of 4 units when prescribed as 4IU.
- Use of trailing zeros can lead to overdoses of 10x or 100x – for example, 4.0 units being interpreted as 40 units.
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Three-fold opioid variation a cue to look at prescribing

Evidence that the number of people being given opioids varies up to three-fold around New Zealand is a cue for hospitals, ... to take a close look at their prescribing, says New Zealand’s Health Quality & Safety Commission (HQSC).

The variations are recorded in the opioid domain of the HQSC’s Atlas of Healthcare Variation – a series of easy-to-use maps, graphs, tables and commentaries that chart the provision and use of specific health services and outcomes. The atlas is available at www.hqsc.govt.nz.

The HQSC notes that while highly effective for managing pain, opioids are also the class of medicine most commonly implicated in patient harm. The opioid atlas records three-fold variations between district health boards (DHBs), and an average of 17/1000 people received a strong opioid, with variations based on age, gender and ethnicity as well as the type of opioid prescribed.

Patients with PPS patients are said to be twice as sensitive to non-depolarising muscle relaxants with a recommendation to use a short-acting agent, starting with half the usual dose and carefully titrating therapy with neuromuscular monitoring against a baseline twitch response.

Avoidance of suxamethonium where possible is recommended as it may result in greater post-operative muscle pain and concern remain regarding the risk of hyperkalaemia although evidence is lacking. Regional anaesthesia has been successfully used and where feasible may result in fewer complications although delayed muscle recovery may occur.

Postpolio syndrome (PPS) occurs in a significant proportion of polio survivors years after the time of recovery from the original illness. Patients with PPS are generally considered to have increased sensitivity to opiates, muscle relaxants, sedative and anaesthetic drugs leading to recommendations to start low and titrate carefully. This is probably multifactorial reflecting changes in the reticular activating system, muscle atrophy and weakness due to denervation and reduced volume of distribution due to muscle loss.

In relation to muscle relaxants, PPS patients are said to be twice as sensitive to non-depolarising muscle relaxants with a recommendation to use a short-acting agent, starting with half the usual dose and carefully titrating therapy with neuromuscular monitoring against a baseline twitch response.

Postoperative respiratory failure related to oversedation and weakness has been reported and consideration should be given to increased post-operative monitoring in an HDU environment. Slow emergence and respiratory concerns will preclude day surgery for the majority. Pain management may be difficult both due the presence of chronic pain and concerns relating increased sensitivity to the sedative and respiratory depressant effects of analgesics.

Postpolio syndrome patients present a number of potential problems for the anaesthetist. However for those who are aware of the syndrome, careful assessment and planning should minimise the risk of perioperative complications and provide optimal patient outcomes.
A significant proportion of blood transfusions are used as an intervention in the perioperative and critical care settings. This makes anaesthetists and intensivists a critical force in any effort to optimise allogeneic blood transfusion through improved clinical practice.

Transfusion should not be the default decision

There is a growing weight of evidence that allogeneic blood transfusion has potentially a wide range of adverse clinical outcomes and that transfusion should not be the default decision. Instead, the decision whether to transfuse should be carefully considered, taking into account the full range of available therapies, and balancing the evidence for efficacy and improved clinical outcome against the potential risks. Transfusion decisions for patients should also take into account each individual's clinical circumstances and physiological status, and their treatment preferences and choices.

Patient blood management

The range of approaches to help patients optimise and conserve their own blood and subsequently minimise the need for transfusion is known collectively as patient blood management (PBM). As a consequence of better management, patients usually require fewer transfusions of donated blood components than avoiding transfusion-associated complications.

There are various techniques to ensure this. For example, the three pillars of PBM model shows how various practices can be initiated during pre-, intra- and post-operative stages of surgery.

PBM guidelines

The National Blood Authority (NBA), in conjunction with key clinical groups, has developed evidence-based PBM guidelines to support improvements in transfusion practice and associated patient outcomes. The guidelines are the world’s first national evidence-based patient blood management guidelines and are developed by clinical/consumer reference groups (CRG) representing specialist colleges, organisations and societies, with consultation from the wider clinical community.

The guidelines, approved by the National Health and Medical Research Council (NHMRC), provide evidence-based recommendations to health professionals that support the implementation of PBM.

WebAIRS was involved in two sessions and two workshops at September’s Australian Society of Anaesthetists/New Zealand Society of Anaesthetists Combined Scientific Congress in Darwin.

The first session about cognitive tools for crisis management addressed how anaesthesia crises are managed as well as cognitive tools and cognitive aids to assist with crisis management. Starting with observations regarding the immediate response to a crisis during simulation, this was followed by a presentation on new approaches to simplify the immediate response. Finally cognitive aids were presented for a formal approach to ensure that nothing is overlooked.

The second session looked firstly at webAIRS data relating to catastrophic events that might occur during an otherwise simple routine case. Professor Keith Ruskin, who is a renowned international speaker, presented data from the American Society of Anesthesiologists Anesthesia Quality Institute database on how large databases can be used to develop training programs. The use of bow-tie diagrams as a potential new tool for anaesthesia risk management was also described.

Where to find the PBM guidelines

The PBM guidelines can also assist hospitals in meeting the requirements for Standard 7 Blood and Blood Products under Standard 7 Blood and Blood Products of the National Safety and Quality Health Service Standards. Specifically, action 7.1.1 of standard 7 requires health service organisation to have policies, procedures and protocols in place that are consistent with national evidence-based guidelines.

Over 100,000 copies of the PBM guidelines and their accompanying quick reference guides have already been downloaded or ordered in more than 60 countries. They are also available as an iPad app in the iTunes store. Details of each module’s systematic review, provided in a two-volume technical report are available on the NBA’s website. The website also lists the endorsements each module has received from specialist colleges and societies.


National Blood Authority, Australia

www.anztadc.net

To register visit www.anztadc.net and click on the registration link at the top right hand side of the page. A demonstration can be viewed at www.anztadc.net/Demo/IncidentTabbed.aspx
Death following appendicectomy

In 2012, a previously healthy 15-year-old boy weighing 45 kilograms underwent surgery at a rural hospital for acute appendicitis that lasted about 30 minutes. He was anaesthetised by a locum anaesthetist who administered 10mg of morphine and 150mcg of fentanyl. After extubation in theatre, the patient was transferred to PACU. During transit he stopped breathing and was hypoxic on arrival. The anaesthetist diagnosed laryngospasm and applied oxygen and PEEP, and breathing resumed. However, the patient remained hypoxic in PACU, with saturations recorded in the low 90s. At one point he coughed up some pink or red fluid. He was prescribed high-flow oxygen and discharged to the children's ward, where his saturations were 95 per cent most of the night despite high-flow oxygen. The nurse removed the pulse oximeter at 5am, and the patient was found moribund at 6.30am. Despite resuscitation, he died a few days later. At post-mortem he was found to have global hypoxic brain injury and signs of pulmonary oedema. The cause for his sudden collapse after some hours of apparent stability was not clearly established.

There was some uncertainty about why the patient stopped breathing and seemed to have no respiratory effort. Despite the diagnosis of laryngospasm, the experts assisting the Health & Disability Commissioner (HDC) pointed out that residual neuromuscular blockade, residual anaesthesia or the effects of opioids could all have this effect. The anaesthetist had examined the patient’s chest on two occasions and reported that it was clear, but did not document her findings. She did not account for his hypoxia but charted oxygen at up to 10l/min via Hudson mask. She did not request close observations overnight or recommend high-dependency care.

In his report of March 18, 2015, New Zealand’s HDC found that the anaesthetist should have further investigated the cause of the patient’s hypoxia before allowing him to go to the ward, and should have arranged closer observation or a review during the night. He was also critical of the anaesthetist’s failure to use the high-dependency unit and her poor record keeping, which did not comply with professional standards. Criticism was also levelled at several nursing and systems failures.

Locum doctors are especially vulnerable to mishap. Their lack of familiarity with a hospital’s organisation, its layout or its facilities can cause problems if they make assumptions based on practice elsewhere. They may not have had the opportunity to develop productive working relationships with colleagues. Locums are advised to make every effort to equip themselves with a good working knowledge of a new hospital and its staff, especially a rural hospital which may have fewer out-of-hours resources than larger centres.

Thorough, clear and contemporaneous documentation is a cornerstone of safe clinical practice and can form the backbone of a successful defence if a doctor’s practice is scrutinised. The full texts of all the HDC reports are available free on its website, www.hdc.org.nz.

Collated by Dr Peter Roessler, Communication and Liaison Portfolio Lead, Safety and Quality Committee

Dr Aidan O’Donnell, FRCA FANZCA
Lead obstetric anaesthetist, Waikato Hospital, New Zealand

Safety alerts

Safety alerts are distributed in the safety and quality section of the monthly ANZCA E-Newsletter. A full list can be found on the ANZCA website: www.anzca.edu.au/fellows/safety-quality/safety-alerts

Recent alerts:
• Astra Zeneca Marcain 0.5% Spinal Heavy solution.
• Propofol adverse effects, June 26, 2015.
• Teleflex Hudson RCI Sheridan SHER-LE BRONCH Endobronchial Tubes – NZ.
• Trading of Targin® in NZ has ceased.
• Propofol adverse effects May 25, 2015.
• HeartWare Ventricular Assist System.
• Recall: ResMed devices that use Adaptive Servo-Ventilation therapy.
The ANZCA Clinical Trials Network (formerly the Clinical Trials Group and then the Trials Group) had its beginnings in the establishment of the MASTER Trial in 1995. In the ensuing 20 years, the network has grown to be the pre-eminent anaesthesia, perioperative medicine and pain medicine clinical trials network in the world, thanks to the support of the College and the hard work of investigators, trial co-ordinators and Fellows and the ANZCA training regions.

The MASTER trial

The MASTER (Multicentre Australian Study of Epidural Anaesthesia) trial of epidural versus intravenous analgesia in high-risk patients having noncardiac surgery was the brainchild of Associate Professor John Rigg of the University of Western Australia.

With Dr Konrad Jamrozik, an epidemiologist, and emerging anaesthesia researchers (Paul Myles, Philip Peyton and Brendan Silbert), Associate Professor Rigg established a network of sites in Australia and south east Asia, and completed a landmark study that changed practice around the world.1 In 1996, the MASTER Trial became the first anaesthesia clinical trial funded by the Australian National Health and Medical Research Council (NHMRC). The study provided invaluable lessons for the emerging investigators, including the need for strong research methodology, advice from epidemiologists and a skilled trial co-ordinator workforce.

Associate Professor Rigg has since been honoured with the ANZCA Robert Oron medal for his role in establishing clinical trial research in anaesthesia in our region.

The B-Aware Trial

The role of the new depth of anaesthesia monitors in preventing awareness during anaesthesia was a hot topic in the late 1990s.

Paul Myles and Kate Leslie established the B-Aware Trial to determine whether bispectral index (BIS) monitoring would reduce the incidence of awareness in patients at risk of awareness during general anaesthesia.

Building on the lessons learned from the MASTER trial, the B-Aware trial group broke new ground by expanding the network of sites and investigators to New Zealand and Europe and by establishing a collaboration with biostatisticians associated with Monash University, in particular Andrew Forbes. The results of the B-Aware Trial generated a great deal of media interest when they were published, and changed practice with respect to the care of patients at high risk of awareness.

