Fighting Ebola: Jenny Stedmon on her time in Sierre Leone

What you told us:
Surveys outline what Fellows want

Research support:
ANZCA divides $A1.5 million for research

Anaesthesia deaths:
Latest ANZCA mortality report out now
Mortality report released

Deaths in anaesthesia from 2009–2011 are explored in the latest edition of the ANZCA mortality report.

National Anaesthesia Day embraced

Hospitals throughout Australia and New Zealand have again supported National Anaesthesia Day and its quit smoking message.

Anaesthetist helps fight Ebola

Dr Jenny Stedmon urges Fellows to volunteer in West Africa to stamp out the deadly Ebola virus.

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

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President’s message

This issue of the Bulletin contains many articles of vital interest to Fellows and trainees including the results of the Graduate Outcomes Survey and the ANZCA Fellowship Survey conducted earlier this year. In addition, we feature the findings of the triennial ANZCA mortality report, Safety of Anaesthesia: A review of anaesthesia-related mortality reporting in Australia and New Zealand 2009-2011.

In November, ANZCA Councillor Vanessa Beavis, Chair of the CPD Committee, the CEO Linda Sorrell, and I attended a workshop on revalidation, convened by the Committee of Presidents of Medical Colleges (COMP). The purpose of the workshop was to determine a consensus set of principles on what revalidation means to the colleges and how it could operate in the Australian context, to refer to the Medical Board of Australia (MBA) for consideration.

The Chair of the MBA has signalled that it will not be introducing revalidation in 2015, although it will be conducting research and setting up an expert panel to make recommendations for a possible model. If you are not sure what revalidation means, I recommend the article in the Medical Journal of Australia by Breen et al.

It should be noted that the Australasian CPD programs of other procedural specialties (for example, surgery, obstetrics and gynaecology and radiology), like ours, also contain elements of practice audit and peer assessment of performance. ANZCA’s program is only unique in having the mandated emergency responses. These have been popular with Fellows – in 2014, 2,469 mandatory responses have already been entered onto CPD online portfolios by 2,396 Fellows.

If you are attending the ASM in Adelaide, please bring your phone, tablet, or laptop. Staff at the ANZCA booth will be on hand if you need help with CPD.

This issue of the Bulletin also contains one of a planned series of articles by private practitioners on how to obtain and enter those elusive practice evaluation points.

ANZCA has successfully launched Networks. Networks delivers online learning including courses, webinars and podcasts and it is also modernising the way of delivering the material through the learning platform.

Fellows and trainees will shortly have access to the trainee orientation and support resources, as well as the supervisor orientation support resources. A primary examination preparation resource has just been launched and I encourage trainees, and Fellows working with trainees preparing for exams, to view this.

I recently attended the Hong Kong College of Anaesthesiologists’ Annual Scientific Meeting and RACS Annual Scientific Congress in Singapore. ANZCA Council has given the go-ahead for another combined meeting with RACS in 2018 to be held in Hong Kong.

While at the Hong Kong meeting, I attended a presentation on the Academy of Medical Royal Colleges’ guideline titled “Safe Sedation Practice for Healthcare Procedures: Standards and Guidance (2013)”. The document recommends fundamental and development standards in safe sedation practice and recommends competency-based formal training for all healthcare professionals involved in sedation.

Fellows may be interested to know that a similar process has already begun in NSW by the Agency for Clinical Innovation (ACI), entitled the Safe Procedural Sedation Project. The underlying principles are risk stratification pre-procedure, a dedicated clinician with appropriate knowledge and skills intra-procedure, and post-procedure monitoring and application of discharge criteria.

A considerable amount of sedation is given by non-critical care specialists in non-operating theatre settings in most hospitals, for example, cardiology and radiology suites, many endoscopy and bronchoscopy suites. These are the areas where such principles would apply to ensure that every patient receiving sedation receives care from individuals who are suitably trained.

I wish you all well for the festive season and hope you manage to spend some time with friends and loved ones over the holiday period.

Dr Genevieve Goulding
ANZCA President

References:
3. http://www.rrsca.ac.uk/revalidation

Awards

Queensland Fellow wins Ray Hader award

A Fellow who compiled a folder full of welfare resources and articles for colleagues while working as a registrar at the Royal Brisbane and Women’s Hospital has won the Dr Ray Hader Award for Pastoral Care.

Dr Anna Hallett, who originally trained and worked as an anaesthetist in England, also presented to colleagues at the hospital about the prevalence of mental illness amongst anaesthetists, the importance of peer support and the existence of the welfare folder. She became Queensland’s first welfare officer while a provisional Fellow at the Queen Elizabeth II Jubilee Hospital in 2014.

She has directly helped at least three colleagues facing difficulties, making her an ideal recipient of the Ray Hader award that recognises those who have made a significant contribution to the welfare of one or more ANZCA trainees in the area of pastoral care.

Recognised for patient safety research

ANZCA councillor Professor Alan Merry was one of 12 New Zealanders elected as Fellows of the Royal Society of New Zealand in October for showing exceptional distinction in research. Professor Merry heads the School of Medicine at Auckland University’s Faculty of Medical and Health Science. He has researched patient safety (particularly in anaesthesiology) and the influence of the law on medical practice.

His work on the conceptual basis of negligence and medical manslaughter has contributed to changes in clinical practice internationally and to legislative changes in New Zealand.

Lifetime achievement for Melbourne anaesthetist

The Chair of ANZCA’s Mortality Sub-Committee and Director of Anaesthesia at the Austin Hospital, Associate Professor Larry McNicol, has received a Victorian Health Lifetime Achievement award for his commitment to the public health system for more than 25 years.

At the awards in October, Associate Professor McNicol was acknowledged as a state and national leader in patient safety and quality of healthcare, including clinical governance in anaesthesia, perioperative care, transfusion medicine and patient blood management.
It has been another busy year for ANZCA as we continue our push towards improving what we offer all ANZCA and FPM Fellows and trainees.

This year we enjoyed an outstanding annual scientific meeting (ASM), preceded by a highly successful FPM Refresher Course Day, in Singapore. The ASM was held with the Royal Australasian College of Surgeons in a Monday to Friday format, the first day given over to workshops.

At the ASM we introduced a new “app” and a new website (the Virtual ASM), which enabled delegates to download the program, view the abstracts and build a personalised schedule. The Virtual ASM allowed anyone access to both audio and slides from nearly all presentations.

Our regional and New Zealand staff supported more than 30 continuing education meetings and more than 40 trainee courses. We also supported several successful special interest group meetings.

We relocated the ANZCA Library and the Geoffrey Kaye Museum of Anaesthesia History within a dedicated knowledge centre as part of the refurbishment of the College’s historic Ulmanna building. The centre includes a new Fellows’ room, which is a space for any Fellows visiting the College.

Almost $34.5 million in research grants was awarded through the Anaesthesia and Pain Medicine Foundation and four new members were recruited to the foundation’s Board of Governors.

In New Zealand, we have been promoting and supporting research in anaesthesia and pain medicine through the inaugural New Zealand anaesthesia research workshop and support of the annual registrar meeting. We also held the inaugural ANZCA meeting for clinical directors of New Zealand anaesthesia departments to enhance communication, understanding and support across the country.

Technology has played a big part in our work this year. We rolled out our world-class continuing professional development (CPD) program with a new online CPD portfolio system and launched Networks, an online system that will greatly improve learning and collaboration opportunities within the College, in particular providing improved support to ANZCA’s many committees and the ANZCA Council.

We made key enhancements to the training portfolio system, including the automation of multi-source feedback, which has saved time for trainee and their supervisors. We also have been developing an online hospital accreditation system, which allows both hospitals and visitors to access their individual data on a streamlined online system.

Online orientation resources to support trainees and supervisors also were launched this year as well as online learning resources for primary examination preparation. Five educational pain medicine podcasts also have been published.

At the beginning of the year we held the inaugural ANZCA meeting for clinical directors of New Zealand anaesthesia departments to enhance communication, understanding and support across the country.

At the annual meeting of the year we held the inaugural annual registrar staff recognition awards to recognise staff who have deployed the highest standards in customer service, innovation, process improvement and teamwork. All ANZCA business units have received service charters to help improve our dealings with key stakeholders.

This year we also surveyed Fellows to find out what matters to them. A full report is on page 16. The annual Graduate Outcomes Survey also has given us workforce data, which is important for our advocacy efforts.

Also this year we reviewed the ANZCA committee structure (see report and chart on page 5), resulting in the creation of a new Professional Affairs Executive Committee (PAEC) to provide oversight for professional and fellowship level issues. The newly named Safety and Quality Committee, Overseas Aid Committee, Continuing Professional Development Committee and Indigenous Health Committee will report to PAEC.

A new ASM and Events Planning Committee will report to me and the IMGS Committee and ANZCA Trainee Committee will report through the educational governance structure.

We also delivered the new ANZCA Project Framework to ensure that ANZCA’s initiatives are delivered in a consistent manner to improve the delivery of successful projects.

FPM has launched its innovative curriculum and training program to be rolled out in 2015 and the online pain management education program “Better Pain Management” for health professionals has been developed.

The FPM Pain Device Implant Registry pilot has advanced with seed funding secured and a wave now completed to collate and manage the data. Stage 1 of the electronic Persistent Pain Outcomes Collaborative (ePOC) has been implemented and an operational model developed.

There is much planned for 2015, but for now I hope you all enjoy a happy and relaxed festive season and I look forward to working towards another successful year.

Linda Sorell
Chief Executive Officer, ANZCA
It is increasingly common for meetings to acknowledge the local traditional owners of the land on which the meeting is held. The public acknowledgement is said to contribute by:

• Recognising and paying respect to indigenous peoples, cultures and heritage.
• Affirming indigenous cultures are living, dynamic entities.
• Assisting to build relationships and partnerships.

This issue was discussed at the September meeting of the Indigenous Health Committee, which firmly supported the principle of acknowledging traditional owners. Such an acknowledgement is in line with ANZCA’s 2013-17 Strategic Plan, which includes to “advocate for community development with a focus on indigenous health and overseas aid”.

The ANZCA Council has supported this recommendation from the Indigenous Health Committee, and will incorporate a formal acknowledgement of the traditional owners of the land in the opening formalities of each council meeting.

Dr Rod Mitchell, Dr Dash Newington and Dr Paul Mills
ANZCA Indigenous Health Committee

College to acknowledge traditional owners

The concept of installing an appropriately inscribed plaque in each of the ANZCA regional and national offices was also supported.

There is no universally accepted wording for the acknowledgement, but the following will be adopted for Melbourne council meetings and regional office plaques, respectively.

Council: “We would like to acknowledge the peoples of the Kulin nation as the traditional owners of this land, and we pay our respects to their elders, past and present.”

Plaques: “ANZCA acknowledges the (relevant nation dependent on where the ANZCA office is) as the traditional owners of this land, and pays respect to their elders, past and present.”

A plaque with similar and regionally appropriate wording will be displayed in the New Zealand National Office.

This year ANZCA and FPM has featured in a wide range of media across our core areas of expertise – from chronic pain management and the latest research showing the possibility of its genetic links – to research into accidental anaesthesia awareness.

At the time of printing the December Bulletin, the Communications unit has created and distributed 28 media releases (including two media alerts), resulting in about 3000 print, TV, radio and online articles. The work of ANZCA and its Fellows reached an estimated combined cumulative audience of more than 10 million readers, viewers and listeners (50,006,795) according to ANZCA’s media monitoring service iSentia.

Highlights since the last Bulletin include an exclusive report on National Anaesthesia Day in the Herald Sun. The story focused on a recent trial that involved collecting the smoking status of every patient across seven healthcare sites in Australia. The Faculty of Pain Medicine’s Professor Milton Cohen was part of an expert panel on the SBS television program Insight, which debated the role of medicinal cannabis. Associate Professor Andrew Davidson also participated in an SBS Insight program on the topic of consciousness, part of which focused on our understanding of anaesthetic depth.

The reopening of the Geoffrey Kaye Museum of Anaesthetic History featured in a prominent Fairfax newspaper article (The Age, circulation 240,000) on Saturday, September 20. This coverage was followed by two ABC radio interviews on the significance of the ANZCA collection.

Ebru Yaman
Media Manager, ANZCA

In 2014 ANZCA has featured in:
• More than 90 print reports.
• More than 300 radio reports.
• Fifty-one television reports.
• More than 500 online stories.
Hospitals embrace National Anaesthesia Day

Throughout Australia and New Zealand – and as far away as Boston, Massachusetts in the US where the first ether anaesthetic was given on October 16, 1846 – ANZCA Fellows again embraced National Anaesthesia Day.

This year the theme was “Stop smoking before your anaesthetic”, coinciding with the release of ANZCA’s PS12 Guidelines on Smoking as Related to the Perioperative Period (see www.anzca.edu.au/resources/professional-documents). This professional document encourages anaesthetists to embrace the “teachable moment” when smoking patients are in hospital and thinking about their health to encourage them to stop smoking. Research shows this works and it’s never too late to quit – even 24 hours makes a difference.

More than 200 National Anaesthesia Day kits were sent to hospitals, private clinics and other health services on the ANZCA database as well as regional/NZ offices and all ANZCA councillors. The kits contained:
- “Stop smoking before your anaesthetic” posters.
- National Anaesthesia Day balloons.
- PS12 Guidelines on Smoking as Related to the Perioperative Period.
- “Stop smoking before your anaesthetic” leaflet (downloadable from website).
- “Who is your anaesthetist?” poster (downloadable from website).

The phrase “Anaesthetists – caring for the body and its breath of life”, a translation of the ANZCA coat of arms motto “Corpus curae spirittumque”, was included on the posters for the first time this year and will be included in future years.

Auckland strongly embraced the day again with staffed booths displaying equipment, mannequins, posters, balloons and information leaflets set up throughout the Auckland City Hospital system, including Stanhope Children’s Hospital, National Women’s Hospital, the Greenlane Surgical Centre and various departments. Anaesthesia staff also organised hands-on public activities, such as ventilating “patients” and using ultrasound, and gave helium-filled balloons to children.

At an Auckland District Health Board smoke-free booth, set up to coincide with National Anaesthesia Day activities, patients could measure their carbon monoxide levels and compare how these differ between smokers and non-smokers. A video clip showed the patient’s journey through an operation.

New Zealand Health Minister Dr Jonathan Coleman visited the displays at Auckland City Hospital.

Many hospitals participating in 2014 National Anaesthesia Day advised the College about their activities. DHBs, for example, set up a foyer display where patients could talk about smoking and its perioperative implications and staff gave demonstrations on giving an anaesthetic. Later, hospital staff held a symposium about the history of anaesthesia and held a quiz, followed by a dinner.

Many other hospitals had staffed foyer displays, including Dunedin Hospital in New Zealand, which displayed an anaesthetic machine and ultrasound equipment and gave the public the opportunity to talk to anaesthetists.

Other participating hospitals included St Vincent’s in Melbourne, Alfred Health (including Alfred Hospital), Peter MacCallum Cancer Centre, Austin Health, Box Hill Hospital, Bendigo Health, Goulburn Valley Health in Shepparton, Northern Health in Epping, Towner’s Hospital, Tamworth Hospital, Lismore Base Hospital, John Hunter Hospital in Newcastle, Gosford Hospital, Alice Springs Hospital and in WA, Sir Charles Gairdner, Joondalup, Rockingham hospitals, and the new Fiona Stanley Hospital. In New Zealand, the College was contacted by Middlemore, Tauranga and Wellington hospitals. The Davis St Anaesthetic Practice in Melbourne also asked for material.

ANZCA’s Communications team is now working towards 2015 National Anaesthesia Day, which will focus on the growing obesity problem and its impact on anaesthesia.

Key messages for patients

Smoking and anaesthesia

If you are having an anaesthetic for surgery you face greater risks if you are a smoker.

- You face more complications during and after your operation.
- Your body is starved of oxygen.
- It is more difficult for you to breathe during and after surgery.
- You can lead to blood clots.
- You will have more trouble recovering.

The good news is that it is never too late to quit – even stopping just 24 hours before your operation helps, but the longer the better.

- After 24 hours, your blood pressure improves and more oxygen reaches your heart.
- After 1 week, your lungs are better at removing mucus, tar and dust.
- After 3 to 4 weeks, your body is better at fighting wound infections.
- Quitting 6-8 weeks before surgery improves your lung function.

Hospitals can support patients to stop smoking in preparation for their operation.

Clearing before your anaesthetic – every day makes a difference

Clearing before your anaesthetic – every day makes a difference
Hospitals embrace National Anaesthesia Day (continued)

“...a model for boosting US awareness

One of the factors that drew me to undertake a Clinical and Research Anaesthesia Fellowship in Boston, Massachusetts was the integral part the city plays in the history of our specialty. In America, October 16 is known as Ether Day to commemorate the famous first public demonstration of inhaled anaesthesia in 1846.

It wasn’t until a few months into my fellowship that I discovered I walked past the Ether Monument daily on my commute to work. One of the inscriptions reads: “To commemorate the discovery that the inhaling of ether causes insensibility to pain. First proved to the world at the Mass. General Hospital in Boston AD MDCCCXLVI.”

Jennifer Ameis, FANZCA
Brigham and Women’s Hospital, Boston, Massachusetts, US

National Anaesthesia Day a model for boosting US awareness

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Brigham and Women’s Hospital, Boston, Massachusetts, US

Smokefree project helps patients quit

A simple change to hospital admission and discharge protocols could dramatically reduce smoking rates among smokers, a project piloted across seven hospitals and health services has shown.

Seven sites across Victoria took part in the Supporting Patients to Be Smokefree Project, which collected data from December 2013 to June 2014. The project is based on New Zealand’s policy of mandatory asking, recording and reporting the smoking status of every patient admitted to hospital.

Sites involved in the project, which was led by Alfred Health and funded by the Victorian Government, included Ballarat Health Services, Bendigo Health, Goulburn Valley Health, Albury Regional Health, Northeast Health Wangaratta, South West Healthcare and Western Health.

The initiative aimed “to ensure all people who accessed the Victorian health system had their smoking identified and were supported with at least a brief intervention response” such as information about quitting and nicotine replacement therapy.

This is in keeping with ANZCA’s Pinz document, guidelines on smoking that state “ANZCA ... recognises that the perioperative period represents a ‘teachable moment’ when many smokers quit or attempt to quit smoking, sometimes permanently”. The guidelines were released to coincide with National Anaesthesia Day on October 16, which had the theme “Stop smoking before your anaesthetic”.

National Anaesthesia Day aimed to spread the simple message that it is never too late to stop smoking before an operation to reduce your risk of surgical complications.

Anesthetist Dr David Bramley, the deputy director of the department of anaesthesia and pain medicine at Western Health, said it should be mandatory for hospitals to ask all patients about their smoking status and to offer advice and support to stop smoking as early as first presentation.

