100 years of ANZAC: The impact of war on anaesthesia

Advocacy: College’s increasing role in stakeholder relations

CPD tips: How to make the most of mobile devices

Your ANZCA: The critical role of local College committees
Adverse events
What we can learn from coronal cases in South Australia and New Zealand.

CPD advice
We continue our series on making the most out of the ANZCA CPD portfolio system.

Foundation lifts pelvic pain profile
The Pelvic Pain Foundation has been formed to improve the quality of life of people with pelvic pain.

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At its last meeting for 2014, the ANZCA Council reviewed the College’s achievements, ANZCA’s strategic plan and the results of the recent fellowship and new Fellow surveys. The council is committed to ensuring the College remains on track to achieve its strategic goals, remains relevant and contemporary, and addresses areas of concern to Fellows and trainees.

Workforce, continuing professional development (CPD) and the training portfolio system (TPS) were identified by council as areas requiring focus. Following a review of all ANZCA’s non-education committees in 2014, a revised committee structure has resulted in a new committee – the Professional Affairs Executive Committee (PAEC), which met for the first time in late February. PAEC is the committee co-ordinating and overseeing activities and functions relative to Fellows and workforce will be a standing item on its agenda. The committee will report regularly to the council and fellowship on the progress of the College’s efforts in implementing its Workforce Action Plan, which commenced in 2013 with three priorities – advocacy, data and communication. Fellows and trainees will continue to be informed first-hand. She is attending committee meetings in each region and New Zealand and undertaking many hospital visits to hear from Fellows and trainees first-hand. The SAQ committee has highlighted important system issues and there are valuable lessons to be learned. These will be highlighted in a brief commentary summarising the relevant issues.

If you do not already do so, I urge you to consider following ANZCA on twitter (@anzca). Twitter feeds are short and punchy – ANZCA tweets and retweets about job vacancies, safety alerts and links to media relevant to anaesthesia and pain medicine – recently, for example, there was excellent media coverage (see page 2) regarding the link between photodermone and anaphylaxis.

CEO resignation
As recently communicated by email, I regret to advise that ANZCA Chief Executive Officer, Linda Sorrell, has announced her decision to retire from fulltime work and will leave the College on July 31. Linda has been a highly visible ambassador for the College, regularly attending committee meetings in each region and New Zealand and undertaking many hospital visits to hear from Fellows and trainees first-hand. She is well-respected for her advocacy for the College with many high-level external organisations and has overseen a number of major initiatives over the past three and a half years including the roll-out of the College’s biggest project, the 2013 revised ANZCA curriculum and more recently, the FPM curriculum. She has also overseen the introduction of the revised CPD program and the introduction of Networks, our new learning and collaboration system.

I wish Linda well in her future endeavours.

Dr Genevieve Goulding
ANZCA President
president@anzca.edu.au
@iggoulding38

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ANZCA President
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The ASM represents a great opportunity for Fellows to meet ANZCA staff face to face and ask questions or learn about the many services offered by the College.

The ANZCA lounge in the healthcare industry area will act as an information hub, with Fellows able to access information on a number of ANZCA services and initiatives. A special focus will be continuing professional development (CPD) and training and assessments. Staff will be available to answer questions about the revised CPD program and CPD portfolio system and to talk through the training program and training portfolio system.

Education and learning resources will be on display, including Networks, ANZCA’s new online learning and collaboration system. The ANZCA Library, one of the most important resources for Fellows and trainees, will demonstrate functions and services available to Fellows and trainees.

The Anaesthesia and Pain Medicine Foundation will be on hand to explain research opportunities for Fellows and trainees and showcase research that has been undertaken or is under way and the Faculty of Pain Medicine, which is rolling out its new curriculum, will be in the ANZCA lounge.

A daily timetable will be distributed so Fellows and trainees can access information relevant to them.

Once again, the Communications team will use the ASM to promote anaesthesia and pain medicine to the wider community via the media, which has shown great interest in the ASM over many years. All Fellows and trainees, including those not attending the meeting, will also be kept in the loop via the ASM E-Newsletter, which will have links to slide presentations (audio-visual) by keynote speakers and interviews with College officials, such as the president, as well as photos, media coverage and other information.

To commemorate the 100th anniversary of the ANZAC landings at Gallipoli and to highlight the participation of anaesthetists and pain medicine specialists in conflict and peacekeeping, ANZCA will have an evocative online exhibition and display at the ASM. A complementary exhibition book, Trailblazers & Peacekeepers,
Honouring the ANZAC Spirit will be launched during the History Special Interest Group sessions. The display, exhibition and book are initiatives of the Geoffrey Kaye Museum of Anaesthetic History.

Over the past four years, the museum has been enrolled in the Museums Accreditation Program (MAP), administered by the Victorian branch of Museums Australia, and has received confirmation of its formal accreditation. Victoria has about 800 organisations fitting the International Council of Museums’ definition of a museum. Of those, 52 are enrolled in Victoria’s accreditation program and only 65 are accredited. Achieving accreditation places the museum well within the top 10 per cent of Victorian museums.

The exhaustive accreditation process demanded examination of all areas of museum practice, demonstrating compliance with relevant regulations and legislation, endorsing a museum-specific code of ethics, strategic planning, reviewing community engagement strategies and development of a full suite of policies and procedures, all in line with industry best practice.

The museum has been popular with Fellows, trainees, staff and the public since re-opening last September in the historical Ultima building adjoining ANZCA House in Melbourne.

Congratulations to the Honorary Curator, Dr Chris Baili, and ANZCA’s Knowledge Resources staff, especially Museum Curator Monica Cronin, who made accreditation possible.

Mo Linda Sorrell
Chief Executive Officer, ANZCA
ceo@anzca.edu.au
Australia Day honours

Associate Professor David Bruce Baines (NSW) has been awarded an AM (Member in the general division) for significant service to medicine in the field of paediatric anaesthesia as a clinician, administrator and mentor, and to medical education.

Associate Professor Raymond Garrick (NSW) has been awarded an AM (Member in the general division) for significant service to medicine in the field of chronic pain management, and to medical education as an academic.

Professor Ken Mark Hillman (NSW) has been awarded an AO (Officer in the general division) for distinguished service to intensive care medicine as a clinician, educator and researcher, as a pioneer in the introduction of the medical emergency team system, and as an advocate for the critically ill.

Dr Neil Eastwood Street (NSW) has been awarded an AM (Member in the general division) for significant service to medicine in the fields of paediatric anaesthesia and malignant hyperthermia, and to the people of the Asia Pacific region through medical aid programs.

Dr Richard John Willis (SA) has been awarded an AM (Member in the general division) for significant service to medicine in the field of anaesthesia, and to professional organisations.

Letter to the editor

NSW ACI Safe Sedation Project

Many thanks to Associate Professor Larry McNicol for the latest version of the Safety of Anaesthesia (mortality report), summarised in the December ANZCA Bulletin1. Airway management and aspiration remain significant factors in death associated with anaesthesia and sedation.

In the same Bulletin edition, ANZCA President Dr Genevieve Goulding referred to the work of the NSW Agency for Clinical Innovation (ACI), and the development of Minimum Standards for Safe Procedural Sedation2. The ACI project involved site visits to more than 50 procedural departments in metropolitan, regional and rural hospitals in NSW. The most common model of care involved nursing staff administering sedative medications, and monitoring and managing sedated patients.

This occurred in a range of settings, including cardiology, haematology, endoscopy, radiology suites and emergency departments.

We found that those units and procedural departments with well functioning sedation services generally had well established and collaborative relationships with local anaesthesia departments. These anaesthesia departments were able to provide timely advice and support for patient risk assessment and triage, and also for staff training and support. Training for nursing staff to improve airway and bag-mask ventilation skills was often provided. Where these relationships worked well, “rescue” services for patients receiving sedation appeared to be rarely required.

The next phase of the NSW ACI Safe Sedation Project will include the facilitation and support of such local relationships. We encourage all anaesthesia departments to become involved in this work.

In this way, patient safety and quality sedation care will be improved.

Dr Joanna Sutherland, FANZCA
Visiting medical officer anaesthetist, Coffs Harbour Clinical lead, NSW ACI Safe Sedation Project

References:
Safety hits the headlines

Since the last edition of the ANZCA Bulletin the Communications team prepared an opinion piece, “Life and death – the challenge for anaesthetists”, on behalf of Fellows Associate Professor Larry McNicol and Dr Neville Gibbs, for Fairfax media in response to their series on euthanasia – “The right to die”. The piece appeared prominently online across all Fairfax media outlets and ignited media interest in the work of ANZCA’s Safety and Quality Committee. The opinion piece reached an estimated cumulative audience of close to 500,000 readers.

The committee’s triennial Safety of Anaesthesia mortality report, created by the ANZCA Mortality Sub-Committee, found that anaesthesia remained very safe in Australia and New Zealand although there was a small rise in anaesthetic allergies. The Communications team prepared a media release, “Anaesthesia still safe – but allergic reactions rise”, which resulted in prominent media coverage across Fairfax media (notably The Age and The Sydney Morning Herald). The stories also featured the work of the Australian and New Zealand Anaesthetic Allergy Group (ANZAAG), which is lobbying to have the use of the cough suppressant agent pholcodine banned in Australia. In turn, Channel 7 news interviewed Dr Michael Rose about the link between pholcodine and the muscle relaxant anaphylaxis. This news item was broadcast across all Australian states. Two weeks later, the ABC’s 7.30 program aired a longer-format report on the same topic, giving the work of ANZCA very prominent media coverage. In total, through radio, print, television and online coverage, this story alone reached an estimated cumulative audience of just under three million readers.

ANZCA and FPM also featured in two two-hour live radio programs on radio 3AW, Talking Health. ANZCA Fellow Dr Chris Ball was invited to speak about the history of anaesthesia and, in February, FPM Fellow Dr Mick Vagg was invited on to the program to discuss pain medicine and the launch of the revised FPM curriculum.

Ebru Yaman
Media Manager, ANZCA

Michael Sexton wins 2014 ANZCA Media Award for pain story

“In chronic pain”, a television report by Michael Sexton that was aired on ABC TV’s 7.30. This story has won the $5000 Australian and New Zealand College of Anaesthetists (ANZCA) Media Award for the “best news story or feature about anaesthesia or pain medicine” that appeared in the Australian and New Zealand media in 2014. Mr Sexton’s report aired in February 2014 and looked at the personal, social and economic burden of chronic pain, which affects one in five people but remains broadly misunderstood.

He said he wanted to prepare a report that started with looking at what was still unknown about chronic pain, and followed where some of the answers could be found – and said he was surprised at the inequity of funding available.

“The greatest take away for me was the scale of the problem, the debilitating effect it has on patients – and yet it almost doesn’t exist in the language of Medicare.”

Entries for the ANZCA Media Award spanned pain medicine and anaesthesia and appeared in print, radio and television media. The award will be run again this year.

The award was judged by former ABC journalist, lecturer and media training expert, Doug Weller; anaesthetist and ANZCA Bulletin Medical Editor Dr Rowan Thomas, and former Age health editor and Ambulance Victoria media director Tom Noble.

The judges agreed that the report highlighted the social and economic burden of chronic pain in Australia, which affects one in five people yet remains little understood.
Increasing the profile of ANZCA advocacy efforts in 2015

The 2016 ANZCA Fellowship Survey identified advocacy as a key strategic issue for the College. The World Health Organization (WHO) defines advocacy as “a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular goal or program” 1. Other organizations and experts have their own definitions of advocacy, which promote a particular approach or understanding. Regardless of the definition, a diversity of approaches can be used when embarking on an advocacy effort. Advocacy is both an art and a science. By combining clarity of purpose with thorough preparation, imagination, research and an occasional spot of luck – organisations can deliver advocacy wins for their constituents.

Queensland election 2015

The 2015 Queensland state election was held on January 31 to elect all 89 members of the unicameral Legislative Assembly. The Liberal National Party (LNP), led by Premier Campbell Newman sought its second term after defeating the Australian Labor Party at the 2012 election in the largest defeat of a sitting government in Queensland’s history. Although Labor hoped to regain much of what it lost three years earlier, most polls pointed to the LNP being returned. On election night the result was inconclusive with neither party securing a clear majority. The final result was announced on February 13 and the Labor Party was invited to form a minor government.

Prior to the election, ANZCA identified key concerns relevant to the practice of anaesthesia and pain medicine in Queensland, and wrote to the Liberal National Party, Australian Labor Party and the Greens to seek commitments on these issues.

Responses were received from Labor and the LNP (no response was received from the Greens). These were published on the ANZCA website (www.anzca.edu.au/communications/advocacy) and an alert email was sent to all Queensland Fellows and trainees prior to election day.

ANZCA will use these responses to establish a platform for conversations with the incoming government, to hold them to their promises, and to advocate on behalf of members during the next term.

A similar advocacy strategy is in place for the March 28 NSW election.

Specialist Training Program (STP)

ANZCA has been funded by the Australian Government to manage the Specialist Training Program (STP) and associated contracts for training posts in anaesthesia, pain medicine and intensive care on behalf of the College of Intensive Care Medicine (CICM) until the end of 2015. The aim of STP is to provide a national approach to health workforce issues. The program helps to ensure an adequate supply of specialists across all sectors and regions by increasing the capacity of the health system to train specialists in accredited specialist training rotations beyond traditional public teaching hospitals.
ANZCA is yet to receive a commitment from the Department of Health on funding for this program beyond December 2015. As a result, 19 specialist-training positions managed by ANZCA are at risk across Australia, along with additional positions managed across 10 other medical specialties (900 positions in total).

Should this funding cease, risks include:

- The loss of financial and human capital to the hospitals that host STP trainees.
- Reduction in subspecialty experience for module completion.
- Decreased diversity of training experience.
- Decreased ability to address poor distribution of anaesthetists across Australia.
- A struggle by the health system to reabsorb the training positions.

ANZCA has developed an advocacy strategy that aims to influence federal government policy and resource allocation decisions. A variety of advocacy elements are underway, including communication to regional committees and the wider fellowship; encouragement of hospital advocacy efforts; development of a campaign webpage; collaboration with other medical colleges; and the lobbying of health ministers and of the major parties in the Queensland and NSW state elections.

**Tasmanian health reform**

The Minister for Health, Michael Ferguson, has announced the One State, One Health System, Better Outcomes (One Health System) reform package to deliver improved leadership, accountability and governance to the Tasmanian health system. As part of this reform the government released a green paper, which outlines proposals for how the government is going to change the health system (located at www.dhhs.tas.gov.au/onehealthsystem).

As is the case with many public policy issues, ANZCA developed a submission in response to the green paper. ANZCA has invited all Tasmanian Fellows and trainees to review the discussion document and respond to questions using an online form. Responses will be used to inform the draft submission before it is provided to the Tasmanian Regional Committee for further feedback.

**Submissions completed by ANZCA**

- Medical Board of Australia revised Guidelines – Supervised practice for international medical graduates (January 2015).
- The Minister for Health on the Pharmaceutical Benefits Scheme listing of Generic modified-release oxycodone preparations (December 2014).
- ACEM Draft Quality Standards for Australian Emergency Departments (November 2014).
- The Australian Medical Council on the Australian College of Rural and Remote Medicine (November 2014).
- Department of Industry Skilled Occupation List (November 2014).
- Department of Health (Tasmania) response to Health Reform issues paper (October 2014).

To see ANZCA’s submissions, please go to www.anzca.edu.au/communications/advocacy

The three examples demonstrate the variety of methods that need to be implemented when embarking on an advocacy campaign. Advocacy can be fast and serendipitous or sustained and strategic. Both approaches (and others) have their place, and this year we will use whatever methods are required to ensure key decision makers consider the interests of ANZCA Fellows and trainees.

To keep up to date with ANZCA’s advocacy efforts, please see our new website pages at www.anzca.edu.au/advocacy

Jonathon Kruger
General Manager, Policy, ANZCA

Reference:
ANZCA has long contributed workforce data to external bodies such as the Medical Training Review Panel (MTRP), which is part of Australian Government Department of Health, Health Workforce Australia, Health Workforce New Zealand. The College also monitors internal workforce trends, including Fellows, trainees, international medical graduate specialists and areas of need.

One thing that is clear is that workforce is complex and modelling is prone to error due to the limitations of the assumptions made, as well as the long lag time from medical school to a qualified specialist.

Accurate longitudinal data and iterative modelling are crucial to understanding and addressing the issues.

ANZCA has undertaken a comparative snapshot of the anaesthesia workforce in Australia and New Zealand (July 2014) based on fellowship data.

- There are on average 18.1 anaesthetists per 100,000 population in Australia. This ratio ranges from 12.88 in the Northern Territory to 21.24 in Tasmania (ANZCA fellowship data).
- There are on average 13.39 anaesthetists per 100,000 population in New Zealand (ANZCA fellowship data).

"Workforce concerns in Australia may be a consequence of maldistribution rather than oversupply. But we need to analyse the data before we can make any definitive statement."

These figures should not be considered in isolation. Further exploration is required.

Are the health systems in the Northern Territory and Tasmania similar or different? Are the health systems in Australia and New Zealand similar or different? If they are similar, then maybe New Zealand should train more specialists? Or should Australia decrease numbers? There is no definitive answer to these questions.

Investigations into international benchmarks for anaesthetists per-capita show a marked variation over time.

Data from several European studies show that in the 1980s, the density of anaesthetists in western Europe was around five per 100,000 population. However by the year 2000, the density had increased to around 15 per 100,000 in western Europe – ranging from 22 per 100,000 in Sweden to 9.3 per 100,000 in Ireland. This compared to 10 per 100,000 in central Europe and six per 100,000 in eastern Europe. While up-to-date figures are difficult to obtain, it is clear there will have been some movement in these numbers over the past 10 years. The workforce is continually shifting.