Formalising trials group governance

ANZCA had been a strong supporter of research for many decades through the research grant program funded through Fellows’ subscriptions and donations. The above trials received seed funding from ANZCA.

During his ANZCA presidency Professor Michael Cousins formally established the ANZCA Clinical Trials Group Executive as a committee of ANZCA Council under the inaugural chairmanship of Paul Myles.

The executive set about developing the various programs that support the network, including the annual strategic research workshop, grants to support pilot studies for multicentre trials, and policies and processes to facilitate survey research by Fellows and trainees.

ANZCA established the role of the trials group co-ordinator (now manager) within the College, and formed a relationship with the Department of Epidemiology and Preventive Medicine at Monash University to share support of the co-ordinator.

The results of the B-Aware Trial were so positive that the trial was a natural extension of the ANZCA Clinical Trials Network (CTN) executive the network has gone from strength to strength. The ENIGMA-I and ENIGMA-II trials, the POSS-I and POSS-II trials (in collaboration with the Population Health Research Institute in Canada and the ATACAS trial (www.atacades.org.au) have both been completed and provided a wealth of new information about preventing major adverse cardiac events and other unwanted complications of anaesthesia.

The network has formed new international collaborations and involved new sites and investigators in North America, the UK, Europe, the Middle East and Asia in its current large multicentre trials – the Balanced Anaesthesia Study (principal investigator, Tim Smith), RELIEF (principal investigator, Paul Myles), METS (principal investigator, Mark Shulman in collaboration with Canadian and UK researchers) and PADDI (principal investigator, Tomas Coonan).

The last six NHMRC grant applications for network trials have been successful with the growing achievements of being awarded the highest grant in the 2014, grant round ($8.6 million for PADDI) and the highest ranked grant in 2012 round for RELIEF.

Conclusions

ANZCA is the only specialist medical college to support a major clinical trials network. Through this support the research careers of numerous investigators and trials co-ordinators have been nurtured and the lives of millions of patients have been improved through the provision of high quality clinical trial evidence that translates into safe and effective practice in anaesthesia, perioperative and pain medicine.

Professor Kate Leslie

Chair, ANZCA Clinical Trials Network Executive

“...The network has grown to be the pre-eminent anaesthesia, perioperative medicine and pain medicine clinical trials network in the world.”

References:
More than 130 investigators, trial co-ordinators, trainees and interested Fellows met to discuss new ideas and share triumphs and challenges at this year’s Clinical Trials Network workshop – the biggest and best yet.

The 7th annual ANZCA Clinical Trials Network Strategic Research Workshop was held from August 14-16 at the Intercontinental Sanctuary Cove on the Gold Coast.

The main aims of the workshop are to develop proposals for new large multi-centre trials and to promote networking among participants, enabling emerging investigators and sites to get involved in established trials and receive advice on new ideas. A great side-benefit of the meeting is that it provides a fantastic update on all the hot topics in anaesthesia, perioperative and pain medicine.

The meeting opened with a workshop for trial co-ordinators and new investigators chaired by the Research Co-ordinators’ Special Interest Group chair, Ms Joanne Douglas. The workshop focused on developing a sustainable trial co-ordinate workforce at sites and across the network. Topics included developing a good position description and discussing “a day in the life” of a trial co-ordinator. The format part of the meeting then opened with a keynote address from Professor David Vaux, deputy director of the Walter and Eliza Hall Institute of Medical Research, on “Researches behaving badly”. In his presentation Professor Vaux identified a number of features of a research paper that should provoke reviewers, editors and readers to probe further about the veracity of the data. He also described several high-profile research fraudsters, many of whom unfortunately were anaesthetists. Later in the meeting Professor Vaux inspired established and new investigators alike with a presentation entitled “Reflections on a research career – walking through the valley of (still) death”. The Clinical Trials Network always invites a biostatistician to the workshop to enlighten us about the latest trends in the statistical management of large trials. This year Dr Jessica Kaeza from Monash University spoke about how to handle missing data and about survivor causal analysis. In large multi-centre trials it is inevitable that some baseline data will be missing (for example, age, ASA physical status, co-morbidities) and that some patients will be lost to follow up. If we assume that patients with missing data are the same as patients with complete data, we may come to the wrong conclusion. Dr Kaeza explained various statistical methods to deal with this issue.

The majority of the meeting was spent discussing proposals for new clinical trials. It was particularly exciting to hear proposals from new investigators. Dr Anjali Radhambhar and Dr Raymond Bu suggested trials related to improving the success of renal transplantation and arterio-venous fistulae respectively. Dr Claire Furyk proposed a study on “pee-hab” for elderly patients presenting for major surgery, and Dr Susan Humphreys and Dr Paul Lee-Archer described studies designed
Directors of Professional Affairs (DPAs) work within ANZCA to support the Fellows who give an amazing amount of voluntary work, from the president through committee members to supervisors of training and annual scientific meeting (ASM) such as DPA assessors' approval of trainees' requests, or requires considerable time, such as the development or revision of our policy documents, or needs specialised knowledge, such as advances in medical education.

We bring knowledge of medical practice and culture, anaesthesia, perioperative medicine, pain medicine and hospitals and healthcare to our activities. While we are often a large bundle of work is being contemplated by a committee, the cry goes up “what about a DPA, can we have one please?”

Dr Ian Graham is the dean of education who leads and provides professional advice on educational matters, and chairs the Education, Training and Assessment Committee. He also brings his expertise in curriculum writing (having led the development of the Australian Curriculum Framework for junior doctors) and information technology support for educational activities. As well, he was a significant part of the development of the ANZCA professionalism guide, having led the development of similar guides for the Royal Australasian College of Surgeons and the Royal Australasian College of Physicians.

The DPA assessors are a group led by Dr Vaughan Laurenson, with Dr Michelle Mulligan and Dr Maggie Wong. Dr Stuart Henderson was the first DPA assessor. Before him, assessor decisions were made by a councillor with the assessor role usually occurring at the end of the day after their hospital work.

Assessors provide assessments of and decisions on trainees progress at critical times in their training (for example, entry to both examinations, admission to fellowships, approval of interrupted/ overseas training, recognition of prior learning) and take part in the committees which oversee various aspects of education, training and assessment.

Many Fellows and trainees are unaware of the work that goes on behind the scenes at ANZCA. This article, about the Directors of Professional Affairs (DPAs), is part of a series on the activities undertaken by ANZCA committees.
It has received excellent feedback over the past five years.

Now, ANZCA’s Teaching and Learning Sub-Committee is looking at new ways to increase the availability and accessibility of the course. Five new modules are being developed, to add to the eight already being taught, as the committee seeks to further enhance the breadth of the course.

I encourage all Fellows and trainees to learn more about the program.

**Dr Genevieve Goulding**

ANZCA President

The new ANZCA Educators Program will build on the successes of the Foundation Teacher Course that it replaces.

**Why do we need an educators program?**

In Australia and New Zealand, the training of doctors to become specialist anaesthetists and specialist pain medicine physicians is conducted entirely by ANZCA and its Faculty of Pain Medicine. ANZCA has a well-developed educational structure consisting of numerous committees, education officers, unit directors, supervisors of training, etcetera.

It requires this network because the training programs utilise a traditional method, an apprentice model, requiring the trainee to be supervised and to interact with consultants in delivering anaesthesia and pain services to patients. This educational network underpins the programs, and without the dedicated time and effort of those involved in these roles, the training program would not be possible.

All anaesthetists and specialist pain medicine physicians involved in teaching or supervising the work of trainees require a basic level of knowledge, skills and attitudes relevant to teaching and assessment.

Although it may appear to be a natural phenomenon, education (and teaching) is based on theoretical concepts that need to be learnt and practised to be effective. Those involved in the organising or elements of education beyond teaching and supervising require a higher level of educational expertise.

There is a paucity of resources or teaching programs for anaesthetists and specialist pain medicine physicians specifically designed for education in anaesthesia and pain medicine. The recent addition of the scholar role is one step in addressing the deficiency within the College related to education.

Universities offer medical education courses at a graduate certificate to masters level that are conducted between six months or up to three years. The Foundation Teacher Course was designed for anaesthetists and specialist pain medicine physicians responsible for teaching and supervising trainees who are not intending to complete a university degree in educational theory.

The course has had excellent feedback in its evaluation but is limited in its delivery due to personnel and resourcing issues, and a recent survey has identified the need for more material to be included.

**What makes up the new program?**

ANZCA’s Teaching and Learning Sub-Committee is developing new methods of delivery and new content to be able to offer more opportunities for training of educators.

These new developments have driven the need for changing the name of the Foundation Teacher Course to the ANZCA Educators Program so that it better represents the future of educational offerings for educators.

**Enhancing delivery and accessibility**

This program will include the existing Foundation Teacher Course in its current format, but will also cover new models of delivery such as local facilitation of content. These include:

- Course delivery expansion
- More facilitators (Fellows)
- More accessible delivery
- Flexibility for delivery
- Utilisation of Networks

(continued next page)
New modules in development
There is a project group working to develop five new modules and these will be piloted in 2016. The new modules are:
• New modes of teaching and learning.
• Teaching in multiple settings.
• Concepts in assessment.
• Organisation of education in departments.
• Trainees experiencing difficulty.
These will complement the existing eight modules:
• Doctor as educator.
• Planning effective learning and teaching.
• Feedback to enhance learning.
• Interactive learning and teaching.
• Teaching in the clinical environment.
• Teaching practical skills.
• Authentic assessment.
• Clinical supervision.
Associate Professor Kersi Taraporewalla
Chair, Teaching and Learning Sub-Committee
ANZCA

How to sign up
Do you want to learn to teach? Can you supervise a trainee to get the best outcomes for both patient and trainee? Do you understand the various ways a trainee can and should be assessed and what the consequences of assessment are?
If you want to learn to teach, sign up for our courses.
Registration will open mid-November 2015 for five face-to-face and two online courses running in 2016. These courses will include the existing eight modules. The face-to-face courses will run over two-and-a-half days, with a two-day version offered before the 2016 ANZCA Annual Scientific Meeting in Auckland. The online course takes about 18 weeks to complete.
There is no charge to attend the course.
Visit the ANZCA Educators Program on the ANZCA website or look out for notices on the ANZCA homepage for when registration is open.
www.anzca.edu.au/anzca-educators-program

Claiming CPD
Both the online and face-to-face courses are eligible for continuing professional development (CPD) credits.
TASMANIA SETS THE PACE

Australia’s southern isle is popular with anaesthetists who come for the lifestyle and stay for the variety and challenge.

Tasmania holds a unique place in Australia and, more specifically, in the minds of Australian anaesthetists. The safe anaesthesia journey now experienced by thousands of Australians every day was first performed almost 170 years ago in Launceston.

The story of Dr William Russ Pugh is well known to Australian anaesthetists and is a source of pride for those practicing today in Launceston and Tasmania.

Pugh was something of a Renaissance man, arriving in Hobart Town in 1835 before walking 200 kilometres to Launceston. He ignored encouragement by settlers along the walk to take up sheep farming, instead persisting with a long, unconventional and sometimes adversarial, medical career.