“Anesthetists care for patients before, during and after surgery. Helping them stop smoking is one of the many things we can do to improve both surgical and general health outcomes,” Dr Bramley said.

“An individual’s surgical journey often involves multiple visits to hospital, which gives us a perfect opportunity to educate patients and support them to stop smoking. Asking patients if they smoked at pre-admission, arming them with facts and linking them to appropriate supports can help cut smoking rates.

“People are very vulnerable at the time of surgery and are more likely to make decisions that will help their recovery.” Smokers run an increased risk of cardiac and respiratory complications during their operations and are more likely to suffer poor healing and wound infections, Dr Bramley said.

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“People are very vulnerable at the time of surgery and are more likely to suffer poor healing and wound infections, Dr Bramley said.

“There are lots of opportunities to intervene – every year more than 300,000 smokers undergo elective surgery in Australia and New Zealand,” he said.

“Anesthetists have a powerful role to play in reducing smoking rates and improving the health of the population.”

While Western Health is still analysing data from the pilot, Dr Bramley said half the patients involved were smoking less at the time of their surgery than when they presented to the pre-admission clinic. One in four smokers took up the offer of free nicotine patches.

Ebru Yaman
Media Manager, ANZCA

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New health minister for NZ

New Zealand

New Zealand’s 51st parliament opened on October 21, following the September 20 general election. The National Party received 47 percent of the party vote, and has 60 of the 121 seats in parliament. Dr Jonathan Coleman has been appointed as Minister of Health, and also holds the Sport and Recreation portfolio. Dr Coleman is medically qualified, has previously worked as a general practitioner, and was an associate minister of health from 2008-11.

There have been no real surprises with the National Party’s health policies. Many of the initiatives are business as usual, or were announced in May 2014, alongside the budget, including investing $90 million to extend free GP visits and prescriptions to children under 13 years of age, and investing $40 million to roll out Healthy Families New Zealand, a community-based program to promote nutrition and physical activity.

A key policy that will affect anaesthesia and pain medicine will be further increases in elective surgery and joint replacements. As part of a strategy to reduce musculoskeletal pain, $44 million will be invested in delivering an extra 2500 orthopaedic operations and an extra 1500 general elective operations over the next three years. This is in addition to usual increases in orthopaedic operations. Also, $6 million will be invested in establishing primary-care based teams for the early intervention of patients with musculoskeletal conditions, to assist with pain management. The teams will be co-ordinated through general practice and will link with hospital services, including pain medicine services. Other policies include investing $4 million to establish a National Renal Transplant Service, with the aim of increasing live kidney donor transplants by 10 per year over four years; training specialist nurses to perform endoscopies; and the Accident Compensation Corporation’s (ACC) focus on moving long-term claimants off ACC.

The Vulnerable Children’s Act will be implemented, introducing new requirements for district health boards (DHBs) and health practitioners who work with children. Under the act, DHBs must adopt and report on child protection policies, and health practitioners who work with children will undergo safety checks. Prime Minister John Key also has signalled to the media that child poverty will be a priority, and has asked Treasury and the Department of Prime Minister & Cabinet to develop policy in this area.

The government also will aim to progress the Trans-Pacific Partnership Agreement (TPP) with the US, Japan, Australia and other Asia Pacific countries. Concerns have been raised that the TPP may impact on New Zealand’s ability to legislate and regulate public health issues such as tobacco and alcohol, and may affect Pharmaco’s ability to purchase low-cost pharmaceuticals. However, the likely content of the TPP is not known at this stage.

Meetings

In September, ANZCA representatives met with Health Workforce New Zealand (HWNZ) and other organisations, including the NZ Society of Anaesthetists, the NZ Anaesthetic Technicians’ Society, the Medical Sciences Council of NZ, the Perioperative Nurses College and others, to discuss the assistant to the anaesthetist workforce. It was noted that there is a shortage of assistants to the anaesthetist workforce. However, the likely content of the TPP is not known at this stage.

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On October 22, the Medical Council of New Zealand (MCNZ) held its annual meeting for Vocational Educational Advisory Bodies. MCNZ presented a draft Memorandum of Understanding between MCNZ and the colleges, ANZCA will be invited to formally consider and provide feedback on the draft document. MCNZ also provided an update on changes to pre-vocational training for postgraduate year one and year two doctors. The MCNZ has approved standards for accreditation of training providers and clinical attachments, and training providers are expected to meet the standards by November 2015.

Regular practice review also was discussed. Although not mandatory for vocationally registered specialist doctors, it must be an optional component of CPD programs. It is mandatory for general registrars, most of whom are participating in the “back in practice” continuing professional development (CPD) program, but some of whom participate in ANZCA’s CPD Program.

Submissions completed:

Australia:

- Australian Health Ministers’ Advisory Council on the Review of the National Registration and Accreditation Scheme for health professions.
- Australian and New Zealand Intensive Care Society Statement on care and decision-making at the end of life for the critically ill.
- Medical Board of Australia on proposed guidelines for the regulatory management of registered health practitioners and students infected with blood-borne viruses.
- Thoracic Society of Australia and New Zealand on Oxygen Guidelines for Acute Oxygen use in Adults “swimming between the flags”.
- Coroners Court of Victoria on:
  - Tramadonal Oral Drops.
  - Opioid abuse.
  - Management of airways in the obese patient.

New Zealand:

- Australia and New Zealand College of Perfusionists, in support of its application for regulation under the HPCA Act 2003.
- Medical Council of New Zealand on:
  - Registration prerequisites for doctors who have obtained registration through NZREX Clinical.
  - Review of locum tenens approved qualifications list.
- Medical Sciences Council of New Zealand on Guidelines for the professional relationship between anaesthesia technicians and anaesthetists.
- Pharmaco on the 2014/15 invitation to tender.
- Congratulatory letters to the incoming Minister of Health from the ANZCA New Zealand National Committee and the FPM New Zealand National Committee.
Overall satisfaction with ANZCA

Overall perceptions of ANZCA are positive (79 per cent rate it as good or very good); nonetheless, they could be improved (15 per cent rate ANZCA as average, 6 per cent give a negative rating).

Increasing the perceived personal relevance of ANZCA to those who are less satisfied is a key. Some concerns about ANZCA’s workforce management, strategy and direction have an impact on overall attitudes.

ANZCA is overwhelmingly perceived to be a professional organisation, as well as reputable and credible. However perceptions it is bureaucratic have increased since the 2010 survey and could be addressed.

ANZCA’s annual subscription fee

2010 survey: 62% Fair & reasonable + acceptable; 29% Too high. 2014 survey: 56% Fair & reasonable + acceptable; 29% Too high.

Fifty-six per cent regard the annual subscription as acceptable or fair and reasonable. This has dropped slightly from 62 per cent in 2010.

World-class training program

Most Fellows (86 per cent) strongly or slightly agree that ANZCA delivers a world-class training program. Only a small minority slightly/strongly disagree (5 per cent).

In 2014, ANZCA commissioned Acuity Research & Insights to undertake a quantitative research study among Fellows. This follows on from the benchmark ANZCA Fellowship Study conducted in 2010. After a long consultation period, new questions were introduced, a few removed and the scale was changed to a more conventional structure.

A total of 5,561 surveys were delivered via email and 5,841 by hard copy. Between August 11 and September 19, 2014, 2,153 Fellows completed the survey – 1,416 were completed online and 732 were completed hardcopy – resulting in more than a one in three response rate, representative of the membership across all demographic data. Acuity provided a very thorough report and the key points in each area surveyed are presented in the next few pages.

Perceptions of ANZCA across all Fellows

Mean score 4.0 out of 5.0.

Very good + Good: 79%
Not good + Poor: 6%
24% 15% 4% 2%
24% 55% 15% 4% 2%
ANZCA’s image: Word associations

Top 10 award associations with ANZCA.

Professional: 86%
Reputable: 75%
Creditable: 65%
Quality: 49%
Expert: 45%
Accessable: 42%
Relavent: 39%
Valuable: 32%
Conservative: 31%

ANZCA delivers world class training program

2014 results across all Fellows.

Agree: 86%
Disagree: 5%
Strongly agree: 61%
Slightly agree: 25%
Neither agree nor disagree: 7%
Slightly disagree: 3%
Strongly disagree: 2%
Remainder is unsure.
Roles and services
Fellows clearly see core roles of importance as the “ANZCA training program” (93 per cent rate this as essential or very important to the profession) and “quality and safety standards” (also 93 per cent).

There are sizable perceived importance-performance role gaps for “workforce advocacy”, “representations and submissions to government” and “media profile of the organisation”. Results suggest that given the degree of importance Fellows place on these ANZCA roles, there is room to improve their perceptions of ANZCA performance.

Continuing professional development
Forty-nine per cent of Fellows do not find the revised CPD program easy to use, more than those who rate it as easy to use (44 per cent). In fact, 17 per cent of Fellows are rating the revised program as difficult. This needs to be addressed.

Locally organised CPD events
While a majority (64 per cent) of Fellows find the locally organised continuing medical education/continuing professional development events useful, one in four rate them as not useful (25 per cent) – a sizeable minority.

Usefulness of locally organised events

Voluntary roles
More Fellows have undertaken a voluntary role within ANZCA than seen in the 2012 survey (now at 99 per cent compared with 95 per cent in 2012). Among those who have undertaken voluntary roles, the most frequently reported involvement is as a lecturer (28 per cent), followed by as a supervisor of training (21 per cent), organiser (18 per cent) and committee or council member (17 per cent).

Publications and communications
Among those who rate all such publication, satisfaction is highest with Acute Pain Management: Scientific Evidence (mean score 4.3), Australasian Anaesthesia (4.1), and Safety of Anaesthesia in Australia (4.0). When reach/readership is taken into account, satisfaction is relatively highest with Australasian Anaesthesia (78 per cent rate it as very good or good).

Involve in developing countries
Sixty-six per cent of Fellows would like a separate email on continuing medical education/CPD events in their region: the top three most popular are in Australasia (72 per cent), South Asia and Indonesia (72 per cent) and NZ only: NZ only (70 per cent).

Involvement in developing countries
Nine per cent of Fellows are currently involved in clinical/education work in developing countries; and in the past, 22 per cent have been involved. Pacific Islands, South-East Asia and Indonesia are the three main areas where Fellows are or have been involved.

Email communication
A strong majority of Fellows (93 per cent) say the current amount of ANZCA email communications is about right – only small minorities say it is either too little (5 per cent) or too much (6 per cent).

Forty-two per cent rate the ease of finding key information within ANZCA email communications as very good/good; few (7 per cent) give a negative rating.

Voluntary roles undertaken within ANZCA
A total of 59% of Fellows indicate they have undertaken voluntary roles within ANZCA.
Contact with staff
One in two Fellows has been in contact with College staff. More recent Fellows, researchers and academics are more likely to have had contact with College staff. Fellows’ experience with College staff is generally positive.

Experience with College staff
Among the 54% who have had contact. Mean score: 4.1 out of 5.

<table>
<thead>
<tr>
<th>Experience</th>
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<tbody>
<tr>
<td>Very good</td>
<td>36%</td>
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<tr>
<td>Good</td>
<td>45%</td>
</tr>
<tr>
<td>Average</td>
<td>14%</td>
</tr>
<tr>
<td>Not good</td>
<td>2%</td>
</tr>
<tr>
<td>Poor</td>
<td>2%</td>
</tr>
</tbody>
</table>

Understanding of College roles and responsibilities
There has been an increase in the proportion of Fellows who feel very/quite well informed about these issues, compared to 2010.

ANZCA roles and responsibilities: Trends

<table>
<thead>
<tr>
<th>The roles &amp; responsibilities of the ANZCA Council</th>
<th>% Very/Quite well informed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>39%</td>
</tr>
<tr>
<td>2014</td>
<td>45%</td>
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</table>

<table>
<thead>
<tr>
<th>The roles &amp; responsibilities of committees and special interest groups</th>
<th>% Very/Quite well informed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>64%</td>
</tr>
<tr>
<td>2014</td>
<td>69%</td>
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</table>

<table>
<thead>
<tr>
<th>How to participate in these forums if interested</th>
<th>% Very/Quite well informed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>36%</td>
</tr>
<tr>
<td>2014</td>
<td>39%</td>
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</table>

Non-retired Fellows are engaged on average 36.6 hours per week in anaesthesia service. Fellows prefer to work slightly fewer hours (34.5 hours per week) than the current average hours worked.

Clinical practice

What is working now - and in the future
Most new Fellows are finding work soon after completing training but many are not working where they would like to be, the 2014 Graduate Outcomes Survey has told us.

The survey, established to help both ANZCA understand the needs of new Fellows when interacting with government, education and training providers and others, is also aimed at identifying how ANZCA can assist new Fellows with their training, practice and professional development. While much information was obtained via the survey itself, New Fellow Councillor Dr Craig Coghlan also spoke to 100 randomly selected new Fellows and was able to gather qualitative data on workforce issues facing new Fellows in 2014.

This experience was also extremely helpful in correlating the “real world” with the data obtained through the survey. The quantitative data obtained on the phone and the data obtained and analysed through the survey complemented each other. Some of the key conclusions that can be made from both the survey and phone calls were:

- The majority of new Fellows enter the workforce within the first year of completing their training.
- A significant number do not obtain employment of their choice initially but within three years this becomes less of an issue.
- Most believe there are adequate job opportunities now but there will be a problem in the future.
- A quarter of new Fellows grew up in regional or rural areas but fewer than one in 10 will return to a regional or rural area to work as a specialist anaesthetist.
- There is a consistent concern about job security associated with appointed positions.
- There is a consistent concern about job security associated with locum, short-term or visiting medical officer (VMO)-

ANZCA next steps are to develop a plan of recommended actions and activities. It will be through this plan that issues will be addressed and measurable outcomes put in place. New Fellows will be encouraged to influence solutions and to support recommendations. The plan and the recommendations will be promoted to the Fellows through ANZCA’s publications and website.

Thank you again to all the new Fellows who participated in the 2014 Graduate Outcomes Survey.

Dr Craig Coghlan, FANZCA
New Fellow Councillor, ANZCA

Key findings
Below is a snapshot of the key findings from the 2014 Graduate Outcomes Survey:

- Satisfaction with all aspects of anaesthesia training is comparable to 2013 survey results – training relevance (86 per cent excellent/very good); practical experience (82 per cent); how well training prepared them for practice (76 per cent). Satisfaction with supervision received was 71 per cent and quality of ANZCA service 62 per cent.
- Similar to 2013, the great majority have entered the workforce and are regularly providing anaesthetic services – 89 per cent of graduates say they have entered the workforce and of those 95 per cent are providing services on a regular basis and most (92 per cent) are working in Australia.
- The reported average hours worked per week has increased slightly from 38.2 hours in 2013 to 39.5 hours in 2014.
- Satisfaction with hours worked has slightly increased from 30 per cent in 2013 to 70 per cent in 2014.
- There is still concern, yet some improvement, that there are sufficient career opportunities in Australia, up from 38 per cent in 2013 to 50 per cent in 2014; the proportion of graduates who feel confident that there will be quality options in locations they want to work increased from 43 per cent in 2013 to 48 per cent in 2014 (but 19 per cent strongly disagree with this) and 75 per cent would still recommend anaesthesia as a career.
- Very few graduates (8 per cent) plan to move to a rural or regional area.

(continued next page)
What is working now – and in the future (continued)

Entering the workforce

Of the 432 participants of the 2014 survey, 197 had also completed the 2013 survey:

• In the 2014 survey more of these graduates had entered the anaesthesia workforce, that is, 97 per cent of these graduates had started working, up from the 2013 result (90 per cent). The increased proportion was particularly seen amongst those who completed their training in 2013 (96 per cent have entered workforce, up from 80 per cent).

• The reported average hours engaged in anaesthesia work per week increased slightly from 37.7 hours to 40.2 hours. There was a higher proportion of these graduates who were doing 41–50 hours (up from 23 per cent to 33 per cent) and significantly fewer working 31–40 hours (down from 42 per cent to 32 per cent).

• Satisfaction with hours worked was fairly comparable between the two surveys. There was a slightly increased number wanting fewer hours (up from 10 per cent to 14 per cent). Fewer graduates who completed training in 2012/2013 wanted more working hours.

• In regard to lower paid/unpaid clinical work; in 2014, 88 per cent stated they were not doing any low paid/unpaid clinical work, whereas in 2013 this was only 76 per cent. The shift has come from those who completed training in 2013 (73 per cent to 90 per cent) and 2012 (69 per cent to 83 per cent).

• There is improving confidence in Australian job opportunities. Among graduates practising in Australia, more felt confident there would be quality career opportunities within Australia in the future (up from 40 per cent last year to 50 per cent).

Longitudinal analysis

Attitudes to future employment prospects

<table>
<thead>
<tr>
<th></th>
<th>2013 survey</th>
<th>2014 survey</th>
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<tbody>
<tr>
<td>Among New Zealand-based</td>
<td>80%</td>
<td>81%</td>
</tr>
<tr>
<td>Among Australian-based</td>
<td>72%</td>
<td>74%</td>
</tr>
<tr>
<td>% Agree a lot/agree a little</td>
<td>65%</td>
<td>62%</td>
</tr>
</tbody>
</table>
Ethics can be the final arbiter when judging patient safety and quality of care.

“Good morning doctor” is the greeting you get from your anaesthesia assistant as you enter the new endoscopy suite to start the all-day list with 22 patients booked. Having worked with the endoscopist at the local public hospital and developed a good relationship you have been invited to provide anaesthesia services for a regular new session every fortnight at his new endoscopy facility, which is registered but not accredited. He has a very busy practice.

Your anaesthesia assistant introduces you to the anaesthesia machine, which is an old “relic” (Anaes Lessaurus Rex) that is still in good working condition but is clearly not compliant with the current College statement.

What would you do?

While there are numerous “solutions” that could be considered, it is interesting to ponder the issues. At one end of the spectrum would be to proceed with the list despite the absence of a compliant machine with the tempting argument that there was a grace period before the introduction of the new requirements.

Another course of action would be to cancel the list until the problem was addressed. Maybe the ideal would have been to visit the facility in advance so as to review the anaesthetising location and recovery areas and provide guidance in the lead up to ensure that anaesthesia requirements are met.

In the first case, invoking the rationale that there was an extended grace period to allow these machines to be used until such time that they could be replaced may be entertained by some as a reason to continue (temporarily).

What about the second option of cancelling all the patients? All 22 patients have had their bowel prep and are likely to get the gripes from being cancelled, as well as from their bowel prep. What action is in the patients’ best interests? Rationalising on the basis that sedation is being provided and patients will be receiving oxygen by mask as opposed to the anaesthesia machine may be tempting.