Some further examples are below:

- Low middle income countries (less than one per 100,000) 2009. www.ncbi.nlm.nih.gov/pmc/articles/PMC2816796/
- Canada (nine per 100,000) 2011. https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC2352
- UK (9.6 per 100,000) 2013. www.aagbi.org/sites/default/files/Sept_ANews.pdf
- Israel (10.8 per 100,000) 2006. www.ima.org.il/FilesUpload/IMA7/14/4/7/24072.pdf
These benchmarks should be cautiously interpreted as there are significant differences in the health services in these countries – particularly with respect to demand for services, funding of services, role delineation and task substitution (for example, the active participation of anaesthetic nurses and anaesthetic technicians may impact on the number of anaesthetists required by a service). Illustrative of this point is the observation that the UK considers this ratio to be bordering on oversupply, yet in the US it reflects a significant workforce shortage.

In addition, it is important to consider factors such as geography and demographics. Australia has a large landmass with a geographically dispersed population. As a consequence we will always need to train more specialists than a country such as the UK.

Workforce concerns in Australia may be a consequence of maldistribution rather than oversupply. But we need to analyse the data before we can make a definitive statement.

This snapshot is a good demonstration of why data is an important starting point in any discussion about workforce, but cannot be analysed in isolation. It is important that data is considered in the context of the health service where people work, and includes analysis of both the demand side drivers and supply side drivers.

In 2015, ANZCA will work with the Australian and New Zealand health departments to update and review the anaesthesia workforce data. Once this project is finalised the College will be better able to determine its priority advocacy activities to ensure the supply of anaesthetists meets the expectation of the community with respect to accessing high quality anaesthetic services.

Jonathon Kruger
General Manager, Policy, ANZCA
What would you do?

Dr Peter Roessler explains ANZCA’s professional documents using practical examples.

Always seek the facts before you raise concerns about a colleague’s different technique.

In this issue I thought I would broach a subject that on the surface may seem clear cut and straightforward, but could prove more difficult than it might first appear.

An experienced anaesthesia assistant (PS08 Recommendations on the Assistant for the Anaesthetist compliant) who is respected and with whom you have a good working relationship asks to speak to you privately because of a concern they have about a senior colleague. The colleague is someone you know, but not well. You are aware they work one day in the public hospital and the other four days in private. You also are aware that with six children and an ill wife to support they are under financial strain.

The anaesthesia assistant is concerned because the anaesthetist is using a technique that differs from that used by other anaesthetists with whom the assistant works, and over the past year there have been a few occasions where there have been concerns in the post-anaesthesia care unit (PACU).

What would you do?

As always, we turn to our professional documents to seek guidance!

Application of these standards to this scenario is designed to assist in effective communication and co-operation to elucidate the scientific basis for the discrepancy between the anaesthetist and his peers.

In particular, item 3.2 raises awareness of the need to organise and participate in educational activities for colleagues; and item 3.8 mentions the need to participate in programs to safeguard personal wellbeing as well as that of colleagues.

What now?

So, the technique is different, there have been problems in PACU and there is the issue of mandatory reporting.

What now?

The assistant’s concern has arisen as a result of departure from a recognised pattern. Pattern recognition is something we all undertake and develop as a shortcut for screening huge volumes of incoming data, but it is a very superficial level of analysing and processing information. Indeed, it can be inhibitory due to the tendency to discard important information simply because it does not fit the pattern. This may be the underlying basis of the misguided/misinformed group.

Without wishing to be provocative, are we figuratively still “burning witches at the stake” in this day and age? Should we be encouraging differences? Certainly, during our training we are encouraged to develop a wide range of techniques and approaches.

Reflecting on these issues may assist us in considering the vexing question about our colleague.

What would you do?

As always, we turn to our professional documents to seek guidance!

Code of Professional Conduct – this is so fundamental that it forms the foundation of our behaviour in our professional lives.

Section 3 Anaesthetists & The Maintenance of Professional Standards states that advice from colleagues should be sought when there is a major discrepancy in practice or results.

Also, that the principles of evidence-based practice should be applied in measuring practice assessment activities.

Section 5 Anaesthetists & Professional Relationships alludes to the fact that there should be collaboration and co-operation based on respect, integrity and honesty.

ANZCA's professional documents

Dr Peter Roessler

ANZCA Director of Professional Affairs (Policy)
Any improvement in conditions for the British or French injured during the Crimean War was due to better field hygiene and nursing care, rather than medical care as such. The Russians in Crimea, on the other hand, had a medical champion: Pirogov, the father of military surgery. Pirogov had used ether in the field as early as 1847, and used it during the war, particularly during the siege of Sevastopol. He also introduced better amputation, triage systems (based on the work of Napoleon’s surgeon, Larrey), a Russian nursing corps and immobilisation of field fractures with plaster casts.

The American Civil War (1861-1865) saw widespread use of anaesthesia. Field anaesthetics were usually chloroform and cases of chloroform poisoning were not unknown. The main cause of death remained sepsis, with 60 per cent of wounded who were operated on dying of infection after surgery.

The Boer War (1899-1903) saw advances in surgery, especially with the use of asepsis. Many prominent British surgeons, including Sir Frederick Treves (of Elephant Man fame) served in South Africa. The British also used x-rays and plaster casts to improve wound and injury care. Dental treatment also improved during the Boer War, with the formation of a Dental Branch in the Royal Army Medical Corps.

(continued next page)

Wartime anaesthesia has come a long way since the ANZACs landed in Gallipoli in 1915.

War is hell. It is an overused cliché, plagiarised from somewhere (I don’t recall its derivation), but it epitomises all that can be said about war and warfare – the evil men do.

I have been invited to offer a few thoughts on war and anaesthesia as we look towards the 100th anniversary of the Gallipoli landing.

To go back a few years to the Crimean War of 1853 to 1856, students of history will realise this was shortly after the discovery of anaesthesia. Although some anaesthesia was available, it is remembered more as the conflict in which nursing care of the wounded became accepted and expected. Soldiers were more likely to die of disease, especially cholera, than wounds. Surgery was rudimentary and brutal, usually amputation with brandy as the only anaesthesia.

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WARTIME ANAESTHETISTS CONTINUED

"During the Crimean War, surgery was rudimentary and brutal, usually amputation with brandy as the only anaesthesia."

We now approach the centenary of ANZAC. Wounded Australians and New Zealanders suffered appallingly in Gallipoli, and later on the Western Front. The recent glamourisation of the ANZAC nurses, brave as they undoubtedly were, cannot detract from the fact that 15 per cent of serving ANZACs were killed in action, a higher rate than Canada or Russia, and roughly equal to those of France and the UK.

Medical advances from the two world wars are reasonably well known. Blood transfusion, plastic surgery requiring intubation, advanced burn care, intravenous anaesthesia and antibiotics all impacted on anaesthesia practice, and all were rapidly progressed during wartime.

Sir Robert Macintosh, the New Zealand born professor of anaesthetics at Oxford, contributed much to medical care during World War II. He invented a temperature compensating vapouriser that could be used in hot climates, especially in the Western Desert campaign. He also trained many anaesthetists for the armed forces, and tested new life jackets by throwing anaesthetised subjects into swimming pools.

Probably less well known is that medical evacuation as we now know it began in Burma in 1944. The first instance of helicopters evacuating wounded under fire occurred in the Philippines in 1945. This concept developed in Korea and Vietnam, and is now well established.

Current care of the wounded includes advanced procedures during evacuation. Many of these require anaesthetic skills – intubation, chest drains, central venous lines, nerve blocks and catheters. The experience of point-of-injury to facility care is now impacting on civilian accident care by ambulance services and paramedics.

Would these innovations in medical care have occurred in the absence of warfare? The answer is probably yes, but at a slower pace. But despite the benefits of medical advances made during conflict, one thing remains true.

War is hell.

Dr Graham Sharpe ONZM FANZCA
Major, Royal New Zealand Army Medical Corps

Above from left: Epstein, Macintosh, Oxford (EMO) ether inhaler and vaporiser; a Kimpton-Brown flask used to facilitate blood transfusions during World War I; range of metal chloroform/ether masks for open administration.
I have always had an interest in disaster and field medicine, which I satisfied by volunteering with St John Ambulance, the South Australian Country Fire Service and on the emergency teams for horse trials and motorsports. Indeed, upon gaining my ANZCA fellowship in 2000, one of my first actions was to resign from work to spend a few weeks on the medical team for the equestrian events at the Sydney Olympics.

I also have a strong interest in military operations and military history, and my ANZCA fellowship opened up opportunities with the Australian Defence Force (ADF), which I joined as a reservist in late 2002, hoping, perhaps, to practise anaesthesia in exotic parts of the world.

At the time, the ADF was emerging from a post-Vietnam era of low activity and I was counselled not to expect too much: the East Timor deployment was the major focus, but it was much too special and a new member like me would not be going there. If I was patient, at some point I might deploy to a lesser mission, such as the Solomon Islands security mission.

(continued next page)
Despite this, within a month I found myself in East Timor as the duty anaesthetist for UNMISET, the UN Mission in Support of East Timor. Conditions were classed as warlike, so I became a "veteran" less than 30 days after joining the RAAF, and indeed I deployed again to East Timor before the year was out. So much for being patient!

Over the past 12 years, my status as a defence reservist has taken me twice to East Timor, and also to Iraq, Aceh, Papua New Guinea, the United Arab Emirates and Afghanistan. Each deployment has been different, difficult and austere and, as often as not, I have been asked to fulfil a role far removed from normal hospital-based anaesthesia. These have included acting as aeromedical evacuation co-ordinator for the UN mission in Dili, East Timor; intensivist in the US Air Force hospital in Balad, Iraq; giving dozens of ketamine anaesthetics without oxygen or monitoring in Aceh; serving as chief medical officer for all Australian military forces in Afghanistan; and embedding with the anaesthesiology staff at the US Navy hospital in Kandahar, Afghanistan.

A strong impression from these wide-ranging deployments is that the broad-based training of Australian medical staff in general, and anaesthetists in particular, allows them to adjust to any challenging environment, ranging from the austere conditions of Aceh after the Boxing Day tsunami, to one of the world’s highest acuity military trauma hospitals in Kandahar, Afghanistan.

Another insight is just how much modern communications have improved to let the resources of the College, and its library in particular, reach out to support Fellows deployed to faraway places. I remember well having no useful internet or phone service in East Timor in 2003, and accosting new arrivals for any scrap of news or reading material. Certainly there was no thought of reaching back to Australia for clinical advice or assistance.
By 2014, communications had improved to the point where I could access the College library from Kandahar on my iPad, and download journal articles in real time to help with clinical problems.

By 2005, while waiting to be deployed to Aceh after the tsunami, I found and downloaded several articles from the College about medicine after tsunamis. These foretold of the severe lower limb soft tissue injuries we were to see in survivors, but not the widespread outbreaks of tetanus. Hopefully the paper we subsequently published in *Anaesthesia and Intensive Care* will help guide the next team.

By 2014, communications had improved to the point where I could access the College library on my iPad from Kandahar, and download journal articles in real time to help with clinical problems. I did this often and the 50 or more journal articles I sourced allowed me to build knowledge subjects such as damage-control resuscitation, tourniquet use and complications, storage of blood products, frozen platelets, dried plasma and resuscitative thoracotomy. My American colleagues were amazed at the quality of support I received, noting no similar service was available from their own college.

Far from being a boring branch of medicine, anaesthesia has taken me to many a faraway place to practise medicine under difficult but rewarding conditions. I would like to thank the Australian and New Zealand College of Anaesthetists for enabling this, both through the high quality and broad range of my training, and for ongoing support, even when working in a tent, under fire, on the other side of the world.

**Dr Bruce Paix**, FANZCA
Wing Commander, RAAF Specialist Reserve

Over the past 12 years, Dr Bruce Paix has served twice in East Timor, as well as in Iraq, Aceh, Papua New Guinea, and more recently in the United Arab Emirates and Afghanistan.
The Geoffrey Kaye Museum of Anaesthetic History has been accredited by Museums Australia, the peak industry body for the cultural heritage sector.

The museum was commended for ensuring its own practice and goals align with wider College values and goals. The Peer Review Panel said such “strategic thinking is an example to be followed by other museums, particularly those that are part of a corporate organisation”.

The Victorian branch of Museums Australia (MAVic) provides training and professional development for museum professionals, as well as an internationally renowned Museum Accreditation Program (MAP).

About 800 Victorian organisations qualify as museums under the definition provided by the International Council of Museums. Of those, 92 are enrolled in MAP; only 65 are accredited.

The Geoffrey Kaye Museum of Anaesthetic History submitted an expression of interest for MAP in 2010. The accreditation process demanded examination of all areas of practice; demonstrating compliance with relevant regulations and legislation, endorsing a museum specific code of ethics, strategic planning, reviewing community engagement strategies, and development of a full suite of policies and procedures, all in line with industry best practice.

The museum also was commended for the strong relationships it has developed with other museums of medical history and, in particular, its attention to the occupational health and safety issues inherent in a collection of this nature.

Additionally, a number of documents have been earmarked for inclusion in the Model Documents resource, only available to museums enrolled in MAP.

The accreditation certificate, signed by the Victorian Minister for Creative Industries, Martin Foley, and the president of Museums Australia (Victoria) will be presented at the Victorian Museums Awards in August.

Monica Cronin
Curator, Geoffrey Kaye Museum of Anaesthetic History
Many Fellows are discovering innovative ways to evaluate their practice that are not only professionally useful, but comply with CPD requirements too.

Peer review earns points

Following on from the “CPD tips” in the last ANZCA Bulletin (in which we note that even the president is not immune from audit!), we would like to share an approach to achieve certain aspects of the revised ANZCA CPD Program.

The Hobart Anaesthetic Group (THAG) is a group of 27 associates and around 10 other affiliates. There has been discussion among members of THAG as to how Fellows can satisfy minimum requirements, and in particular, for the new Category 1 “practice evaluation”.

After reviewing suggested activities in Category 1, it was decided that two members of the group would spend a day performing a “peer practice review” (see www.anzca.edu.au/fellows/continuing-professional-development/breakdown-of-cpd-activities).

A suitable all-day vascular list was organised, consisting of an endovascular AAA repair, a carotid endarterectomy and a couple of cases of varicose vein corrections. The plan was that the list would be divided into two sections, allowing each anaesthetist to be observed as well as do the observing.

The appropriate forms were downloaded and signed (see www.anzca.edu.au/fellows/continuing-professional-development/handbook-and-resources/cpd-handbook-and-appendices) and the surgeon and other theatre staff were advised about the arrangements.

All cases were performed without incident. At the end of each session, the cases were discussed and documentation completed. The new CPD portfolio system allows for easy upload of photographed forms via smartphones in case of audit.

As a result of this one day of activity, each anaesthetist achieved 20 points for being observed and 20 points for doing the observing, thus achieving 40 points for Category 1 (out of a required 100 points in a triennium). They more than achieved the 30 points per year minimum requirement for any one year.

Dr Andrew Mulcahy and Dr Richard Waldron
The Hobart Anaesthetic Group, Tasmania
Fortunately, being faced with a “can’t intubate, can’t oxygenate” (CICO) emergency is rare. But when it happens, knowing how to respond is a life-saving skill, and this is why the emergency responses category is now an essential part of CPD. Following is a real-life account of an incident where an ANZCA trainee and team saved the life of a patient, thanks to CICO training.

Sunday evening, the ear, nose and throat (ENT) consultant and team are ready to remove a foreign body from a 30-year-old patient’s bronchus. The patient, a mother of four children, had inhaled something when she used an inhaler earlier that day. A plan is made for TCI with propofol, topicalisation of the airway, spontaneous breathing and rigid bronchoscopy. The patient is not distressed, but does have a slight repetitive cough. Upper airway examination predicts a straightforward intubation.

The case starts uneventfully but as laryngoscopy is attempted by the ENT team, the patient coughs and desaturates mildly. Bag mask ventilation is used without effect, even two-handed. The patient is given suxamethonium in order to facilitate intubation. The C Mac D-blade is ready to use (the ENT team chose this to help them visualise the larynx). A perfect view of the cords is on display but the anaesthetist cannot get the tube to pass. Again the patient can’t be ventilated by face mask, nor laryngeal mask, nor ventilating LMA.

The anaesthesia trainee declares a CICO event; pre-packaged equipment on the anaesthesia workstation is quickly located. Help is called from the ICU team. The drill, as per the CICO workshops, kicks in with the trainee leading the way. The ENT surgeon is handed the cannula with syringe and saline and it is quickly introduced into the trachea. Jet ventilation is performed with the Rapid O₂ – but the chest doesn’t rise, the saturations stay low (very low) and gas can be heard escaping from the mouth. Not even closing the mouth helps.

Rapidly the team progress to a tracheostomy and using the size 6 endotracheal tube (found in our pre-packaged equipment), the trachea is intubated. To their despair, they are still unable to ventilate: there is still no ETCO₂. The trainee notes the tube is a long way down the trachea and, on withdrawal, the first signs of ventilation occur – CO₂ and chest movement.

The patient improves, and the foreign body (a lolly wrapper) is retrieved via an orally placed ETT and flexible scope with grasping forceps under more controlled circumstances. The patient continues to improve and leaves hospital two days later looking well.

What was learnt from this episode?

• ANZCA CICO workshops and training saved this patient’s life, even though the obstruction was tracheal and not upper airway. The only manoeuvre that could have saved the patient (pushing the foreign body back in to the bronchus) would not have been possible with a tracheostomy tube.

• Team work is the key to crisis management.

• The D-blade can make an easy intubation difficult and an impossible intubation possible. We will reinforce the use of two different blades in this scenario and suggest starting with the ordinary Macintosh C blades. The rigid bronchoscope could also have been used.