Shortly after seeing the first European depiction of Hooper’s ether inhaler in the Illustrated London News, Pugh made medical history. Using a modified Nooth’s Apparatus, a household device for making carbonated water, Pugh performed the first Australian anaesthetic in Launceston in 1847.

Living true to the old-school anaesthesia adage that “there is no case that cannot be cancelled”, Pugh also has the honour of cancelling the first surgical case for anaesthetic reasons being unable to perform the third and final surgery due to a medical euphemism that lives on today – “equipment issues”.

Come and sample the sites, tastes and extremes of Tasmanian anaesthesia in February 2016, at the combined ANZCA and Australian Society of Anaesthetists Tasmanian 2016 Annual Scientific Meeting: “Anaesthesia in the extreme”. World-renowned experts will be a highlight, including Professor Peter Slinger from Toronto General Hospital, along with the return of the cadaveric difficult airway workshop. See you in February!

Anaesthetists have made a strong contribution to Tasmania’s aeromedical retrieval services. Retrievals by anaesthetists from the Royal Hobart Hospital have even included the extremes of Antarctica, including the retrieval of patients from an Australian Antarctic Division helicopter crash on the Amery Ice Shelf in 2013.

The importance of aeromedical retrieval to Tasmania’s emergency services has been highlighted by the push to establish a helipad on the roof of the Royal Hobart Hospital. The significance of the Golden Hour is even greater when trauma may be mixed with exposure to an unforgiving climate.

The effects of extreme weather are not limited to Tasmania’s wilderness. Recent cold weather saw snow in suburban Hobart in mid May. Extreme snowfall again in August meant one ANZCA exam candidate was at risk of being snowed in and missing his exam!

Bass Strait creates something of a moat for Tasmania, producing a relative remoteness considering its short, one-hour flight from Melbourne. As the tertiary referral centre for the state, this remoteness requires the Royal Hobart Hospital to provide services across a range of surgical and perioperative domains, including hyperbaric, paediatric, cardiac, advanced thoracic and neurosurgical services.

The breadth of practice, from the routine to the extremes of surgical and physiological pathology, makes anaesthesia practice in Tasmania one of constant variety. Recent years have seen both former Tasmanians and new anaesthetists relocating to the southern isle. They return for the family friendly lifestyle, the bushwalking and world-class mountain-biking, the incredible fresh food and dining, and the growing art and cultural scene encouraged by the likes of the Museum of Old and New Art (MONA).

But what keeps anaesthetists in Tasmania, which now has the greatest per-capita concentration of FANZCAs in Australia, is the professional satisfaction of working in a varied, challenging and collegial environment – routine and extreme.

Dr Daniel Jolley and Dr Clare McArthur

Tasmania’s vast wilderness makes it a popular eco-tourism destination, with sites as varied as Australia’s largest temperate rainforest, the Tarkine, and the world famous Cradle Mountain National Park. The relative remoteness of these destinations, coupled with extreme weather changes, means the state’s retrieval services play an important role in maintaining the safety of people who visit these sites.

Dr Roger Wong, FANZCA.

Photographs of Hobart and surrounds: Dr Roger Wong, FANZCA.
Four machines were donated: Two compact Sonosite machines from the anaesthetic department of Sir Charles Gairdner Hospital, and two WED 2018 portable ultrasound machines from Rotary Australia World Community Services as part of a specific equipment donation program.

A group of 15 consultant anaesthetists presented for the two-day workshop held at the Mongolian National University of Medical Sciences. We covered introduction to ultrasound, vascular access, upper limb, lower limb and abdominal wall blocks with a combination of lectures and hands-on scanning.

Although it is the world’s 19th largest country, Mongolia has a modest population of just over three million people. About 45 per cent of the population lives in the capital, with 30 per cent continuing a nomadic lifestyle in the varied geography of desert, steppe and mountains.

Ulaanbaatar is a fascinating mix of fading Russian monoliths and shiny glass towers, a juxtaposition of its recent communist past and current mining-fuelled economic growth. The health system maintains legacies of that recent past. Although there are many public hospitals, they are relatively poorly resourced, and foreign donations and training remain a vital part of healthcare delivery.

Medical training in Mongolia consists of a five-year degree course followed by a number of resident years before junior doctors can embark on specialist training. The previously brief anaesthetic fellowship of just three months has expanded now to a far more credible two years of unpaid training.

Australian doctors have been visiting Ulaanbaatar annually for more than 10 years providing training in a variety of anaesthetic and surgical disciplines. In conjunction with improvements to training, there has been a gradual improvement in the amount and quality of medical equipment, such as anaesthetic machines and ventilators, available at the larger city hospitals. Much of it has been donated from foreign countries.

The topic for this particular trip was ultrasound-guided regional anaesthesia, and we planned a two-day workshop and then a number of days performing and teaching blocks in hospitals in the capital.

The world’s largest contiguous empire under the rule of Kublai Khan – grandson of the founder of the Mongol Empire, Genghis Khan – has retreated to more modest dimensions since the grandeur of Xanadu, the historical site of which is now located over the border in Inner Mongolia, China.

"In Xanadu did Kubla Khan
A stately pleasure-dome decree"
– A Vision in a Dream: A Fragment, Samuel Taylor Coleridge, 1816

Trip tips

• Sending a small team of four to six for teaching to aid easy co-ordination, and having at least two practitioners with extensive clinical experience. (Mongolia required greater than five years consultant experience for registration purposes).

• Keeping the team together for the lectures and workshop component, and having a plan for models for live demonstration.

• Morning lectures and afternoon workshops worked well.

• Taking ultrasound machines to donate was the only model that will work in countries with limited access. There is little point teaching techniques requiring unavailable technology.

• Incorporating basic medical perioperative clinical teaching is essential, that is, hand hygiene, adjuvant analgesia and basic pain management.

• Repeat visits to assess impact are requisite.

• Planning a year ahead is vital to co-ordinate the team, equipment, visas and registration.

• Incorporating vascular access techniques increased the scope of practice and was particularly appreciated by the local doctors.
The mantra “find the tip”, or üzüüriig olokh, was repeated extensively, and the consultants took this on board quickly. From the perspective of improving needling skills, we emphasised that simple, safe blocks, such as axillary blocks, should be attempted in significant numbers. Once confidence improved with finding and following the needle tip it was time to move on to the more difficult blocks. Visualisation of local anaesthetic within the ultrasound field while injecting was also emphasised.

Our great hope is that these anaesthetists will continue to use ultrasound, gain confidence with various block techniques, and then teach other anaesthetists in their hospitals. By teaching experienced anaesthetists who already were proficient in performing regional anaesthesia, we maximised the impact of the short time we had in Ulaanbaatar.

Our group plans repeat visits to Mongolia in the future to run further workshops and to assess the progress of anaesthetists in the hospitals that received the donated equipment.

Dr Mark Zammit
MBBS FANZCA
Northern Hospital, Epping

Our visits to the trauma hospital proved particularly fruitful. The hospital had nine theatres and covered all forms of trauma-related surgery, including neurosurgery. Patients came from Ulaanbaatar and from outlying regions where transfer times were often extended, resulting in significant deterioration by the time they arrived. We spent time in ICU (demonstrating ultrasound-guided central access on adults and children/infants), and in theatre.

We concentrated our efforts in theatre on orthopaedic surgery, where there was a significant caseload of long bone fractures from various mechanisms (for example, road trauma and horse-riding accidents). After demonstrating a particular block, we could then watch the local anaesthetists perform a number of blocks in succession.

We covered supraclavicular, axillary and femoral blocks, and had excellent success in providing anaesthesia sufficient to perform surgery with these blocks alone. This gave both the Mongolian surgeons and anaesthetists great confidence in using ultrasound for their blocks.

We were keen to reinforce safety aspects of performing regional anaesthesia under ultrasound, particularly with blocks where the potential for serious complications was greater (supraclavicular block and pneumothorax for instance).

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The provision of a goat leg was much welcomed for practising needling skills. This removed the need for acquiring expensive needling models and provided a realistic “feel” and appearance under ultrasound. The gel marinated and well-tenderised leg was donated to some local pets at the end of the day.

Workshop attendants also proved excellent models for scanning various regions of interest, and gave our team a good feel for the quality of image we could expect once we moved to a hospital environment.

Although the donated ultrasound machines did not have the resolution of machines available in Australia, they were more than adequate to achieve safe views for performing blocks. Importantly, they were robust machines with simple operating systems and requiring minimal servicing. Our course and the donated machines would be of little use if the machines did not stand up to the rigour of repeated daily use for years to come.

All the attending anaesthetists were keen to gain exposure to ultrasound, and were quick to pick up the skills required to achieve adequate views. Once we moved to the hospital environment, we tried to concentrate our efforts on a smaller number of consultants in order to create a core group of “sub-specialists” in the short time we had.
Essential Pain Management: Five years in five continents

In partnership with the Association of Anaesthetists of Great Britain and Ireland, information about EPM programs are now available on the Global Anaesthesia Partnerships Map www.aagbi.org/ international/ the site which provides information regarding collaborative anaesthetic projects in low and middle-income countries.

EPM is governed by the EPM Sub-committee which has adopted a regional management approach. With membership from Australia, New Zealand, Malaysia, England and Honduras regional EPM champions have been able to further develop the program.

In March, Dr Mary Carcosa and Dr Linda Huggins ran a program at the International Association for the Study of Pain Camp at Tagaytay Philippines with representatives from ten South East Asian countries.

During the workshop participants reviewed the first five years of the program to date and reflected on the lessons learned from running programs across five continents. Monitoring and evaluation was a key focus with participants challenged to develop methods to demonstrate how the program was “improving lives around the world by training health workers to recognise, assess and treat pain”.

The program uses a train-the-trainer model which has seen 56 instructor courses training 783 instructors around the world. This model has been highly successful in providing educational tools and skills to local EPM champions with an interest in improving pain management. The program materials are made available free for download in seven languages under a creative commons license from www.essentialpainmanagement.org.

Papua New Guinea has received its first anaesthesia simulator. The simulator was donated to PNG anaesthetists at the PNG Medical Symposium in Port Moresby. The simulator is used to teach fibre-optic skills and was donated by Dr Colin Marsland, from New Zealand.

The workshop also provided an opportunity to analyse delivery of the program, assessing activities providing the most value, least value and what could be added to improve the running of the course. Different approaches and experience with adult learners were identified across many of the countries in which EPM operates. There was significant focus on the methods best suited to outcome evaluation, the group agreed to explore the place of quantitative assessments for EPM. The next 12 months will see workshop participants busy, refining and developing new materials to continue and improve EPM.

The EPM instructors’ workshop program was supported by ANZCA and a grant from the Ronald Geoffrey Arnott Trust managed by Perpetual Trustees.

Associate Professor Roger Goucke Chair, Essential Pain Management Subcommittee

Within six months of returning to Kenya from Sir Charles Gairdner Hospital in Perth, Dr Timothy Murithi Mwiti had helped start the first pain management service for Kenyatta National Hospital and The Maker Hospital in Nairobi.

Dr Mwiti, who received the ANZCA International Scholarship in 2014, spent six months in Perth to develop skills in pain medicine, a discipline he says is desperately under resourced in his home country of Kenya.

It was during and after his postgraduate training in anaesthesia and critical care that he developed a keen interest in pain management.