In the third option involving a prior visit to the facility, there may be resistance or flat refusal to invest in the necessary equipment. What then? Patients may still be booked and another “seditionist” engaged. What is our responsibility in this case?

No doubt, there are multiple variations on the above themes but the final common pathway that should direct our actions will be based on ethics, and applying ANZCA’s mission statement in regard to promoting safety and quality care. This article is not intended to provide the “right answer” but rather to guide Fellows to the relevant College documents designed to assist in coming to the most appropriate decisions, taking each case on its merits.

In the above scenario the relevant documents include:

- Code of Professional Conduct – with specific reference to sections 1, 2, and 8.
- PS54 Statement on the Minimum Safety Requirements for Anaesthetic Machines and Workstations for Clinical Practice.
- PS55 Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations.
- PS26 Guidelines on Consent for Anaesthesia or Sedation.

One might expect that a response to the above case would be fairly uniform and consistent, but that has not been the case.

Dr Peter Roessler
ANZCA Director of Professional Affairs (Policy)

Professional documents – update

The professional documents of ANZCA and FPM are an important resource for promoting the quality and safety of patient care for those undergoing anaesthesia for surgical and other procedures, and for patients with pain. They provide guidance to trainees and Fellows on standards of anaesthetic and pain medicine practice, define policies, and serve other purposes that the College deems appropriate.

Professional documents are also referred to by government and other bodies, particularly with regard to accreditation of healthcare facilities.

Professional documents are subject to regular review and are amended in accordance with changes in knowledge, practice and technology.

Definitive versions of the following documents are now available:
- PS12 Guidelines on Smoking as Related to the Perioperative Period.
- PS31 Guidelines on Checking Anaesthesia Delivery Systems.
- PS42 Statement on Staffing of Accredited Departments of Anaesthesia.
- PS57 Statement on Duties of Specialist Anaesthetists.

Queries or feedback regarding professional documents can be directed to profdocs@anzca.edu.au.

The complete range of ANZCA professional documents is available via the ANZCA website, www.anzca.edu.au/resources/professional-documents.

Faculty of Pain Medicine professional documents can be accessed via the FPM website, www.fpm.anzca.edu.au/resources/professional-documents.
Supporting Anaesthetists’ Professionalism and Performance – a guide for clinicians

What is professionalism? Is it what a good doctor does, how a good doctor behaves? And how do we know this? It used to be that it was assumed that we’d pick it up in our training by osmosis from our guides and mentors while we were being taught the medical expert roles, such as diagnosis of heart failure. However, teaching was sporadic, and our mentors and guides weren’t always the best examples to follow.

The medical landscape is changing with increasing expectations regarding transparency and accountability regarding the performance of medical practitioners. We are required to demonstrate high standards of performance to our patients, colleagues, organisations with whom we work and the wider society in general.

To help our Fellows and trainees understand how a good doctor behaves, ANZCA has developed a framework for anaesthetists (the guide). The guide has been structured to mirror the ANZCA Roles in Practice. Four “patterns of behaviour” are identified under each role and each pattern of behaviour is illustrated by a set of eight “behavioural markers”. These examples of good and poor behaviour are readily observable and can be used to describe standards of performance in the clinical workplace.

ANZCA’s guide is based on the RACS Surgical Competence and Performance Guide and the RACP Supporting Physicians’ Professionalism and Performance Guide, and was “anaesthetised” by an ANZCA working party, consisting of myself (chair, anaesthetist NZ and ANZCA Executive Director of Professional Affairs), Dr John Biviano (previous ANZCA General Manager, Policy), Dr Liz Fenney (anaesthetist, NSW), Dr Ian Graham (ANZCA Dean of Education), Dr Jodie Graham (anaesthetist, WA), Mr Oliver Jones (General Manager, ANZCA Education Unit), Dr Rod Mitchell (anaesthetist, SA), Dr Peter Roessler (anaesthetist, Vic and Director of Professional Affairs, Policy) and Ms Linda Sorrell (ANZCA CEO).

Dr Graham was involved in the development of the RACS and RACP guides, and his facilitation of ours was of great benefit to us. We’re also grateful to RACS and RACP for agreeing to allow ANZCA to use their guides to help develop our own.

The RACS guide was described as a framework to assess the performance of practicing surgeons, either self assessment or assessment by colleagues and co-workers. ANZCA’s guide has been developed with more general aims; while it can be used for assessing an anaesthetist’s performance, it can be more properly considered as a very practical description of behaviours.

For example, if an anaesthetist is considering undertaking a new technique, such as a new nerve block, there is guidance under ANZCA Role in Practice “Medical Expert” pattern of behaviour “demonstrating medical skills and expertise”, in which good behaviour includes “goes through appropriate processes when learning a new technique, for example, visiting an expert, training or mentoring”, and poor behaviour includes “introduces new technology or procedures without adequate consultation”.

When considering what makes a good team player, there are multiple behaviours listed. In ANZCA role “Collaborator”, pattern of behaviour “establishing a shared understanding”, good behaviour includes “encourages input from members of the team including junior medical staff and nurses”, while poor behaviour includes “fails to explain the rationale for decisions to other team member”.

What makes a good leader? Leadership is covered under ANZCA role “Manager”, pattern of behaviour “leadership that inspires others”. Good behaviours include “remains calm under pressure, working methodically towards effective resolution of difficult situations”, and poor behaviour “blames others for errors and does not take personal responsibility”.

The examples above can be used as practical examples of how to behave, and serve as a focus for trainees’ and Fellows’ aspirations, educational meetings, as well as a focus for self assessment or assessment by others.

The draft document has been accepted by ANZCA Council, and is now being circulated for comment.

Dr Leona Wilson, FANZCA
Chair, Professionalism Expert Group
Stedmon does not believe any person should be forced to go to into the hard-hit countries of Sierra Leone, Liberia or Guinea. Nevertheless she believes that more ANZCA Fellows – “well-rounded doctors” – should be encouraged to volunteer a short stint of their time to help control the latest outbreak of the disease.

“They specifically asked for anaesthetists among the groups of volunteers they were looking for,” Dr Stedmon said. Anaesthetists, she said, were in demand because of their range of skills.

Dr Stedmon has worked as a volunteer with the Red Cross in countries affected by natural disaster and war for the past 20 years. Most recently she volunteered as part of the relief effort after the deadly Typhoon Haiyan devastated parts of the Philippines in November last year.

But all of Dr Stedmon’s 20-plus years of Red Cross volunteer aid work did not prepare her for the storm of misinformation and controversy she found on her return to Australia in September.

“It wasn’t like that before I left,” Dr Stedmon said. She likens “Ebola hysteria” in affluent countries such as Australia to the lack of awareness about Aids in the 1980s – where people were often cruelly and unnecessarily discriminated against if they were HIV positive, as were those who worked with them.

“With Ebola we are seeing all the stigma again and the lack of information that creates it,” Dr Stedmon said. The likelihood of an outbreak in Australia was “minimal” – Australia does not face the same desperate poverty as West African countries; the average person’s health and immune system is not as compromised as those living in the developing countries worst hit by the Ebola virus.

We need to stop Ebola in its tracks in Africa – it is spreading,” she said. “We can do that by sending our experience and expertise to establish protocols to assist in isolation units and support local health care workers. But by treating people like lepers when they come home we are putting people off volunteering at all.”

Each volunteer to a country with an Ebola outbreak is subject to a 21-day quarantine period when they return home and are released from quarantine when they show no symptoms after that period. “Ebola is a pathetic virus, if it’s on the skin it is killed by soap and water,” Dr Stedmon said.

“Alcohol wipes, chlorine – the staple of antiseptics – are enough, it is easy to stop its spread.

“The problem in combating Ebola in African countries is lack of access to clean water and the overcrowding of hospitals – not only are they not treating anything else (but Ebola) but there isn’t the room to allow the 1.5 metre separation needed to help contain the spread.”

Dr Stedmon believes Australia could learn from Sierra Leone’s example of spreading the word about Ebola – information and awareness to counter myth and promote safe practices.

“In Sierra Leone they have gone about education in a different way than we have – if they can do it why can’t we? They have an Ebola song – it plays on the radio frequently which is a very effective way of reaching a significant number of people as most people have or can listen to a radio.”

There also are posters pasted on to the bonnets of cars and a concerted effort to increase awareness of how every individual can reduce the spread of infection.

“You think that we would do that here.” The physical strain of working in an Ebola centre is not to be underestimated but the countries most affected by the virus need Australia’s help. It is by offering that help we have the best hope of stopping the spread of the disease, Dr Stedmon said.

“If we want to stop Ebola killing more people or spreading outside of the African countries where it is a problem we need to help those countries to stamp it out.”

Ebru Yaman
Media Manager, ANZCA
What is Ebola?

Key facts

- Ebola virus disease (EVD), formerly known as Ebola haemorrhagic fever, is a severe, often fatal illness in humans.
- The virus is transmitted to people from wild animals and spreads in the human population through human-to-human transmission.
- The average EVD case fatality rate is around 50 per cent. Case fatality rates have varied from 25 per cent to 90 per cent in past outbreaks.
- The first EVD outbreaks occurred in remote villages in Central Africa, near tropical rainforests, but the most recent outbreak in West Africa has involved major urban as well as rural areas.
- Community engagement is the key to successfully controlling outbreaks. Good outbreak control relies on applying a package of interventions, namely case management, surveillance and contact tracing, a good laboratory service, safe burials and social mobilisation.
- Early supportive care with rehydration, symptomatic treatment improves survival. There is as yet no licensed treatment proven to neutralise the virus but a range of blood, immunological and drug therapies are under development.

There are currently no licensed Ebola vaccines but two potential candidates are undergoing evaluation.  

Source: World Health Organization

Symptoms of Ebola virus disease

The incubation period is two to 21 days. Humans are not infectious until they develop symptoms. First symptoms are the sudden onset of fever; fatigue, muscle pain, headache and sore throat. This is followed by vomiting, diarrhoea, rash, symptoms of impaired kidney and liver function, and in some cases, both internal and external bleeding (for example, oozing from the gums, blood in the stools). Laboratory findings include low white blood cell and platelet counts and elevated liver enzymes.  

Source: World Health Organization

How many have died?

Estimating Ebola numbers is both “art and science”, a WHO spokesman has been quoted as saying and the figures the organisation releases vary. In October it was estimated there had been 9936 Ebola cases in 2014 and 4877 people had died from the virus this year. The actual figure, however, could be as much as three times higher, the organisation has stated.

The race for drugs

BBC News Health reports that two Ebola vaccines have been rushed from promising animal studies into human trials. One is produced by GlaxoSmithKline (GSK) and the National Institutes of Health in the US, and the other was designed by the Public Health Agency of Canada and is being produced by Merck. GSK has inserted an Ebola gene into a weakened chimpanzee virus, which is unable to replicate in the human body. Initial tests on 20 volunteers in the UK showed it was safe and that the tiny fragment of Ebola’s genetic code was enough to generate an immune response. Further trials are taking place in the UK, US, Switzerland and Mali to see if the immune response is strong enough to fight off an Ebola infection and how long any such protection would last.

Above right: A locally-made t-shirt raising awareness.
ANZCA awards $A1.4 million for research

The ANZCA Research Committee has awarded funding of $A1,446,618 through the Anaesthesia and Pain Medicine Foundation for research projects in 2015. The funding supports the Lennard Travers Professorship, one academic enhancement grant, 20 project grants, five continuing project grants; one simulation/education grant, four novice investigator grants and the pilot grant scheme. These important research initiatives will be carried out in leading hospitals and universities in Australia, New Zealand and Hong Kong and will continue to advance and maintain a high international standing in safety and quality patient care in anaesthesia, intensive care, perioperative medicine and pain medicine.

Brain-derived neurotropic factor and chronic postsurgical pain: mechanisms and preventive strategy

Background

Paediatric patients undergoing elective or emergency surgery, or who have been admitted to a neonatal/paediatric intensive care unit often require mechanical ventilation. During the perioperative period, these patients are at risk of developing lung injuries including atelectasis, pneumonia, collapsed lung, acute lung injury and acute respiratory distress syndrome. While a good lung-protective strategy will reduce the risk of these conditions occurring and may lead to improved outcomes, failure to tailor ventilatory support to each individual patient can result in ventilator-induced lung injury or may exacerbate any underlying lung conditions.

By measuring the respiratory resistance and pulmonary compliance of children undergoing surgery before and after anaesthesia, the investigators believe they will be able to develop robust prediction equations that define the optimal lung function for anaesthetised children receiving mechanical ventilation.

This study therefore aims to provide a scientific evidence-based tool for paediatric medical practitioners to use in order to tailor and offer lung protective strategies based on each patient’s respiratory parameters, thus limiting ventilator-induced lung injury while improving patient safety and outcomes, particularly in the intensive care unit where efficient ventilation and oxygenation is paramount.

The following were awarded for 2015:

• The Harry Daly Research Award was awarded to Dr Chris Bain for his project “Analysis of the impact of pre-existing differential DNA methylation on inflammatory gene expression and the inflammatory response to major abdominal surgery” (page 36).

• The John Boyd Craig Research Award was awarded to Dr Philip Finch for his project “Clarifying the molecular mechanism of sympathetically maintained pain” (page 37).

• The Dr Russell Cole Memorial ANZCA Research Award was awarded to Dr Susan Evans for her project “Investigation of the role of TNF in the endotoxin response and sepsis” (page 38).

• The Pfizer ANZCA Research Award was awarded to Dr Paul Wrigley for his project “Optimising the neurophysiological assessment of residual thermo nociceptive sensation following spinal cord surgery” (page 40).

Research awards

The Harry Daly Research Fellowship was established by the Faculty of Anaesthetists, Royal Australasian College of Surgeons, in 1981. The Harry Daly Research Award may be made in any of the categories of research awards made by the College provided the project is judged to be of sufficient merit. The award is made each year to the highest ranked grant assessed by the ANZCA research grant process.

The John Boyd Craig Research Award was established following generous donations from Dr John B Craig to the Anaesthesia and Pain Medicine Foundation to support pain related research by Fellows, particularly Western Australians.

The Dr Russell Cole Memorial ANZCA Research Award was established following a generous donation to the Anaesthesia and Pain Medicine Foundation from the family of the late Dr Russell Cole to support a highly ranked pain-related research grant.

Pfizer is a major sponsor of the Anaesthesia and Pain Medicine Foundation. The Pfizer ANZCA Research Award was established to be awarded to a highly ranked pain-related project grant.

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Post-exercise cardiac PET imaging: a pilot study of cardiac risk assessment in patients undergoing major cancer surgery
Dr Marissa Ferguson, Peter MacCallum Cancer Centre, Melbourne, VIC
$A19,871

Major perioperative cardiac complications such as myocardial infarction, cardiac arrest, and cardiac death account for a significant burden of disease, affecting over 900,000 patients worldwide after non-cardiac surgery. In particular, patients undergoing major cancer surgery are often at increased risk for cardiac complications due to advanced age, multiple comorbidities, and the effects of preoperative chemo-radiotherapy. Furthermore, the impact of cardiac complications after cancer surgery is particularly significant as delayed return to intended oncologic therapy may negatively impact overall survival. To address this, the investigators hypothesise that cardiac PET imaging will be feasible and may provide additional diagnostic and prognostic information compared to conventional studies that more simply assess myocardial blood flow.

The novelty of this study is the direct assessment of myocardial metabolism at a cellular level. This is possible due to the preferential uptake of glucose by cancer cells and the accumulation of radiolabelled glucose in ischaemic myocytes, with myocardial ischaemia subsequently appearing as a “hot spot” on PET imaging. This innovative use of PET technology may facilitate more accurate quantification and anatomical localisation of regions of myocardial ischaemia, taking into account supply-demand imbalance and cellular metabolic factors. This is in contrast to standard myocardial perfusion imaging in which ischaemia is detected indirectly by identifying reversible stress-induced defects in myocardial blood flow. By investigating this novel imaging technique, the investigators hope to contribute to improvements in the perioperative care of patients at risk for cardiac complications after major surgery.

A prospective study of the relation between perioperative condition and disability after cardiac surgery
Dr Natalie Kruit, Dr Jeremy Field, Westmead Hospital, NSW
$A15,000

Morbidity and mortality associated with cardiac surgery has fallen and stayed low despite patients’ increasing age and comorbidity. Suture instruments are now required to assess the results of cardiac surgery focusing on functional status and patient satisfaction and quality of life following surgery.

This project aims to correlate periparative variables with change in disability after surgery in patients undergoing cardiac and cardiopulmonary bypass. Health-related quality of life (HRQoL) has been recognised as an important and measurable dimension of health status and may be assessed using both generic and specific instruments. The investigators chose the World Health Organization Disability Assessment Schedule (WHODAS) 2.0 for the general and practical quality and importantly its measurement of the effect of medical interventions on disability. The questionnaire will be administered to patients both before and six months following surgery. Data collection from clinical registries is instrumental in the process of quality improvement. Patient data will be collected from the Australian Society of Cardiothoracic Surgeons and the Perfusion Downunder Collaboration.

The likely benefits of this study will allow patients to be presented with a tailored description of the likely nature of their recovery after surgery, and will allow patients not achieving the expected changes in disability to be identified and provided appropriate treatment. It also will serve to generate hypotheses for future studies concerning perioperative optimisation and clinical decision making.
This genomic analysis will investigate the changes in the activity of the genes in circulating inflammatory cells, known as peripheral blood mononucleocytes, in a selection of patients in the RELIEF trial who have either a minimal or marked inflammatory response after surgery. This will reveal the genes whose increased and decreased activity is related to the stress of the surgery. This analysis will provide novel insights into the mechanisms by which altered patterns of gene expression distinguish a marked response from a minimal response.

The investigators will also look at the potential impact of chemical modifications of DNA, known as DNA methylation, on those genes whose activity or inactivity appears to be central to either a minimal or marked inflammatory response. Currently little is known of the role DNA methylation plays in the inflammatory response to surgery. However it is a form of epigenetic modification that has recently been demonstrated to play an important role in limiting gene expression in experimental models of the cellular immune response to infection.

The tranexamic acid in lower limb arthroplasty (TALLAS) pilot trial
Dr Thomas Painter, Royal Adelaide Hospital, SA; Dr Roman Kluger, St Vincent’s Hospital, Melbourne, Vic
$458,495

More than 85,000 lower limb arthroplasty procedures take place in Australia each year. Although tranexamic acid reduces bleeding and the risk of blood transfusion during, and immediately following hip and knee joint replacement, there is a theoretical concern that this action might also increase the risk of clots forming in other areas of the circulation leading to thrombotic complications.

To date, no study has been designed or sufficiently powered to examine for uncommon, but serious thrombotic complications. Any study that has included thrombotic complications has almost exclusively focused on deep vein thrombosis and pulmonary embolism, with few examining for myocardial injury after non-cardiac surgery. Similarly, the benefits of tranexamic acid in this setting have not been fully explored. None have studied patient-centric endpoints such as quality of recovery or quality of life following surgery.