• Training and better techniques are required to use videoscopic blades with a high degree of angulation.

• There are many ways to do bronchoscopy, all of which can turn into this scenario.

• Support is required for all our trainees. There are many difficult and stressful situations that can destroy a young doctor’s career. Skilful and patient debriefing as well as full analysis and shared learning are essential to the progress of our trainees.

Dr Scott Fortey, FANZCA on behalf of the trainee
Teamwork culture central to eradicating operating room mistakes

Poor communication is a factor in a significant number of avoidable cases of patient harm.

Simulation training to improve operating room (OR) communication could help reduce costly patient errors, says anaesthetist and director of the University of Auckland’s Centre for Medical and Health Science Education, Associate Professor Jennifer Weller.

The effective use of the World Health Organization’s (WHO) Surgical Safety Checklist can vary around New Zealand and research led by Associate Professor Weller, a member of ANZCA’s Research Committee, could help turn this around.

Her Multidisciplinary Operating Room Simulation (MORSim) study has involved researching the communication and teamwork of multidisciplinary teams comprising anaesthetists, surgeons, nurses and anaesthetic technicians, with a focus on sharing information among the whole OR team.

After observing OR teams working at Auckland City and Middlemore hospitals in Auckland, Associate Professor Weller and team designed simulation training to help overcome problems with communication and errors in patient management. The aim was to give participants a better understanding of the need for information sharing, expose their assumptions, identify stressors and barriers to effective teamwork, and provide a setting in which they could reflect on their practice and come up with ideas for improved communication.

Associate Professor Weller and her research team then put 20 multidisciplinary OR teams each of six people who already knew each other through highly realistic exercises at the university’s Simulation Centre for Patient Safety. Worldwide, this is one of only a few simulation-based training opportunities for all team members to engage together.

“Research has shown that communication is a contributing factor to more than 60 per cent of avoidable patient harm. Training together is one way to improve this and simulation is an ideal method,” Associate Professor Weller says.

The teams worked as they normally would, but without risk to patients, in an attempt to change the culture of teamwork, communication and patient safety in the OR.

The simulations included realistic patient mannequins with novel surgical models all within a realistic environment and with real equipment. The scenarios were based on real-life cases requiring strong clinical co-ordination among all team members. Each scenario, of about 65 minutes, included a handover, the initial urgent surgical management and a crisis. Each team member was given a brief of the case with a critical piece of information that no one else got, and there was discussion after the scenario about why these clinically important pieces of information were or were not shared.

“It was quite enlightening that they hadn’t shared quite important information about such things as allergies or antibiotics given, and were not aware that they were not sharing it,” Associate Professor Weller says.

After doing the course, many participants said they would go back into the clinical environment and do things differently, and more than 60 per cent said they felt more confident about speaking up in the OR setting.

Associate Professor Weller says not everyone buys into the need for the WHO Surgical Safety Checklist but the training showed how getting the team together and talking to each other at certain points can have an astounding effect on attitudes towards teamwork and communication.

“Its strength is in getting people talking to each other and aware of the issues. We need to build a culture of open communication in the OR. The simulation training showed some real insights into how people didn’t necessarily all have same idea of what was going on. “There can be a hierarchy in the OR but the training also showed the value of every team member feeling that if they spoke up, it would be appreciated.”

Communication tools presented to the participants over the day included briefings (including the WHO checklist), closed loop communication, and structured call-outs. Debriefs after each scenario, didactic lectures, and time together in breaks are all thought to be contributing factors to the success of the pilot.

The research team which includes surgeons hopes to pilot the simulation training in hospital settings and eventually see it widely adopted in New Zealand hospitals so that it becomes normal practice training for multi-disciplinary operating teams. While there would be initial training costs, these would be more than offset by huge savings from avoiding costly mistakes, Associate Professor Weller says.

Susan Ewart
ANZCA Communications Manager, NZ.
Regional committees have a purposely diverse make-up – new and experienced Fellows, trainees, heads of departments and supervisors of training, co-opted ANZCA councillors, rural and metropolitan staff specialists or anaesthetists working in private practice and efficient administrative staff. All bring a broad perspective of opinions, expertise and knowledge.

Regional committees have working relationships with heads of departments and state-based organisations and can put specialists in touch with others so problems can be shared and solved collectively. Problems arising with trainees (including where they work as a specialist) can be brought to the regional committee for advice.

This is the reason ANZCA is involved with the issue of workforce, which may be seen to be an industrial issue and not for a national training and accreditation organisation. ANZCA is involved because regional committees through their trainee representatives raised this as a concern. If an issue affects training or threatens standards, it is regional committee business.

Each regional committee has its own areas of interest and focus. Although we run along similar lines, I’m sure we are very different in our approaches. This flexibility makes the regional committees valuable to the anaesthesia community.

We can listen, assess and raise the issue with ANZCA if needed or perhaps solve it ourselves.

Why don’t you try it? If you’ve got an issue within our scope that you can’t solve try your regional committee. Even better, get involved with your regional committee.

Dr Scott Fortey, Chair, NSW Regional Committee, with input from Dr Nico Terblanche (Chair, Tasmanian Regional Committee), Dr Andrew Hehir (Chair, ACT Regional Committee), Dr Kerstin Wyssuuk (Chair, Queensland National Committee), Dr Debra Devonshire (Chair, Victorian Regional Committee), Dr Irina Kurowski (Chair, WA Regional Committee) and Dr Angelo Ricciardelli (Chair, SA/NT Regional Chair).

Many Fellows and trainees are unaware of the work that goes on behind the scenes at ANZCA. This article, about the Australian regional and New Zealand committees, is part of a series on the activities undertaken by ANZCA committees.
New Zealand committee

As well as having responsibilities similar to those of the Australian regional committees, the New Zealand National Committee (NZNC) has the wider role of representing ANZCA nationally in New Zealand and advising government and non-government agencies on standards of practice, training, workforce, international medical graduate matters, education and the promotion of anaesthesia and pain medicine.

The committee represents ANZCA in dealing with the Medical Council of New Zealand (MCNZ), New Zealand’s minister of health, the Ministry of Health, Health Workforce New Zealand, the Health Quality and Safety Commission, Pharmac, other government, regulatory and medical organisations, the NZ Society of Anaesthetists (NZSA), the College of Intensive Care Medicine and other medical colleges and organisations. It is a member of the Council of Medical Colleges and is one of the MCNZ’s vocational education and advisory bodies.

As well as regularly making submissions on a wide range of topics and assessing international medical graduates for both MCNZ and ANZCA purposes, in recent years this wider role has seen the NZNC work directly with these national bodies on such matters as the anaesthesia workforce, the training and registration of assistants to the anaesthetist, Pharmaco’s funding criteria, how ANZCA’s Continuing Professional Development Program can meet MCNZ requirements and the issue of doctor competence.

The committee’s role extends to being ANZCA’s voice in the media on ANZCA-related issues in New Zealand, and with anaesthesia generally, including National Anaesthesia Day activities.

The NZNC works jointly with the NZSA to provide an annual scientific meeting, a Part 3 Course, a visiting lecturership program and scholarships for senior trainees. Recent new NZNC initiatives have included facilitating a meeting for all anaesthesia department clinical directors and holding an inaugural NZ anaesthesia research workshop. This year, the committee will host its own annual scientific meeting in Wellington in November.

For more information on the work of the NZNC, visit www.anzca.org.nz.

The Faculty of Pain Medicine has a New Zealand National Committee to represent and advise the Faculty in the same way.

Dr Nigel Robertson
ANZCA NZNC Chair

Contact details for the Australian regional and New Zealand committees can be found at www.anzca.edu.au/about-anzca/council-committees-and-representatives/Committees/regional-and-national-committees.
ASM sessions
The ANZCA Clinical Trials Network (CTN) Executive will host two sessions at the upcoming 2015 ANZCA Annual Scientific Meeting being held in Adelaide (May 2-5). We eagerly await the results of the aspirin limb of the Aspirin and Tranexemic Acid from the Coronary Artery Surgery (ATACAS) trial, which will be presented by Professor Paul Myles in our “breaking trials” session. In addition, Professor Kate Leslie and Professor Matthew Chan will present results from the one-year mortality follow-up and the one-year chronic pain follow-up of ENIGMA-II (Nitrous oxide anaesthesia and cardiac morbidity after major surgery).

The CTN is hosting a second session on the keys to successful recruiting into clinical trials, with presentations from Mr Jonathan Schauder, Professor Paul Myles and Dr Tom Painter. There will be two small-group discussions on getting started in research and getting your research published.

Pilot grant scheme
The ANZCA Pilot Grant Scheme assists Fellows who wish to conduct pilot studies for high-quality multicentre trials, which will potentially attract National Health and Medical Research Council or other large-scale peer-reviewed funding. Grants of up to $A10,000 are available each year and applications for two-year grants will be accepted. Fellows wishing to apply for a pilot grant are encouraged to present their research proposal at the Strategic Research Workshop in August. Deadlines for 2015 applications are June 5 and September 25. For further information about the Pilot Grant Scheme and to download the guidelines, visit: www.anzca.edu.au/fellows/Research/trials-group/pilot-grant-scheme.html

PADDI trial update
Fellows are able to register their interest in participating in the Perioperative Administration of Dexamethasone and Infection – The PADDI trial. The trial, led by Clinical Professor Tomás Corcoran, recently received $A4.6 million funding from the NHMRC. For more information about PADDI and to register your interest, visit, www.anzca.edu.au/fellows/Research/paddi.html

Clinical Trials Network website and contact
For more information on our current clinical research activities, what we offer, our policies and guidelines, and up-to-date information about the strategic research workshop, visit www.anzca.edu.au/fellows/Research or email Karen Goulding, ANZCA Clinical Trials Network Co-ordinator, at ctn@anzca.edu.au.
About the ANZCA Clinical Trials Network

The ANZCA Clinical Trials Network (CTN) fosters investigator-initiated, multicentre research, to definitively answer important clinical questions and deliver high-quality evidence to guide practice in anaesthesia, perioperative and pain medicine.

Previously known as the ANZCA Trials Group, the Clinical Trials Network is the only trials group administered by a specialist medical college in Australia and New Zealand. Clinical Trials Network investigators are world leaders in clinical trial methodology and delivery, achieving more than $A25 million in competitive research grants to date, and completing numerous large, international, multicentre trials within budget, across nearly 100 sites worldwide.

The Clinical Trials Network aims to strengthen research capacity and institutional culture, drive patient recruitment, and share resources and infrastructure with anaesthesia departments to become sustainable in delivering research.

Our vision

The ANZCA Clinical Trials Network will be a world leader in delivering high-quality trial evidence that translates into safe and effective practice in anaesthesia, perioperative and pain medicine.

Strategic priorities

We will deliver:
- High-quality evidence to guide safe and effective practice.
- A capable network of leaders, sites and collaborations.
- Engagement of our stakeholders in Clinical Trials Network activities.
- A sustainable Clinical Trials Network infrastructure.

Current clinical trials

Balanced Anaesthesia study: The influence of anaesthetic depth on patient outcome after major surgery
Recruitment 1804/6500. New sites are welcome. For further information and to register your interest please go to balancedstudy.org.nz. Per patient payment: $A600.

RELIEF: REstrictive versus LIbEral Fluid therapy in major abdominal surgery
Recruitment 918/2800. Recruitment target is expected at the end of 2015 and new sites welcome. For further information and to register your interest please go to www.relief.org.au. Per patient payment: $A700.

Upcoming trials

PADDI: Perioperative ADministration of Dexamethasone and Infection trial
Recruitment target 8800. This study is expected to get underway around mid 2015. For more information and to register your interest, go to www.anzca.edu.au/fellows/Research/paddi.html.

Thank you

We would like to take this opportunity to thank all the hard-working people, nationally and internationally, who contribute to the success of our multicentre research.

For further information please contact Karen Goulding, ANZCA Clinical Trials Network Co-ordinator, ctn@anzca.edu.au.

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New sites needed for clinical trials

We need your help

The ANZCA Clinical Trials Network wants to build on the success of its multicentre research by engaging all ANZCA sites (especially two to three-years accredited sites) to participate in our trials.

We believe Fellows and trainees supporting multicentre research to improve the evidence base to guide safe and effective practice should be core to their role as a medical specialist, so they and their patients can reap the many benefits of participating in clinical research.

Running a large number of trials requires recruitment of thousands of patients, and this cannot be done without the dedication of people at our sites across the entire network.

We aim to increase capacity of our network and are calling for new sites – including private, rural and regional hospitals – to join our trials to enable a higher recruitment rate of patients and to allow more trials to be conducted and completed, on time and within budget.

What we offer

- A business case template to help justify the employment of a qualified research co-ordinator by your department or group. Each patient enrolled in our current clinical trials will receive per patient payments.
- Sites capable of recruiting an average of four patients per week may be in a position to fund a full-time qualified research co-ordinator, which is vital to the success of research.
- Centralised research ethics and governance support to help get your site started in our trials.

An invitation

If you are a Fellow or trainee with a strong interest in supporting multicentre research, please contact Karen Goulding, CTN co-ordinator (ctn@anzca.edu.au), for further information on how to get your site started in multicentre research and to receive a copy of the business case template.
Donors drive growth in support for research and education

Research funding growth 2010–14
The Anaesthesia and Pain Medicine Foundation experienced steady growth in donor contributions during 2014 towards its support for research, education, scientific evidence and patient outcomes.

As a result, funding of $A1,414,618 for research projects was granted by the Research Committee in 2014 for disbursement to projects this year, representing an increase of 21 per cent on the $A1,195,618 granted in 2013, which in turn was an increase of 13 per cent on the $A1,054,691 granted in 2012.

During the period 2010 to 2014, research grant funding provided by ANZCA and the foundation has increased by 126 per cent; from $A639,530 to $A1,446,618.

The consistent growth in financial support for research in anaesthesia and pain medicine has been made possible by the foundation’s generous donors, both individual and corporate, and the College.

Private fundraising
Ongoing generosity from foundation donors drove encouraging growth in the total contribution received from private fundraising in 2014. These donations and sponsorships supplement the annual contribution from the College, which is committed to supporting research through its strategic priorities.

In 2014 the private fundraising total was $A390,000 up from $A248,000 raised in 2013. The increase was assisted by large contributions from generous Fellows and their families, particularly those who gave major gifts to establish named, ongoing research awards.

A significant contribution was made by Pfizer Australia, a founding sponsor, which again is providing major sponsorship of the pain medicine research program. In 2015 this has been given through the Pfizer Pain Care brand.

Subscriptions appeal
The foundation team thanks Fellows who donated over and above their 2015 subscription payments. Total giving through subscriptions mailing stands at $A423,342 (including $43500 from foundation patrons), compared to $A43,000 at the same time last year. This will be used to support the advancement of patient care through research, overseas aid or indigenous programs, according to the wishes of each donor.

Anaesthetic Services Group Victoria scholarship
Since 2013, the members of the Anaesthetic Services Group Victoria have supported the provision of specific medical education opportunities for anaesthetists from developing countries, with positive feedback received from the recipients to date.

The foundation was pleased to learn that the group will continue this sponsorship in 2015, facilitated by the foundation, the ANZCA Overseas Aid Committee and the ANZCA Policy Unit. The plan for 2015 is to assist in funding Papua New Guinea anaesthetists to attend the 2015 ANZCA Annual Scientific Meeting in Adelaide.

The foundation team thanks its donors and supporters for an encouraging 2014 and a strong start to 2015.

Robin Smallwood bequest
On February 26, Mrs Rosalind Smallwood and Mr Kate Smallwood presented the Robin Smallwood Bequest to ANZCA President Dr Genevieve Goulding, the ANZCA Council, and the Anaesthesia and Pain Medicine Foundation on behalf of the Smallwood family (pictured above). The Robin Smallwood Bequest has provided $A135,000 for a perpetual grant to support research into anaesthesia, intensive care and/or pain medicine, according to the requirements of the will of the late Dr Robin Smallwood (1934–1987), a past dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons.

The College is very grateful to the Smallwood family for their generosity. In addition to supporting important new research in the specialties, the bequest will recognise the great contribution Dr Smallwood made to the advancement of the specialties during his lifetime, through his leadership of the Faculty and other appointments, including his time as director of anaesthesia and intensive care at Melbourne’s Austin Hospital.

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
The family of a former director of anaesthetics at Royal Melbourne Hospital has established an annual grant to carry his legacy to pain medicine in perpetuity.

The Dr Russell Cole Memorial ANZCA Research Award was established this year by Ann (Tuppy) Cole and her family, in memory of the late Dr Russell Geoffrey Cole, director of anaesthetics at Royal Melbourne Hospital from 1965 to 1980.

The new award will provide an annual grant for medical research in the field of pain medicine. The award will be administered through the Anaesthesia and Pain Medicine Foundation and the ANZCA Research Committee and, where possible, directed towards research in the area of the relief of cancer pain.

In August, the ANZCA Research Committee granted the inaugural Dr Russell Cole Memorial ANZCA Research Award to Dr Susan Evans, Professor Paul Rolan and Associate Professor Mark Hutchinson at the Royal Adelaide Hospital, for their project, “Is oestrogen simulation of toll-like receptor pathways the missing link between dysmenorrhoea and late progression to chronic pain?”

Dr Cole had a long interest in the anatomical basis of the relief of intractable pain by nerve block. He published informative articles on the subject, pioneering the management of cancer pain in Melbourne as it had been similarly pioneered in Sydney by Brian Dwyer.

Dr Cole graduated MBBS from the University of Melbourne in 1944 and started his career in the Royal Australian Navy (RAN) as a medical officer at HMAS Bataan. He became a surgeon lieutenant in 1948, and was ultimately appointed senior anaesthetic specialist to the RAN in Victoria.