“There is little in-depth teaching and training in pain in most of the healthcare personnel training programs in Kenya,” Dr Mwiti said.

“This has resulted poor pain recognition, assessment and treatment of all types of pain.”

Under the tutelage of Dr Roger Goucke, Dr Max Majedi, Dr Chin Wern Chan and Dr Mark Schurace, Dr Mwiti gained experience in the role of psychosocial input in the total pain perception, pain behavior, detection and diagnoses of different types of pain and pain syndromes, rational use of imaging and laboratory investigations in pain management.

This has translated into new programs and initiatives since he returned to his hometown of Nairobi in December.

“At the Kenyatta National Hospital, our focus so far has been implementation,” Dr Mwiti said.

“The patients we see include those with post-surgical pain, burn pain, pain in critically ill patients, cancer-related pain, post-traumatic pain and patients with neuropathic pain syndromes.

“At the Mater Hospital, in addition to patient services we have recently started an outpatient pain service, which is very beneficial.

“However, the overall pain training and management in Kenya is still in its infancy, as it is in many developing countries.

“This has led to widespread recognition now that pain has previously not received the attention it deserves in our country,” Dr Mwiti said.

“A number of clinicians – especially specialists in other fields of medicine – are recognizing the need for adequate pain treatment and are constantly referring patients to me so I can help control their pain.”

“I have made diagnoses like complex regional pain syndrome and chronic widespread pain, which clinicians here, because of the limited pain-training resources, hardly think about,” Dr Mwiti said.

Part of the requirements for the successful candidate of the ANZCA scholarship is willingness to help in the development and delivery of anaesthetic and pain services on their return home.

In May, Dr Mwiti, has been a resounding success.

Ebru Yaman
Media Manager, ANZCA

Above from left: Dr Timothy Mwiti, Jane Ryle, Natalie Goodman, Brigitte Tampoe, Deneen Fairclough and Associate Professor Roger Goucke

Simulators donated to PNG

Scholarship winner sets up pain clinic in Nairobi

Clockwise from top: The EPM team stops to take a photo. The course under review most value, least value and new; Maurice Hennessy leading a session on improving program delivery.

Above from top: Dr Roni Krieser, senior anaesthetist Royal Melbourne Hospital, Dr Harry Geoghegan, executive director ANZCA, ANZCA’s Overseas Aid Committee chair, Dr Michael Cooper, Dr George Tate, Dr Roni Krieser, Dr Linda Huggins, Dr Lian Painap and Dr George Tate, Dr Roni Krieser, Dr Michael Cooper and Dr Max Majedi.

Papua New Guinea has received its first anaesthesia simulator. Dr Anthony Lewis, donated the simulator equipment following discussions with ANZCA’s Overseas Aid Committee.

“Simulation is incredibly valuable to clinical training at all levels but especially in developing countries,” the chair of ANZCA’s Overseas Aid Committee, Dr Michael Cooper, said.

“It is particularly suitable for such a rugged country as PNG as it can be carried as hand luggage with a mannequin and there can be set up at any one of the remote 22 provincial hospitals in the country.”

The College joined author Dr David Borschott, from Perth, in donating an open copy of the Anaesthesia Crisis Manual. “Those manuals are invaluable and let the trainers learn how to deal with scenarios that occur with each emergency simulation,” Dr Cooper said.

In early September, Dr Chris Acott presented a Frontier airways pneumatic AED defibrillator at the Frontier Medical Symposium in Port Moresby. The simulator is used to teach defibrillator skills and was donated by Dr Colin Mainland, from New Zealand.
From etheriser to anaesthetist: The development of a medical specialty

More than 80 people enjoyed the fourth Pugh Day Lecture, “From etheriser to anaesthetist: The development of a medical specialty”, in Launceston on June 21.

The former honorary curator of the Geoffrey Kaye Museum of Anaesthetic History, Dr Rod Westhorpe, delivered an amusing and informative lecture.

After the lecture, 18 guests enjoyed a pleasant dinner at the Quill and Cane restaurant in the Launceston Colonial Inn. Dr John Paull, dressed as Pugh’s brother-in-law – 1840s solicitor and businessman John Ward Gleadow – addressed the dinner. In his speech, he queried Pugh’s importance compared to himself — in his opinion a much more important citizen — but nevertheless thanking Dr Westhorpe and grudgingly offering a toast to Dr Pugh.

“Mr Gleadow” then presented Dr Westhorpe with a laminated poster advertising the lecture and the text of his address. The restaurant was chosen because of Pugh’s role as a founding trustee and organiser of the Launceston Church Grammar School, which was established in the Colonial Inn building in 1847.

Dr Westhorpe was interviewed on Tasmanian ABC radio for 20 minutes prior to the lecture and a long article, “When surgery crossed the pain barrier”, summarising the highlights of the lecture appeared in The Examiner newspaper the following day.

Dr Paull, ANZCA Fellow and historian Dr Dan Hoorn and Dr Lachlan Doughty created a major exhibition at the Queen Victoria Museum and Art Gallery at Inveresk, Launceston. Titled “The Evolution of Anaesthetic Equipment and Techniques, from Pugh to the Present”, the exhibition ran through June and July. Overall anaesthesia received significant media coverage before, during and after the lecture.

Honorary archivist steps down
Dr John Paull has stepped down as ANZCA’s honorary archivist after nearly two years.

Dr Paull was appointed to the position in 2013, coinciding with the formation of the History and Heritage Expert Advisory Panel.

In this role, Dr Paull worked towards last year’s redevelopment and relaunch of the Geoffrey Kaye Museum of Anaesthetic History, provided initial support for the Gwen Wilson Archive Project, contributed to the museum’s accreditation, and gave invaluable time and energy to ANZCA’s Knowledge Resources team.

Dr Paull was a recognised author before accepting this appointment, with over 70 peer-reviewed scientific papers, a number of chapters for anaesthesia texts, and a comprehensive biography of the life and times of Launceston doctor William Russ Pugh. Research into the history of anaesthesia continues to be of interest to him and perhaps he will produce another gem like Not Just an Anaesthetist: The Remarkable Life of Dr William Russ Pugh, MD.

We wish Dr Paull all the best in his future endeavours.
To donate, or for more information on supporting the foundation, please contact Rob Packer, General Manager, Anaesthesia and Pain Medicine Foundation on +61 3 8517 5306 or email rpacker@anzca.edu.au. Gifts can be made via www.anzca.edu.au/fellows/foundation.

New Western Australian representative for Board of Governors
The foundation committee and the Anaesthesia and Pain Medicine Foundation Board of Governors voted unanimously in May to appoint Mr Warrick Hazeldine as its new WA representative on the Board of Governors. Mr Hazeldine is the co-founder and managing director of the WA public relations firm Cannings Purple, which is connected to advertising agency Ogilvy and Mather and Australia’s largest communications firm, STW.

Mr Hazeldine is enthusiastic about promoting the foundation and raising money for research in anaesthesia, pain medicine and perioperative medicine—particularly in Western Australia.

Western Australia lunch event
The foundation and Mr Hazeldine arranged a lunch event at the Richardson Hotel in Perth in September to promote the foundation and ANZCA’s research program to philanthropic and business contacts in Western Australia. Western Australian research investigator Professor Tomas Corcoran, Professor Mike Paesche, Professor Britta Regli-Von Ungern-Sternberg, and a life patron of the foundation, retired Associate Professor John Rigg, spoke at the event.

Melbourne Board of Governors Luncheon
The Board of Governors and the foundation will hold a promotional lunch in Melbourne on September 28. The foundation thanks the Board’s Deputy Chair, Mr Rob Bazzani, and FPMP for hosting the function.

The Chair of the ANZCA Clinical Trials Network Executive, Professor Kate Leslie, will speak to guests about how ANZCA research investigators are advancing knowledge and evidence-based clinical practice to improve patient outcomes.

Guests will include members of the Melbourne philanthropic and business communities, including health insurance industry representatives.

Major sponsor Pfizer Pain Care
The Pfizer Pain Care brand again sponsored the foundation in 2015, including the long-standing Pfizer ANZCA Research Award for pain medicine research. This year the award was given to Dr Paul Wrigley for his project “optimising neurophysiological assessment of residual sensorineural sensation following spinal cord injury”. Professor Alan Merry presented the award at the Gilbert Brown Prize Session during the Adelaide annual scientific meeting.

A founding sponsor and major sponsor since 2007, Pfizer has been a consistent supporter of the foundation’s efforts to increase support for pain medicine research in Australia and New Zealand. The foundation greatly values Pfizer’s partnership.

ANZCA Research Committee meeting
The ANZCA Research Committee met at the College on August 28 to allocate research funding grants for next year. Recipients will be announced in the December issue of the ANZCA Bulletin after all grant applicants have been told the outcomes.

The committee had a total of $41,444,945 to allocate to projects, including existing multi-year commitments, the academic enhancement grant, project grants, simulation/education grants, novice investigator grants and pilot grants.

The foundation thanks all Fellows, donors and sponsors whose commitments make it possible to distribute this funding to enhance research, continuous improvement and patient outcomes and to support anaesthetists and pain medicine specialists in advancing perioperative medicine.

Rob Packer
General Manager, Anaesthesia and Pain Medicine Foundation ANZCA

Understanding cerebrovascular autoregulation

As part of a study to better understand the CVAR function, and in turn protect it in vulnerable patients, Dr Chuan is leading a pilot study: “The clinical significance of cerebrovascular autoregulation during non-cardiac anaesthesia”.

“Impairment of the CVAR function has been associated with increased risk of perioperative stroke, poorer outcomes after brain surgery and acute kidney injury,” he said.

“With an increased demand for surgery and anaesthesia by an ageing population, this represents a significant burden of disability, poorer recovery and an overall burden on the health system,” Dr Chuan said.

Dr Chuan is applying his research to non-cardiac patients undergoing anaesthesia and hopes to add to the growing body of knowledge of CVAR dysfunction in the elderly who are undergoing major non-cardiac related elective procedures. This will be done by using near-infrared spectroscopy (NIRS) which can now be used to measure CVAR function. It is a non-invasive process that involves attaching optical sensors to the patient’s forehead.

Dr Chuan will monitor his patients using NIRS and then follow up with them 12 months after their surgery to see if impairment of their CVAR mechanism caused worsening post-operative outcomes and their recovery.

This pilot study is designed as a sub study of the BALANCED clinical trial on the effect of depth of anaesthesia on patient outcomes.

Dr Chuan will monitor his patients using NIRS and then follow up with them 12 months after their surgery to see if impairment of their CVAR mechanism caused worsening post-operative outcomes and their recovery.

This pilot study is designed as a sub study of the BALANCED clinical trial on the effect of depth of anaesthesia on patient outcomes.

ANZCA Fellow Dr Alwin Chuan is excited by the brain, in particular its critical cerebrovascular autoregulation (CVAR) function – and it shows in his research.

“Let’s think of it as the black box of the body,” Dr Chuan said.

Cerebrovascular autoregulation, he explains, is the mechanism which regulates blood supply to the brain to prevent cell death, a mechanism which is impaired by age, chronic disease and – importantly – anaesthesia and surgery.
Winter is coming...Reflections on working in Scotland

In August of last year, bags packed with my warmest clothes, I headed to Scotland to work at the Royal Infirmary of Edinburgh. Living and working abroad has been immensely satisfying on a personal and professional level. If you’re interested in a UK fellowship, the key to success is advanced preparation, patience during the registration process – and vitamin D supplementation.