Given the large numbers of patients undergoing lower limb arthroplasty annually, only a small increase in thrombotic risk may have a significant impact patient morbidity, mortality and cost to the community and thus potentially outweigh the benefits. This is especially important when taking into account the increasing age and comorbidity of arthroplasty patients.

To properly understand the risk-benefit profile of tranexamic acid in lower limb arthroplasty, a large randomised controlled trial is required. The aim of this pilot study is to establish the feasibility of such a study, to define primary endpoints and to examine for associations between tranexamic acid use and other outcomes that will ensure that any future randomised controlled trial will prove definitive.

Investigation and prevention of fixation errors during airway management
Dr Stuart Marshall, Professor Michael Lenné, Monash University, Melbourne, Vic
$588,000

Fixation error, also known as “loss of situation awareness”, has often been identified as the cause of accidents and incidents in industries, most notably aviation. Attempts to solve fixation have included checklists, calling for help and broadening the team focus. However, fixation is a difficult problem to address, as the lack of ability to see other solutions to the problem is part of the problem. Often the magnitude of the problem can only be seen in hindsight.

A recent literature review has found there are few empiric studies of fixation errors in anaesthesia. This study will address this important gap in the literature by investigating normative decision-making in both elective and emergency situations in airway situations and investigate why and how fixation occurs in airway management crises. The information will be collated and a model of fixation constructed and tested to ensure it is genuinely fit for use in clinical practice.

A successful cognitive aid for airway management with additional supports such as education and other potential devices would minimise the risk, morbidity and mortality of patients due to airway difficulties.

Clarifying the molecular mechanism of sympathetically maintained pain
Dr Philip Finch, Professor Peter Drummond, Murdoch University, WA
$487,000

Chronic pain is a major cause of suffering worldwide. For many patients, the mechanisms that drive their pain are poorly understood and effective therapies are lacking. Identifying these mechanisms is crucial for the advancement of pain management.

Following tissue injury, inflammatory mediators are released from injured tissue, infiltrating immune cells, and keratinocytes, mast cells and Langerhans cells. The investigators hypothesise that the inflammatory mediators either directly, or through the induction of nerve growth factors, trigger increased expression of a key molecule, α1-adrenoceptor, in the plasma membrane of nerve fibres and other cells at the site of injury. In turn, the stimulation of this receptor may compound inflammation and pain and increase the likelihood of secondary changes that maintain chronic pain.

A cell culture approach will be used to identify abnormalities in cells harvested from patients with complex regional pain syndrome, and to establish whether this can be prevented or reversed. They hope the findings could provide new therapeutic approaches to preventing and/or managing certain forms of chronic pain in vulnerable patients.

Analysis of the impact of pre-existing differential DNA methylation on inflammatory gene expression and the inflammatory response to major abdominal surgery
Dr Chris Bain, Alfred Health, Professor Andrew Shaw, Vanderbilt University, US; Clinical Professor Tomas Corcoran, Royal Perth Hospital, WA; Dr Kimyet Bozaoglu, Baker IDI Heart and Diabetes Institute, Melbourne, Vic
$469,000

This research project will use DNA sequencing technology to examine how the human genome, the inherited DNA sequence and modifications around DNA (known as the epigenome) impact on cellular functions during the perioperative period.

RELIEF Genomics is a sub study of a large ongoing trial known as RELIEF (REstrictive versus Liberal Fluid therapy in major abdominal surgery). The RELIEF trial is an investigation into the impact of different intraoperative intravenous fluid therapy on short and long-term outcomes in patients having major elective abdominal surgery. More specifically, the trial is assessing the long-term impacts of surgery on health and wellbeing, and includes patients who experience life-threatening complications that relate to infection and a marked systemic inflammatory response.

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Is estrogen stimulation of Toll-like receptor pathways the missing link between dysmenorrhoea and later progression to chronic pain?

Surgery and anaesthesia in infants during the perioperative period: a prospective observational cohort study

Post-operative cognitive dysfunction (POCD) represents one of the greatest challenges to anaesthetic and surgical practice, mainly affecting the elderly who now comprise more than a third of all anaesthetic and surgical cases in Australia. POCD interferes with cognition, affecting quality of life, is associated with longer hospital stays and has the potential to cause further cognitive deterioration over time. Current evidence supports the systemic inflammatory process as directly leading to downstream effects on the central nervous system. The study seeks to elucidate the role of inflammation as a cause of POCD by investigating the inflammatory response resulting from anaesthesia and surgery by analysing the blood for specific proteins, which rise during and after surgery. By also measuring cognitive function both before and after surgery, the investigators hope to relate the levels of these inflammatory proteins to any subsequent cognitive decline. Identifying which inflammatory proteins are associated with POCD is the first step in instituting preventative strategies.

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Cognitive decline after anaesthesia and surgery - the role of inflammation

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ANZCA awards $A1.4 million for research (continued)

Project grants (continued)

**Optimising the neurophysiological assessment of residual thermoneciceptive sensation following spinal cord injury**

Dr Paul Wrigley, Pain Management Research Institute, New South Wales, Professor Philip Siddall, GreenHow Hospital, HammondCare Health, NSW $A29,000

Over 350 new cases of spinal cord injury (SCI) occur in Australia every year. Injuries occur more commonly in younger people with profound lifetime consequences for health and productivity.

Neuropsychiatric pain remains one of the most difficult consequences of SCI to manage, being a major cause of suffering and added to the physical, emotional, and societal impact of the injury. Improvements in treatment continue to be held back by a lack of understanding as to why some people with SCI develop pain and others do not.

Progress in SCI pain research is limited by the inability to fully assess the extent of sensory damage following SCI. Trauma to the spinal cord rarely results in complete division of the cord with surviving nerves sometimes remaining silent or failing to carry out their normal function. Clinical examination has a limited capacity to detect partial fibre tract preservation following SCI. While neurophysiological tests are more sensitive, none are routinely available that assess temperature and pain transmission.

This study will evaluate a promising neurophysiological technique able to assess the connections between peripheral nociceptors and the brain. The project aims to determine whether contact non-evoked potentials (CNePs) are able to detect surviving pain and temperature nerves in the spinal cord following SCI. This test measures brain activation following a computer driven heat pulse to the skin. The presence of a brain wave indicates communication between the skin and brain and intact temperature and pain pathways in the spinal cord.

This research will improve clinicians’ capacity to assess more objectively the neurophysiological pathways affected by SCI, particularly those associated with the development of neuropathic pain. It has the potential to identify individuals at greater risk of developing pain, and may also assist in the assessment and management of nerve pain associated with other conditions.

**Malignant hyperthermia and exertional heat stress: the genetic and molecular connections**

Dr Neil Pollock, Palmerston North Hospital, NZ, Associate Professor Kathryn Sowell, Macquarie University, N2 $A42,000

Malignant hyperthermia is a potentially fatal genetic disorder triggered by inhalational anaesthetics. Malignant hyperthermia can be managed if diagnosed prior to general anaesthesia, it is critical that the molecular basis of the syndrome is determined. In their groundbreaking research over many years, the investigators have solved the genetic basis of malignant hyperthermia in more than half of the susceptible families in New Zealand, which has made it possible to offer DNA-based diagnostic tests to many families. As a result of this, many individuals can now avoid the invasive and morbid muscle biopsy test for malignant hyperthermia. In the course of the research, it has become clear that not all malignant hyperthermia is created equal. There is a range of clinical severity both within susceptible families with the same genetic variant and also between families with different genetic variants. Of recent interest is the potential link between malignant hyperthermia susceptibility and exertional heat stress. While some patients exhibit exertional heat stress, which can have similar clinical presentation to malignant hyperthermia, they do not all carry variants in the most common gene known to be associated with malignant hyperthermia.

The accessibility of new, rapid and relatively inexpensive DNA sequencing technologies provides novel molecular tools to investigate the connections at the gene level of variants associated with either or both malignant hyperthermia and exertional heat stress.

**Osteoporosis: alterations in lung mechanics - impact on the incidence of perioperative respiratory adverse events (PRAE)**

Professor Britta Regli-von Ungern-Steinberg, Princess Margaret Hospital for Children, WA $A30,000

In paediatric anaesthesia obesity is a significant problem with obese children not only having anaesthesia-relevant co-existing diseases such as asthma or hypertention, but also having a higher incidence of anaesthesia-related complications. Many factors during general anaesthesia, such as supine positioning, anaesthetic agents and the type of surgery, affect the functioning of the respiratory system and in particular lung volumes and respiratory mechanics. The anaesthesia-related changes in lung function are expected to be even more significant in obese patients. Despite the development of anaesthesia management guidelines, perioperative respiratory adverse events (PRAE) are among the most common complications observed in this population.

This study aims to assess the incidence of breathing problems of overweight and obese children compared to children with a healthy weight in the perioperative period. The main outcomes of the study are the incidence of PRAEs and the impact of respiratory mechanics by obesity will help improve the management of these high-risk patients.

**Pre-hospital assessment of residual thermonociceptive sensation following spinal cord injury**

Dr Andy Weatherall, Dr Alan Garner, CareFlight, NSW, Professor Noel Lovell, Dr Stephen Redmond, University of New South Wales, Professor Anna Leow, The Chinese University of Hong Kong, HK, Dr Jonathan Egan, Dr Justin Skowro, The Children’s Hospital at Westmead, NSW $A42,000

Traumatic brain injury (TBI) is a significant cause of death and severe disability. Yet despite advances in hospital care of patients with TBI, minimal improvements in outcome have been evident over the past 20 years. Current research on optimal monitoring and management following TBI occurs in a hospital with no technology being used to provide direct information on the brain in the period immediately after the trauma. This is a vital period where further injury may be caused by low oxygen levels or blood pressure.

Near infra-red spectroscopy (NIRS) tissue oximetry can show real-time information about blood flow and oxygen delivery within the brain tissue as it only requires the application of probes on the forehead and can be used immediately at the site of an accident. To evaluate whether NIRS technology can provide real-time information about the acute evolution of TBI, the investigators will conduct a prospective cohort study in which NIRS tissue oximetry will be commenced in the earliest stages after TBI, well before the patient reaches hospital. As well as comparing NIRS tissue oximetry signals with pathology on cerebral imaging, patients will be assessed at six and 12 months following TBI to establish any association between NIRS parameters and the long-term recovery after TBI. Establishing these associations would be a significant first step towards better evidence-based patient care and will confirm the role of this technology in the pre-hospital setting.

This study aims to answer the question of whether there is a difference in the haemodynamics, and specifically, if there is a difference in preload responsiveness in patients randomised to the restrictive and liberal arms of the RELIEF trial. This will add a mechanistic dimension to any differences in outcome that may be found in within RELIEF. The results from this study will help determine the usefulness of these cardiovascular signs for the specialist anaesthetist and will assist the clinician to tailor appropriate fluid resuscitation for the patient.

(continued next page)
ANZCA awards $A1.4 million for research (continued)

Project grants (continued)

**Obesity and the risk of septic complications in major abdominal surgery**

Dr Usha Gurunathan, Dr Ivan Rapchuk, The Prince Charles Hospital, Qld; Professor Paul Myles, The Alfred, Melbourne, Vic

$A3000

Obesity is known to be associated with medical problems such as diabetes, increased blood pressure, sleep disorders and increased cardiovascular risk. Body mass index (BMI) has been the most popular measure of obesity, however it cannot discriminate between body fat mass and lean body mass and hence may not be a sufficiently accurate measure of cardiometabolic risk.

Waist circumference is a simple clinical measure associated with total body fat mass and the amount of abdominal visceral tissue. Measures of central obesity such as waist circumference and waist to hip ratio have been shown to be directly associated with mortality and cardiovascular events in patients with coronary heart disease. However waist circumference alone cannot distinguish between visceral and subcutaneous adiposity. Waist circumference along with the level of serum triglycerides is likely to give a more accurate estimate of a patient’s metabolic risk.

This study will measure obesity in patients by BMI, waist circumference and waist to hip ratio to assess which of these measures best predict the occurrence of septic complications at 30 days following major abdominal surgery.

The benefits of this study will be to identify a very simple, yet accurate measure of body fat that will assist clinicians to predict the risk of post-operative adverse outcomes in patients undergoing major abdominal surgery. This will identify high-risk patients and enable the perioperative team to target the patients most likely to develop post-operative complications.

**Is fluid resuscitation pre-inflammatory?**

Dr Shay McGuinness, Dr Rachael Parke, Auckland City Hospital, New Zealand, Professor Andrew Bersten, Dr Shailesh Bihari, Flinders Medical Centre, SA, Dr Dani-Louise Dixon, Flinders University, SA.

$A36,000

Administration of intravenous fluid for the purpose of resuscitation is ubiquitous in pre-hospital and hospital practice and is considered fundamental in the management of critically ill patients. However, recent evidence from the investigators, and others, suggests that rapid or bolus intravenous fluids may have negative effects that are particularly manifest in the lung.

Studies by the research team investigating the mechanism by which large doses of intravenous fluids may adversely affect the lung have indicated the importance of inflammation and the movement of inflammatory white blood cells into the lung. The movement into the lung of large numbers of these cells can lead to a condition called acute lung injury or acute respiratory distress syndrome (ARDS). ARDS is a common problem in intensive care units with a high mortality rate worldwide, which is often attributed to multiple organ failure due to a systemic inflammatory response.

The aim of this study is to investigate whether the administration of intravenous fluids can lead to inflammatory lung injury by examining inflammatory mediators in the blood of patients undergoing cardiothoracic surgery who have been treated with either standard or restricted fluid interventions. Identification of the mechanism by which intravenous fluids may contribute to the inflammatory response in ARDS may provide potential targets for therapeutic intervention and the safe administration of fluid resuscitation to critically ill patients. This study is a trans-Tasman collaboration incorporating clinical and laboratory research.

**Safety of sedation for endoscopy in University of Melbourne-affiliated hospitals**

Professor Kate Leslie, Melbourne Health; Dr Megan Allen, Melbourne Health and Peter MacCallum Cancer Centre; Dr Elizabeth Hessam, Western Health, Melbourne, Vic

$A39,000

Gastrointestinal endoscopy is the highest volume medical procedure performed under sedation in Australia, and is likely to increase with growth related to an aging population and need for colon cancer surveillance. Therefore, the incidence of significant unplanned events is important for patients, providers and funders.

Sedation for gastrointestinal endoscopy is provided by a range of health professionals in a range of settings using a range of drugs and monitoring techniques, although specialist anaesthetist-administered sedation dominates current practice. Australian governments are driving health workforce innovation, and programs to introduce alternative sedation providers are inevitable. The safety of sedation for gastrointestinal endoscopy in specialist anaesthetist-based Australian practice has not been assessed.

The study will take place in nine Victorian public hospitals affiliated with the University of Melbourne in patients presenting for elective or emergency gastrointestinal endoscopy with planned care by a specialist anaesthetist. The investigators will determine the risk profile of patients presenting for gastrointestinal endoscopy, the incidence of significant unplanned events and the risk factors for significant unplanned events.

The results of this study will provide a baseline for further multi-centre or nationwide studies on the impact alternative practice models and innovative sedation techniques on safety outcomes and fitness for independent discharge after sedation for gastrointestinal endoscopy.
Sharing evidence – stop the paper chase

Let’s face it, not everyone is “tech savvy”. Coming to grips with ANZCA’s new online CPD portfolio is one area that some participants have balked at, but feedback has shown that the system is user friendly and intuitive once users take the time to log in and navigate around it.

Uploading evidence is as easy as attaching a document to an email.

To use this feature, participants need to log into their portfolio. Go to the ANZCA homepage – www.anzca.edu.au, click on the CPD quick link on the right, log in and save the log in so you only have to log in once in future. Many participants have saved their portfolio access as a short-cut on their smartphone or tablet.

Each CPD participant has a dashboard where they can see at a glance how they are progressing within their three-year CPD period (triennium).

On the “Select activities” page, choose the activity you would like to record.

Fill in the session information (date, hours and details) then click “add additional evidence”. This opens the usual window on your computer (Microsoft or Apple) that allows you to locate and upload your evidence, for example, a scan or pdf of a receipt or a certificate of attendance. You can take photos of evidence using your tablet or smart phone and this can also be uploaded using the photo gallery.

Once uploaded, the evidence will appear on the activity screen. Press save.

To review all activities, click on the “activities” tab at the top of the page and a list of all your completed activities will be displayed. If evidence has been uploaded, the last column will have a tick in it. ANZCA events attended will be automatically in the list. A final point – beware the hospital firewall – it may prevent you from saving activities.

To access the evidence, click “supporting evidence”.

Online portfolio makes it easy

In April this year I was selected for audit of my continuing professional development (CPD) triennium, which ended on December 31, 2013. I had to find “supporting evidence” for the minimum activities required for each of the three years. I printed off my portfolio summary and started hunting!

I had almost all the required bits of paper, the last being a statement from my department confirming the departmental CME and QA meetings I had attended.

In September this year I was notified I had been selected for audit again, this time just for 2014, year one of my current triennium. (The information will be due for submission in early 2015).

This time it will be effortless – I need to provide evidence for 30 credits. Evidence for more than that has already been uploaded into my portfolio (by photo or scanning) and ANZCA staff will be able to sign off on my audit just by inspecting my online portfolio.

Dr Genevieve Goulding
ANZCA President

CPD tips

Many Fellows are discovering innovative ways to evaluate their practice that are not only professionally useful, but comply with continuing professional development requirements too.

Snooze News – a lunch gathering that pays dividends

Practice evaluation – case discussions/conferencing

Around five years ago, our informal lunching group of Fellows was formalised as a group called Snooze News, which was registered and accredited with the College, for continuing professional development (CPD) points.

We meet about five times a year in the private dining room of a good suburban cafe. These get togethers are a little like the popular problem-based learning discussions held at the annual scientific gathering that pays dividends in anaesthetic topics and who participated. This has now been printed and then distributed at the next meeting but now is emailed to the participants. Each can then save the document and upload it to their online CPD portfolio, noting the date and time.

Doing this three or four times a year for three years (the length of time of a CPD triennium) gives each participant 20 to 25 of the 100 points required in the practice evaluation component of CPD.

The lunch format allows anaesthetists across age groups to discuss relevant clinical issues informally. It is a most successful group.

Dr Vanessa Beavis
Chair, ANZCA CPD Committee

From this...

In the past, ANZCA has audited continuing professional development (CPD) participants in the year following the end of their triennium. Supporting evidence was required to confirm enough activities to satisfy the minimum credits required for each category over the three years. Now participants are notified in September that they will be audited for the one, two or three year period ending December 31. This gives plenty of time to accumulate all the evidence required.