In 1950, Dr Cole and the late Dr Alfred Nathan were appointed the first anaesthetic registrars in the Royal Melbourne Hospital’s newly established Department of Anaesthesia, the first in Victoria under a full-time director.

In 1951 Dr Cole travelled to London and worked as an anaesthetic registrar at St Thomas’ Hospital, where he obtained a diploma of anaesthetics and, in 1954, attained fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons. He returned twice to St Thomas’, working for two six-month sabbatical periods. Dr Cole also worked on sabbatical at Parkland Memorial Hospital in Dallas, Texas.

In 1952, he entered part-time practice with the Melbourne Anaesthetic Group, a group of private anaesthetists, where he worked alongside Dr Lennard Travers.

During the Vietnam War, Dr Cole served on secondment to the Australian army, working as an anaesthetist at the Vung Tau hospital, and participating in many hair-raising helicopter retrievals of injured soldiers.

In 1962, he ceased private anaesthetic practice and was appointed a full-time executive medical assistant at Melbourne’s Peter MacCallum Cancer Centre. His duties included supervision of the Consultant Pain Relief Clinic, in which he maintained a deep interest until his retirement.

In 1965, Dr Cole was appointed director of anaesthetics at Royal Melbourne Hospital, succeeding the legendary Norman James, and held the post until 1980. He remained a senior staff specialist until his formal retirement in 1985, after which he continued medical activities for a further several years including endoscopy lists, surgical assistance and a role as one of two medical officers to Pentridge Prison.

Appropriately, the award established by the Cole family will serve to continue Dr Cole’s passion for and contribution to pain medicine in perpetuity. Each year it will encourage Fellow investigators to further develop specialists’ capacity to effectively prevent, treat and relieve pain.

The foundation greatly appreciates the Cole family’s contribution on behalf of Dr Cole and thanks Ann, Rowena and Victoria Cole for their support and assistance in developing this inspiring new perpetual research award.

Robert Packer, General Manager Anaesthesia and Pain Medicine Foundation
Positron emission tomography (PET) imaging is usually only used in oncological staging with cancer patients, she said, but this research would see every recruited cancer patient scheduled for surgery undergo a PET scan of their heart. Exercise stress tests, traditionally used to assess cardiac risk, were limited in their ability to accurately predict patients at risk.

“These patients who would normally have a cardiopulmonary exercise test (CPET) to assess overall physiological fitness prior to major cancer surgery go on to have a PET scan of their heart. “It is extremely difficult to predict who will have a perioperative cardiac event but using a PET scan provides a different imaging of the heart – in this study we are directly assessing myocardial metabolism at a cellular level.”

If they return a positive test, the patients are referred on for more thorough testing ahead of surgery.

Dr Ferguson said other tests measure stress-induced alterations in myocardial perfusion (for single photon emission computed tomography myocardial perfusion scans) or regional wall motion abnormality (for stress echocardiography). In contrast, cardiac PET measures anaerobic metabolism (induced by myocardial ischaemia) directly through uptake of radioactive labelled FDG and thus provides imaging evidence of the cellular metabolic consequences of myocardial ischaemia.

Dr Ferguson said she hoped this innovative use of PET technology could lead to better diagnoses of those who may develop problems during and after surgery. Patients in the study would be followed up after surgery with blood tests to determine whether damage to the heart occurred.

“If we are trying to reduce the illness and death caused by cardiac events in surgery then we have to improve our risk-assessment tests.”

Ebru Yaman
Media Manager, ANZCA
Dr Ferguson wishes to credit her ANZCA Novice Investigator Grant supervisors who have contributed greatly to the project: Associate Professor Bernhard Riedel, Director of the Department of Anaesthesia, and Associate Professor Michael Hofman, Nuclear Medicine Physician (both at Peter MacCallum Cancer Centre), as well as the many other people involved in the study at Peter Mac in the departments of anaesthesia, nuclear medicine, and cardiology, as without great teamwork this project would not have been possible.
A review: The Anaesthetic Crisis Manual

David C Borshoff – Leeuwin Press 1st published 2011

A number of manuals/checklists have been produced over the years, including the original 1996 APSF Anaesthesia Crisis Management (2nd edition is available), Emergencies in Anaesthesia (2nd ed) edited by Allman K, McIndoe A and Wilson I (Oxford University Press 2009 – available as an e-book), Anaesthesia Emergencies Book (Oxford University Press 2011 Oxford University Press – also available on slideshare.net) edited by Ruskin KJ and Rosenbaum SH. This manual was first published in 2011 by Dr David C Borshoff, who works in both the public and private sectors in Western Australia. The website also lists Dr Geoffrey Lightball (Associate Professor, Stanford) as the North American editor. This publication has the support of the Australian Society of Anaesthetists and is endorsed by the European Society of Anaesthesiology. Its checklist/algorithms have been validated by the Harvard School of Public Health and the website at www.theacm.com.au carries logos from a number of hospitals (including Monash Health, Royal Perth, Sir Charles Gairdner, St Vincent’s Melbourne, John Flynn, St John of God Subiaco and Murdoch Hospitals) as well as the Western Australian Department of Health, NSW Health among others.

My copy came with a somewhat friendly (but hardy) bright orange cover – unfortunately there was no “don’t panic” or a towel! It is obviously designed to endure wear and tear.

It is divided into two parts:

- Part one with 23 various crises roughly subdivided into four sections – cardiovascular, respiratory, obstetric and then miscellaneous (including events such as local anaesthetic toxicity, hyperkalaemia, malignant hyperthermia)
- Part two (in grey) called “Crisis Prevention” with a further 10 sections including such topics as elevated airway pressure, hypotension, desaturation, increased and decreased end-tidal CO2.

The format has a checklist/algorithm/protocol on the left hand side with more detailed information on the right.

As a comment, step one on 14 of the algorithms seems to be “call for help, communicate the problem and delegate”. The algorithms are based on a number of references (located in the middle of the manual just before part two) from organisations including the AAGBI, UK Resuscitation Guidelines (2010), 2010 American Heart Association guidelines, National Health and Medical Research Council patient blood management guidelines (accessed in May 2013) and others.

As with any manual/publication in this area, currency of information will always be an issue. The website has an update section which lists four updates, the latest being March 14, 2014. The manual can also be purchased either in hard copy or electronic versions (Apple and Android versions) as well as a North American version. It appears that an app for smartphones is in the pipeline.

Anaesthesia crisis or emergency management is now quite topical. The recent revision of the ANZCA Continuing Professional Development Program includes category 3 emergency responses and a Victorian coroner’s report from August 2014 (court reference: 2006/4376) recommends “specific training with emergency situations” on an annual basis. This publication would certainly merit consideration for those wishing to keep abreast of the latest protocols/algorithms in such situations although, given the plethora of notices in most operating theatres/rooms, an electronic version with regular updates may be the preferred option.

Dr Richard Waldron, FANZCA
The Hobart Anaesthetic Group
International effort addresses small bore connectors

Serious, sometimes fatal, outcomes have been reported when medical devices have been misconnected and the incorrect drug, solution or air is administered to patients.

An international effort, via the International Organization for Standardisation (ISO) Technical Committee TC210 (Quality management and corresponding general aspects for medical devices), is underway to develop a series of connectors for medical devices to reduce the chance of such misconnections. ISO 80369 series small-bore connectors for liquids and gases in healthcare applications.

There will be a specific connector for use on medical devices of differing applications, rather than the current system in which the ubiquitous Luer connector is used for many therapies. The applications for which connectors are under development are:

- ISO 80369-2 breathing systems and driving gases.
- ISO 80369-3 enteral.
- ISO 80369-5 limb cuff inflation.
- ISO 80369-6 neural.
- ISO 80369-7 intravascular or hypodermic (Luer).

The philosophy is for each connector to not misconnect with other connectors of the series, and to have only one connector for each application, unless there are clinical or technical reasons to have more.

Computer-aided design has been used to predict potential misconnections and the dimensions for each connector have been chosen based on minimising this risk. The rigidity of the material of which the connectors will be made has been specified to reduce forcing together of non-matching connectors if the plastic is too soft.

There are other connectors in frequent use with which these connectors may misconnect. Often some of the dimensions of these connectors are not defined and therefore not standardised, so cannot be designed against. The ISO committees responsible for some of these other connectors have been asked to better define the dimensions, if clinically acceptable, to assist with the efforts to design connectors that do not misconnect.

An example of this is the 15mm conical connector used in airway devices such as tracheal tubes. As well as developing the series for connectors for use at the patient end, the committee has embarked on the project to design connectors for reservoirs, ISO 18250 series connectors for reservoir delivery systems for healthcare applications. Use of the "bag spike" as a universal connector contributes to the risk of medication errors. Other jurisdictions are likely to mandate the use of equipment with the new connectors, for example California requires in 2016 connectors of enteral and neural devices to not misconnect with other applications.

Australia and New Zealand rely on international manufacturers for much of the supply of medical devices. Once the designs for the connectors have been verified, it is expected that manufacturers will supply to Australia and New Zealand medical devices with these connectors. Although the intention of the connector series is promotion of patient safety, the implementation of such a significant change in the provision of medical services has the potential to compromise patient safety during the changeover period. It seems inevitable that clinicians and patients and others in the medical device market in the Australian healthcare system will be exposed to this change.

From January 19-23, meetings of the two working groups responsible for developing series of standards for specific connectors (ISO/TC210/JWG4 and JWG5 small bore connectors and connectors for reservoirs) were held at ANZCA House, with JWG also meeting on January 18 at the Department of Anaesthesia and Perioperative Medicine, Alfred Hospital. Delegates from 11 countries attended and the meetings ran from early morning to late into the evening to maximise valuable discussion time. The meetings were very successful on all fronts with further progress toward publication of standards. In addition, the attendees were impressed with ANZCA as a venue, the museum, and Melbourne! The facilities were ideal and the convener and others commented that this was "the best meeting ever".

Dr Phoebe-Anne Mainland, FAZNEA Member, ISO/TC210/JWG4 small bore connectors and ISO/TC210/WG5 connectors for reservoir delivery systems

Safety alerts

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

Recent alerts:

- Intravenous catheters for power injection
- Warfarin review.
- Update – Riata and Riata ST Silicone cardiac leads.
- Metoclopramide and neurological adverse events.
- Philips anaesthesia machines.
- Reprocessing of reusable medical devices.
- Alere INRatio PT/INR monitor system.
- Hynalazine shortage.
Adverse events

SA case highlights risks in patient assessment

Inquest raises screening issues

A coronial inquest into the deaths of two patients in South Australia has raised the question of how patients with significant medical co-morbidities are screened preoperatively.

The coroner identified that in both cases there was a failure to detect or recognise early signs of deterioration. The court was assisted by evidence from a number of medical practitioners to consider how these patients might have been better managed, with the benefit of hindsight.

Both cases involved morbidly obese patients with sleep apnoea and co-morbidities undergoing orthopaedic procedures in a small private facility. In both cases there were system failures that resulted in the anaesthetists being unaware of the state of health of their patients until the day of surgery, leaving no opportunity to review and optimise their patients. Both anaesthetists expressed concern about proceeding, however both succumbed to pressure to proceed.

Despite the anaesthesia challenges, both patients managed to have their surgery. Unfortunately both patients died during the post-operative period resulting from a combination of factors, including limited specialist pain management strategies with consequent opioid administration in the presence of morbid obesity and sleep apnoea.

The level of nursing care was identified as an issue in this facility as was the absence of an onsite medical practitioner. The coroner was critical of the decision to manage such patients with multiple co-morbidities in facilities that do not have specialised nursing care and appropriate post-operative monitoring including high dependency unit and intensive care unit.

The coroner’s findings stress it is imperative that informed consent should include disclosure of the absence of such capabilities, as well as any pecuniary benefits.

As a result of the inquest, the coroner has made several recommendations including:

- The development of robust preadmission processes in small facilities without intensive care unit and onsite medical practitioners to screen and exclude higher risk patients for overnight admission, as a requirement of accreditation.
- That the Medical Board of Australia (MBA), Australian Medical Association, Australian Medical Council, and colleges of nursing attempt to raise awareness of the inherent risks in obese patients receiving opioid analgesia.
- The MBA formulates a code of conduct requiring practitioners to disclose financial interests to their patients, and also raise the issue concerning suitability of the facility to any specialists to whom they refer patients.
- That ANZCA (SA) considers reaching an understanding with the Royal Australasian College of Surgeons (SA), and the Australian Society of Orthopaedic Surgeons to streamline the process by which higher risk patients are referred for pre-anesthesia assessment and to avoid last-minute changes to operating lists where this would result in a different anaesthetist taking over immediately before surgery.
- That board members and chief executive officers of hospitals with staff and facilities similar to, or less than, those at the hospital at the centre of the inquest, consider implementing policies whereby those hospitals decline to admit higher risk patients to their facilities.

Dr Peter Roessler, FANZCA
ANZCA Director of Professional Affairs (Policy)

Boojums of adverse events: Can we prevent them?

Unearthing something (unexpectedly) unpleasant or dangerous underlies the Boojum in Lewis Carroll’s nonsense poem “The Hunting of the Snark”, and underlies the theme of a meeting in Adelaide to discuss early postoperative adverse events.

The February meeting was in part precipitated by a coroner’s report on two early post-operative deaths in a private hospital involving patients with significant co-morbidities who had had orthopaedic surgery.

The meeting focused on the emerging challenges of co-morbidities in patients presenting for elective surgery, especially in the private sector, and brought together clinicians (primarily anaesthetists, but also surgeons, physicians, GPs and intensivists), and representatives from hospital management, regulation and the medicolegal sector.

An emerging perioperative problem in high-risk patients should not be unexpected. Similar cases and coroner’s reports exist in Australia and other countries. Published works, such as the Australian REASON study, the UK NCEPOD report “Perioperative Care: Knowing the risk (2011)”, and ANZCA’s triennial reports on post-operative mortality, provide insights into the scope of the problem.

High-risk patients are increasingly common and, without provision of appropriate preoperative assessment and management, and intra and post-operative care, we can expect an increase in preventable morbidity and mortality.
What do we do for these patients?

appropriate management and planning? risk? How will this be determined to allow morbidity and mortality. Who is at high in relation to early post-operative

February, we can consider three questions and the discussions in Adelaide in

Unfortunately this is not a precise science

essential in high-risk cases, but probably appropriately trained physician, is

an anaesthetist, and sometimes an

Advanced referral to face-to-face

How will high risk be determined?

Robust mechanisms for patient triage therefore become critical. Existing approaches include surgical judgement, GP information, allied health clinics, phone screening, questionnaires and computes systems. With a high demand but capacity-limited healthcare future, and with a need for good early warning systems to identify risk, evidence of pathways and mechanisms of high value (as defined by both quality and cost) becomes increasingly essential, but is often lacking.

What we do for these high-risk patients?

Post-operative management of those identified at risk is a complex area, although there are some key issues. Firstly, the most appropriate clinicians to provide care, and when and for what they are responsible, is an evolving area. Discusisons on new changes to surgical training in Adelaide suggesting their skills in medical assessment and management appear likely to decline, are highly relevant.

Secondly, the best facility to provide care is no longer simply a binary decision of ward care versus intensive care unit, with options including better technology (cardio-respiratory monitoring) in general wards, extended recovery rooms and a range of high dependency-type areas.

Thirdly, the impact on general ward care of initiatives such as post-operative adverse events and value in preoperative assessment. He is convenor of the combined special interest group meeting in Noosa in September this year, which will cover, among other topics, the issue of value in healthcare.

References:


3. www.ncepod.org.uk/02010poc.htm
Central venous access device safety

The Health and Disability Commissioner has released three reports relevant to anaesthetists practising in New Zealand.

Two New Zealand coronial findings in 2014 relating to the safety of central venous access devices (CVADs) demonstrate the need for treating staff to be vigilant, even where the event may be rare.

In the first case, a patient died following migration of a Portacath from the superior vena cava (SVC) to the azygos vein and subsequently into the trachea, with the result that chemotherapy drugs went directly into his lungs. Placement of the catheter was not checked despite numerous CT scans and chest x-rays showing it had migrated.

While this may have been rare, the coroner said what was happening was quite clear and should have been recognised and acted upon earlier.

The coroner’s recommended protocol, which he said should be applied nationwide, included:

- Hospital standard operation procedures should be available where CVADs are used.
- CVADs should not be used unless they are in a position where blood is freely flowing as evidenced by easy aspiration of blood prior to injecting into them.
- Phrases such as “position is unchanged” should not be used on radiology reports with respect to CVAD position.

The second case concerns a patient who died after migration of a PICC line perforated the right ventricle wall, leading to inadvertent infusion of fluid into the pericardial cavity with cardiac tamponade. This followed a similar case five years earlier at the same hospital where PICC line migration, with pericardial tamponade, was judged to be the cause of death of a child. The coroner pointed out that the “institutional memory” of the first death seemed to have been lost.

In the later case, initial checks showed the PICC line to be in the correct position but two days later it was noted to have migrated and was pulled back. Further x-rays noted an acceptable position at the junction of the SVC and the right atrium. Total parenteral nutrition was started. Eight days after the PICC line was inserted, the patient complained of the sudden onset of chest pain and shortness of breath. She then suffered a cardiac arrest from which she could not be resuscitated.

The autopsy showed that the PICC line had perforated the apex of her right ventricle and the patient had died from a cardiac tamponade. Drugs and fluid injected down the line at the time of attempted resuscitation may have compounded the situation.

Following recommendations in the subsequent root cause analysis report, the district health board (DHB) created a CVAD Governance Group, which meets ten times per year and is seen as creating the institutional memory lost after the first death from PICC line migration.

The coroner said the CVAD Governance Group’s work had improved clinical processes surrounding CVADs and reduced the chances of death occurring in similar circumstances. He recommended that the DHB ensure that the group’s work continued long term, and that its existence and work be made known to other DHBs.