The original Royal Infirmary was established in 1729 in a little (wee) house in Edinburgh’s Old Town with four inpatient beds. There were 35 documented admissions in the first year for conditions such as pain, palpitations and consumption.

Three moves and three centuries later, the new Royal opened in 2003 on the fringe of the capital – it is a monster of a hospital with 900 inpatient beds, 24 operating theatres and provides specialty services for patients from the south-east of Scotland and beyond.

The anaesthetic training program in the UK is structured in a similar manner to our own; consequently ANZCA trainees are able to slot into the British system with relative ease, although it does take time to become accustomed to the local lingo.

There were some awkward pauses in theatre in my first weeks when the surgeons would turn and ask “Rachel, whaur ar ye frae?” (where are you from?) and “kinnae ‘ave more heid doon?” (can I have more head down?)

Having now experienced both systems, I feel ANZCA trainees are given relatively more responsibility at an earlier stage of anaesthetic training, which is appropriate given our training program is shorter (five years not seven).

ANZCA allows up to 12 months of any given training period to be undertaken overseas provided prospective approval is obtained.

Once a position has been secured, the relevant forms can be downloaded from the ANZCA website – and please note, there are separate documents required for the different training periods.

Registering with the General Medical Council (GMC), the UK’s licensing board, is the next step and this can be a Complicated, tedious and expensive process with the specialty requirements in a state of flux. My advice would be to look into all available pathways at least a year in advance and don’t give up at the first hurdle.

During the first six months in Edinburgh, I completed advanced training with rotations in high-risk obstetrics, major vascular and colorectal surgery (applying for a job well in advance helped secure desired rotations).

This year I transitioned to provisional fellowship training and have been attached to the Scottish Liver Transplant Unit – an expanding service delivering over 70 liver, 120 kidney and 15 pancreas transplants per year. The unit also covers bariatric surgery, hepatobiliary surgery and all major upper GI and endocrine work.

The volume and variety of work has been terrific and I have particularly enjoyed the camaraderie and “chat” on the unit. Of course working in the National Health Service (NHS) is not all roses and there are daily challenges to overcome – theatre inefficiency for one, with the NHS being often under-resourced to deliver the optimum treatment to patients in a timely manner.

Working overseas has allowed me to reflect on some of the strengths and weaknesses of our own system and hospital culture and the broader issues facing healthcare.

After living here for more than a year, I’ve developed a strong affinity with Scotland. There is so much more to love about this country than the clichés of kilts, tartan, haggis, whisky, hairy coos and golf (although they all have their merits – except haggis!)

I’ve found the Scots are affable people who love good banter. They are incredibly proud of their heritage, have a strong sense of community spirit and I’ve witnessed humbling examples of locals helping each other and looking out for the less fortunate. Daily life is not bound by as many rules and regulations as it is in Australia (for example, dogs are welcome in pubs and on public transport and you can park your car in the street facing whichever way you like).

Anyone with a love of the outdoors will appreciate the spectacular countryside all within a couple of hours’ drive. Even on the most dreich (Scottish word for cold/damp/miserable/grim) of days, there really is no city quite like Edinburgh with its ancient streets and cobblestoned alleyways it looks like something straight out of a fairytale.

Many people worry about the weather but the truth is the Scottish summer has been lovely (this year it was on a Wednesday) and the long days do make up for the darkness over the winter. Besides, continental Europe is only a couple of hours away!

Lang may yer lum reek!

Dr Rachel Corris
Anaesthesia Fellow
Royal Infirmary of Edinburgh

Useful links:
www.gmc-uk.org
www.ahpra.gov.au

This year I transitioned to provisional fellowship training and have been attached to the Scottish Liver Transplant Unit – an expanding service delivering over 70 liver, 120 kidney and 15 pancreas transplants per year.
New online books
Online textbooks can be accessed via the library website: www.anzca.edu.au/resources/library/online-textbooks


Medical training review panel: eighteenth report / Medical training review panel. -- Canberra: Australian Government, Department of Health, 2015.


New books for loan


ABC Learning and Teaching in Medicine


Trip database – find evidence fast
Trip is a clinical search engine designed to allow users to quickly and easily find high-quality research evidence to support their practice and/or care. The database has been online since 1997 and has developed into the internet’s premier source of evidence-based content. Trip’s motto is “Find evidence fast”.

As well as research evidence, Trip allows clinicians to search across content types including images, videos, patient information leaflets, educational courses and more.

Trip recently introduced a free registration process, which allows clinicians to:
• Keep up to date with new research based on your clinical specialty and/or specific topics of interest. Each month, Trip will identify new content focused on your interests and email these to you.
• Save searches for future research.
• Keep track of activity that can be used for CPD purposes.

Available through the ANZCA Library databases list: www.anzca.edu.au/resources/library/databases

New Journal of Anesthesia History now available online
Launched in 2015, the Journal of Anesthesia History (JAH) is the next iteration of the Bulletin of History Anesthesia. The Journal of Anesthesia History is an international peer-reviewed journal dedicated to advancing the study of anesthesia history and related disciplines. The journal addresses anesthesia history from antiquity to the present. Its wide scope includes the history of perioperative care, pain medicine, critical care medicine, physician and nurse practices of anesthesia, equipment, drugs, and prominent individuals. The journal serves a diverse audience of physicians, nurses, dentists, clinicians, historians, educators, researchers and academics. The webpage has articles, referenced quizzes, information about events and editors, and more.

Access to the journal is available through the ANZCA Library online journal list: www.anzca.edu.au/resources/library/journals

Continuing Education in Anesthesia, Critical Care & Pain name change
The companion journal to the British Journal of Anaesthesia (BJA), Continuing Education in Anesthesia, Critical Care & Pain (CEACCP) has changed the journal title to RJA Education. This journal is very popular with ANZCA trainees as it supports the FICA training program, and is well used by Fellows for continuing professional development. The change came into effect in June.

Guidelines in AccessAnesthesiology
Under the guidelines section of AccessAnesthesiology you can find a collection of recommendations issued by governing agencies, expert panels and other professional and scientific organisations, readily accessible for clinical decision-making. Two recent guidelines added to the portal include:
• Most recent version of the ASA Guideline patients with OSA (obstructive sleep apnea).
• Digest of new ASRA Practice Advisory on LAST (local anaesthetics systemic toxicity).

Available through the ANZCA Library online textbooks list: www.anzca.edu.au/resources/library/online-textbooks

Position statement: Policies on the use of smartphones should balance the benefits and the risks. Smartphones have become an essential tool in many care environments. Nevertheless, these (and similar) devices are associated with risks that must be managed. ECRI has outlined recommendations to help confirm that your policies strike the right balance.

Why carbon dioxide is better than air for flexible GI endoscopic insufflation
ECRI Institute believes that carbon dioxide, rather than air, should be the preferred gas for insufflation during GI endoscopic procedures. ECRI states that this is the best way to avoid air embolisms, which, however rare, can cause devastating injuries.

Contact the library to obtain any ECRI publications: library@anzca.edu.au

Contact the ANZCA Library
www.anzca.edu.au/library
Phone: +61 3 9031 0467
Fax: +61 3 9652 7538
Email: library@anzca.edu.au
In Australia and New Zealand, there is a calls to legalise cannabis to treat a number of ailments. Public approval is driving this without the scientific data needed to justify a new medication.

General practitioners routinely treat patients who smoke cannabis for so-called medicinal reasons.

In New Zealand, Associate Health Minister Peter Dunne granted permission for the use of medical cannabis to treat 39-year-old Alex Benton, who died on July 1 after being in Wellington Hospital for three months, sedated with drugs to stop refractory status epilepticus. Mr Dunne noted there was no clinical evidence of marijuana’s efficacy.

Legislation continues around the world. In Australia, the Regulator of Medicinal Cannabis Bill 2014 is expected to be debated this year. The use of cannabinoids for therapeutic purposes has been legalised in 23 US states, a federal law, and in countries such as Canada, the Netherlands and Israel.

The NSW Government has committed to clinical trials to explore the use of cannabis or cannabinoids for treating patients with debilitating and terminal conditions. Australia’s first medicinal cannabis trial begins at the Calvary Mater Newcastle Hospital next year.

Queensland and Victoria will join NSW in decriminalising cannabis for trials involving patients with epilepsy, end-of-life pain and chemotherapy-related nausea.

In addition, a new cannabis research centre in NSW will receive $12 million over four years.
There are many benefits to adding research to a professional private practice.

While we are all familiar with research happening in public hospitals and government-funded research centres, the concept of research in private practice is not well developed. It generally is thought to be too difficult to achieve due to factors such as service demands, lack of access to research infrastructure, lack of experience in conducting research.

However, private practice, be it anaesthesia, intensive care or pain medicine, provides a wealth of clinical experience and at times interesting and pertinent cases, which would be worthy of publication for the benefit of practitioners.

I have found adding clinical research to my professional practice has been rewarding, intellectually stimulating, has increased my professional network and reduced the sense of professional isolation that can sometimes affect private practice. It can even lead to new friends!

This may seem daunting, but there are a number of steps one could consider in exploring this pathway.

1. Define your interest and expertise area. Where is the boundary of your knowledge and what do you know a lot about? Do lots of reading – on new areas, research areas, new technologies, even in other fields. Read in areas of potential weakness, such as statistics, trial design etc.

2. Try your hand at simple literature publishing. If there is an interesting article that leaves you with questions (sub-group analysis, methodology concerns) then write a letter to the editor of the publication commenting or seeking clarification. Consider taking an interesting case and writing it up as a case report with short literature review and submitting it to a relevant journal. This gives you experience in the publishing pathway.

3. Join forces with like-minded individuals and start work on collaborative research where you may only enrol a small number of subjects and the back office functions are handled by more experienced principle investigators and teams. This leads to meetings and exposure to the process and “learning the ropes”.

4. Consider hiring a medical writer on an ad hoc basis to assist with manuscript preparation. Look for a PhD as a good qualification to indicate they can do the job and read their publications and research output to gauge their capacity to help you. They may be better at writing up the paper than you, at least initially.

5. Cultivate the habit of corresponding with authors over their interesting work and develop a network. They may turn into collaborators, peer reviewers, mentors or even friends!

6. If you are in a large anaesthetic or intensive care unit group then consider pooling resources (time, jobs, financing) and develop an animal research plan and budget. It doesn’t have to be huge, but from little things, big things grow. More people in the group may start to be interested in helping this way.

7. Establish a mentor – choose someone with a lifetime of experience who may be winding back and would have time to assist with advice and by sharing experience, expertise and wisdom. The value of this can be immeasurable. In my experience, people who are asked to be mentors rarely refuse. They are honoured to be asked and gladly help.

If this sounds challenging then remember the benefits. Patients may directly benefit from new therapy or validation of existing ones. It is intellectually stimulating and provides an additional creative output to “just doing cases”. It can raise your profile and can be used for career development or subsequent broadening of work options.