Note: All activities and evidence must be entered by December 31, 2014.

To this...

Have you got a CPD tip? Please send suggestions in 300 words or less to communications@anzca.edu.au.
After many years of extraordinary contribution, Francis Xavier Moloney retired from anaesthetic practice six months ago and has now retired from ANZCA Council.

I first met “Cranky Franky” at St John’s College at the University of Sydney, me a fresher and Frank a sophomore in 1968. I’ve had the great privilege of being a colleague of Frank’s at the Orange Health Service, in NSW, since 1985.

Frank was a valuable and popular member of college, showing his leadership qualities and determination early, especially on the sporting field, and was elected house president in 1970. Frank married Cate, a skilled paediatric nurse, at the end of that year and I remember seeing them at inter-hospital sporting fixtures, twins David and Sarah in tow. Jock was born in 1978, the year Frank gained his fellowship. From working for lifelong friend and mentor Fred Berry (who now lives in Orange) at Sydney Hospital, Frank became Ross Holland’s first senior registrar at Westmead Hospital.

Frank began anaesthetic practice in Orange in 1980 with the late Graeme Worsley and Tony Burrell and with the advent of formalised structures in 1982, Frank became director of the department and Tony became director of the intensive care unit.

The three made a formidable team and services at the Orange Base Hospital expanded rapidly. Richard Warney joined them from private practice and Frank established the format of anaesthetic practice—a shared roster, rotating through surgical lists both public and private. This practice remains in place today and has enabled us to attract very good people as they got an equal share of the work from day one. The fact that seven of the 14 anaesthetists in Orange have been registrars of ours is testament to Frank’s vision in establishing rural rotations for registrars from the Royal Prince Alfred and Concord hospitals in Sydney.

In the early 1980s Frank saw a need and pushed for formalised training for GP anaesthetists. He established a program in Orange where rural GP trainees had six months training with us. This was not necessarily looked upon favourably by the “ivory towers”. With Frank’s dogged determination, quirky humour and considerable powers of “gentle persuasion”, this evolved over time into a national program supported by the Joint Consultative Committee on Anaesthesia (JCCA). Frank was a founding member of the JCCA, examiner from 1992 and chaired this committee from 2006-14.

In 1991 Frank was co-opted as rural representative onto the NSW Regional Committee of ANZCA. He served on the committee until 2004 (including chair from 2000-01). He became inaugural chair (1993-95) and ongoing member of the Rural Special Interest Group. He was a ministerial appointee to the Institute of Rural Clinical Services from 2004-10. His extraordinary contribution to anaesthesia in Australia was recognised in 2005, when he was awarded ANZCA’s prestigious Robert Orton Medal. The citation that accompanied the Orton Medal said in part: “No other individual in the rural medical setting has achieved more than Frank for his specialty and for rural medicine.”

Frank was co-opted onto the ANZCA Council in 2005 and elected 2006-14. His commitment and contribution to the College has been impressive. During his eight years service he has been a member and chair of the Training Accreditation Committee, chair of the Continuing Professional Development (CPD) Committee, member of the Education and Training and Quality and Safety Committees, MOPS officer and member of the GP anaesthesia working group as well as several other College committees.

“On joining the ANZCA Council I was suddenly the adopting father of Teik Oh’s new brainchild—the CPD Program. MOPS was undergoing serious transformation... I was the ‘herder of the cats’.”

I have given a chronological, incomplete account of Frank’s myriad achievements. What of Frank the colleague, mentor and man? Orange anaesthetist Paul Birrell and fellow member of a practice subgroup defined by Frank as the “dinosaurs” has said over the years “every town needs a Frank”. How true. We have all benefitted greatly from Frank’s leadership and generosity—he volunteers for everything! When Frank is “on song” he is great company. Frank is a master of nicknames or his quirky sense of humour or turn of phrase meant he was revered by many registrars and operating room nurses; not to mention his teaching and mentoring— if one didn’t score a nickname it meant you weren’t trying hard enough—whatever that entailed.

Frank also played a full role in all hospital activities, particularly with clinical training for junior doctors, and was director of anaesthetics from 1982-2013. He has been active in community affairs, was judge at the Orange Turf Club for 10 years, a member of Orange Golf Club and involved in amateur dramatics and the Orange Men’s Choir.

Frank’s loving wife Cate has supported him through all of this, along with raising three children of their own and fostering 24 young children between 1987-2011. No wonder Frank was appointed a Member of the Order of Australia (AM) in the Queen’s Birthday honours in 2013, an honour richly deserved by them both. Orange Citizen of the Year, Cate says being foster parents greatly enriched their lives.

Dr Anthony J Kirkwood, FANZCA

Tribute to retiring Frank Moloney
There are four training hospitals for the Palestinian residents (registrars): One in East Jerusalem and three in the West Bank (Ramallah, Nablus and Hebron). The West Bank is governed by the Palestinian Authority (PA), which has its own ministry of health. The East Jerusalem Hospitals (which are all privately run), fall within the State of Israel, yet serve a predominantly Palestinian population and I was not sure I completely understood their relationship with the Israeli Ministry of Health.

Political discussions can be a sensitive subject in this region; I set myself a purely educational objective for the trip and swore not to enter into any political dialogues with locals. However, just asking a Palestinian about the geography of the region becomes political.

My first week was spent in Al-Makssed Hospital in East Jerusalem, established in 1966 and considered the best hospital in Palestine.

The first few days of my mission coincided with Eid al-Adha, a major Muslim holiday, which meant theatres were performing emergency cases only. On entering the hospital, the first thing I smell was cigarette smoke. This would be a perpetual odour for the duration of my stay in the Middle East – smoking is still a majority pastime.

I spent these days with the on-call residents who seemed to split their time between doing anaesthesia and “putting out fires” in the rest of the hospital.

The residents had decided to start with ketamine and this worked well… until the surgeon touched the patient. His examination turned into a classic case of pain coming from the patient. We were able to replace these screams with hallucinations by giving more ketamine.

After a second plastics case we were called to obstetrics for an urgent caesarean section. Most patients choose general anaesthesia, despite the protestations of the anaesthesiologists. The anaesthetic residents usually have no help at all for these cases. The standard intravenous induction is propofol and atracurium, with few anaesthetists in Palestine using suxamethonium or rocuronium.

I later discovered that the arrest was due to hypoxaemia following an accidental extubation, a common occurrence in this hospital – I saw two on that day.

In fact, despite having both of these drugs available in two out of the four hospitals I worked in, they were rarely used. Suxamethonium, due to its side effects, and suxamethonium, due to the perception that it is longer acting than atracurium. Because most hospitals don’t have the ability to assess depth of neuromuscular blockade and recovery care is minimal to non-existent, there was considerable reluctance (for safety reasons) to use anything other than atracurium. They told me they had not had issues with aspiration in this patient population.

After a lunch break I found myself performing chest compressions in the ICU on a young man who had arrested. He had been intubated for poisoning and as we arrived the ICU resident was trying to reintubate the patient who had a heart rate of 40 and no output. I suggested we start CPR to circulate the adrenaline and atropine that had been given. After a few rounds of CPR and some oxygenation and further adrenaline, we achieved return of spontaneous circulation. I later discovered that the arrest was due to hypoxaemia following an accidental extubation, a common occurrence in this hospital – I saw two on that day.

Some practices are very similar to our own, the importance of the morning coffee break was not to be underestimated. Others were quirkiest. The paediatric theatre in Ramallah contained the only neonatal Resuscitaire in theatres, so several times during a case a paediatric resident would burst into the room with a fresh newborn to do his neonatal resuscitation, while our theatre team continued unphased.

The anaesthesia equipment is not bad by Australian standards, however the condition of much of it was capricious. In most hospitals no two anaesthetic machines were alike, end tidal gas and CO2 monitoring availability was inconsistent, and prone to malfunction at crucial times.

Pre-induction checking of equipment was uncommon. One hospital would have insulated nerve block needles but no nerve stimulator, whilst another would have a stimulator but no needles. Transient drug shortages are common and post-operative analgesia is very much in its infancy. Surgical co-operation in this regard was again variable, depending on the age and training of the surgeon. I assisted a colleague to insert two paediatric thoracic epidurals for major spinal incisions that worked well, however one was removed the next morning by the surgeon. This was a lesson on the importance of clearly communicating post-operative plans and performing effective surgical expression.

While most of the residents were technically proficient and several were extremely well read, major patient safety issues exist – and this is something that the WFSA program sees as an important area of focus. There is a chronic shortage of consultants to supervise trainees, occasionally less than one resident per theatre, and a phenomenon I termed “resident drift”, whereby residents would start a case and drift into another theatre, off to have a cigarette, off to pray, or off completely without handing over to anyone, usually leaving a technician, sometimes none, in one, in the room. Recovery nursing is rudimentary or absent, and the awareness of the importance of this aspect of care was inconsistent among the trainees.

Overall it was an intense and fascinating month, one that allowed me to see some of the most ancient cities on earth and to work with a group of talented professionals whose needs have been obscured somewhat in the narrative of constant conflict in the region. For more information please visit www.wfsa.org/palestinaeanesthesia-teaching-mission-patients.

Dr Derek Rosen, FANZCA
Mater Children’s Hospital, Brisbane

* For the purpose of simplicity (but not partisanship) in this article I will refer to the region I worked in as Palestine, however I acknowledge the differing views on what parts of this area should be called.

Above from left: Dr Derek Rosen’s view on the way to work, Jerusalem; The Tomb of the Patriarchs, Hebron; Al Ahli Hospital entrance, Hebron; Often improvisation is necessary – note the fluid warmer bottom left.
New committee to be the voice of Fellows

Professional and fellowship issues will be the focus of a new ANZCA committee, which will meet for the first time in February 2015.

The establishment of the Professional Affairs Executive Committee (PAEC), which replaces the Fellowship Affairs Committee, is one of the major changes that followed a review of Fellow-related ANZCA committees and sub-committees, and the ANZCA Trainee Committee.

PAEC will have strategic oversight for three areas – fellowship, community development and policy.

Another result of the review, which commenced earlier this year, is the renaming of the Quality and Safety Committee to the Safety and Quality Committee, reinforcing the College’s commitment to patient safety.

This committee will report to PAEC, as will the Overseas Aid Committee, the Continuing Professional Development Committee and the Indigenous Health Committee.

This means a decrease in the number of committees directly reporting to the ANZCA Council, enabling it have a clearer strategic role.

Another change is the establishment of an ASM and Events Planning Committee, which will report to ANZCA CEO, Ms Linda Sorrell, on operational matters relating to the ANZCA annual scientific meeting and other educational events run by ANZCA.

The International Medical Graduate Specialist Committee and Trainee Committees will report through the educational governance structure to provide them with educational specialist input alignment.

The Review of Committees Working Group included Dr Vanessa Beavis (chair), Dr Genevieve Goulding, Dr Rodney Mitchell, Associate Professor David Scott and Dr Leona Wilson. Ms Linda Sorrell, Ms Carolyn Handley, Ms Elaine Jenkins and Ms Veronica Haslam provided support.

Terms of reference for the new and restructured committees have been written and the new structure will be formally launched early next year.
The latest edition of the ANZCA mortality report, Safety of Anaesthesia: A review of anaesthesia-related mortality reporting in Australia and New Zealand 2009-2011, has now been finalised. Edited by Associate Professor Larry McNicol, this triennial report is produced by the Mortality Sub-Committee which reports to ANZCA's Safety and Quality Committee. The executive summary and clinical aspects of category one anaesthesia-related deaths sections are reproduced here.

Executive summary

1. This is the ninth triennial report of anaesthesia-related mortality in Australia (the first being for the triennium 1985-1987). The format is similar to previous reports, and contains data from five states (New South Wales, South Australia, Tasmania, Victoria and Western Australia). The ANZCA Mortality Subcommittee has supported these triennial reports and has encouraged the establishment or re-establishment of anaesthesia mortality reporting in other Australian states and territories and in New Zealand. The South Australian Mortality Committee was re-established in 2010 and has been able to provide mortality data for 2009-2011.

2. While this report contains data from only five states, these five states include more than 90% of the population of Australia. The report is therefore likely to provide a reasonable estimate of anaesthesia mortality across Australia for this period.

3. The Australian Capital Territory (ACT), the Northern Territory and Queensland did not provide anaesthetic mortality data for this report because they did not have functioning anaesthesia mortality committees during the 2009-2011 triennium. However, the Queensland Perioperative and Peri procedural Anaesthetic Mortality Review Committee in place in all five states in 2012 and will be able to provide mortality data for the next triennial report (2012-2014). The ACT Regional Committee of the Australian and New Zealand College of Anaesthetists (ANZCA) is working with the ACT Audit of Surgical Mortality (RACS) to develop anaesthesia mortality reporting similar to the model that has been established in Tasmania. It is possible that the South Australian committee could receive data from the Northern Territory, as has occurred previously. New Zealand has established a multi-disciplinary perioperative mortality committee, and although this committee is unable to provide specific anaesthesia mortality data using the Australian classification system, the report is informative.

4. As with all anaesthesia mortality reporting, it should be appreciated that classification of anaesthesia-related deaths relies on expert opinion and is therefore somewhat subjective and for the most part uncertain.

5. During the triennium, the number of anaesthesia-related deaths (category one, two and three) reported from the five states was 156. However, in only 22 cases were the deaths classified as category one (where it was considered “reasonably certain” that death was caused by anaesthesia factors alone). In five cases (category two), and in the remaining 119 cases, “medical, surgical and anaesthetic” factors were implicated (category three). This demonstrates a continued reduction in the percentage of category one deaths in recent triennial reports. In 2003-2005, category one deaths were 21 per cent of the total anaesthesia related deaths, and this reduced to 15 per cent in 2006-2008 and 14 per cent in 2009-2011.

6. During the triennium, the combined population for the five states was about 17.3 million (Australian population statistics). Using this figure, the anaesthesia-related mortality rate for these five states was 1.01 deaths per million population per annum. This is slightly higher than the figure (2.79) for the four states (NSW, Tasmania, Vic, and WA) in the previous triennium (2006-2008). This is also lower very slightly to the anaesthesia mortality rate per million population in all triennial reports since 1997 (3.12 deaths per million population per annum). It was also lower significantly than the results for the four states (NSW, Tasmania, Vic, and WA) in the previous triennium (2006-2008; 1.55,490). This figure was obtained from the Australian Institute of Health and Welfare (AIHW). The data was obtained from codes at all public and private hospitals. A coding hierarchy was used to ensure that only one anaesthesia item number was counted per episode of anaesthesia care. Using this hierarchy, 2012, the anaesthesia-related mortality rate was 1.08,929 (per million population) for the five states in this report. This is similar to the figure for the four states (NSW, Tasmania, Victoria, WA) in the previous triennium (2006-2008; 1,55,490).

7. The accuracy of the number of episodes of anaesthesia care (the denominator) obtained from the AIHW is supported by the relatively constant ratio between the number of episodes of anaesthesia care identified for each state and the population of each of the five states. The ratio was consistent across all five years (NSW 0.56, WA 0.17, SA 0.18, Tasmania 0.18, Victoria 0.18).

8. Most anaesthesia related deaths (84 per cent) occurred in older patients (age over 60 years). Fifty-one per cent of deaths were female. It is of some interest that 70 per cent of anaesthesia-related deaths occurred when surgery was either urgent or emergent. This is a significant change from the previous triennium where when approximately a third were urgent or emergent. Only a very small proportion (7 per cent) occurred in patients considered low risk (ASA P 1-2). Hence 93 per cent of anaesthesia-related deaths occurred in patients assessed as high risk (ASA P 3-5). The types of surgery most frequently associated with anaesthesia-related death were orthopaedics (48 per cent), cardiovascular (14 per cent), vascular (10 per cent) and abdominal surgery (10 per cent). An emerging trend is the increased frequency of anaesthesia-related deaths in gastro-intestinal endoscopy and interventional procedures in cardiology/radiology (to per cent). Of note, some of these did not involve an anaesthetist at all.

9. For the first time information has been included regarding the location of the event leading to death, as well as the location of death. Most fatal events, 96 per cent, occurred in the operating or procedural room (OPR) during the time of surgery. 24.4 per cent, excluding WA, from which data was not obtained, were in the recovery room. In WA, location of death was ICU (39 per cent), followed by the operating or procedure room (17 per cent). The only survival rates from these states have been in the recovery room (9 per cent). The anaesthesia care unit was operated in 50 per cent. 50 per cent were on an anaesthetic care unit (category one). As in previous reports, most deaths occurred in metropolitan teaching hospitals and larger regional teaching hospitals (O&PR). However, this would be expected with the acuity of the cases in these institutions. The mortality of deaths (85 per cent) involved specialist anaesthetists (121/145 as of December 2014). Twelve cases involved non-specialist/GPs, seven were anaesthetists, and in at least one case the cause of death was unknown.

10. An interesting trend over the past decade has been a progressive reduction in the ratio of the number of anaesthetic causal or contributory factors per death. This was 2.42 in 2000-2002, 1.58 in 2003-2005, 1.30 in 2006-2008 and 1.25 in 2009-2011. Over the same period, there has been a progressive increase in the percentage of deaths in which the patient’s chronic medical condition (H) was deemed to have contributed to the death. This was 28 per cent in 2000-2002, 25 per cent in 2005-2007, 22 per cent in 2006-2008 and 17 per cent in 2009-2011. However, the data are consistent with the likelihood that there has been a progressive reduction in preventable anaesthesia-related mortality over this period, and that the most important factor is the severity of the patient’s underlying medical condition (H). It is also noteworthy that the number of deaths in which no correctable factor could be identified (G), has also progressively increased, from 20 per cent in 2000-02, 33 per cent in 2003-05, 49 per cent in 2006-08 to 58 per cent in 2009-11. As in the previous report, these figures were heavily influenced by a large number of cases from NSW that were classified as “GIH. This classification typically describes extremely high risk patients, in which the stress of surgery and anaesthesia most likely contributed to or hastened death, but in which the death was not attributable to preventable, other than by withholding of the surgery and anaesthesia.

11. For the first time, this triennial report includes a brief clinical summary of the cause of death in those classified as category one (where it is “reasonably certain” that death was caused by anaesthesia factors alone) who died in the five states during the previous triennium. The summary includes information about whether the death was caused by anaesthesia that was correctable, by anaesthesia that was not preventable but could have been preventable with earlier diagnosis and appropriate crisis management, by anaesthesia that was not preventable but could have been preventable with better, safer anaesthesia, or by insufficient anaesthesia care.