Dr Geoff Laney, FANZCA
Safety and Quality Officer, New Zealand National Committee
Dr Hamish Gray, FANZCA
Christchurch Hospital

Learning points

- Although it is rare for migration to cause a cardiac or tracheal perforation, it can never be discounted.
- Some PICC catheters are shorter than others and have additional features such as reverse tapering with differing devices to secure the catheter.
- Careful daily evaluation of all CVADs is required.
- Migration of a catheter should lead to a thorough reassessment before use. The most appropriate course of action may be to remove it.
- Trusting that a PICC line is in the correct position cannot be relied upon and it should not be used after it has migrated.
- Where patients with CVADs are acutely unwell, consideration should be given to the CVAD being the cause of the acute deterioration.
- Failure to maintain institutional memory of events risks their repetition.
Inadequate analgesia during caesarean section
Mrs A had a labour epidural placed by a locum specialist anaesthetist. Two hours later the anaesthetist topped up the epidural for a category two caesarean section, with 10 ml 1 per cent lignocaine. When the block was tested, Mrs A reported that she could feel the cold, and painful pinching, but surgery was allowed to proceed.

Mrs A complained of pain when her abdomen was opened, and her movements made delivery of the baby difficult. She still had pain during suturing of the uterus. Despite the voiced concerns of the obstetrician, midwife, patient and her partner, the anaesthetist did not address the problem.

There were several issues with the anaesthetic management of this case. Suitable solutions for topping up epidurals for caesarean are 15-20 ml of 0.75 per cent ropivacaine, 0.5 per cent bupivacaine, or 2 per cent lignocaine with adrenaline. A reliable method of checking the block is essential. Here, the block was tested and shown to be inadequate. At this point, surgery should not have continued, but more anaesthetic should have been given, or an alternative technique such as a spinal should have been considered. In extreme urgency (which was not present here), general anaesthesia should be considered. General anaesthesia should not be withheld due to concerns for the baby.

In the unusual circumstance where a regional block proves inadequate for caesarean section, the patient should be offered general anaesthesia and her response documented. Some patients may, for their own reasons, refuse but even then they can be offered inhalational, intravenous or further epidural analgesia. None of these options was offered to Mrs A.

The Health and Disability Commissioner’s expert anaesthetist was highly critical of the anaesthetist’s performance. The commissioner was critical of the anaesthetist’s “striking lack of empathy” throughout the whole procedure. The commissioner ruled that the anaesthetist had breached the Code of Health and Disability Services Consumers’ Rights in several places, referred him to the director of proceedings, and recommended that the medical council consider carrying out a competence review of him.

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

Failures of communication
A woman in her 60s saw a specialist anaesthetist for assessment prior to general anaesthesia for dental clearance. The patient was a heavy smoker and diabetic. The anaesthetist found a new murmur, and referred her for echocardiography and chest x-ray. The radiologist noted an opacity on the chest x-ray, but the report was only sent to the dental unit, which did not act upon the report.

The patient arrived for surgery, but the second anaesthetist did not know a chest x-ray had been performed. The anaesthesia proceeded uneventfully, but about a year later the patient was found to have inoperable lung carcinoma.

In another report, a patient in her 30s underwent nurse-led pre-admission, during which it was documented that she did not consent to receive blood or blood products. She was later anaesthetised by a specialist anaesthetist for a laparoscopic cholecystectomy. No mention was made of her refusal of blood products at the surgical “time-out”. The surgeon was unaware of it, and the anaesthetist judged that the operative risks were low enough not to mention it to anyone else. The cholecystectomy was converted to open, with moderate blood loss, and the patient taken to recovery, where she reiterated her stance on blood products. She was taken back to theatre later the same day for recurrent bleeding, but despite packing of the liver bed, died that evening.

It is becoming more common for patients to be pre-assessed by a different person from the one who provides anaesthesia on the day. Although this process is designed to improve efficiency and safety, it has the potential to create problems if information is not reliably passed on. Good communication is a cornerstone of anaesthetic safety, and may require the use of several channels: verbal, written and electronic.

Professionalism dictates effective communication and the surgical “time-out” is an opportunity to improve safety by sharing important information with all members of the team.

The full texts of all the HDC reports are available free on its website, www.hdc.org.nz.

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

Collated by Dr Peter Roessler,
Communication and Liaison Portfolio,
Safety and Quality Committee
Private sector has important training role

Teaching is associated with high standards of care, says ANZCA Fellow Associate Professor John Stokes. High standards of care are not confined to public hospitals – traditionally the gatekeepers of medical training – so why should teaching our next generation of specialists be restricted to training in the public sector?

“The training occurs in the public sector. Why are we denying a significant part of a trainee’s medical education by removing that training experience?”

Associate Professor Stokes is a strong advocate of medical education and training in Australia across a diverse range of settings, both in the public and private health sectors.

“Public teaching hospitals continue to be the cornerstone of medical training in Australia, but training in private settings should be recognised as an important adjunct to the public hospital teaching model,” he says.

“We need a sense of balance. In the last 100 years or so we have developed this idea that training only occurs in the public sector, but if you work in the private sector – and many anaesthetists do – why should you be denied the ability to have an active teaching role?”

“Teaching should occur everywhere we deliver health. In our experience, patients like being involved in teaching where they can be, during their stay in hospital.”

In Australia, anaesthesia training is primarily funded through the public hospital system. The Australian Government’s Specialist Training Program (STP) provides one avenue for trainees to experience training in other settings. The College has managed the STP since 2012 and currently funds 32 positions. Funding is due to expire at the end of 2015.

Brisbane-based fourth-year anaesthesia trainee Dr Michael Hussey took up an STP placement at Mater Hospital in Brisbane in the second half of 2014. Mater encompasses the adult, children’s and mothers’ hospitals, and involves a heavy public/private case mix.

Dr Hussey said his placement exposed him to a strong mix of anaesthesia delivered in private and public hospital lists.

“There are a lot of differences – the logistics of private lists, the way billing is organised; it was good to see how the system works in the private sector.”

Dr Hussey said he feared some private hospital patients would not expect or want a trainee involved in their care – but this is a point Associate Professor Stokes disputes.

“Our overwhelming experience is that patients like being involved in teaching. “They are generally happy to have a supervised trainee involved in their care; we associate our teaching hospitals with high quality – why should that be restricted to the public system?”

“We are carrying an outdated idea of the private medical sector,” Associate Professor Stokes says.

“We are missing a great opportunity to use a valuable resource for teaching and for expanding the medical education sector for the good of the Australian population.

“Anaesthesia could become a leader in this area.”
Bombs, burns and battles – the challenges of working in Syria

In 2013, I worked with the humanitarian aid agency Médecins Sans Frontières (MSF) as an anaesthetist in Syria. The civil war commenced in 2011 after a revolt against the Syrian government. It is now a country dominated by violence. Gun fights between government and rebel forces occur frequently. There are daily bombings from government airplanes on the rebel strongholds.

Refugees wait in camps, desperate to escape the violence. MSF has a policy to remain impartial, neutral and to provide assistance to all people, regardless of their race, religion or political affiliation. These policies allow the organisation to work relatively safely and unhindered in areas of conflict. Although I had worked with MSF previously, I was full of fear and trepidation about my assignment to Syria.

Location/border refugee camps

The hospital was located in a rebel-held area, close to the border and several refugee camps. The war has caused a collapse of infrastructure and many areas did not have access to healthcare. The scenes at the Syrian border are quite shocking – thousands and thousands of tents in all shapes and forms. Many tents were donated by non-government organisations/charities and had the organisations’ logos on the side. Many individuals had made their own shelters/tents from tarpaulin. People swarmed everywhere, but they were still kept firmly on the Syrian side of the border by oppressive barbed wire fences and armed soldiers in watch towers, ready to stop anyone by force that might cross illegally. Several men had shotguns or Kalashnikovs slung across their shoulders. Women in traditional Muslim dress kept a low profile. Children played, grubby and unkempt. Disease could spread rapidly in these over-crowded living conditions and the numbers in the camps increased daily. There were insufficient numbers of latrines and no pumped water.

Hospital facilities

The hospital was located in a large converted Syrian house. The ground floor had four reception rooms, which had been converted into an operating theatre, a recovery room, an emergency department and a sterilising room. The first floor had four bedrooms and these became a male, female and paediatric ward and an administration office.

As civil war continues in Syria, Sydney’s Dr Janet Loughran reflects on her assignment there with Médicines Sans Frontières in 2013. She hopes to go again in 2015.
Initially, we focused on trauma patients and the work varied from simple procedures such as wound debridement and removal of shrapnel. There were more challenging cases such as laparatomies for gun-shot wounds and putting on external fixators to stabilise fractures of the extremities.

The morning and evening ward rounds gave us a chance to interact with our patients and learn about their concerns. It was a fascinating window into Syrian culture. Each day we had to answer a torrent of questions such as “am I going to theatre today, doctor?” “are my wounds still infected? Do you think they are getting better?” “do I need a skin graft?” It was so rewarding to be able to reassure the parents of the children on the paediatric ward, many of whom were completely distraught by the injuries that had been inflicted on their children.

There were some truly sad stories too, for example, two brothers (aged three and five) were playing with their father’s gun when it went off. The three-year-old boy lost his foot in the accident. I will never forget the haunted look in the eyes of the five-year-old brother who was barely old enough to understand that he had pulled the trigger, firing the shot that caused his brother to lose his foot.

On another occasion, a six-month-old girl was brought to the hospital after the car she had been travelling in with her family was hit by a bomb on the roadside. Both her parents were killed in the blast. She was extremely pale and did not seem to be breathing adequately. We unwrapped her blanket and found that shrapnel had ripped off her right leg which was still precariously attached by a thin filament of skin and muscle. We started to resuscitate her, giving her oxygen, fluids and blood and then brought her to theatre. We were unable to save her leg, which required amputation. After the girl had recovered from anaesthesia, she was doing poorly on the ward and appeared very lethargic and unable to feed. Despite our best efforts with bottled milk, she refused to feed. We started intravenous fluids to stop her becoming dehydrated. After 48 hours, the little girl was refusing to eat or drink.

However she started to become more alert, interacting and started to feed on the third day. The other patients on the ward started to laugh on the morning ward round – they had seen our failed attempts to get the baby to feed. During the night, it was a woman on the ward who finally got her to start feeding.

The little girl’s aunt came forward and agreed to take the little girl home with her when she was fit for discharge. She brought a brand new set of challenges for the MSF physios who were determined that she would not languish and who were planning to arrange a prosthetic limb at a later date.

### Burn surgery

Surprisingly, a distinct pattern in the presentation of injuries started to emerge. Many patients had sustained severe burn injuries through variable mechanisms. For example, women in the refugee camps brought hot water into their tents for washing. Sometimes children fell into boiling pans of water/hot oil that were lit for cooking. Men transporting bombs suffered injuries after bombs were accidentally detonated and sustained burns due to the release of heat by the explosion. But there was a further unpredicted source of burn injury. It was extremely difficult to buy petrol for cars in Syria but crude oil was more readily available. The Syrians realised that by simply heating the crude oil, they could fractionate an impure form of petrol. Most men in Syria smoke, and frequently the men would have a cigarette while fractionating the petrol. A significant percentage of patients who sustained burns were injured when fractionating the petrol in this way.

Although I had worked with Médecins Sans Frontières previously, I was full of fear and trepidation about my assignment to Syria.

(continued next page)
The management of burn patients was extremely labour intensive. Some patients were brought to us immediately after the burn injury had taken place. We were generally alerted to the arrival of a new burn patient by the ambulance sirens outside the hospital. Often the patients were screaming in agony and we immediately set about the process of resuscitating the patients (giving them oxygen, fluids and pain relief) and then taking them to theatre for cleaning and dressing of their wounds.

Other patients suffered burn injuries, but were treated at other hospitals or stayed at home. They typically presented a few days later, with seeping painful wounds which were foul-smelling and infected.

Many patients were depressed about their condition. We started taking them to theatre each day or every second day and administering a general anaesthetic. The wounds were so painful that anaesthesia was necessary so that we could clean and debride the wounds adequately. Many wounds were infected, but with simple measures we could see that they were starting to heal very slowly.

Some patients required skin grafting and blood transfusions. There was a sincere sense of gratitude and relief from the patients when they learned that their wounds were healing. However, other members of the expatriate team played a crucial role in the recovery of the patients. The physiotherapists worked daily with the patients to prevent contractures. Nutrition was important to ensure a fast recovery and all the patients received meals that were rich in protein. Psychological assistance was available for any patient who required it.

In August 2014, MSF decided to suspend the presence of international staff inside Syria until the organisation obtains reliable security guarantees from the armed groups, particularly those manifesting suspicion and intolerance of what is perceived as foreign aid. However, the move to a modus operandi with only national teams inside the country has enabled the humanitarian organisation to continue providing critical medical assistance in Aleppo to this day. In addition, the uninterrupted and growing support of local medical teams and structures is also an important contribution of MSF’s medical assistance in Aleppo.

Conflict goes on

As the war in Syria enters its fifth year, Médecins Sans Frontières runs two health facilities in Aleppo governorate. One of the hospitals, located near the Turkish border, has 28 beds and services include an emergency room, maternity and out patient care (about 50 consultations per day). Another MSF hospital in the outskirts of Aleppo city carried out last year roughly 16,000 consultations and admitted 430 patients. MSF also supports 10 field hospitals, nine first aid points and three health centres in the province.

In August 2014, MSF decided to suspend the presence of international staff inside Syria until the organisation obtains reliable security guarantees from the armed groups, particularly those manifesting suspicion and intolerance of what is perceived as foreign aid. However, the move to a modus operandi with only national teams inside the country has enabled the humanitarian organisation to continue providing critical medical assistance in Aleppo to this day. In addition, the uninterrupted and growing support of local medical teams and structures is also an important contribution of MSF’s medical assistance in Aleppo.
We were woken daily by the village call to prayer from the mosque in the morning. Many of the staff were keen to pray at frequent intervals during the day. Alcohol was unavailable. We were only allowed in the hospital or the house as all other areas were out of bounds. Some of the expatriates had movies stored on hard drives or computers and these were a welcome distraction.

However we were working six days each week from 8am to 7pm and I found myself exhausted at the end of each day. There were 13 expats living in the house and usually this meant that two or three of us would share a room. We did have warm showers, sit down toilets and the food wasn’t bad!

**Other MSF activity in the refugee camps:**
Since the beginning of the war, few Syrian children had been vaccinated against common childhood diseases. MSF commenced a program to start vaccinating children. A general expat doctor and outreach team, of national staff, visited the refugee camps, vaccinating children and collecting data on the number of refugees, outbreaks of disease, availability of fresh water and latrines.

Logisticians went to the refugee camps to increase the number of latrines available and to improve the availability of clean water.

**Dr Janet Loughran, FANZCA**
Children’s Hospital at Westmead, NSW

An edited version of this article first appeared in *The Irish Times*.

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**Since May 2012, MSF is the main healthcare provider in Domeez refugee camp where more than 55,000 people have settled. MSF is providing humanitarian assistance to Syrian refugees in the camp through general health, mental health, and immunisation. So far, MSF medical teams have held over 40,000 consultations. MSF is also providing targeted hygiene kits for refugees, safe water supplies and efficient sanitation. As well as following up the health situation in case of any emergency break outs in the camp.**

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**The hospital was located in a large converted Syrian house. The ground floor had four reception rooms, which had duly been converted into an operating theatre, a recovery room, an emergency department and a sterilising room.”**

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A MSF medical team checking on a man who fainted the minute he arrived to the transition area after walking for several hours to cross the border between Syria and Iraq under harsh conditions where the temperature reached 50 degrees.
Childbirth revolution: How epidurals arrived in the ancient mid-east

With a university purchasing order in my pocket, I found the warehouse where plastic materials of all kinds were held in storage. In halting French I explained to some man that I needed a supply of “petite tubule en plastique, tres petite, et peut-être en nylon, s’il vous plait”. The attendant nodded and to my great delight, soon reappeared carrying a large drum loaded with fine gauge nylon tubing… more than 1000 metres of it. It looked small enough to easily pass through those large Tuohy needles. I triumphantly carried the bulky thing in my arms by tram to the hospital, where I immediately powered up the autoclave and steam-cooked a length of tubing. That nylon tubule emerged intact.

The next step was to fabricate a length of tubing ready for use. How do you connect a tiny plastic catheter to a syringe? Our tough nylon catheter was too small and too stiff to accept a 25 gauge needle, until I first softened it with a momentary pass through the flame of a spirit lamp. One problem solved. At the catheter’s other end, what kind of ending would best distribute the injected solution inside the epidural space? A single orifice at the end ran the risk of depositing drug in just one location, like an intervertebral foramen, where it might reach one nerve root but miss others. Several small orifices might achieve a watering can effect. Again a spirit lamp came to the rescue. I heated a small needle in a flame until it was bright hot, and then touched the side of the catheter with its sharp point. Three or four such holes made a fine “watering can”.

The rest of our epidural story – placing the needle, identifying the space, injecting a test dose – followed a learning curve familiar to all anaesthetists. Except I had to start from scratch and perfect a routine that worked faultlessly for me, and fast. Even choosing the contents of each sterile tray/kit made a difference.

Acceptance of this new pain relief was another story. Delivery nurses were suspicious, but soon became convinced of its value, and reassured questioning mothers. Many patients were doubtful. But in a two-bedded labour room one woman might be having a hard time while the other was comfortable and enjoying her labour. After a few months women on the street would recognise me, and smother me with thanks for making childbirth so enjoyable. And other obstetricians, hesitant at first, learned epidural-assisted childbirth was here to stay.