At the end of the day, we owe it to our specialty to pass on collected knowledge and wisdom. If one never teaches, researches or publishes, then the risk is that one’s accumulated knowledge disappears from the field upon retirement. This is a good way to avoid that and add professional enrichment.
Two workshops covered CPD emergency scenarios with Dr Helen Kolawole from Melbourne covering anaphylaxis and Associate Professor Ross Kerridge covering major haemorrhage. The third workshop was hosted by Dr Joanna Sutherland and Dr Vida Villanusa from Canberra who explored ways of completing the practice evaluation aspects of the new CPD program.

The meeting continues to host a poster session with the prize going to Dr Patrick Coleman for his poster on credentialing GP anaesthetists in WA. We plan for a meeting in June 2016 in early stages with an ICU-themed meeting likely to be held in Canberra.

De Dr David Rowes, Convenor
Clockwise from top: Delegates enjoying a guided tour of Cradle Mountain National Park; Delegates networking at the welcome reception; Dr Craig Mitchell and Dr Patrick Coleman from Ballarat and Dr Patrick Coleman from Bunbury and some tips on completing department audit from Dr Joanna Sutherland from Cooffs Harbour.

The Rural SIG held its 8th annual meeting at the Cradle Mountain Hotel in Tasmania from July 3-5 with the title “ERAS – Every Rural Anaesthetist Should...”. The meeting continues to prove popular with more than 60 delegates attending. About a third were GP anaesthetists. Fortunately the snow that greeted us didn’t hamper too many travel plans and only enhanced the beautiful scenery.

The clinical focus of the plenary sessions were the Patient Blood Management (PBM) and the Enhanced Recovery After Surgery programs. Our keynote speaker Associate Professor Ross Kerridge, from Newcastle, did a fine job covering the three pillars of the PBM over three sessions and the ERAS topics were covered by Dr Judith Killen and Dr Igor Lemich from Wagga Wagga, Dr Sonniht Gilpin and Dr David Rowes from Armidale and Dr Mark Reeves from Burnie.

The final plenary session had an interesting discussion about GP Anaesthetist training, qualification and ongoing credentialing lead by Dr Craig Mitchell from Ballarat and Dr Patrick Coleman from Bunbury and some tips on completing department audit from Dr Joanna Sutherland from Cooffs Harbour.

The meeting was a great success and I would like to acknowledge the great work done by ANZCA events team member Eloise Garcia, hosting her first meeting, to ensure the smooth running of the meeting. Plans for a meeting in June 2016 are in early stages with an ICU-themed meeting likely to be held in Canberra.

De Dr David Rowes, Convenor
Clockwise from top: Delegates enjoying a guided tour of Cradle Mountain National Park; Delegates networking at the welcome reception; Dr Craig Mitchell and Dr Patrick Coleman from Ballarat and Dr Patrick Coleman from Bunbury and some tips on completing department audit from Dr Joanna Sutherland from Cooffs Harbour.

The Rural SIG held its 8th annual meeting at the Cradle Mountain Hotel in Tasmania from July 3-5 with the title “ERAS – Every Rural Anaesthetist Should...”. The meeting continues to prove popular with more than 60 delegates attending. About a third were GP anaesthetists. Fortunately the snow that greeted us didn’t hamper too many travel plans and only enhanced the beautiful scenery.

The clinical focus of the plenary sessions were the Patient Blood Management (PBM) and the Enhanced Recovery After Surgery programs. Our keynote speaker Associate Professor Ross Kerridge, from Newcastle, did a fine job covering the three pillars of the PBM over three sessions and the ERAS topics were covered by Dr Judith Killen and Dr Igor Lemich from Wagga Wagga, Dr Sonniht Gilpin and Dr David Rowes from Armidale and Dr Mark Reeves from Burnie.

The final plenary session had an interesting discussion about GP Anaesthetist training, qualification and ongoing credentialing lead by Dr Craig Mitchell from Ballarat and Dr Patrick Coleman from Bunbury and some tips on completing department audit from Dr Joanna Sutherland from Cooffs Harbour.

The meeting was a great success and I would like to acknowledge the great work done by ANZCA events team member Eloise Garcia, hosting her first meeting, to ensure the smooth running of the meeting. Plans for a meeting in June 2016 are in early stages with an ICU-themed meeting likely to be held in Canberra.

De Dr David Rowes, Convenor
Clockwise from top: Delegates enjoying a guided tour of Cradle Mountain National Park; Delegates networking at the welcome reception; Dr Craig Mitchell and Dr Patrick Coleman from Ballarat and Dr Patrick Coleman from Bunbury and some tips on completing department audit from Dr Joanna Sutherland from Cooffs Harbour.
New Zealand news

Visiting lectureship program proves popular

The NZ Anesthesia Visiting Lectureship Program, which this year has five lecturers, is providing much appreciated in-house education at anaesthesia departments around the country, including several regional-based meetings.

Hutt Hospital, near Wellington, wrote to the NZ Anesthesia Education Committee (NZAEC), which manages the program, to express their appreciation for the presentation on August 6 from Dr Doug Campbell of Auckland City Hospital.

“Doug presented on anaesthesia research, concentrating on New Zealand involvement in multi-centre international clinical trials run under or with the support of the ANZCA Clinical Trials Group.

“We had an excellent turnout and this visit will serve as a focus for increased Hutt involvement in research. It was also useful that we could meet and discuss this as a group within our own department; this aim is often not achieved if only a few of us can attend such sessions at off-site conferences.”

On August 1, Dr Campbell joined Dr James Cameron (the new head of anaesthesia at the Hutt Hospital) to present at a regional meeting held at Hawke’s Bay Regional Hospital for 30 attendees from Palmerston North, New Plymouth, Whanganui, Masterton and Hawke’s Bay Hospitals. Dr Cameron also presented at Nelson Hospital on August 7, and outlined ways to improve the safety of newborns.

Head of anaesthesia at Hawke’s Bay, Dr Murray Hardy, who organised the combined meeting with Dr Nigel Waters from Palmerston North, said: “This is a cost-effective way for the lecturers to be able to present to more departments and it promotes regional collaboration.”

A third speaker was added to the meeting – local anaesthetist Dr Tony Diprose, who spoke about being part of the NZ Medical Assistance Team’s (NZMAT) response to Cyclone Pam in Vanuatu earlier this year. He said being able to respond quickly required prior planning, a co-operative employer, supportive colleagues and an understanding family.

Dr Ben Griffiths, from Auckland City Hospital, presented on “Emergency laparotomy perioperative outcome and quality improvement pathways: a UK and NZ perspective” at Whangarei Hospital on May 8 and will join Dr Emma Patrick to present at Taunui Hospital on October 10. Anaesthetists, trainees, anaesthetic technicians and theatre nurses from Taunui, Rotorua, Whakatane and Thames hospitals are being invited to this regional meeting.

Dr Patrick, whose topic is “Blood topics/transfusion update”, will make her second presentation at Timaru Hospital on December 2.

The fifth lecturer, Dr Jeanette Scott from Middlemore Hospital, of experience in running airway management and fellowship programs, is guest facilitator for the CICO (can’t intubate/can’t oxygenate) workshops being held at the Wellington Hospital Simulation and Skills Centre. This is also the location for a trauma/anaphylaxis simulation-based workshop.

On the welfare side, various workshops examine how to develop mentoring skills and how to support colleagues in difficulty, plus the secret to living a fulfilling life.

Change of officers for NZNC

Some office bearers for ANZCA’s New Zealand National Committee (NZNC) changed at the June meeting. Dr Gary Hopgood took over as chair, succeeding Dr Nigel Robertson (Auckland), who had completed two years in the role, but remains as a committee member. Dr Bogroo, a generalist and cardiac anaesthetist at Waikato Hospital, has been a member of the NZNC since 2010, deputy chair for the last two years and is an ANZCA primary examiner. His interests include cardiac and thoracic anaesthesia, echocardiography and governance in healthcare.

Other new officers confirmed at the meeting were Dr Jennifer Woods (Christchurch) as deputy chair and Dr Brent Waldron (Hutt) as education officer. Re-elected were Dr Geoff Laney (Dunedin) as safety and quality officer, Dr Woods as formal project officer, Dr Sally Ure (Wellington) as deputy education officer, Dr Geoff Long (Waikato) as TAC officer and Dr Kerry Gunn (Auckland) as fellowship affairs officer.

The other elected committee members are Dr Sabine Pecher and Dr Indu Kapoor (both Wellington), Dr Vanessa Beavis and Professor Alan Merry are on the NZNC ex officio as ANZCA Councillors. Dr Kieran Davis is the FPM representative; Dr Rachel Dempsey, the New Fellows’ representative; and Dr Lizi Edmonds, the NZ Trainees Committee representative.

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On August 6, 2016, the NZNC held its annual general meeting to register.

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Award for cultural competence leader

A member of the group developing an ANZCA professional document on cultural competence, Associate Professor Suzanne Pitama, was presented with the Prime Minister’s Supreme Award for tertiary teaching excellence in August.

Associate Professor Pitama is the Director of the Māori/ Indigenous Health Institute (MHI) at the University of Otago, Christchurch. Her teaching program has been described as “the most comprehensive indigenous health curricula (in medicine) in Australia and New Zealand.”

Associate Professor Pitama also picked up two of six awards on offer at the Leaders of Indigenous Medical Education (a New Zealand and Australian network) conference held in Townsville, August 11-13. As well as being on the document development group for ANZCA, Associate Professor Pitama recently ran a workshop for the anaesthesia department at Christchurch hospital.

Above from top left: Dr Nigel Waters, Dr Murray Hardy, Dr Doug Campbell and Dr James Cameron pictured at the regional meeting held at Hawke’s Bay Regional Hospital. The audience at the Hawke’s Bay regional meeting for the visiting lecturers.

Above: Some of the NZNC members for 2015-2016 pictured in June with the ANZCA President, from left: Dr Kieran Davis, Dr Jennifer Woods, Dr Kerry Gunn, Dr Sabine Pecher, Dr Indu Kapoor, Dr Vanessa Beavis, Dr Gary Hopgood, Dr Sally Ure, Dr Brent Waldron.
ACT Trainee Committee

Following the completion of his training, we farewelled Dr Ross Hanrahan from the ACT Trainee Committee. Ross has worked tirelessly on the committee over many years, most recently in the position of chair. We thank Ross for his efforts and congratulate him on his admission to fellowship. Dr Jennifer Hartley will take over as chair for the remainder of 2015 and will be joined by co-chair Dr Julia Hoy on her return to Canberra in January 2016. We also welcome a new member, Dr Pallavi Kumar, to the committee.

39th Annual Queensland ANZCA/ASA Combined CME Conference

On a spectacular winter’s day on June 27, 132 delegates gathered at the Brisbane Convention and Exhibition Centre for the 39th Annual Queensland ANZCA/ASA Combined CME Conference. The theme this year was “Enhanced recovery after surgery – the myths, methods and monitoring”.

In the first session we had an informative reflection from our surgical and nursing colleagues regarding implementation of an ERAS program for colorectal surgery in a major metropolitan centre.

Following this, Dr Peter Schuller explained his groundbreaking research into the Bispectral Index undertaken in Cairns. Suffice to say the audience was amazed by video footage of the research. I commend all Fellows to follow this in his recent publication in the British Journal of Anaesthesia.