12. An interesting pattern over the past decade has been a progressive reduction in the ratio of the number of anaesthetic causal or contributory factors per death. This was 2.42 in 2000-2002, 1.58 in 2003-2005, 1.30 in 2006-2008 and 1.25 in 2009-2011. Over the same period, there has been a progressive increase in the percentage of deaths in which the patient’s chronic medical condition (H) was deemed to have contributed to the death. This was 28 per cent in 2000-2002, 25 per cent in 2005-2007, 22 per cent in 2006-2008 and 17 per cent in 2009-2011. However, the data are consistent with the likelihood that there has been a progressive reduction in preventable anaesthesia-related mortality over this period, and that the most important factor is the severity of the patient’s underlying medical condition (H). It is also noteworthy that the number of deaths in which no correctable factor could be identified (G), has also progressively increased, from 20 per cent in 2000-02, 33 per cent in 2003-05, 49 per cent in 2006-08 to 58 per cent in 2009-11. As in the previous report, these figures were heavily influenced by a large number of cases from NSW that were classified as “GIH. This classification typically describes extremely high risk patients, in which the stress of surgery and anaesthesia most likely contributed to or hastened death, but in which the death was not attributable to preventable, other than by withholding of the surgery and anaesthesia.

13. For the first time, this triennial report includes a brief clinical summary of the cause of death in those classified as category one (where it is “reasonably certain” that death was caused by anaesthesia factors alone) who died in the five states during the previous triennium. The summary includes information about whether the death was caused by anaesthesia that was correctable, by anaesthesia that was not preventable but could have been preventable with earlier diagnosis and appropriate crisis management, by anaesthesia that was not preventable but could have been preventable with better, safer anaesthesia hope.

14. Notwithstanding the effect of jurisdictional differences in methodology for case reporting and classification, this report indicates that anaesthesia mortality rates in modern Australia are low, whether assessed by the number of anaesthesia deaths per million population per annum (1 in 500,000). The emerging pattern is that anaesthesia risk is now extremely low in patients who are basically fit for anaesthesia. However, if anaesthesia mortalit...
Safety of Anaesthesia in Australia and New Zealand (continued)

Clinical aspects of category one anaesthesia related deaths

For the first time, in the ninth triennial anaesthesia mortality report, we have included deaths due to aspiration, one from the 22 deaths (category 1) where it is reasonably certain that the death was caused by an aspiration event or other factors under the control of the anaesthetist. The inclusion of this information was deemed appropriate in order to highlight the major clinical issues involved in the deaths directly related to anaesthesia and it is anticipated this has been achieved without compromise to confidentiality. There were seven deaths due to aspiration, involving five, involving management of the airway, five involving pulmonary aspiration, three deaths involving cardiac arrest (three cases attributed to inappropriate choice or application of anaesthesia technique and two fatal outcomes resulting from invasive cardiovascular procedures.

Anaphylaxis (seven)

There were seven deaths from anaphylaxis due to drugs administered by the anaesthetist. Five of them involved profound hypotension and cardiac arrest and in the other two the major initial presentation was severe bronchospasm/bronchoconstriction and hypoxia with subsequent cardiac arrest. In four of the cases, the trigger agent was a non-immediate reaction (e.g. succinylcholine, fentanyl, mepipvacaine, lidocaine). In four cases, the trigger agent was a non-immediate reaction (e.g. succinylcholine, mepipvacaine, lidocaine). In one case, the trigger agent has been given a delayed reaction (e.g. epinephrine) and the patient was a non-immediate reaction. In one case, the trigger agent was a non-immediate reaction (e.g. epinephrine) and the patient was a non-immediate reaction.

Aspiration (five)

There were five deaths due to pulmonary aspiration, four of which occurred in the setting of endoscopy with an unprotected airway. One case involved a patient who had a 2-hour history of chest pain, in the setting of ongoing bleeding, and in the absence of any anaesthetist, the endoscopist administered sedation and aspiration before repeat endoscopy. The patient had a cardiac arrest which was attributed to aspiration of blood, hypoxaemia, and underlying cardiac disease. There were also three other cases of aspiration in which high-risk upper GI endoscopy was performed under anaesthesia without protection of the airway. In an elderly frail patient with an incarcerated umbilical hernia, an emergency physician trainee attempted to reduce the hernia under intravenous sedation, but abandoned the procedure due to agnoea and aspiration.

Cardiac arrest (three)

There were three deaths involving cardiac arrest resulting from inappropriate choice or application of anaesthesia technique. There were two patients with multiple co-morbidities who suffered cardiac arrest after induction of anaesthesia, both of whom received excessive doses of induction agents. One of them was also scheduled for emergency surgery and was hypovolaemic. Another patient with severe cardiac disease died during intravenous sedation for diagnostic endoscopy, as a very minor procedure that was not either required at all or could have been performed under local anaesthesia alone.

Invasive procedure related deaths (five)

There were five deaths associated with the use of a pulmonary artery catheter (PAC) used for monitoring during surgical cardiac care. Pulmonary artery rupture was attributed to uncertainty regarding the position of the PAC and inappropriate advancement. Another death resulted from inadvertent misplacement of a central venous device intended to provide parental nutrition. There were issues associated with the type of catheter used and the monitoring of its position after insertion.

Note: Both these cases involved uncertainty about the anatomical position of the vascular access device.

Mortality reports can be found on the ANZCA website at www.anzca.edu.au/resources/college-publications

The Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) has had a successful year with an increase in the number of sites registering and incident reporting rate.

Sites registered

<table>
<thead>
<tr>
<th></th>
<th>Nov 13</th>
<th>Nov 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>49</td>
<td>56</td>
</tr>
<tr>
<td>New Zealand</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>71</td>
<td>80</td>
</tr>
</tbody>
</table>

There are 80 registered sites as of November 1, a 31 per cent increase since the same time last year. Fifty six of the sites are in Australia and 24 are in New Zealand. One of the barriers to registering a site in Australia is the need for ethics approval. However smaller hospitals, private practices, day surgeries and individual practitioners may accept the ethics approval of another human research ethics committee (HREC). ANZTADC plans to simplify the process by allowing this to be accepted online. With the help of a working committee, the advice of that committee should be sought regarding the best approach for these situations.

There is also a requirement for an agreement for the data to be used for analysis by ANZTADC. While this might seem obvious, a formal process is still required. This has previously been conducted by a signed agreement but in future versions of the program this agreement will also be able to be completed online.

Incident reporting summary

<table>
<thead>
<tr>
<th></th>
<th>Sep 13</th>
<th>Sep 14</th>
<th>Sep 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory/airway</td>
<td>485</td>
<td>732</td>
<td>768</td>
</tr>
<tr>
<td>Other organ</td>
<td>95</td>
<td>68</td>
<td>47</td>
</tr>
<tr>
<td>Neurological</td>
<td>107</td>
<td>160</td>
<td>167</td>
</tr>
<tr>
<td>Miscellaneous/other</td>
<td>126</td>
<td>187</td>
<td>194</td>
</tr>
<tr>
<td>Medical device/equipment</td>
<td>304</td>
<td>377</td>
<td>387</td>
</tr>
<tr>
<td>Medication</td>
<td>323</td>
<td>456</td>
<td>475</td>
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<tr>
<td>Infrastructure/system</td>
<td>124</td>
<td>174</td>
<td>178</td>
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<tr>
<td>Nonsurgical</td>
<td>129</td>
<td>442</td>
<td>480</td>
</tr>
<tr>
<td>Assessment/documentation</td>
<td>127</td>
<td>176</td>
<td>183</td>
</tr>
<tr>
<td>Total</td>
<td>1957</td>
<td>2772</td>
<td>2882</td>
</tr>
</tbody>
</table>

ANZTADC received 2772 incident reports and 85 for the 12 months to September 2014. This represents a 42.6 per cent increase since September 2013. This may be attributed to the successful promotion of webAIRS, the increased recruitment of sites and to the use of webAIRS as a tool to facilitate practice evaluation and obtain CPD credits. This trend continued to the beginning of November, with a further 4 per cent increase.

Presentations at national and international meetings this year have included the Asian Australasian Congress of Anaesthesiologists (AACA), Australian Symposium on Ultrasound and Regional Anaesthesia (AUSRA) and the New Zealand Society of Anaesthetists (NZSA) combined meeting (February 2014), the Airway SIG Meeting (May 2014), the Combined Scientific Meeting for ANZCA (May 2014) and the Australian Society of Anaesthetists National Scientific Congress (October 2014).

During the interim analysis of the data by ANZTADC, one of the interesting points that have been noticed is that in some cases there is an initial difficulty in reaching the correct diagnosis. At the time an incident is evolving, the clinical signs observed may vary and the anaesthetist may be performing other routine tasks. There is a natural tendency to treat the most likely cause of the initial sign before formally looking for alternative diagnoses. The anaphylaxis data presented at the recent ASA NSC supported this conclusion.

First sign of anaphylaxis

<table>
<thead>
<tr>
<th>Not stated</th>
<th>Desaturation</th>
<th>Arrhythmia</th>
<th>Rash</th>
<th>Respiratory event</th>
<th>Hypotension</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>17</td>
<td>12</td>
<td>15</td>
<td>15</td>
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<tr>
<td>Total</td>
<td>64</td>
<td></td>
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</tr>
</tbody>
</table>

The first sign of anaphylaxis was stated in 81 of the 82 incidents that were analysed. The most common sign was hypotension but it was interesting to note that this was observed first in less than half the cases. Respiratory events, which included desaturation, bronchoospasm and high ventilation pressure, were noticed as the first sign in 27 cases, which is almost as frequent as hypotension. A rash was noticed first in 12 cases and arrhythmia, which included two cases of cardiac arrest, in seven (8.5 per cent) cases. This resulted in other interventions before adrenaline was used, but vasopressors were used first in five of the cases and adrenaline was used first in six.

The final outcome of the cases was generally good: 58 cases were admitted to either ICU or HDU, but CPR was required in 18 cases and the patient wasn’t intubated in two cases. The take home message from this interim analysis was that while anaphylaxis is an uncommon event, the unexpected falls in blood pressure, the development of difficulty in ventilation or the occurrence of arrhythmias should trigger a search for other signs of anaphylaxis. The observation of a rash is also important, but in general this does trigger an immediate search for other signs of anaphylaxis. It should also be noted that in severe anaphylaxis the rash may not emerge until the blood pressure has been restored.

ANZTADC thanks everyone who has submitted incidents and who are contributing to the wealth of data that is being collected.

ANZTADC received 2772 incident reports and 85 for the 12 months to September 2014. This represents a 42.6 per cent increase since September 2013. This may be attributed to the successful promotion of webAIRS, the increased recruitment of sites and to the use of webAIRS as a tool to facilitate practice evaluation and obtain CDP credits. This trend continued to the beginning of November, with a further 4 per cent increase.

Presentations at national and international meetings this year have included the Asian Australasian Congress of Anaesthesiologists (AACA), Australian Symposium on Ultrasound and Regional Anaesthesia (AUSRA) and the New Zealand Society of Anaesthetists (NZSA) combined meeting (February 2014), the Airway SIG Meeting (May 2014), the Combined Scientific Meeting for ANZCA (May 2014) and the Australian Society of Anaesthetists National Scientific Congress (October 2014).

ANZTADC thanks everyone who has submitted incidents and who are contributing to the wealth of data that is being collected. Contributing incidents or analysing incidents is eligible for 2 CDP credits per hour. If you wish to register, then register online at www.anzca.net, or if you would like to be involved in the analysis of incidents already collected, please contact ANZTADC at anzta@anzca.edu.au.

The Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) has had a successful year with an increase in the number of sites registering and incident reporting rate.

Safety and quality

First sign of anaphylaxis

<table>
<thead>
<tr>
<th>Not stated</th>
<th>Desaturation</th>
<th>Arrhythmia</th>
<th>Rash</th>
<th>Respiratory event</th>
<th>Hypotension</th>
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<tr>
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<td>17</td>
<td>12</td>
<td>15</td>
<td>15</td>
<td>15</td>
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<tr>
<td>Total</td>
<td>64</td>
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Updated ACHS Clinical Indicator Set – Anaesthesia and Perioperative Care Clinical Indicators

The Australian Council on Healthcare Standards will publish its revised clinical indicator set for anaesthesia in January. ANZCA's professional documents are acknowledged and used to underpin the revision. The changes will be of interest to anaesthetists, as well as to other clinicians who contribute to perioperative care.

ANZCA's CFD program places increased attention on practice evaluation, which includes audit. Clinical audit can address structure, process or outcome measures.1 Interestingly, facilities have struggled to demonstrate compliance with mandatory accreditation standards in Australia.2

In part as recognition of the expanded role of the anaesthetist as perioperative physician, the indicator set has been renamed the Anaesthesia and Perioperative Care Clinical Indicators (Version 6.1). The working party deleted one clinical indicator and introduced four new clinical indicators, which reflect that quality perioperative care relies on well functioning teams, with good communication skills and processes for task allocation, delegation and handover.3 Where available, the new clinical indicators relate to a relevant ANZCA professional document.

Quot “smoking” advice has been identified by ANZCA in PS12 as an important component of pre-operative care, and a new clinical indicator has been introduced to reflect the proportion of smokers who are offered such advice and support. Irrespective of the challenges of day of surgery admissions and private practice, it is possible to incorporate such advice and support and this aligns with National Standard 3.

Wrong side regional anaesthesia block has been reported in the literature, and is an important component of pre-operative care, a new clinical indicator has been introduced to reflect the proportion of smokers who are offered such advice and support. Irrespective of the challenges of day of surgery admissions and private practice, it is possible to incorporate such advice and support and this aligns with National Standard 3.

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Dean’s message

As the end of the year approaches it is time to reflect on the progress made by our Faculty and to consider our wider strategic plan and direction. Our accomplishments over the past 12 months have been immense. I will touch on a few here.

**Curriculum Redesign Project**
Training and education of specialist pain medicine physicians lies at the heart of the Faculty’s role. The revised FPM curriculum and training program was launched in September and will create a first-class training program, leading the world in its structure and philosophy.

The revised curriculum is competency-based and focused on particular CanMEDS roles, especially the Pain Medicine Roles in Practice of clinician, professional, scholar, communicator, collaborator manager/leader and health advocate. It focuses on the patient’s perspective rather than be driven by the skills of the doctor, incorporating ongoing work-based formative assessment and progressive summative assessment, completed in two stages, the core training stage and the practice development stage.

The core training stage is a mandatory 44-week period of approved activity chosen by trainees, and directly relevant to pain medicine. Examples include chronic pelvic pain, consultation liaison psychiatry, paediatric pain medicine, pain medicine in aged care, palliative care, physical interventions, rehabilitation medicine or a research project. Trainees will be required to submit their learning plan for approval by the Faculty assessor and the supervisor will be a Faculty Fellow (exceptions may be considered). There will be a long case assessment and summative assessments, including the fellowship examination with written and viva voce sections.

New Zealand trainees will start the revised training program in December 2014 and Australian trainees will start in January 2015. My grateful thanks go to Dr Meredith Craigie and the FPM Curriculum Redesign Steering Group for all their hard work in this regard.

**Better Pain Management**
Better Pain Management – Pain Education for Professionals is an interactive online education program that aims to foster consistency and excellence through a multi-disciplinary approach to the management of pain. Development is underway on a further six modules and Fellows will soon be approached to join the authoring groups. The updated original six pain management education modules are ready for use by the allied medical disciplines.

**Pain device implant registry**
A high level business plan seeking industry support for this Faculty initiative was presented to key stakeholders, including industry, Medical Technology Association of Australia and the Australian Commission on Safety and Quality in Health Care and there is strong support with an appropriate governance structure. Medtronic provided seed funding to allow the project to progress in its early stages and Monash University won a tender as a university partner to develop, maintain and manage the registry. Once contractual arrangements are finalised, a steering committee will be formed. The longer term aim is to get the government to facilitate a funding system where industry is charged per device to fund it.

**Electronic persistent pain outcomes**
This working group continues to make good progress led by Professor Stephan Schug and his team. The mammoth task is much appreciated. It is anticipated the publication will be launched at the 2015 annual scientific meeting in Adelaide.

**Conclusion**
Thank you to all those who have contributed to our Faculty’s success this year. There are too many people to name but they include the many Fellows who work hard on our committees (in education, examination, hospital accreditation, research, professional development and scientific meeting oversight) and sub-committees, our assessor, deputy assessor, and treasurer, my fellow board members, the chairs of all our portfolio committees, regional committees, and the NZ National Committee of FPM. Thanks also to Professor Milton Cohen, our director of professional affairs, and our general manager, Helen Morris, and her team, our ANZCA President Genevieve Goulding, the ANZCA CEO and her staff.

I am constantly amazed at the hours our Fellows donate to developing our Faculty. Thanks to you all. I wish all our Faculty Fellows and trainees a well-deserved rest and good health over holiday period.

Professor Ted Shipton
Dean, Faculty of Pain Medicine
Admission to fellowship of the Faculty of Pain Medicine

By examination:
Dr Gavin WEEKES, FCARCSI (Ireland),
Dr Chi Wing CHAN, FANZCA (Hong Kong).

This takes the total number of Fellows admitted to 366.

Foundations of Pain Medicine Examination

Trainees entering the 2015 training program undertook the first sitting of the Foundations of Pain Medicine examination on November 7. All 17 candidates were successful in this examination.

The 2014 Faculty of Pain Medicine clinical examination was held from November 29-30 at the Royal Adelaide Hospital, South Australia. The written examination was held on November 7. Thirty-two of the 42 candidates were successful. The Barbara Walker Prize for Excellence in the Pain Medicine Examination was awarded to Dr Martine O’Neill (NSW). Merit awards went to Dr Suzanne Cartwright (Vic), Dr James Jarman (WA) and Dr Wei Chung Tong (Vic).

The significant contributions of retiring examiners Professor Milton Coelen, Dr Matthew Crawford and Professor George Mendelson were gratefully acknowledged.

Experience mimics real life in hospital simulation training program

It’s the ultimate theatre of theatre. Improvisation calls on your sharpest skills and under the hot operating lights, you’re on a stage, and you’re on your own. The mannequin is life-like; its chest rises and falls with “breath”. Blood pressure and heart rate are monitored. The machine beeps. You’re on. Intubate.

Simulation training is an effective, engaging way of allowing anaesthesia trainees to confront scenarios they may encounter in their careers, says simulation training (SIM) supervisor Dr Adriano Cocciante.

In a mock-operating theatre at Sunshine Hospital, part of Western Health in Melbourne, Dr Cocciante and his colleagues Dr Navroop Johal and Dr Zoe Wake are enacting their third simulation exercise of the morning with a group of 12 anaesthesia trainees, two anaesthetic nurses and a surgical registrar.

Every exercise is structured in the same way – the trainees walk in, ready for their patient, but with no warning of their “condition” until briefed by the handover anaesthetist. They must proceed as they would outside of the training exercise – check vital signs, respond to them, let the surgeon know when they are ready for the procedure to begin.