Necessity breeds invention in obstetric anaesthesia in 1950s Beirut.

In 1958 a new professor of obstetrics arrived at the American University of Beirut and his name was William Bickers. He came from Richmond in Virginia and, in both manner and speech, he was a fine example of a southern gentleman. He was jovial and pragmatic, and he was fun. I liked him.

But Dr Bickers soon let me know he did not like the way obstetric deliveries were managed at our hospital. In Richmond he had started using lumbar epidural anesthesia for vaginal deliveries. And he declared this kind of pain relief had transformed his approach to delivering babies. It was not just the comfort of mothers that pleased him. His own convenience mattered too.

The method gave to him the accoucheur, control over the timing of the baby’s arrival. Instead of being at the mercy of each baby, presenting itself unpredictably at any hour, he could stop its progress. He could activate pain relief with an epidural block. With sensation gone, and no urge to bear down, the mother could just stop pushing. The baby could stay put until the doc was able to come. Then, with the mother smiling her way through the event, he could perform a simple outlet forceps delivery with a routine episiotomy.

But in the late 1950s this was a new thing even in American obstetrics. Caudal anesthesia had been used in some hospitals; my wife had reported how successful it had looked in her Pennsylvania Hospital. But the lumbar approach was different, tried in only a few places and still being tested. I dragged my feet.

To his credit, Dr Bickers did not give up and finally I surrendered and started to assemble the necessary bits and pieces. Lidocaine, the preferred drug, was easily available in the 2 per cent used by Dr Bickers. From the US I ordered two dozen 16 gauge Tuohy needles. They had a curved tip that, in the epidural space, could help direct the catheter north towards the head. Those needles were very sharp, liable to easily puncture the dura. So I went to work with an emery stone and ground off all the needle points and sharp edges.

We also needed small catheters for insertion through the needles and I did not know where to find them. Could we possibly make them ourselves, at reasonable cost?
I decided to give the first thousand epidurals myself, to make likely mistakes, learn how to avoid them, and teach others. I followed this intention, remaining on obstetric call 24/7 for months until I reached the goal. A thousand patients, and not a single dura puncture! Bless those blunt needles!

Not every case went perfectly. One problem was epidural hematoma, which came from damaged epidural veins; blood could be withdrawn from a catheter after its insertion. If the blood extravasation was large it would interfere with the spread and effectiveness of the anesthetic. There was no effective remedy. I knew our stiff nylon catheters were largely to blame and in later years new, no-kink, soft and pliable catheters might become available.

More problematic was the result when a torn vein was not suspected and the injected lidocaine was pushed inboard and entered the venous circulation. My most memorable patient was the wife of a valued colleague, our professor of pharmacology. When I inserted her catheter I did see a little blood, but hoped it was only a small collection. So I took the risk and injected a sizable activating dose of lidocaine. In just over half a minute, close to a circulation time, the drug had entered her epidural veins and reached her brain circulation, causing her to complain of dizziness. It lasted about 10 seconds and was a sharp warning. Dare I persist? Hoping for the best, I waited several minutes for that first dose to be dissipated, and delivered another dose. Exactly as before, disorientating dizziness appeared 35 seconds after my injection. I was defeated, and apologised as best I could.

I reported to others our groundbreaking efforts at the American University of Beirut. One who took a keen interest in our work was Sir Robert Macintosh, of Oxford. He spent several weeks as visiting professor in Beirut and asked if he could watch me giving an obstetric epidural. I was ready, eager to strut my stuff. With Sir Robert watching, I went through the familiar routine, advancing the Tuohy by small increments and demonstrating the final loss-of-resistance, sure I was through the ligamentum flavum. Then I disconnected the syringe – and there gushed from the needle a copious flow of cerebrospinal fluid. My first-ever dura puncture. I turned and looked up at Sir Robert. He was grinning from ear to ear.

About the author

Dr Bernard Brandstater was born in Perth in 1929. He studied medicine at Adelaide University and received a Fulbright grant for postgraduate study in anaesthesiology at University of Pennsylvania in Philadelphia. Further studies in London, plus a year of research at U.C. San Francisco, were followed by 13 years as associate professor and department head of anaesthesiology at the American University of Beirut. He did pioneer work in the introduction of epidural anaesthesia in obstetrics, and was the first advocate of prolonged intubation in babies with respiratory failure.

Dr Brandstater served as consultant to the World Health Organization, inspecting teaching hospitals in Iraq and Iran, and was founding editor of the Middle East Journal of Anaesthesiology. He was a personal physician to the King of Saudi Arabia and gave anaesthesia to three queens in the royal family.

In 1969 he became professor at Loma Linda University, and department chair in 1971 through to 1981. He continued in diverse anaesthesia practice from 1981 to now. He has organised and hosted international medical conventions; has lectured in numerous centres in the US, Europe, Australia, Asia, South America and Russia. He has authored 37 scientific articles in the field of anaesthesiology, and edited or re-written many more. He has served as on-site consultant to the US State Department concerning education aid programs in Syria.

Professor Brandstater’s hobbies/interests have included music (he plays keyboard and various brass instruments) and mountain-climbing – he has summited the Matterhorn, Aconcagua in Argentina, Demirkasek in Turkey, and Everest Base Camp in Nepal. He has done blue-water sailing (he crewed on a tall ship, the “One and All”, during the Bicentennial First Fleet Re-enactment in 1980) and television production (he has hosted a weekly church-based TV program). Professor Brandstater is married, has four adult children and a herd of grandchildren.

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Other visitors also took notice of our pioneering work. Dr Harry Churchill-Davidson from St Thomas’ Hospital in London was among them. Since we were ahead of most hospitals in Europe, Churchill-Davidson chose to make the subject a major half-day symposium at a European Congress in Copenhagen in 1966 and asked me to give a keynote lecture. Other interested visitors were two reps from the Portex Company, manufacturers of plastic tubes and other medical supplies. I told these men it was time for Portex to make and market epidural catheters and sterile kits. These methods of pain relief must eventually become a part of everyday obstetric practice with a huge potential market. They were not convinced, but I presented them with several samples of our own catheters, fabricated from that original drum of nylon tubing.

No comments came from Portex headquarters in Hythe, but 14 years later, I inaugurated a new obstetric epidural service at Loma Linda University Hospital in California and out of a cupboard emerged an epidural kit, bearing names of Concord and Portex. When I opened it and examined the catheter, it was identical in length and design to our Beirut catheters. Years after that amusing discovery, I wrote to the Portex office, asking if they had any record of those first sample catheters they had used as a template for their product. I received a gracious response. Yes, inquiries among senior personnel had identified a long-time technician who recalled those first sample catheters from Lebanon. Our early work had lived on in the marketplace.

With a university purchasing order in my pocket, I found the warehouse where plastic materials of all kinds were held in storage. In halting French I explained to some man that I needed a supply of “petite tubule en plastique, tres petite, et peut-etre en nylon, s’il vous plait”.

In the 1980s, I uncovered a nostalgic sequel. While preparing a lecture on obstetric anaesthesia I reviewed recent articles on alternative catheter designs. Among those articles were writings from Dr Felicity Reynolds, obstetric anaesthetist at St Thomas’ Hospital in London. Dr Reynolds was defending her preference for the multi-orifice catheter. At that time she had no way of knowing that the catheter she liked had its provenance, through Portex, in the trial-and-error efforts of an earlier St Thomas’ man, struggling to solve problems in Beirut. He had simply applied humble inventiveness to satisfy a persistent obstetrician. I was delighted to find I still had friends on the Thames.

Professor Bernard Brandstater, FANZCA
Loma Linda University, US

Childbirth revolution: How epidurals arrived in the ancient mid-east (continued)
Undergraduate training

Undergraduate medical teaching is woefully deficient in pain-related content on both the basic science and clinical levels. Pain is the most common symptom with which patients consult healthcare professionals. For physicians, the proper management of pain remains one of their most important obligations. As a Faculty, we need to take a strong stand on the inclusion of pain education throughout the medical school curriculum and encourage our allied medical disciplines to do the same.

Tackling the cost and suffering of chronic pain

Tackling the cost and suffering of chronic pain, and ensuring access to pain services and how we need to target subacute (or acute persistent) pain2 also is a priority for the Faculty this year, but I will address these another time.

Armed with a talented board and dedicated staff, I am confident we will continue to make progress in these areas.

Professor Ted Shipton
Dean, Faculty of Pain Medicine

References:
News

Admission to fellowship of the Faculty of Pain Medicine
By examination:
- Dr Suzanne Louise CARTWRIGHT, FANZCA (Victoria)
- Dr Pavla Anna WALSH, FRACP (Victoria)
- Dr James Paul JARMAN, FANZCA (Western Australia)
- Dr Kang Yung SHUM, FAFRM (RACP) (Victoria)
- Dr Paul Giles VROEGOP, FRANZCP (New Zealand)
- Dr Amanda JOHNS, FAFRM(RACP) (NSW)
- Dr Liam Michael RING, FANZCA (NSW)
- Dr Michael John STONE, FANZCA (NSW)
- Dr Paul Emery FERRIS, FANZCA (NSW)
- Dr Ian Geoffrey THONG, FERACGP (NSW)

This takes the total number of Fellows admitted to 392.

FPM Undergraduate Prize in Pain Medicine
The recipients of the 2014 FPM Undergraduate Prize in Pain Medicine are Mr Lukman Anderson from the University of Newcastle, Ms Chloe Attree from the University of Notre Dame Australia, Mr Tim Manzie from the University of Wollongong and Ms Johanna Warren from the University of Adelaide. The undergraduate medical student prize of $A500 and certificate are awarded to the best undergraduate student in pain medicine in the last two years of undergraduate training in medical schools across Australia and New Zealand as part of FPM’s strategic plan to increase education and training in pain medicine.

Congratulations to Mr Anderson, Ms Attree, Mr Manzie and Ms Warren. We hope this award is the first of many successes in their medical careers.

Training unit accreditation
Princess Alexandra Hospital has been accredited for pain medicine training and Nepean Hospital and Liverpool Hospital have been reaccredited following successful reviews. The number of accredited pain units stands at 30.
The first cohort of trainees has begun the core training stage of the revised curriculum and training program in Australia and New Zealand. A range of new learning opportunities and resources will become available to trainees, supervisors and Faculty Fellows throughout 2015. These include eLearning resources focused on nine essential topic areas, and five new workplace-based assessments tailored to facilitate development of trainees’ knowledge and clinical skills in pain medicine. The first eLearning module, on acute pain including trauma, is now available in Networks. The revised training program also incorporates changes to the summative assessment processes and documentation, as outlined in the FPM Training Handbook.

The introduction of the revised training program is the start of a new phase for the Faculty. In order to strive for quality improvement and continually respond to the feedback, the 2015 training year will be a transitional period. Throughout this year, the Faculty will seek feedback on elements of the program from trainees, supervisors of training and other stakeholders. The Faculty strongly encourages collaboration among stakeholders and aims to modify and fine-tune aspects of the training program as required, based on feedback received.

The Faculty has implemented an evaluation strategy and plan for 2015-17. Early opportunities for engagement with supervisors of training and directors of training units included teleconferences in the first few weeks of the Australian hospital employment year. The first round of supervisor orientation and support resources has been published in Networks and additional, tailored resources will be launched at the supervisors of training workshop in May. The Chair of the Curriculum Redesign Project, Dr Meredith Craigie, will visit a number of training units, and will be available for consultation at upcoming pain medicine conferences in Australia and New Zealand in March.

New trainees received a detailed orientation to the training program and revised curriculum in February at a workshop entitled “So you want to be a specialist pain medicine physician?” and other helpful hints”. Preliminary feedback on the new foundations of pain medicine examination was collected and will be used for ongoing quality improvement purposes.

The Faculty is committed to supporting all trainees and looks forward to hearing their feedback as they progress through the revised training program.

Access the 2015 curriculum, training handbook and accompanying resources via the FPM website, www.fpm.anzca.edu.au/training. For more information email painmed@anzca.edu.au.
Dr O’Neill did her undergraduate degree in Perth at The University of Western Australia. She moved to Sydney as a resident and did her anaesthetic training at St Vincent’s Hospital. She has completed two years at Royal North Shore Hospital as a pain management fellow part-time, job sharing a full-time position with another anaesthetist. She did it that way so she couldn’t afford to give up her anaesthetic practices and she also wanted to be at home part of the time with her young children. Dr O’Neill is keen to pursue a career in both anaesthesia and pain medicine and is particularly interested in the relationship between acute pain and chronic pain, and in developing practices and services that could potentially reduce the risk of that progression. 

Merit awards went to Dr Suzanne Cartwright (Vic), Dr James Jarman (WA) and Dr Wei Chung Tong (Vic).

Thirty two candidates successfully completed the FPM final examination and are listed below:

**New South Wales**
- Aditi Chandak
- Eric Cheok
- Jason Chow
- Paul Ferris
- Amanda Johns
- Martine O’Neill
- Freshanthy Rajeswaran
- Anandhi Rangaswamy
- Stephen Smith
- Willem Volckchen
- Tze Choo Wee
- Liam Ring

**Queensland**
- Jeremy Rammer
- Shaun Clarke
- Suran Dhanapala
- Kylie Hall
- Jeffrey Mott
- Scott Smith

**South Australia**
- Peter Carlin

**Tasmania**
- Cameron Gourlay
- Mark Alcock
- Guy Buchanan
- Suzanna Cartwright
- Michael Foss
- Msita Rush
- Mir Wais Sekandarrad
- Srirekha Vadasseri
- Wei Chung Tong

**Western Australia**
- Adeline Fong
- James Jarman
- Michael Veltman

**Hong Kong**
- Po-Che Yip
The Pelvic Pain Foundation of Australia is a not-for-profit organisation formed in 2014 to build a healthier and more productive community by improving the quality of life of people with pelvic pain.

The Pelvic Pain Foundation of Australia (PPFA), which was formed last year, aims to minimise the suffering and burden of pelvic pain on individuals, their families and the community through awareness, education, funding, support and research.

Pelvic pain affects a large number of girls, women and men of all ages, ethnicities and social backgrounds. One in five women and one in 12 men will be affected by pelvic pain at some time in their life, yet the condition is rarely discussed.

The need to address this significant cause of suffering was first recognised at the National Pain Summit held at Parliament House, Canberra, in 2010, which raised awareness of chronic pain as a major health issue for Australia. The National Pain Strategy evolved from this and is being implemented throughout Australia by Painaustralia in collaboration with state and federal governments. However, the strategy addresses chronic pain generally and the needs of those with pelvic pain were not specifically addressed by groups represented at the summit.

In 2011, the Pelvic Pain Steering Committee, in collaboration with Painaustralia and the Faculty of Pain Medicine, looked at ways to remedy this problem. Their report, titled The $6 Billion Woman and the $600 Million Girl: The Pelvic Pain Report, followed wide consultation with health professionals and those affected by pelvic pain. The report, which can be found on the FPM website, outlines the problems with pelvic pain services and policies and makes recommendations on how these problems may be overcome. Since then, the extent of pelvic pain in men also has been recognised.

The Pelvic Pain Foundation of Australia was formed to address these issues.

Over the past 12 months the foundation has made substantial progress with the establishment of a diverse board, including FPM Fellows Dr Susan Evans and Dr Meredith Craigie, and development of a comprehensive website – www.pelvicpain.org.au.

The foundation is supported by ambassadors Mr Graham Smorgon, a well-known Melbourne businessman, and Ms Eugenie Lee, a Sydney-based visual artist who uses her art to explore the human body and mind, particularly chronic pain.

A key goal of the foundation is to provide high-quality information for those affected by pelvic pain, as well as their families and healthcare providers, regardless of income, location or access to services.

The foundation officially launched in Adelaide on February 24 and an event was scheduled in Melbourne for March 24, at Mr Smorgon’s home.

Community education events were held last year and preparations are underway for a training seminar for general practitioners this year. The foundation is already supporting several researchers (see above), thanks to generous donors.

More information about the foundation can be found on the PPFA website www.pelvicpain.org.au.

Dr Meredith Craigie, FANZCA, FFPMANZCA
Pelvic Pain Foundation Board member
Dean of education looks to the future

Dr Ian Graham was appointed as ANZCA’s dean of education in 2014. He outlines his vision for the College.

I was inspired and enthused to be appointed to the part-time position of dean of education at ANZCA in August 2014 following the retirement of Professor Barry Baker.

As a specialist medical manager in the Victorian public healthcare system, I have worked closely with postgraduate medical trainees in a range of settings as they balance the sometimes competing demands of education, training and clinical service provision in a busy hospital environment. I also have been actively involved in curriculum development and have worked as a consultant to several medical colleges, including the Royal Australasian College of Surgeons, the Royal Australasian College of Physicians and ANZCA.

The 2013 revision of the ANZCA curriculum is a credit to the many Fellows, ANZCA staff and others who contributed to its development. Throughout the world, at all levels of training and across all disciplines of medicine, competency-based medical education is better defining the knowledge, skills, experience, attitudes and behaviour expected of trainees as they progress through training and attain fellowship. The approach focuses on outcomes with a reduced emphasis on a rigid time-based approach to postgraduate training and is exemplified by the ANZCA curriculum.

There is international interest in the development of standards or milestones that more clearly define our expectations of trainees at each level of training. The concept of “entrustable professional activities” (EPAs) has emerged, describing key clinical activities that can be used as “scaffolding” for the assessment of clinical performance at each level. EPAs combine a variety of competencies into meaningful, observable and assessable activities. They highlight the decisions supervisors make day-to-day regarding their preparedness to entrust trainees with clinical tasks.

It is hoped that ANZCA can build on this work to further define milestones and EPAs to support anaesthesia and pain management training in Australia and New Zealand.