Dr Kerstin Wyssusek
Convener
Formal Project Officer, Queensland
Chair, Queensland Regional Committee

Primary Examination Preparation Course

The June 2015 Primary Examination Preparation Course (PEPC) was well received by all 33 exam candidates. On the basis of the positive feedback received in January and June we intend to continue the new exam-focused format in 2016. The intention is to run it as a one-week intensive course before each sitting of the 2016 primary exam. Many thanks to all who presented and helped with the organisation of the 2015 courses. Please see the Queensland Regional Committee website for the dates of the 2016 PEPCs.

Dr Brown Thomas
Course convenor

Above from left: Dr Peter Casey received his award from Queensland Chair Dr Kerstin Wyssusek; Dr Rebecca Kamp receives her award from Dr Nicole Fairweather; Dr Paul Slocombe, winner of the ANZCA Tess Cramond Award, with Dr Wyssusek.

2016 Art of Anaesthesia

Save the date! Next year’s Art of Anaesthesia scientific meeting will be held over the weekend of October 15-16, 2016. This coincides with the renowned Floriade Festival on the shores of Lake Burley Griffin and is a beautiful time to visit the nation’s capital. Co-convenors Dr Carmel McInerney and Dr Girish Palnitkar have many wonderful ideas to make the meeting bigger and better than ever so save the date now!

Workshops

The ACT Regional Committee will present three workshops on Saturday November 7. Two emergency response workshops (CICO and ALS) will be held in the morning from 9-11am, and a workshop on Peripheral Nerve Block Ultrasound Scanning will be held during the afternoon from 1.5-3pm. The workshops will be held at Calvary Hospital (Bruce). Further information, including online registration, will be soon available on the ACT website: http://act.anzca.edu.au/
FPM VRC Inaugural Victorian Registrars’ Scientific Meeting

The FPM Victorian Regional Committee held its Inaugural Victorian Registrars’ Scientific Meeting 2015 at ANZCA House on Wednesday August 12. The meeting was devoted to presentations from four trainees and newly graduated Faculty Fellows, who presented their clinical case reviews. The quality of the four reviews was excellent and the topics quite varied, but relevant to everyday practice in pain medicine. The presenters were Dr Jacquelyn Nash, Dr Mark Alcock, Dr Noam Winter and Dr Stiofan O'Conghaile. The inaugural prize was awarded to Dr Jacquelyn Nash. Our sincere thanks go to adjudicators Dr Anthony Weaver and Dr Carolyn Arnold for their participation, and to the directors of pain units and other Faculty Fellows who attended and contributed to making our inaugural event a success.

We also thank our meeting sponsor, bioCSL, for their support of our academic endeavours.

Dr Diarmuid McCoy
Convenor
Chair, Faculty of Pain Medicine Victorian Regional Committee

Supervisors of training workshop

The Victorian Regional Committee hosted a half-day supervisor of training workshop at ANZCA House in Melbourne on the topic of “Teaching clinical reasoning by making expert thinking visible and accessible for students”. This seminar covered two main goals: to introduce a method for teaching clinical reasoning ‘Making expert thinking visible thinking’; and to provide participants with an opportunity to practice the method and plan for future clinical reasoning teaching in the clinical area of anaesthetics.

The guest presenter was Associate Professor Clare Delany, from the Department of Medical Education at the University of Melbourne. Clare facilitated an interactive workshop entitled “Making thinking visible: An approach for teaching clinical reasoning in anaesthesia”. Participants worked through exercises to clarify the nature of our own thinking and explore how we can use this to develop thinking routines for our learners. While this was a challenging exercise, the workshop was enjoyable and generated practical guidance for use in our own teaching practice, with the annual supervisor of training dinner following as a reward!

Professor David Story will present on clinical audit at our next meeting on Thursday November 5.

Dr Damian Castanelli
Education Officer, Victoria

Combined CME meeting

Once again held on the last Saturday in July in Melbourne, a varied program was presented with the theme of “Art and science, tips and tricks”. Convened this year by Dr Michelle House from the ASA, the meeting largely brought a pragmatic approach to sub-speciality anaesthesia practice. Full of enigmatic speakers, favourite sessions included new oral anticoagulants, point of care haematological testing and bedside ECGs, paediatric practice and “What’s hot in (adult) RMT”. The energetic Professor David Story concluded the meeting with the Embley Memorial Lecture on “The big questions for academic anaesthesia”, attended by the president of the AMA (Victoria) Dr Tony Bartone. More than 100 registrants and with a focus on audience engagement, themes of perioperative medicine, paediatrics, innovations in anaesthesia: iPads for induction, programmed intermittent epidural block for labour analgesia and where to in research anaesthesia (towards a more multi-specialty approach?) were explored. A live Twitter feed was employed throughout the meeting during panel discussions for the first time and we will seek participant feedback to see if it will become a usual fixture.

Above from top: Dr Kara Allen, Dr Mark Hurley, Dr Damian Castanelli, Dr Charla Padmanathan, Dr Heather Kocent, Dr Bridget Langley, Dr Andrew MacCormick, Dr Burger van der Merwe, Dr Heather Loane, Dr Louise Parker, Dr Andrea Noar, Dr Heather Butler, Dr Al-Mtaweel, Dr Andrew Jones.

Above from top: Dr Debra Devonshire, Convenor Dr Michelle Horne, Dr Peter Seal and Dr Irene Ng; Dr Tony Bartone and Professor David Story.
Freycinet Winter Workshop

On a cold, wet and wintry weekend that saw snow and sleet hit the state, 35 dedicated participants made their way from all over Tasmania, as well as from warmer states to attend a one-day meeting at the beautiful Freycinet National Park.

Delegates had the choice of either attending one of two hands-on workshops in the morning, followed by an afternoon of speakers, all examining the “human face of anaesthesia”.

Dr Marion Andrew travelled from South Australia to deliver a “Key-2-Me” Process Communication Model Seminar. This workshop provided participants with an introduction to a logical tool to assist them in gaining a deeper understanding of their behavior under stress. They also developed techniques to understand the motivations and needs of their colleagues in order to avoid conflict. Feedback from the workshop was positive with some acknowledging the importance both professionally and personally of gaining a greater understanding of human interactions.

Those who attended the Advanced Life Support Refresher Course also valued the teaching from this workshop. Delegates greatly appreciated the small groups that allowed plenty of hands-on learning.

Delegates appreciated the variety of speakers and the opportunity to listen to talks that didn’t cover the “true classical anaesthesia content”.

At the end of the one-day meeting, delegates enjoyed the opportunity to socialise together at a dinner that specialised in fresh local produce.

The meeting convenor, Dr Gregg Best was pleased with the outcomes of the day and thought that the workshops, presentations and opportunities to socialise with colleagues all coordinated well together to form the theme “the human face of anaesthesia”.

ANZCA/ASA Winter Scientific Meeting

The ANZCA/ASA Winter Scientific Meeting “Blood, sweat and TEGs” convened by the WA CME Committee was held on July 4. It was held at the University Club at the University of Western Australia with 109 delegates and 10 healthcare industry representatives in attendance.

Dr Paul Kruger, a haematologist and consultant physician at Fiona Stanley Hospital in Western Australia attended the meeting and spoke on the management of anticoagulants in the perioperative setting. Dr Anastasia Keegan, a transfusion medicine Fellow, also from Fiona Stanley Hospital presented on massive blood transfusion. Dr Simon Zidar, a cardiac trained anaesthetist and perfusionist spoke on “Platelets and perioperative/POC testing – no more graph!” and Dr Subhi Malhotra, a consultant anaesthetist and honorary senior lecturer at Imperial College NHS Trust presented on obstetric haemorrhage.

This meeting also hosted several workshops including Cell Salvage, Rotem and CICO.

We have received excellent feedback in regards to content of presentations as well as conference facilities, catering standards and the general organisation of the conference resulting in a very successful meeting.
Difficult airway relativity

The “Difficult airway relativity” 83rd NSW regional meeting was held on June 13 at the Sydney Hilton. The meeting attracted anaesthetists from across Australia and New Zealand and was very well received with more than 360 delegates in attendance.

Some of the topics that the keynote lectures covered were: Airway management, Fires in the operating theatre, Obstetric airway update, Paediatric airway cases, OLV – old and new techniques for the non-thoracic anaesthetist. A highlight of the talks was the presentations given by Dr Anil Patel on Nap A – “What have we learned and how do we implement change?”. THRIVE nasal oxygenation to give more time for intubation and Strategies for safe extubation and the place for nurse-led awake extubation of low risk cases in recovery.

The PBLDs and workshops as always, were a great success and addressed new techniques and equipment facilitated by expert presenters. A highlight of the workshops was the emergency response workshop, that we have now become expert at facilitating.

We congratulate the NSW ACE Committee, convenors and NSW ANZCA staff on the success of this event and they are already planning for next year.

Foundation Teacher Course

The ANZCA Office in Sydney hosted a Foundation Teacher Course from June 17-19, 2015, with 18 Fellows and senior trainees attending from various regions across Australia and New Zealand. This interactive course was one of five face-to-face courses this year, with others held in Adelaide, Hobart and Perth, and the final course to run in Auckland in October.

The course enabled participants to engage with colleagues over three days, to work together to expand their knowledge and skills related to learning and teaching. Participants learned how to implement a learner-centred approach to facilitating trainees and came away with useful tools for facilitating learning in and out of the operating theatre.

The courses this year have been supported by Fellows and provisional Fellows who have committed their time to facilitate sessions within the course. We would like to thank and acknowledge Dr Elizabeth Chye, Dr Shona Osborn, Dr Jessie L, Dr David Law and Dr Emelyn Lee for their contribution. The Teaching and Learning Subcommittee are looking at ways to increase capacity for many more Fellows to become facilitators of the course in the future.

If you are interested in being notified when registrations open in November 2015, for courses running in 2016, please get in touch at ftc@anzca.edu.au. An article on the ANZCA Educators Program (formerly the Foundation Teacher Course) can be found on page 54.
CME meeting “Anaesthesia Research Update”

SA and NT Continuing Medical Education Meeting “Anaesthesia Research Update” was hosted by ANZCA/Australian Society of Anaesthesiologists on July 29 at the Women’s and Children’s Hospital. Dr John Dally, RMO at the Queen Elizabeth Hospital, opened the meeting with study outcomes she has been working on for the past three years on the “effect of perineural versus intravenous Dexamethasone on ankle block duration”. Dr Allan Cyna, Senior Consultant Anaesthetist at the Women’s and Children’s Hospital and Clinical Lecturer at the University of Adelaide presented “Research questions: What’s hot and what’s not?”. Dr Cyna covered current research being undertaken at The Women’s and Children’s Hospital and the research guidelines they use such as “What is a good research question?” and “Should we be shooting sacred cows?” when we ask research questions. He quoted the ethics of placebo and types of placebo and whether RCTs are the best way to answer a question and how they choose a primary outcome. Very interesting points were raised on communication and how it can affect anaesthesia outcomes such as “Do words hurt? Can they help?”.

Dr Douglas Fahlbusch, Anaesthetic Consultant, introduced the attendees to the new PADDI (Perioperative Administration of Dexamethasone and Infection) Trial that will commence shortly with primary outcomes to address the impact of Dexamethasone on surgery site infection (SSI) and a range of secondary outcomes in relation to its safety profile. Of approximately four million operations around Australia per year, a quarter receive Dexamethasone postoperatively with up to 12 per cent of patients having SSIs – big numbers, very expensive to treat and morbidity and expense to the patient is at an estimated cost of $52 million per year in Australia and approximately $40 billion worldwide per year. This is an Australian-driven study that has potentially significant impact internationally.