At the end of the room is a reflective glass partition hiding a small space where the controls, microphones and dials are operated by Dr Cocciante, Dr Johal, Dr Wake and a technician. They manipulate the mannequin and call action.

The Tuesday morning the ANZCA Bulletin visited the training exercise, the 5’8” simulated patient was to undergo an apparently straightforward and low-risk gynaecological procedure. Somehow, though, the surgeon cuts through a blood vessel and unanticipated “bleeding” begins. Although the bleeding is clearly visible on the laparoscopic monitor, with an ear piece receiving prompts from Dr Cocciante, the surgeon underplay his mistake. Still backstage, the trainers dip the mannequin’s blood pressure, increase its heart rate and the dummy shows signs of early distress.

“The trainees must make the next call – do I ask for back up? The surgeon insists he has the surgery under control. A tweak of the monitors in the control room and the “patient” is critical. Simulated blood is leaked through a catheter which has been prepared ahead of the exercise and within 10 minutes the trainee is facing life and death of their patient.

“We do everything we can to make the scenario as realistic as possible,” Dr Cocciante says.

He says the training has the strong support of the anaesthetic and surgical teams at Western Health so all anaesthetic nurses and surgical registrars are able to attend the sessions and help recreate a “real life” theatre team.

“Thanks to the support of the anaesthetic and surgical departments here at Western Health, our anaesthetic nurses and surgical registrars all attend these sessions, which enable us to recreate a real life theatre team. Getting to know and understanding the points of view of other members of the theatre team assists in creating an efficient, relaxed environment which allows us to do our jobs better, the theatre team and the patient care.

“It tests the resourcefulness and communication skills, as well as technical skills of our trainees.”

A group of other trainees is called, unaware of the scenario they are entering, and they must operate as a team to get the patient under control. They must be briefed quickly and they must find a solution to a recalcitrant surgeon and a patient who is now bleeding out.

How do they cope if the mannequin dies?

“That’s still one of the controversies in simulation education – letting the patient die. We try to ensure that this doesn’t happen,” Dr Cocciante says.

“It’s our view that the emotional stress of that situation – you must remember we make this as realistic as possible and the participants get very involved, we all do – would greatly outweigh any educational benefit of the session.

“We don’t want to traumatise the participants, we want to expose them to a controlled hypothetical scene and support them to use their problem-solving skills – to put their theory into practice.”

Dr Cocciante is a passionate advocate of simulation training but it is a labour and resource-intensive model of education.

Funding has been allocated through ANZCA’s Specialist Training Program (STP) to enable Dr Wake to work as SIM coordinator for 50 percent of her full-time anaesthesia workload, Dr Cocciante and Dr Johal, who write the scenarios and roster the training, run the program while each carrying their own full-time clinical load.

“Having Zoe is a great privilege because the training is very time-consuming,” Dr Cocciante says.

“The planning, scheduling, the set up, and the documentation use a lot of resources. We’re very lucky to have the support and I know we are training a group of more empathic anaesthetists.”

Key to this high-fidelity training experience is the detailed debrief after every scenario – an hour is spent with Dr Cocciante and Dr Johal drawing out of the trainees what it felt like, how the scenario evolved, how planning is important and what they might take away from the exercise.

“In medical school, we learn how to ‘do stuff’, how to treat conditions, but nowhere, as yet, are the emotive, non-technical aspects of our work covered and simulation training gives us the opportunity to do that.

“The best learning happens at the edge of your comfort zone.”

Ebru Yaman
ANZCA Media Manager

From left: Dr Zoe Wake, Dr Adriano Cocciante and Dr Navroop Johal with a simulation mannequin; the simulated procedure underway; the mock operating theatre.
New institution, new beginning for anaesthesia in WA

For the first time in healthcare in WA, facilities management services will be provided in partnership with a private company (Serco Australia) under the direction of the State Government. Serco provides a range of non-clinical and support services within the hospital including security, building and grounds maintenance, transport, procurement, sterilisation, linen and cleaning.

Much of the clinical care and services at the hospital are co-ordinated via innovative information and communication technology systems. This includes a new digital medical record; automated guided vehicles to deliver linen and food; a pharmacy robot and automated medication units to replace anaesthetic drug trollies.

Discussions about the new hospital within the department of anaesthetics at Fremantle Hospital highlighted the importance of preparedness and safety as core values for our profession. Contingency planning and familiarity with both environment and equipment are strong themes in our training curriculum. The dynamics of teamwork, the principles of good communication and mitigating risk are reinforced in crisis resource management training.

And so the challenges were set: new processes and movement of old ones; a new building and new equipment; different systems and modes of operation; the highest standards of patient care; and the presence of patients and their relatives. Our task was to ensure that high-quality, safe and efficient care was borne out of the former and delivered to the latter.

There is no simple formula. Corporate behaviours associated with good outcomes during large institutional change frequently involve some form of operational readiness assessment. There is little in the medical literature, however, describing this in a clinical context. CRA plan has embedded a governance structure for clinical care from the beginnings of the hospital.

CRA was not only critical to the provision and design of perioperative systems. It was adopted hospital wide by the executive committee as a template for peer-reviewed simulation to determine their own CRA, ensuring that it remained appropriate, relevant and achievable.

Simulation was integral to the delivery of the CRA program at both departmental level and for the hospital as a whole. CST involved the use of high-fidelity manikins and immersive scenarios with professionals from healthcare, Serco and outside agencies such as the police and fire services. Multiple areas and systems were tested, often simultaneously, as the complex process of patient care was simulated.

Every CST was designed around detailed multi-disciplinary objectives. Extensive de-briefs proved invaluable in highlighting potential systemic issues. Undoubtedly, we have unlocked the potential application of simulation way beyond clinical training and into the planning of whole hospitals.

Although we have focused so far on processes and systems, the potential challenges to developing effective teamwork are just as critical. FSH is a new service with a mix of staff from several institutions and blending these cultures presents some unique issues.

Developing a single team approach is the core philosophy of the service. FSH describes a "CARE" model (Commitment, Accountability, Respect & Excellence) upon which it has been founded. The CRA process was pivotal in building teams and reinforced engagement of staff members from all areas. It highlighted potential issues in a very clear format; provided an open forum for discussion and drove the implementation of change by working together.

All of this describes a small part of what has occurred in the past 12-18 months. We now find ourselves in the first part of our phased opening process, setting up a new anaesthetic department from scratch. That sounds like an exciting, appealing opportunity, right? And of course it is, but not without the odd challenge and a few extra grey hairs along the way ...

The challenges of starting a new anaesthetic department are manifold. There is great risk as well as great opportunity. Every challenge, however, presents us with an opportunity to affect change and make a difference. For that reason, no matter how insurmountable individual problems can seem in a project as big as this, we view it as a privilege to be involved in the beginnings of a new department that will last for decades to come.
Foundation news

Board of Governors
The Board of Governors will review recently compiled lists of organisations and individuals with a strong interest in improving community health outcomes, and develop contact strategies, during its December meeting. These lists will be used in approaches to prospective partners to present the Anaesthesia and Pain Medicine Foundation’s case for support.

The board has identified organisations from a wider spread of industry sectors than previously approached by the foundation, including leading corporations and foundations in health, health insurance, general insurance and banking and financial services.

The foundation greatly values the long-term support it already receives from the healthcare industry, and hopes this strategy will further diversify its supporter base.

The board also will discuss its strategy and criteria for identifying new member candidates and extending the geographic representation on the board during 2015.

In October, four board members joined hospital visits arranged by the foundation. Associate Professor David Scott hosted Ms Kate Spargo and Mr Rob Bazzani on a tour of Melbourne’s St Vincent’s Hospital, including the operating suites, intensive care unit and recovery room. Professor Paul Myles, head of anaesthesia and perioperative medicine at The Alfred in Melbourne, hosted an excellent tour for Ms Priscilla Bryans and Mr Bruce Brook.

The visits aim to give board members an inside view of the roles of anaesthetists and pain specialists, their influence on patient outcomes, and the importance of research in improving such outcomes.

Pfizer Australia
Pfizer Australia will continue as a major sponsor of the foundation during 2015. The sponsorship supports the pain medicine research support program, and will now be provided through the Pfizer Pain Care brand.

Pfizer Pain Care’s support will provide financial support for the general pain medicine research program and will not be linked to a specific project.

As part of new sponsorship arrangements, Pfizer Pain Care will promote the foundation’s fundraising and research grants program through its national field force. This will greatly assist in spreading the foundation’s message about the urgent need to increase donor support research.

The program will place promotional posters in healthcare locations nationwide.

Rotary Club of Glen Waverley dinner
A combined foundation and Glen Waverley Rotary Club dinner was held at ANZCA House on Monday October 20. At the request of ANZCA Fellow, past ANZCA Medallist, and active Rotarian Dr Peter Lowe, foundation general manager Rob Packer spoke about the foundation and its work. The presentation included reflections on international health-related fundraising and development experiences, and the generosity of donors in the Asia region.

Members were invited to consider supporting the foundation, and the club included the evening’s speech notes in its newsletter.

Thank you to the many Fellows and donors who have given so generously. Your support has helped the foundation more than triple its private fundraising growth since 2012, supplementing the continuous growth in funds available to distribute as grants.

The foundation team wishes all donors, supporters, Fellows and other readers a safe and happy festive season. As usual, gifts can be made through the foundation’s online donation page, by mail or by calling Rob Packer on +61 3 8517 5306.
Perth anaesthetist Professor Tomás Corcoran, and the ANZCA Clinical Trials Network (CTN) investigators and Monash University, have been awarded the largest National Health and Medical Research Council (NHMRC) project grant in the 2014 grant round for the Perioperative Administration of Dexamethasone and Infection trial (PADDI). This study was endorsed by the CTN Executive and will be co-ordinated through the network’s office at Monash University under the leadership of Professor Corcoran.

The success of this $A4.6 million grant application in a climate of increased competition for a reduced pool of funds (overall funded rate of 14.95 per cent) again demonstrates that ANZCA CTN investigators are world leaders in clinical research. It recognises the importance of anaesthesia in determining the outcomes of patients following surgery, and highlights the commitment of the ANZCA CTN to delivering high-quality evidence to support common anaesthesia interventions. This success also underscores the importance of network’s endorsement process, which involves rigorous peer-review of the protocol at the network’s annual strategic research workshop. This large grant builds on the success of the RELIEF and BALANCED trials in securing NHMRC funding in 2012.

PERRIOpoPerative ADministration of Dexamethasone and Infection - The PADDI trial

Millions of patients undergo surgery each year worldwide. Surgical site infections (SSI) occur in up to 12 per cent of these patients. Complications resulting from SSI lead to increased morbidity and mortality, and extended hospital stays, with an associated cost of up to US$10 billion per annum.

Dexamethasone is widely used by anaesthetists perioperatively, principally as an effective antiemetic to prevent postoperative nausea and vomiting (PONV). While the underlying molecular mechanisms of dexamethasone’s action are not fully understood, it is hypothesised infections may occur as a result of hyperglycemia and immunosuppression, in particular in diabetic patients who are already at increased risk of complications. How dexamethasone impacts blood glucose levels, and its association with surgical site and other infections, has not been definitively established. This is an important health priority as in Australia alone up to one million patients will receive dexamethasone as part of their anaesthesia care annually.

The study aims to definitively establish the safety profile of dexamethasone in the perioperative setting. Specifically, it will address the impact of dexamethasone on surgical site infection (primary outcome) and will be stratified according to diabetic status.

Summary

Study size
8800 adult patients worldwide.

Study design
International multi-centre prospective, double blind, active control, parallel assessment, stratified, non-inferiority safety and efficacy study.

Primary outcome
Surgical site infection within 30 days.

Secondary outcome
Infection from other sources, including pneumonia, systemic sepsis at 30 days and one year, quality of recovery, acute and chronic pain, hospital stay and disability free survival up to one year, cancer recurrence, WHOQoL score, association between diabetic status and infective outcomes.

Study population
Adult patients, ASA physical status 1-4, undergoing non-urgent or time critical, non-cardiac and non-neurosurgical surgical procedures using general anaesthesia with or without regional block, post-op stay of minimum of one night.

Study duration
Final follow-up at one year post procedure.

We look forward to getting this study underway and having your site onboard in 2015. For up-to-date information visit www.anzca.edu.au/fellows/Research and to register your interest, please email the ANZCA Clinical Trials Network at ctn@anzca.edu.au.

Pilot grant funding

The ANZCA Clinical Trials Network pilot grant has been awarded to Dr Joreline van der Westhuizen for her project “The effect of upfront administration of Fibrinogen concentrate in obstetric haemorrhage – a pilot study”. Professor Alan Merry received CTN endorsement for his study “Apprehending micro-organisms injurious during anaesthesia: The ‘Z bugs’ randomised controlled trial to reduce surgical site infection” (Z bugs). The CTN Executive congratulates and thanks both Dr van der Westhuizen and Professor Merry for presenting their studies at the annual strategic research workshop this year.

7th Annual Strategic Research Workshop 2015 – save the date

The ANZCA Clinical Trials Network is pleased to host its seventh annual strategic research workshop at Sanctuary Cove, Queensland from August 14-16, 2015. This meeting will feature discussions on new research ideas, keynote presentations from Professor David Vaux and Dr Jessica Kasza, research co-ordinators and early career researchers workshops, and plenty of opportunities for social interactions with fellow researchers. Lock in the dates for what will be another enjoyable meeting, filled with thought-provoking ideas for clinical research. For up-to-date information, visit www.anzca.edu.au/fellows/Research/anzca-clinical-trials-network-events.html

Name change announcement

The ANZCA Trials Group is proud to announce its name change to the ANZCA Clinical Trials Network (CTN). The name change brings our name into alignment with other clinical trials networks locally and internationally. The name change also represents the growth in the size and extent of our collaboration with ANZCA Fellows and trainees and other healthcare professionals here and around the world. The CTN Executive will continue to operate under the same structure and report to the Research Committee. The new general inquires email address is ctn@anzca.edu.au. All other contact details remain the same.

Karen Goulding
ANZCA Clinical Trials Network Co-ordinator
Study highlights prevalence of accidental awareness

The Royal College of Anaesthetists’ National Audit Projects investigate anaesthesia-related problems with low incidences, such as complications arising from neuraxial blockade and failed endotracheal intubation. The latest project, NAP5, was conducted in collaboration with the Association of Anaesthetists of Great Britain and Ireland, and investigated accidental awareness during general anaesthesia in the UK and Ireland. The results were published in September 2014.

Awareness during general anaesthesia continues to be reported despite increased “awareness” of the issue and improved monitoring, and so was a suitable topic for NAP5. A network of study co-ordinators was established in all UK and Irish public hospitals. All new reports of awareness in these hospitals were collected over one calendar year. Data included the nature of the event, details of anaesthesia and any sequelae. Reports were entered into a central database and were categorized by a multidisciplinary panel. It is important to note that a history of awareness was not systematically sought from every patient – only spontaneous reports made by patients to their carers were recorded. A parallel national anaesthetic activity survey provided denominator data (nearly three million patients).

The incidence of certain/probable and possible accidental awareness cases in NAP5 was 119,600 anaesthetics with a higher incidence reported during relaxant general anaesthesia (1:8200) and caesarean section (1:670). Most cases of awareness occurred during induction and emergence. Risk factors for awareness included rapid sequence induction, obesity and difficult airway management. Depth of anaesthesia monitors were used only in about 3 per cent of the general anaesthetics in the UK and 9 per cent of the general anaesthetics in Ireland. Interestingly, these monitors were more likely to be used in patients who ultimately reported awareness, an observation almost certainly due to selection bias (with high-risk patients being monitored). NAP5 reported that most patients found their awareness distressing and many suffered debilitating sequelae.

NAP5 was praised for the high degree of engagement of public hospitals in the UK and Ireland, and for the wealth of detailed information about patients’ experiences of awareness that were collected. However, it was widely acknowledged that the project’s reliance on spontaneous reports probably led to a significant underestimate of the true incidence of anaesthetic awareness. This would explain the difference in the reported incidence of awareness between NAP5 and studies in which awareness is systematically sought: these studies more often report incidences of awareness around 1:1000. On the other hand, the awareness episodes in NAP5 did not necessarily have to occur during the study period – some episodes occurred prior to commencement of the study. This means the timeframe of the numerator was larger than that of the denominator leading to an overestimate of the incidence of spontaneously reported awareness.

What does NAP5 mean for anaesthetists in Australia and New Zealand? The study has shown that anaesthetic awareness continues to be a problem in a healthcare system very similar to our own, and that certain patients are more at risk than others (those receiving muscle relaxants, with difficult airways and having caesarean section in particular). The study does not provide any reliable data about the utility of depth-of-anaesthesia monitors in preventing awareness, and so existing guidelines should be followed.

Perhaps the most important message is that when UK and Irish hospitals, departments and individual anaesthetists worked closely together towards a common goal and were supported by college-funded co-ordination, important new information was produced that advances the cause of safe and high quality anaesthesia care. This also is the goal of our own ANZCA Clinical Trials Network (please contact Ms Karen Goulding, ANZCA CTN co-ordinator at ctnpanzca.edu.au for information about participating in our studies).