Continuous, workplace-based assessment is fundamental to competency-based medical education. The assessment tools must be reviewed and refined to ensure their reliability, validity and practicality in the clinical workplace. Further development and improvement of ANZCA’s training portfolio system (TPS) is required, perhaps including the use of purpose-built smartphone apps to allow workplace-based assessments to be administered, feedback to be provided and results to be recorded more easily and efficiently in the clinical workplace.

Similarly, recording of cases and procedures could be enhanced to allow simple, efficient, contemporaneous documentation of volume of practice.

Summative assessment, in particular the primary and final examinations, remains a critical component of the continuum of assessment in anaesthetic training. To enhance the validity, reliability and practicality of these examinations, ANZCA is exploring the possibility of online exam delivery. This would allow a range of question formats using high-resolution images and multimedia features, and support the automated marking of multiple-choice questions and simpler processing of short-answer questions by examiners.

A comprehensive, well integrated, technologically enhanced assessment program also would produce a wealth of data, which can be analysed, reported and used by trainees, supervisors, directors of professional affairs assessors and others to track trainees’ progress, and to evaluate the performance of the ANZCA curriculum and training program. Given the rapid pace of change in postgraduate medical education and training, and the complexity and demands of training, the welfare and pastoral care of trainees is paramount.

I am strongly committed to further developing our mechanisms for supporting trainees in difficulty so every trainee is able to achieve their full potential in anaesthetic training.

Dr Ian Graham
MB,BS; M. Health Planning; Cert. Essential Skills in Medical Education; FRACMA
New in the library

New online books
Online textbooks can be accessed via the library website: www.anzca.edu.au/resources/libraryonline-textbooks


New books for loan

Online resources expanded
The ANZCA Library has expanded the collection of online resources to include the full ClinicalKey Flex product. This package not only provides a range of well-known anaesthetic and pain medicine texts but also covers more popular general medicine titles.

Journals include the entire “Clinics” series, as well as:
- The Lancet.
- American Journal of Surgery.
- AORN Journal.
- Critical Care Clinics.
- Mayo Clinic Proceedings.
- Respiratory Medicine.

Books include the entire “Secrets” series, as well as:
- Becoming a Doctor: Surviving and thriving in the early postgraduate years.
- Cardiovascular Physiology.
- Cases in Pre-hospital Retrieval Medicine.
- Clinical Pharmacology.
- Essentials of Law for Medical Practitioners.
- Guyton and Hall Textbook of Medical Physiology.
- Mechanical Ventilation: clinical applications and pathophysiology.
- Oh’s Intensive Care Manual.
- Perioperative Medicine.
- Practice of Clinical Electrocardiography.
- Understanding the Australian Health Care System.

Access ClinicalKey through the ANZCA Library online textbooks list.

Ovid journals iPad app now available
An iPad app, Ovid Today, is now available to download and access journals such as Anesthesia & Analgesia, Anesthesiology, PAIN and Regional Anesthesia & Pain Medicine.

The app allows you to:
- Browse ALL the ANZCA Library’s Ovid journal holdings – search by A-Z journal name or by category to find journals that best fit any specialty area, such as anaesthesiology.
- Intuitive interface and navigation – made with the busy user in mind to make reading journal articles a simple experience.
- Personal reading list – you can create a list of journals to follow that is most relevant to your research, practice and education.
- Stay up-to-date – the latest content from the ANZCA’s subscribed journals is instantly available on the app once on Ovid.
- Read PDF articles – access articles while on the go, even when you are offline.
- Access wherever you are – at home or at work.

Find out more on the ANZCA Library online journal list.

European Journal of Anaesthesiology
The European Journal of Anaesthesiology (EJA) is now available to be accessed online through the ANZCA Library from 2004 onwards.

EJA publishes original work of high scientific quality. Preference is given to experimental work or clinical observation in humans, and to laboratory work of clinical relevance. The journal also publishes commissioned narrative reviews by an authority in a field of interest to those working in anaesthesiology, pain, emergency medicine or intensive care. Editorials, commissioned commentaries and book reviews also included. It is published on behalf of the European Society of Anaesthesiology.

Access through the ANZCA Library online journal list.

Contact the ANZCA Library
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Library update

New in the library (continued)

ECRI top 10 health technology hazards for 2015
Find out which technology safety topics we believe warrant particular attention for the coming year. Once again, alarm hazards come in at number one.
2. Data Integrity: Incorrect or Missing Data in EHRs and Other Health IT Systems.
3. Mix-Up of IV Lines Leading to Misadministration of Drugs and Solutions.
4. Inadequate Reprocessing of Endoscopes and Surgical Instruments.
5. Ventilator Disconnections Not Caught because of Mis-set or Missed Alarms.

ECRI 2015 top 10 hospital C-suite watch list
1. Disinfection Robots: A Front-line Assault on Hospital-acquired Infections?
2. Three-dimensional (3-D) Printing Buzz: How Many 3-D Printers Should You Plan on in 2015?
3. Middleware Is Everywhere: Can It Help You Meet the National Patient Safety Goal on Clinical Alarms?
4. Postdischarge Clinics: Do They Prevent Readmissions and Save You Money?
5. Google Glass—Dead for Consumers but Maybe Not for Healthcare: Will Your Clinicians and Patients See Any Benefits?
6. New Anti-obesity Devices: Should You Create Adolescent and Young Adult Cancer Centers to Improve Outcomes?
7. Caring for Millennials with Cancer: Should You Create Adolescent and Young Adult Cancer Centers to Improve Outcomes?
8. Fecal Microbiota Therapy: New Hope for Other Serious GI Disorders?
10. Telehealth: Have We Passed the Tipping Point in Clinical Use?

Latest anaesthesia and pain medicine research
All articles can be sourced in fulltext from the library’s online journal list: www.anzca.edu.au/resources/library/journals

Trauma the focus for NZ annual scientific meeting

Trauma in its widest sense will be the focus of the 2015 New Zealand annual scientific meeting (ASM) being held at the Te Papa Museum in Wellington from November 5-7. The New Zealand National Committee (NZNC) is the ASM’s sole host this year with the NZ Society of Anaesthetists committed elsewhere. The organising committee is drawn from Wellington Hospital, with Dr Graham Sharpe as convenor and Dr Mohua Jain and Dr David Pirotta as scientific program convenors.

Under the theme “Trauma: Personal, professional and patient perspectives”, the program will explore advances in trauma care, how anaesthesia practice can affect the welfare of colleagues and the trauma patients being anaesthetised can experience. Scientific program topics will include lessons from military anaesthesia, advances in transfusion relevant to the anaesthetist, an update on erythropoietin, historical perspectives, national trauma program, injuries to patients and welfare issues for the practising anaesthetist. Three keynote speakers from the UK have been confirmed – Professor Beverley Hunt, Dr Nancy Redfern and Lieutenant Colonel Rhys Thomas.

Key skills and scenarios being covered in workshops include trauma scenarios, CPR updates, major haemorrhage, can’t intubate can’t oxygenate (CICO), anaphylaxis, ultrasound and welfare.

The social program will make the most of Te Papa’s superb waterfront location with welcome drinks on Thursday evening and a magnificent gala dinner on Saturday night. As a bonus, there will be the city’s annual Guy Fawkes’ fireworks display on the harbour.

FPM NZNC meeting in Auckland

The Faculty of Pain Medicine’s New Zealand National Committee will hold its first meeting for the year in Auckland on March 25, immediately preceding the NZ Pain Society’s (NZPS) 40th annual scientific meeting. Agenda items will include workforce issues, the revised curriculum and a referral to the National Health Committee for assessment of a national paediatric pain service. As happened last year, the NZPS president will be invited to meet the Faculty’s NZNC to discuss items of common interest and how the groups can work together.

This is an election year for the FPM NZNC membership and nominations are sought and close at Easter. If required, an election will be held in April.
Research workshop a great success

There was no doubting the interest in the inaugural NZ Anaesthesia Research Workshop held at Auckland City Hospital on December 4. This was a new initiative for the NZNC in 2014 and the committee hopes it will become an annual event.

Nearly 50 people registered to hear from, and network with, internationally recognised researchers who shared their knowledge of how to participate in and make the most of anaesthesia research. The all-day event concluded with a “Dragon’s Den” in which participants submitted research projects for expert critique.

The NZNC is particularly grateful to convenor Dr Tom Fernandez, who did an excellent job putting together the program, to Auckland City Hospital for hosting and to the presenters: Professor Alan Merry, Associate Professor Tim Short, Professor Brian Anderson, Professor Jamie Sleigh, Dr Doug Campbell, Dr Johan van Schalkwyk, Associate Professor Ross Kennedy and Associate Professor Jenny Weller.

BWT Ritchie Scholars 2014

The NZ Anaesthesia Education Committee has awarded the 2014 BWT Ritchie scholarships to Dr Kerry Holmes (Auckland), Dr Ross Scott-Weekly (Dunedin) and Dr James Broadbent (Lower Hutt).

Dr Holmes will use the award to support a cardiac anaesthesia fellowship at the Bristol Royal Infirmary in England, beginning in May, and specialising in transoesophageal echocardiography and quality assurance. After undertaking his first year of anaesthesia training at Tauranga Hospital, Dr Holmes has been completing his training in Auckland. During 2014, he worked as an obstetric fellow and then as a liver fellow at Auckland City Hospital, where he also has been involved in various teaching roles. Dr Holmes has secured a permanent consultant position at North Shore Hospital, Auckland, starting in June 2016.

Dr Scott-Weekly will undertake a paediatric fellowship at the Royal Children’s Hospital (RCH) in Melbourne. He completed his provisional fellowship in anaesthesia in Dunedin, where he has contributed significantly to the quality and teaching of clinical anaesthesia. He also has maintained his work with St John Ambulance and has used his extensive information technology knowledge to assist with the computer modelling of a pharmacokinetic study being conducted by the Dunedin department. At the RCH, Dr Scott-Weekly plans to further his interest in teaching and he will have exposure to a number of paediatric sub-specialities, including craniofacial, cardiothoracic, neurosurgical and transplant surgery. He hopes to return to Dunedin as a specialist.

Dr Broadbent also is using the scholarship to support a paediatric fellowship at the RCH, having begun a six-month fellowship in paediatric anaesthesia in February to be followed by a six-month fellowship in paediatric intensive care medicine. Dr Broadbent has trained in anaesthesia and intensive care, and has worked at the Hutt Hospital since December 2013 where he has managed the anaesthesia department’s equipment portfolio, promoted research in the intensive care unit, recently got involved in teaching and has been the site investigator for a national research project into MET calls. During his fellowships, Dr Broadbent plans to attend several instructor courses and to gain experience that will be invaluable for the care of Hutt Hospital’s significant number of paediatric patients.

The BWT Ritchie scholarships provide funding to assist New Zealand-based anaesthesia graduates to gain overseas experience and bring it back to New Zealand. Applications close on October 31 and must include a proposal detailing how the scholarship will be used. For further information, see www.anaesthesiacciation. org.nz. The website includes reports from previous BWT Ritchie scholars, which serve as a guide as to how the scholarships have been used.
New Zealand news continued

ANZCA support for registrar meeting

NZNC Chair Dr Nigel Robertson and NZSA President Dr Ted Hughes discussed the wider roles of their two organisations during the morning session of the Annual Registrar Meeting held at Auckland City Hospital in early December. The NZNC supports the meeting financially and offers a scientific prize. The morning session focused on professional development for trainees, particularly topics they may not be exposed to in their everyday training. As well as covering the ANZCA and NZSA roles, this session included a discussion of medico-legal risk and anaesthesia, and a forum in which FANZCAs recently returned from overseas fellowships shared their experience. In the afternoon’s scientific session, trainees presented their audit and research. An innovation this year saw each participant prepare a poster for display. Each of the 11 presenters also delivered a 15-minute oral presentation, which was used to help judge the three prizes on offer.

The winners were:
• ANZCA Prize for the Best Scientific Presentation – Dr Jeyanjali Jeyarajah for “Restricting oral intake and antacid use in labour – an audit and guideline proposal”.
• NZSA Prize for the Best Quality Assurance Presentation – Dr Paul Young for “Audit of the actual preoperative fasting times of elective oncology patients at Starship Hospital”.
• Caduceus Award for Excellence in Anaesthesiology Research – Dr Chang Kim for “Maximum blood ordering schedule for adult elective surgeries at Auckland District Health Board.”

Perioperative mortality workshop in June

This year’s Perioperative Mortality Review Committee (POMRC) annual workshop will be held in Auckland on June 15. POMRC, which is headed by ANZCA Executive Director of Professional Affairs Dr Leona Wilson, is an independent mortality review committee, which advises the Health Quality & Safety Commission on how to reduce the number of perioperative deaths in New Zealand. The annual workshop provides an opportunity to learn about the latest perioperative mortality data for New Zealand and its implications for clinical practice.

Formal Project Prize 2014

The ANZCA NZNC has awarded its 2014 formal project prize to Dr Olivia Albert, commending her for a professional, clinically relevant project of a very high quality. Her project was titled “An exemplar video of teamwork and communication in a resuscitation scenario”. Dr Albert trained in Auckland and is working in Sydney for a year before returning to New Zealand.

Above from left: NZNC Chair Dr Nigel Robertson; Dr Jeyanjali Jeyarajah and Dr Olivia Albert.
Art of Anaesthesia meeting
a great success

The highly anticipated 2015 combined Art of Anaesthesia meeting was held over the weekend of March 14-15. Organised by the ACT regional committees of ANZCA and the Australian Society of Anaesthetists, the theme of this year’s meeting was “Great Expectations: But can we deliver?” with separate sessions on airways, drugs, obstetrics, ultrasound and pain.

More than 130 delegates attended the Saturday lecture series at the John Curtin School of Medical Research, a renowned scientific institution situated at the Australian National University (ANU) campus, in Canberra. Dr Neroli Best, from Sydney’s Royal North Shore Hospital, opened the program with an excellent presentation on the consequences of intubation on the airway. Throughout the day, delegates were presented with insightful presentations by both local and interstate speakers, concluding with Dr Paul Burt who gave a thought-provoking presentation on the use of H₂O₂ during a complicated surgical procedure on the brain.

Three workshops were held on Sunday, an advanced life support (ALS) workshop at the Canberra Hospital, a can’t intubate can’t oxygenate (CICO) workshop at Calvary Hospital, and a transesophageal echocardiogram workshop also at Calvary Hospital. All three workshops were fully subscribed and provided an opportunity for delegates to refresh their knowledge on these important topics while also providing a means for completing their emergency response requirements under the ANZCA Continuing Professional Development (CPD) Program. The feedback provided on each of the workshops was excellent with delegates praising both the facilitators and the content covered in each workshop.

The Art of Anaesthesia meeting was complemented by a full weekend of social activities in the Canberra area, giving interstate and local guests the perfect opportunity to experience Canberra at its best. The spectacular Canberra Balloon Festival was held on Saturday and Sunday mornings, with more than 25 balloons launched from the lawns of Old Parliament House. The festival is listed as one of the top four hot air ballooning events in the world, with unique shapes from across the globe filling the Canberra sky each morning. Saturday evening brought the famous “SkyFire” fireworks display, lighting up the skies over Lake Burley Griffin in a tremendous array of colour. A truly wonderful weekend to experience Canberra.

Thank you to the conference convenors, Dr Carmel McInerney and Dr Girish Palnitkar for their tireless efforts in bringing together a wonderful meeting. A special mention also to our workshop convenors Dr Andrew Watson and Dr David Canty, and the many facilitators who helped to deliver outstanding workshops.

ACT Trainee Committee

In 2015 we welcome a new trainee committee and look forward to working closely with members over the next year. Newly elected members are: Dr Ross Hanrahan (chair), Dr Anthony Gray, Dr Jennifer Hartley, Dr Julia Hoy, Dr Ben Wilson, and Dr Chris Mumme (co-opted GASACT representative).

Clockwise from left: Delegates enjoy a break at the meeting; Dr Andrew Hehir, Dr Carmel McInerney, Dr David Banfield and Dr Anna O’Gorman; ALS workshop scenario; Dr David Canty leading the TTE simulation; Dr David Wright leading a CICO scenario.
Tasmanian Annual Scientific Meeting

Warm, sunny days greeted delegates at the Tasmanian Annual Scientific Meeting, which was held in Hobart from February 20 to 22.

With the theme of “Optimising perioperative outcomes: Science to bedside”, the meeting was held at the impressive Medical Science Precinct and attracted a record number of people.

Professor Daniel Sessler, the Michael Cudahy Professor and chair of the Department of Outcomes Research at the Cleveland Clinic in the US, discussed topics including long-term outcomes in patients undergoing anaesthesia and “big data” providing a review of registry research. The other keynote speaker, Professor David Story, from the University of Melbourne, spoke about the management of perioperative complications and periperaoperative diabetes.

Professor Kate Leslie (University of Melbourne) and Dr Maggie Wong (Royal Women’s Hospital, Melbourne) also contributed to the inspiring scientific program. Professor Leslie provided an update on perioperative cardiac outcomes and Dr Wong spoke about the state of perioperative medicine, as well as the management of the high-risk parturient. ANZCA President Dr Genevieve Goulding and Australian Society of Anaesthetists President Dr Guy Christie-Taylor contributed insightful presentations on current workforce issues.

All three workshops were fully subscribed with a difficult airway workshop held on the Saturday and two anaphylaxis workshops on the Sunday morning. Feedback was extremely positive for all workshops and delegates valued the small groups, which allowed them plenty of hands-on practice.

A successful trainee day was held on February 20 with the keynote speakers as well as local speakers contributing to the program.

The conference dinner was held at Prassers on the Beach, where delegates enjoyed a magnificent view of the Derwent River while enjoying a delicious three-course meal with Tasmanian wines.