Dr Roelof Van Wijk, head of the anaesthesia department at the Queen Elizabeth Hospital and Senior Clinical lecturer at the University of Adelaide told of why the Queen Elizabeth Hospital started their pilot study “Deep neuromuscular block reduces intra-abdominal pressure requirements during laparoscopic cholecystectomy”. They wanted to know if deep neuromuscular block reduced the intra-abdominal pressure requirement during laparoscopic surgery and would you have a clearer view? How large is the effect size if you administer a high dose of Rocuronium and have a very deep block? They could not find an answer anywhere in literature, it was never quantified and if you can’t quantify you can’t do any research around it as you can’t do a power calculation so you don’t know how many patients you need for the trial – thus emerged the study comparing the effect of deep block versus no block.

The second CME meeting of the evening series was well attended with the meeting closing with a lucky door prize draw for a GoPro camera provided by our corporate sponsor with Dr John Dally being the lucky recipient.

Above clockwise from left: Dr Allan Cyna; Dr Douglas Fahlbusch; Dr Simon Macklin; Doorprize winner Dr John Dally; Dr Roelof Van Wijk; Dr Rachel Dawson.

South Australia and Northern Territory

NT Biennial ASM “New answers to old questions”

The 7th Biennial Northern Territory Anaesthesia CME meeting had a fresh look with a change of scene this year at Skycity Darwin, having outgrown the traditional venue. The theme of the meeting was “New answers to old questions”, with the talks ranging from difficult airway management and perioperative cardiology to the latest in peri-operative diabetic management.

Our keynote speaker, Dr Keith Greenland, opened the day with a fascinating approach to the airway, a theme which was continued from a surgeon’s perspective by Dr Graeme Crossland. Their unique approaches to the age-old problems gave us all new insights into the potential crises and their management for our patients.

A practical review of perioperative cardiological management was given by Dr Hussam Tayeb, a cardiologist from the Royal Darwin Hospital. His approach, that went beyond what we are used to seeing, was an exceptionally insightful bridge between cardiologists’ and anaesthetists’ perspectives.

Our local speakers Dr Nathan Oates, Dr Sorcha Evans and Dr JP Cotter all gave us excellent insights into obesity and OSA, diabetes and renal failure respectively.

For the first time this year, there were also concurrent CICO and anaphylaxis workshops that enabled delegates to meet the ANZCA CPD emergency response criteria.

Finally a beautiful dinner at Char restaurant concluded a very successful meeting.

Dr Simon Roberts, FANZCA
Royal Darwin Hospital, NT ASM Organising Committee

Change of FPM SA chair

At the July SA FPM CME evening, Dr Graham Wright was thanked for his dedication and contribution as chair of the SA FPM Regional Committee over the past four years. Dr Wright’s involvement has been integral from the inception of the committee and his input ensured informative CME evenings engaged South Australian members on a regular basis. His efforts continued to address issues in relation to strengthening the regional framework of the Faculty. We would like to thank Dr Wright for his dedication in serving his term and welcome Dr Bruce Rounsefell to the role as chair.

A synopsis of pain research was presented at the meeting by Dr Tasha Stanton, Dr Andrew Somogyi and Dr Susan Evans.

Above left, clockwise from left: Dr Allan Cyna; Dr Douglas Fahlbusch; Dr Simon Macklin; Doorprize winner Dr John Dally; Dr Roelof Van Wijk; Dr Rachel Dawson.

Above: Dr Bruce Rounsefell and Dr Graham Wright.
Colin James Friendship spent his early years at Bronte, attending Sydney Boys High School before graduating from the medical faculty at the University of Sydney in 1955. After a few years in general practice in Killara, Col travelled to England, feeling his way through orthopaedics and obstetrics until he found his niche in anaesthetics, gaining a DA. More importantly while in Wales, he met and married Rita, and they settled in Caringbah in the Sutherland Shire of Sydney, where he worked as a GP anaesthetist for three years.

A career in anaesthesics beckoned with the opening of the Sutherland Hospital in 1958, and Col returned to England where he fulfilled the requirements for the Fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons (FFARCS) in 1961. His appointment that year as the first full-time visiting anaesthetist at Sutherland Hospital was followed by appointments at St George Hospital, Prince Henry Hospital and the Royal Hospital for Women in Paddington. His FRCA was awarded in 1967.

Over the next 10 years, the onerous after-hours roster commitments at four hospitals forced him to relinquish the latter three positions to focus on the Sutherland Shire, the fast-growing area in which he raised his family.

He inevitably became involved in the acute management of critical incidents, made more frequent by the ubiquitous waterways and unfenced pools, the predominant paediatric population and proximity to...in home swimming pools, bays and beaches, he managed snake and funnel web spider envenomation and ciguatera poisoning.

In the ensuing decade, Col was the driving force behind a new intensive care facility, a 24-hour labour-epidural service and a training program for anaesthetics registrars in conjunction with the University of NSW group of hospitals. He provided unswerving and generous support to anaesthetics colleagues around Australia, especially those in single-practice, seeking respite.

Col was a superb anaesthetist in every sense: highly competent, safe, unflappable and reassuring. He loved war-torn Vietnam in the early 1970s with the South-East Asia Treaty Organization (SEATO) gaining valuable experience in...newly appointed orthopaedic surgeon.

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He inevitably became involved in the acute management of critical incidents, made more frequent by the ubiquitous waterways and unfenced pools, the predominant paediatric population and proximity to Sydney’s Royal National Park. In addition to drownings in swimming pools, bays and beaches, he managed snake and funnel web spider envenomation and ciguatera poisoning.

In the ensuing decade, Col was the driving force behind a new intensive care facility, a 24-hour labour-epidural service and a training program for anaesthetics registrars in conjunction with the University of NSW group of hospitals. He provided unswerving and generous support to anaesthetics colleagues around Australia, especially those in single-practice, seeking respite.Over the next 10 years, the onerous after-hours roster commitments at four hospitals forced him to relinquish the latter three positions to focus on the Sutherland Shire, the fast-growing area in which he raised his family. 
Obituary

Dr Peter Yorke
1953 – 2015

He was an active chair and did much to boost hospital morale by organizing hospital picnics, car rallies and extensive 50th anniversary celebrations in 2001. He devoted much effort to help increase the hospital’s business following the acquisition of the Lidia Perin Hospital, a day surgery. By 2004, the hospital’s financial pressures forced him to spend a large amount of time negotiating the sale of the John James hospital business, which was eventually purchased by Calvary Healthcare. These were trying times and many meetings were held with clinicians, staff, and administrators.

The transition to Calvary John James Hospital and the resulting John James Foundation was difficult but ultimately successful and his efforts were recognised by lifetime membership of the foundation and the renaming of the Clinical Services Building in his honour in 2011. His chairmanship of the foundation was marked by the establishment of a volunteer specialist program in the Northern Territory in which he was a keen participant and a medical student elective program for James Cook University students in their final year.

As an anaesthetist, Peter Yorke was highly regarded for his considerable clinical skill, his attention to detail and excellent post-operative care. He was much appreciated by surgeons for his “unflappable” and his prompt starts to the operating day; the latter wasn’t always liked by all nursing staff. He was very popular as a teacher of medical students; he made the day interesting and fun. There are quite a few doctors who were first exposed to anaesthesia by Peter and then encouraged, and supported, to make it their career; the author being one.

Peter was also a keen participant in the RACS Pacific Islands Project and first went to Tuvalu in 1997 and subsequently to the Marshall Islands, Pohnpei, Fiji and Nauru. He enjoyed the challenge of working in those primitive conditions, bringing specialist medical care to people while enjoying the beautiful surroundings. As an extension of this, Peter joined the RAAF Reserve in 1997 and completed overseas deployments as Squadron Leader and Medical Officer to Bougainville and East Timor. He was awarded an Australian Service Medal and Active Service Medal.

Outside medicine, Peter’s interests included his dogs, English Setters, classical music, art, cricket and restoring classic cars, including makes such as Aston Martin, Rolls Royce and Mercedes Benz. He restored his well known blue Aston Martin DB5; more than once, drove it regularly and ensured that its performance was occasionally tested. Other cars to occasionally grace the hospital car park included a wonderful 1934, Rolls Royce and a lovely 1967, Mercedes Benz 230SL. “Pagoda” roadster. As a member, he regularly attended the New Year Sydney cricket test. He travelled widely and enjoyed sailing and opera in far flung places. More recently, he developed an interest in horse racing and was a part owner of two horses (or “nags” depending on how they fared at the track). The Melbourne Cup-carnival, including Derby Day, was something he really looked forward to. He was a generous and charming host whose functions were always memorable affairs; the Australia Day functions at his south coast retreat were legendary. He was full of stories about cars, places and people and they usually left one laughing.

The diagnosis of oesophageal cancer in December 2012 was met with his usual quiet resolve and determination; treatment began immediately. The complication and further extensive treatment caused by the diagnosis of malignant melanoma did not alter this approach. After 12 months it seemed that treatment had been successful and he enjoyed a wonderful 60th birthday party. However, even Peter could not beat the odds this time and further chemotherapy and radiotherapy was needed. But this did not dent his incredible stoicism and up until February 2015, he enjoyed a busy social calendar meeting with friends and colleagues for coffee, lunch or dinner. He spent time with his family and focused on his 15-year replica Aston Martin DB5 racing car project, the completion of which eluded him.

That the Albert Hall was filled to capacity for his memorial service is testament to the large number of people, from within and outside medicine, from far and wide, who were influenced by him. He was a pleasure to be around and will be very much missed.

We send our condolences to his partner Andrea and son Will.

Dr Arne Schimmelfeder, FANZCA
ACT

Peter David Yorke was born on August 5, 1953 in Sydney, and died on April 14, 2015 in Canberra. Peter grew up in Darlinghurst and Bexley, the only child of Reginald and Dorothy. He completed his schooling at Sydney Technical High School. After a stint working on the NSW Railways, he undertook his medical degree at the University of NSW. Having been in Canberra in his final year of medical school, he returned there for his internship in 1979. Living in the Woden Valley Hospital residents’ quarters, his penchant for classic cars was readily apparent, either in the car park or on the ramp to the Casualty Department entrance!

After three years, he went to England with a plan to further his training in anaesthesia, obstetrics and possibly paediatrics. He never got past anaesthesia. After he completed his Diploma of Anaesthesia, he continued with anaesthesia training in Taunton, Somerset. The time in England was one he remembered with great fondness: the cricket, travel and great camaraderie with his medical colleagues.

Peter returned to Australia in 1985 and completed his anaesthesia training at Royal Hobart Hospital. In 1987, he took up consultant positions at Royal Canberra, Woden Valley, Calvary and John James Memorial hospitals. He returned to Hobart in 1991 but came back to Canberra in 1995, and quickly established a busy practice with a focus on John James Memorial Hospital.

Peter first joined the board of John James Memorial Hospital in 1990 and, after his Hobart sojourn, became chairman in 1996, holding that post until 2009.