The meeting convenor, Dr Peter Wright, was very pleased with how the meeting went, the largest to date, and was impressed by the level of local and interstate attendance, including delegates from New Zealand. He paid tribute to the organising committee for their hard work in making the meeting a success.
GASACT Part 0 Course

The GASACT Part 0 Course is run for new trainees selected to start on the WA Rotational Training Program. The course aims to provide trainees with an introduction to the anaesthetic program as a whole – where to start, what to expect and a few hints on finding their feet.

The 2015 GASACT Part 0 Course was held on Thursday, February 5, at the Uni Club, University of Western Australia. The course was sponsored by Smith Coffey, BOQ Specialist and MDA National. Twenty-five trainees and their partners attended the event and the speakers delivered well-prepared and punchy speeches offering a balance of perspectives. Feedback on the evening from both new trainees and their partners or support people was very positive.

The ANZCA Part 0 Course was held on February 6 at the ANZCA office; Dr Jay Bruce convened the afternoon and trainees had an opportunity to mingle and get to know the training expectations and the curriculum.

The first WA committee meetings have been held for the year. The Australian Society of Anaesthetists Committee met on February 16 and the Western Australian Regional Committee met on March 10. The Education Officer/Supervisor of Training Committee held its annual dinner and first meeting for 2015 at the Old Crow on January 28.

The primary exam was held on February 23 at the Western Australian Regional Office and we wish all candidates well in their results. The final exam will be held on March 20 and 21 and we wish the candidates well in their exam preparation.

The WA conference dates for 2015 are: Autumn Scientific Meeting, March 14, at the University of Western Australia; Winter Scientific Meeting, July 4, at the University of Western Australia; and the Country Meeting, October 16-18, at the Pullman Resort Bunker Bay. Registrations for the autumn meeting are open; see the ANZCA events calendar for further information.

Primary Exam Preparation Course

The Queensland Regional Committee has changed the format of Primary Examination Preparation Course in Brisbane from a two-week course held once a year to a one-week course held twice a year, about a month before the primary written exams.

The new format incorporates more short-answer questions (SAQs) into talks. Some presenters give focused revision talks with SAQs interspersed and others run it as more of a viva-style session.

The aim is to give candidates more practice with answering SAQs, to practise verbally answering SAQs (such as viva practice) and at the same time show up the gaps in their knowledge. There is also multiple-choice question practice.

The result is a course more closely focused on the exam, which aims to improve the chance of a candidate passing the written part of the primary exam.

Feedback about the Primary Examination Preparation Course held in January has been overwhelmingly in favour of the new format.

Thank you to all the presenters for re-organising their presentations and again volunteering their time to present at the course.

Annual conference

The 39th annual ANZCA/Australian Society of Anaesthetists combined Queensland conference will be held on Saturday, June 27 at the Brisbane Convention & Exhibition Centre. Convenor Dr Helen Davies and the organising committee are making final plans for the program. The conference will focus on relative issues of enhanced recovery after surgery (ERAS).

Further information will be available shortly on the ANZCA Queensland website, http://qld.anzca.edu.au.
Anaesthesia Allsorts annual scientific meeting

The combined ANZCA/Australian Society of Anaesthetists South Australian and Northern Territory annual scientific meeting was held on November 29, 2014, at the Sanctuary Function Centre, overlooking Adelaide Zoo.

In line with the allsorts theme, the one-day speaker program was broken into four sessions titled “Allsorts of locations”, “Assorted providers”, “Allsorts for research” and “Assorted sub-specialties”.

The 70 delegates enjoyed stand-out presentations from speakers such as military anaesthetist Dr David M Scott (Qld), who shared his views on what is required to prepare for deployment as a battlefield anaesthetist, working with a DAS unit (deployable anaesthesia system), frozen platelets and blood products, trauma environments, defence surgical facilities and to live by the rule “always expect the unexpected”.

Kangaroo Island-based rural anaesthetist Dr Tim Leeuwenburg’s TEDx-style talk on “GP anaesthesia – 2020 and beyond” was extremely entertaining considering the seriousness of his topic, which included difficult airway management outside of theatre, human factors, use of crisis checklists and “guerilla” sim training.

Plastic and craniofacial surgeon Dr Mark Moore’s presentation, “Could we or should we do this here?”, gave an intriguing insight into his 39 volunteer missions over 14 years to places such as East Timor and Aceh to treat patients living with conditions such as severe burn contractures, benign tumours and congenital cleft lip and palate abnormalities. Although extremely rewarding, Dr Moore was frank about the physical, emotional and social implications of volunteer missions and the reality that they are never entirely altruistic.

Anaesthetist Dr Andrew Fenton’s presentation, “Anaesthesia at ground zero of a super typhoon”, about his AusMAT deployment to Tacloban, Philippines in November 2013 in the aftermath of the Haiyan super typhoon, covered the challenges and dilemmas of being part of an emergency response team, the new era of professional management for
Part 0 Orientation Course

The South Australia and Northern Territory Part 0 Orientation Course was held for new trainees entering training at the start of the year. The acting Deputy Chair of the SA and NT Trainee Committee, Laura Willington, facilitated the course, supported by a number of consultants, who provided input on trainee issues including the anesthesia curriculum, workplace-based assessments, training portfolio system, welfare, rotational issues, Part 1 course and GASACT.

Associate Professor Andrew Pearce, an anaesthetist and the clinical director of training and education at MedSTAR, the statewide emergency medical retrieval service in South Australia, provided many mind-boggling scenarios. Topics included remote places and difficult spaces and how emergency staff treat and retrieve these patients pre-hospitalisation, MedSTAR’s scenario training, protocols and checklist systems.

The SA and NT Continuing Medical Education Committee thanks all 11 speakers for their time and contributions to ensure a very successful and rewarding meeting.

Clockwise from top left: Inside a C-17 Globemaster Transport Plane hospital facility – Air Force via military anaesthetist speaker Dr David Scott; Australian Medical Assistance Team AusMAT landing in Tacloban, Philippines in November 2013; Speaker Dr Glenda Rudkin, FANZCA; Speaker Associate Professor Andrew Pearce and Dr Peter Lilie, Flinders Medical Centre Director of Anaesthesia; Guest speaker, surgeon Dr Mark Moore with his first Timorese cleft patient; Associate Professor Mary White, ICU Consultant, responding to questions from the audience; Speaker plastic and craniofacial surgeon, Dr Mark Moore; Speaker Dr Cormac Fahy, FANZCA; Speaker Rural GP, Dr Tim Leeuwenburg; Speaker Dr Andrew Fenton, FANZCA (left) in the AusMAT operating facility in Tacloban, Philippines; Panel discussion. Military Anaesthetist, Dr David M Scott, Dr Sarah Firth FANZCA and Dr Ravi Cooray Provisional Fellow.
Obituary

Dr Thomas Lo
1967-2014

Family, friends and colleagues were deeply saddened by the recent death of Canberra anaesthetist Thomas Lo. Thomas was born in Hong Kong on September 30, 1967, the eldest of three brothers. His parents, Dickson and Susannah, migrated to Australia with the family in 1974, settling in Canberra. Thomas undertook his primary and secondary education at Higgins Primary School, Ginninderra High and Hawker College, and was dux of the school at the latter two. Thomas then went to Sydney University between 1986 and 1991 to study medicine, where he also excelled academically, graduating with an MB BS with first class honours. After graduation, Thomas completed an internship and residency at the Canberra (then Woden Valley) Hospital, followed by anaesthetic and intensive care unit training in Newcastle, Canberra and the Gold Coast.

While Thomas worked and trained interstate at various times, the majority of his life and career was spent in Canberra. One of the first anaesthetic registrars to train predominantly in the ACT, he proudly identified as a “Canberra boy” and never seriously entertained working anywhere else in the longer term.

They were always his highest priority and the greatest tragedy of his premature passing is the future he won’t share with them.

Thomas was someone who always had his work-life balance in good stead. Devoted to his young family, other passions of golf, skiing, computing and a nice (preferably German) car were also entertained. He relished a night out with friends and colleagues, a drink or two (though never excessive) and was always ready to don a fancy dress costume. He was a very accomplished photographer and many people benefited from his artistic eye behind the lens, whether at social functions, school concerts or as the club-sanctioned photographer for the girls’ soccer team.

Always an incredibly hard worker, he continued working right up until the time his advancing illness required his admission to hospital. He confronted his rapidly worsening health, with its initial, uncertain diagnosis and eventual cruel prognosis, with typical dignity and seemed more concerned about the effect it was having on those around him than on himself.

Thomas passed away peacefully in Canberra on November 19, 2014. He touched many people’s lives and his kindness, dedication and generosity will live on in many ways. He will be sadly missed by Vivienne, Camille and Genevieve, his parents, brothers Wilson and Alan and their families, and his numerous friends and colleagues in the wider medical community.

Vale Thomas.

Phil Morrissey, FANZCA
Canberra, Australian Capital Territory
Obituary

Dr Ian Painter
1945-2014

Many are mourning the passing of Ian Painter, a remarkable physician and a special man.

Ian was born in the shadow of World War II. His father was irreversibly affected by his experiences during the war and this was to affect his family forever; Ian's mother kept body and soul together. Growing up, Ian was faced with many adversities and would usually turn them into positives. He spent a lot of his childhood with his uncle in Otford, a small village in northern Illawarra, NSW. Ian was bright, went to Sydney Boys Tech and was the first person in his family to attend university. He enrolled in the Faculty of Medicine at Sydney University and graduated in 1972.

When he told me about the cruelty of motor neurone disease, I resorted to a cliché: "It’s not fair, mate." He said, "The word ‘fair’ is not part of my life, it’s just sad." I shared a lot with Ian, which may be unusual for Australian men. There wasn’t much we didn’t talk or laugh about. He hauled his past along with him, the good and the bad, the triumphs and regrets. He was Australian, not in a mindlessly patriotic way, but in a considered, critical and genuine way, without sentimentality.

He was one of the most professional and committed doctors I have ever had the privilege of knowing. Ian did his anaesthetic training at Prince of Wales Hospital. Like many Australians at the time, he then moved to the UK for further experience and spent time in Edinburgh. From there, he worked in Holland and felt so comfortable working there that he was soon speaking fluent Dutch and was appointed as a specialist. One of the reasons he was attracted to working in Holland was because at that time, he could practise more pain medicine.

Ian returned to Australia in 2002 and continued practising full-time pain medicine in Newcastle, where he joined the Bone and Joint Institute at Royal Newcastle Hospital.

Ian was an anaesthetist, but also a brilliant pain physician. He explored many aspects of pain medicine, including acupuncture and radio frequency methods. He not only concentrated on physical therapies and interventions and worked closely with disciplines such as psychology and physiotherapy. He was always committed to a holistic approach, working closely with patients to achieve the most ideal result.

There are few things more debilitating for a patient than to suffer chronic unrelied pain. Ian was always supportive and, at the same time, honest about the potential of relief and the possibility that pain may continue. Not every doctor is capable of taking this journey with patients. Ian provided enormous patience and empathy and was careful not to shift the blame to a patient when there was a frustrating lack of progress.

He was not one for the trappings of office, but valued the trust of his patients and the respect of his colleagues. An anaesthetic colleague of mine, wanting to practise pain medicine, spent a sabbatical in many pain centres around the world. On his return I asked him which was the best centre. Without hesitation, he said Ian Painter was the master.

Ian valued his friends and no one was more special than his wife, Jennifer Beckett-Wood. Ian and Jen met while medical students; Jennifer was a well-known and highly respected anaesthetist at the John Hunter Hospital in Newcastle. A lot happened in each of their lives before they re-met, fell in love and married late in life.

It is a great sadness that they didn't have more time together. Ian and Jennifer purchased a farm near Dungog, north of Newcastle. They designed and built a beautiful house and started farming with the same extraordinary commitment that Ian gave to most things in life. Ian completed courses in many aspects of farming and, together with Jennifer, became a respected member of the local farming community.

You would be hard pressed to have been in the presence of two people as much in love as Ian and Jennifer. He had the same warm and committed relationship with his daughter, Rebecca, and his three grandchildren. Jennifer's sister, Sarah, was his "second carer" and a close and integral part of Ian and Jennifer's life.

The last time I saw Ian he was almost totally paralysed, lying in his bed in the early morning sun, chatting like we always had, but he with laboured breathing. And there it was, the expression that was so much part of Ian. He looked sideways, a twinkle in his eye, a slight smile and then the outrageously funny comment. The smile got bigger. Then he said, "you’ve got to go now and I won’t see you again." My wife, Bobbi and I were dismissed.

Courage, pragmatism, honesty, warmth, humour; all features of this very special man.

Professor Ken Hillman
Professor of Intensive Care, Liverpool Hospital, University of New South Wales
Director of The Simpson Centre for Health Services Research, University of New South Wales

Ian Painter was the master.
Dr Jennifer (Jen) Margaret Best
1983-2014

On December 8, against odds that would have overwhelmed most people, Dr Jennifer Best was awarded her FANZCA, just 11 days before she died of cancer, aged 31.

Short in stature, large in character, Jen filled her 31 years with much energy and mischievous fun, balanced with a professionalism and dedication to her work that few could match.

Raised in the Waikato region of New Zealand, Jen completed her secondary schooling at Rangitoto College in Auckland. She worked hard for what she achieved and somehow made it look easy, though it all, she always strove to do her best and learn as much as she could. She gained the Duke of Edinburgh Gold Award in 2000, before embarking on a career in medicine after a Rotary science forum in year 12 confirmed her career goal.

Jen graduated from the University of Auckland Medical School in 2006, as the distinguished Douglas Robb prize winner for academic performance throughout the MBChB program. Along the way she also collected a Senior Prize in Human Biology (2003), the Dean's Award for the top academic scores in the year IV clinical exams (2004) and the SR de la Mare Memorial Prize as the top female student (2005). Despite this, Jen was always humble, instead enjoying successes shared with friends, usually over a “high five”, such as outside the delivery room after her first epidural.

House officer years began in Illenheim, a place where her resourceful knowledge, confidence and natural tendency to leadership allowed her to excel. It was here she also developed a love of great food and wine, and began fostering a passion for preparing gourmet delights. During a week of night shifts at Waiau Hospital she met Neil, and was reportedly the happiest nightshift house surgeon ever seen. Neil shared Jen’s excitement about life, adventures and grand ideas. They made a superb team, encouraging and competing with each other in a hilarious fashion. Jen never thought of herself as short, proven by her belief that she matched up to eye level with Neil.

Jen began her ANZCA training in 2009 at Tauranga Hospital, where she quickly developed a reputation for being clever, confident and dependable. Her interest in anaesthesia was matched only by her passion for cooking and entertaining friends (including murder mystery evenings where guests had to reverse roles and cross dress, such was her cheeky humour). Pain rounds were tackled with vigour, and she still holds a record for epidural steroid injections. Her primary exam success was marked with a shopping “mission” though Melbourne, resulting in a beautiful pair of shoes, which would be worn on her wedding day.

Jen moved to Dunedin, settling in Macandrew Bay with her new husband Neil to complete her training, while renovating their house. It was to become a reflection of their passions, with shelves crammed with cooking books, a small flock of chickens, and a large collection of shoes. It was a product of Jen’s vision and Neil’s energy.

Jen loved active relaxation, and was a keen tramper, though this may have been more about outdoing oneself with decadent but cuisine. Her skill at playing squash had been described as “trying to match a demented bee moving around by your knees”. She always got involved and made stuff happen, and had a unique skill for gathering people around her though her charisma, liveliness, vitality, fun and mischief. She would always be the first to suggest Friday drinks, especially to welcome new people.

She looked out for those around her and within medicine this translated into an interest in teaching. Jen became an NZ Resuscitation Council CORE Instructor, and took it upon herself to guide other anaesthesia trainees through the primary and fellowship exam, and instructed on the Part 1 Course. Jen was active in overseeing the trainees intern’s airway education program in Dunedin, and gained the title honorary clinical lecturer of Otago University. She was much loved by all the anaesthesia and technician colleagues she worked with, and had a leadership quality that motivated and united a a theatre team.

Those who met up with Jen in Singapore at the 2014 ANZCA Annual Scientific Meeting would never have guessed she was illing, as she kept up her signature attention to detail in the shopping precincts. It was a massive shock to learn sooon afterwards she had metastatic disease with aggressive spread, and her life was to be measured in months.

Despite this, she completed her specialist training in December, while undertaking extensive treatments, attaining FANZCA as she moved to Auckland to start a fellowship post in obstetric anaesthesia closer to family. After her diagnosis, she worked harder than ever. This reflected her dedication to being an anaesthetist, relieving others’ pain and suffering, Jen saw this opportunity to make a difference every day as a privilege.

Jen was determined to hang on beyond what seemed physically or medically possible. Despite knowing the horse had bolted from the time of diagnosis, she remained as active as she could, and called the shots until the end, giving it her best fight with science-proven treatments, and retaining her characteristic sense of humour.

We will miss Jen’s boundless energy for adventure, love of a good prank (both receiving and giving) and her intellectual capacity. This enthusiasm and feistiness showed in both her clinical brilliance and professionalism dedicated to bettering the lives of others; her patients, but also colleagues, as a teacher, mentor and friend. To her, the day was complete when her patients were comfortable and safe, her technician appreciated, and junior colleagues supported and well taught, while uniquely also looking out for her seniors. It was clear she valued friendships, making time to share appreciation and joy with us individually, and she will be remembered for that.

Jen, passed away peacefully at home on Friday December 19, after a courageous battle with cancer, surrounded by people who love her – stolen from us too early, just as it would seem she was about to make a real difference in anaesthesia. Daughter of Peter and Trish, she was the adored wife of Neil Barr, and a great friend to many in the anaesthesia community. Rest now, little Jen.

Dr Logan Marriott, FANZCA
Department of Intensive Care, Wellington Hospital