Professor Kate Leslie, FANZCA
Royal Melbourne Hospital

References:
Successful candidates

Primary fellowship examination
August/September 2014

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

AUSTRALIA

Australian Capital Territory
Louisa Alice Kippin

New South Wales
Adi Pavan Prabhala
Breton Sanderson
Christopher Wai Keng Yong
David Brian Reid
Deegala Niranjali Anuradha
Dominique Parnell
Erika Amy Wear
Grace Yee-Hua Ho
Johnny Lester Burston
Mirela Ana Markovic
Nicola Jane Allwright
Phoebe Mills
Renee Dianne Burton
Rustin John Quin
Sahil Kumar Mathur
Simon Gomez-Vieira
Tinaaab Dofola
Victor Chan

Queensland
Adam Lindsay Bacchi Keys
Andrew Godfrey Wright
Angela Rachel Tognolini
Boon Tien Chang
Chloe Lauren Butler
Iain Doherty
Kavindri Rashmi Jayatilleka
Lucas Dugdale Edwards
Maryann Cristina Turner
Nevin Mark Fernandez
Scott Martin Popham
Shannon Lynsay Morrison
Simone Lauren Fagan
Tiffany Ellen Holmes
Timothy D. Rance

South Australia
Alister Mark Mathieson
Divarab Sudhanthira Kumar
Ian Chiat Lim
Phong Lam Markman
Rebecca Jeffery
Yap Phak Hor

Northern Territory
Rain Jackson

Victoria
Adam Daniel John Sutton
Adriana Mira Ribbo
Alison Thría
Anday Altas
Andrew Alexander Campbell
Andrew Christopher Jarzebowski
Andrew William Downey
Elliot Marcel Schullberg
Evan James Thompson
Fleur Roberts

Helen Kim Hong Nguyen
Hieun Minh Lam
Hoimin Prasai Thapa
Jonathan Andrew Galtieri
Joseph William Speekman
Liam Colm O’Doherty
Kellie Louise Brick
Meghan Frances Cooney
Michelle Andrea Haeusler
Tejinder Kaur Metto
Tom Callahan

Western Australia
Arya Gupta
Christopher McGrath
David Forbes Hamilton
Grace Yee-Hua Ho
Johnny Lester Burston
Mirela Wilke
Parris Alexandra Dove
Samuel James Fitzpatrick
Steven Michael De Luca
Thomas James Ryan

NEW ZEALAND

Alastair John Proud
Anna Waylen
Ashwini Maduka Nanayakkara Kahawatta
Cara Wanda Thomson
Catherine Louise White
Charlotte Emily Adamsom
Connor Patrick Hughes
Elizabeth Rose Dunn
Emily Charlotte Buddhicom
Emily Elizabeth Morton
Felicity Judith Dominick
Galina Andrea Gaidamaka
Gareth Shivantha Ansell
George Bowell
Grant Mathew Frow
James Richard McAlpine
Jee Young Kim
Jonathan Ashley Panchurkhst
Lora Borisavlova Pencheva
Martin Gay Hurst
Matthew Paul Musker
Matthew Stephen Kirk-Jones
Natalie Rose Jarvis
Nicola Smith
Nip Ken Ka Kin
Orla Helena Ryan
Petra Maria Van Der Linden-Ross
Richard Paul renew
Sai Venkata Raja Rao Palepu
Sanamtha Seelawathie Paul
Samuel Poriana Wall
Stephanie Laura Pettit Clark
Thida Ching
Timothy Patrick O’Brien

Renton Prize
The Court of Examiners recommended that the Renton Prize for the half year ended March 31, 2014, be awarded to:

Dr Steven Michael De Luca,
Western Australia

Dr Steve De Luca, from Royal Perth Hospital in WA, studied medicine and sports science at the University of Edinburgh and is a dual anesthesiologist and emergency department trainee. He also has worked in Bunburry and Joondalup. His sub-specialty interests include trauma, toxicology and rural and remote medicine and he plans to pursue a career in anaesthesia and emergency medicine, working towards collegial patient care and shared learning between specialties.

The Court of Examiners recommended that the Renton Prize for the half year ended May 31, 2014, be awarded to:

Dr Adam Mahoney,
New South Wales

Dr Adam Mahoney, from the North West Regional Hospital in Burnie, Tasmania, won the Renton Prize, awarded for the highest marks in the ANZCA primary examination, in July 2014. Dr Mahoney studied at the University of New South Wales before working in Hobart and rural Tasmania. He is interested in medical education and perioperative medicine and plans to pursue a career in the Australian Army.

Merit certificates
Merit certificates were awarded to:

Gabrielle Papeix, New South Wales
Kellie Louise Brick, Victoria
Samuel Poriana Wall, New Zealand

Final fellowship examination
August/October 2014

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

AUSTRALIA

Australian Capital Territory
Christopher Harold Van Leuven

New South Wales
Amardeep Singh
Andrew John Arrowmith
Arjun Sido
Claire Louise Goldsborough
Dammage Hasith Vishapavarthi
Wickramaratne
David Dao
David Sai Wo Cheng
David Ziggy Fyfe
Hee-Sun Kim
Jesse Ly
Joshua Frank Rzysztek
Karina Simone Renzin
Margot Elizabeth Heaney
Neil David Branch
Robert John Scott
Sivapathasundaram Achuthan
Wei-Jie Zhuo

Northern Territory
Jonathan James Nicholson

Queensland
Adam Richard Storey
Chia Yee Jen Jane
Christian Horst James McMahon
Christopher Scott Lamon
Daniel Hyde
Dominic Peter Ormsby
Edney Richardson
Eliza Jane Dorey
Holmes Dawe
Rajnie Murali

Western Australia

Adam Isaac Mossenson
Andrew John Arrowmith
Andrey Ivan Meng Lee
Andrew Peter Challen
Anna Michelle West
Christine Siang-Vin Ong
Duncan Bunning
Graeme Howard Johnson
Rajiv Menon

Renton Prize
The Court of Examiners recommended that the Renton Prize for the half year ended December 31, 2014, be awarded to:

Steven Michael De Luca,
Western Australia

Dr Steve De Luca, from Royal Perth Hospital in WA, studied medicine and sports science at the University of Edinburgh and is a dual anesthesiologist and emergency department trainee. He also has worked in Bunburry and Joondalup. His sub-specialty interests include trauma, toxicology and rural and remote medicine and he plans to pursue a career in anaesthesia and emergency medicine, working towards collegial patient care and shared learning between specialties.

The Court of Examiners recommended that the Renton Prize for the half year ended May 31, 2014, be awarded to:

Dr Adam Mahoney,
New South Wales

Dr Adam Mahoney, from the North West Regional Hospital in Burnie, Tasmania, won the Renton Prize, awarded for the highest marks in the ANZCA primary examination, in July 2014. Dr Mahoney studied at the University of New South Wales before working in Hobart and rural Tasmania. He is interested in medical education and perioperative medicine and plans to pursue a career in the Australian Army.

Merit certificates
Merit certificates were awarded to:

Gabrielle Papeix, New South Wales
Kellie Louise Brick, Victoria
Samuel Poriana Wall, New Zealand
Evaluating the curriculum – quality improvement and seeking feedback

The focus of the evaluation has been on numerous areas, and on November 17 a group of key stakeholders including the ANZCA Education, Training and Assessment Development Committee (ETADC), the former Assessments Committee, and key staff members conducted a comprehensive review. The objective of the review was to evaluate the curriculum and identify areas for improvement.

Key areas being monitored this year include the analysis of feedback relating to introductory training, volume of practice requirements including cases and feedback on the curriculum in rural and metropolitan training. The TPS is the tool that is crucial for effective training recording and monitoring. In 2015, a modular review of the TPS will be occurring in addition to the development of a product roadmap – this phased, feature-based approach to achieve the total state of TPS for the future.

Two-years have passed since the introduction of the 2013 curriculum and ANZCA is committed to its ongoing improvement. This includes looking at the learning outcomes, the learning and assessment tools and processes, the training portfolio system (TPS) and the information available in the handbook for trainees, supervisors and tutors.

Evaluation is overseen by the Education, Training and Assessment Development Committee (ETADC), chaired by Dr Damian Castanelli (Victoria) and a series of activities have been running according to the five-year evaluation plan developed by the former Assessments Committee, chaired by Associate Professor Jenny Weller (New Zealand). The modular review due in 2015 will ensure gaps in functionality and improvements in usability are all reviewed comprehensively. Throughout the second half of 2014, a TPS strategic planning activity has occurred to seek the desired features of the TPS from users - this occurred at local sessions with trainees and supervisors. This strategic planning combined with findings of the modular review will inform the TPS product roadmap.
New approach for training site accreditation

A revised online system will simplify evaluation methods and be paper free. In order to offer ANZCA’s training program, a site needs to be accredited according to the approved standards and guidelines. ANZCA’s accreditation process is manual and fragmented, resulting in labour intensive and sometimes inefficient practices. It also does not allow for insight into a hospital’s performance during the seven-year accreditation period unless issues are raised and reported. Due to the manual nature of the existing process, hospital data often has to be re-collected, reviewed and re-validated, resulting in process overheads that can cause frustration among Fellows, trainees and ANZCA staff.

A new approach to training site accreditation will be launched in 2015. This approach combines a new online accreditation system, a revised datasheet supported by, and comprehensive reports based on, logged information from the training portfolio system. The revised process simplifies the evaluation of a training site with focus on the imperative aspects of ANZCA’s training program. The technology is an easy-to-use, cohesive, online system that has been tailor made for training site accreditations and will enable the entire process to be paper free. In addition to revising the process and technology, the reports based on the information logged by the trainees will provide an insight into the culture and quality of training offered by the training site between accreditation visits, removing the need for trainee workload surveys from accreditation visits.

Fellows interested in going on hospital training accreditation visits on behalf of ANZCA are encouraged to apply to tac@anzca.edu.au. The role involves being part of a training site accreditation team that undertakes on site visits under the direction of a team leader and contributing to reports for the Training Accreditation Committee. It also involves the participation in training workshops and keeping up to date with relevant ANZCA policy and processes. Fellows undertaking this role are eligible for continuing professional development points.

There will be a workshop held at ANZCA House on April 10 next year. For more information on requirements or details of the workshop please visit the website or email tac@anzca.edu.au.

New education resources coming to Networks

The Education unit is launching three new learning resources in Networks, coming this month and early 2015.

Primary examination preparation resource

This new eLearning resource for the primary examination provides trainees with:

- Insights into the exam process.
- Useful tips for preparing for the exam.
- Information about what happens on the day.

The primary examination is a major milestone in a trainee’s career and can involve months of study leading up to sitting the examination.

The resource will offer a series of videos showing simulated vivas with trainees and examiners, so trainees can watch example vivas but also see examples of some do’s and don’ts. Other videos present trainees and examiners sharing their personal insights about the examination and advice to trainees on how to best prepare.

To complement the online resources there will also be two webinars in 2015 for trainees, delivering practical advice and tips for the examination during a one-hour interactive session with a facilitator.

The resources will be an invaluable tool for trainees preparing for the examination. The resources were launched in Networks on December 8. Access the resources in the curriculum teaching and learning network under “Basic training”.

Trainee orientation and support resources

The project group developing this resource is chaired by Dr Noam Winter, Co-Chair ANZCA Trainee Committee, Victoria. The resources are planned to launch in Networks early next year. Look out for them!

Supervisor orientation and support resources

The project group developing this resource is chaired by Dr Emily Wilcox, Supervisor of Training, NSW. The resources are planned to launch in Networks early next year.

These new resources for trainees will offer a range of tools, including:

- Simple, practical advice and tips for trainees in each training period.
- An overview of the important training milestones.
- Advice on balancing work and life.

The College is developing online resources to provide support for supervisors, in a simple and accessible format. The resource will offer a wealth of information and also provide an online collaborative network for supervisors to share their experiences.

The project group developing this resource is chaired by Dr Emily Wilcox, Supervisor of Training, NSW. The resources are planned to launch in Networks early next year.

Just some of the resources that will be available include:

- Tips on co-ordinating your team.
- Information on providing support and education for team members.
- Easy-to-use checklists for staying on track with requirements.
- Advice on looking after yourself and trainees.

Supervisors are vital to the ANZCA training program. The College is developing online resources to provide support for supervisors, in a simple and accessible format. The resource will offer a wealth of information and also provide an online collaborative network for supervisors to share their experiences.

The project group developing this resource is chaired by Dr Emily Wilcox, Supervisor of Training, NSW. The resources are planned to launch in Networks early next year.
Maintaining the business records of the College in a digital world

ANZCA holds a substantial collection of records created since its foundation in 1992 and a rich collection of historical records accumulated by its forebear, the Faculty of Anaesthetists, Royal Australasian College of Surgeons, established in 1952. For many years a professional archivist has managed ANZCA’s business records and the historical records of the College. The recent review of the College archives has identified potential improvements, including the development of a new archival strategy, the separation of the ANZCA business and historical archive functions, and the updating of policies and procedures. As the College produces more information and records, particularly electronically through systems such as the training portfolio system and continuing professional development portfolio system, more attention is being given to the business records and archives.

Part-time College Archivist Fraser Faithfull is now focusing on the business records of the College and working with Monica Cronin, the Curator of the Geoffrey Kaye Museum of Anaesthetic History, to hand over responsibility for historical records. ANZCA’s Honorary Archivist, Dr John Faulk, and Dr Christie, all, the Honorary Curator of the Geoffrey Kaye Museum of Anaesthetic History, also provide valuable assistance. The ongoing contribution of the members of the ANZCA History and Heritage Expert Reference Panel is gratefully acknowledged.

The “digital archive” of the near future is likely to be a system for managing electronic records over time within an enterprise, rather than a physical entity in its own right. ANZCA is adjusting to these changes by engaging consultants to review the College archives, maintaining awareness of initiatives taken by other medical colleges, and keeping up with best practice in the archival sector. The ANZCA Archives service is operating almost as usual while we implement changes:

• Several hundred boxes of archival records were sent to secure-offsite storage this year. The space freed in the archive storeroom at ANZCA House has been used by the ANZCA Library, which in turn provided extra space for the new heritage centre in Ultimo. Staff in the Records Management unit can obtain Fellow records directly from the offsite facility while trainee records are updated and maintained onsite.

• The ANZCA Archive is now focused on managing the business records of the College while the management of the historical collection is moving to the Geoffrey Kaye museum. Examples of historical records include photographs held by the College of past events and people, biographical information relating to deceased Fellows, old College and Faculty documents and letters, and anaesthetic records created by significant people. Questions about historic records can be directed to Monica Cronin, Curator of the Geoffrey Kaye Museum of Anaesthetic History, at museum@anzca.edu.au.

Examples of ANZCA business records include ANZCA Council and committee deliberations, information about past College initiatives, and information about College prizes and awards. Contact ANZCA Archivist Fraser Faithfull, at archivist@anzca.edu.au.

• During late 2014 contractors assisted in developing a new business records-focused strategy and update our policies and procedures relating to the management of business records and historical records. Our focus is on creating practical business solutions, which respond to the ways ANZCA staff create, store and search for their electronic documents.

Fraser Faithfull, ANZCA Archives

Ultrasound training in Papua New Guinea

On August 25 we started our long-anticipated journey to attend the 29th annual meeting of the PNG Anaesthetic Society held in the highland city Goroka. Joining me on the flight were PNG veteran and difficult airway specialist Dr Chris Acott, recognised researcher and anaesthetist Professor Andre van Zundert, his wife Vera Meussen, and Storz representative Layne Thompson, who has visited PNG numerous times and has supported multiple airway workshops in her effort to help out the local medical community.

Also on board was roughly 100 kilograms of excess luggage, mostly thanks to Sonosite, which generously provided three M-Turbo Ultrasound machines and Blue Phantoms for workshops, but also because of the countless medical supplies contributed by donors.

According to PNG Health Minister Michael Malabag, quoted in an issue of Island Business in October 2013, “Papua New Guinea has the highest incidence of mouth cancer in the world.” (As per cent of all cancers in PNG are oral cancers). But the world does not end here for anaesthetists in PNG. Questions such as: “How would you anaesthetise a patient with a spear sticking out of his chest vibrating in a sinus rhythm?” might sound like something from a Monty Python movie but reflects the day-to-day life in PNG, where fights to death between rival tribes – there are more than 500 tribes speaking an astonishing 800 identified languages – are a regular occurrence. (Ask Pauline Wake for the video should you ever meet her).

Of course, as it goes in PNG, many other topics were discussed and we are already in the planning phase for 2015. I warmly thank everyone who has supported our journey, especially to the ANZCA Overseas Aid Committee, which supported my trip through the ANZCA Overseas Aid Trainee Scholarship.

Ultrasound training in Papua New Guinea

Another interest of Dr Ball’s was the Forreger Company and the anaesthetic equipment and machines which they made. This company was founded in 1928 in Long Island, New York by two brothers, Dr and Mr Forreger. It began by making anaesthetic machines and evolved into a large company. The anaesthetic equipment was of very high quality and was used worldwide. One of their machines, the A-2000, was the first machine to use a demand valve, which allowed the anaesthetist to control the flow of gas to the patient. This machine was used in many countries, including Australia, where it was sold by the Westcoast Medical Equipment Company.

Historians can generate international goodwill which became evident at the time of the World Congress of Anaesthesiology in Buenos Aires in 2012. Dr Ball was a member of the congress and was responsible for organizing the history of anaesthesia session. She presented a historical overview of the development of anaesthesia in Argentina, including the use of ether and chloroform. She also discussed the role of women in anaesthesia, including her own work as a anaesthetist in Western Australia. Her presentation was well received and was published in the congress proceedings.

Dr Ball did most of her anaesthesia paper at the International Symposium on the History of Anaesthesia in London. She gained her FFARACS in 1988. In 1989 she was appointed assistant honorary curator of the Geoffrey Kaye Museum, the beginning of, so far, 25 years working with the College. She was appointed honorary curator of the Geoffrey Kaye Museum in 2013. During this time, Dr Ball also held the position of honorary archivist from 1999-2005, and from 2010-2013. She also gained her MD at Monash University in 2013 for her thesis “A History of Anaesthesia”. The same year she contributed to the success of a fascinating “Geoffrey Kaye Workshop” following the International Symposium in Sydney. Many items of interest were displayed in the Kaye Collection, a virtual tour and an amazing array of anaesthetic delivery systems.

Over the years, Dr Ball has interviewed a number of Australian and New Zealand Fellows who have made a significant contribution to anaesthesia and pain medicine. She started with informal recordings using her own video camera. This has now developed into the high quality “Anesthesia Stories” series of oral histories, displaying her fine interview skills. We are very fortunate to have a such a dedicated person as Dr Ball, who has already made a great contribution, to be honorary curator of the museum. We congratulate her and wish her well for the future.

Modern museums require every object to earn its place in their collections. Selection criteria applied throughout the sector include relevance, significance, provenance and documentation, condition (intactness and integrity), interpretive potential, rarity, representativeness, duplication and legal requirements. Having these criteria enables museum curators to consider the objects in a more objective fashion. Museums around the world ask how potential donations stack up against these criteria and the Geoffrey Kaye Museum is no exception. As we strive toward achieving accreditation via the Museums Australia (Victoria) Museum Accreditation Program, this question becomes increasingly important.

This year the museum was offered a Lidwill machine. Although not perfect, it was essentially intact, came with excellent, easily documented provenance, the legal owner was offering complete transfer of ownership, and it would fill a recognised gap in the collection. The museum happily accepted the offer and the Lidwill machine is prominently displayed in the new museum space.

Sometimes significant objects are hidden away for generations, emerging as a result of relocation, a departmental reshuffle or a good, old-fashioned clean out of a dark, dusty room. Despite having a collection of more than 5000 objects, there remain areas with little or no representation in the Geoffrey Kaye Museum of Anaesthetic History, including significant milestones in the specialty. Equally, some areas are over-represented and, in time, these will be measured against the criteria. The history of anaesthesia and pain medicine is rich and diverse and there will always be ways to improve the collection.

If you have an object you think may be of interest, please contact the museum via email museum@anzca.edu.au, tell us what you have, include a photo if possible and as much information as you have available.

Kaye portrait gets a face lift

Following the 1988 annual general meeting of the Faculty of Anaesthetists, Royal Australasian College of Surgeons, the Australian Society of Anaesthetists (ASA) presented to the Faculty a photographic copy of Robert Hannaford’s portrait of Dr Geoffrey Kaye. (Robert Hannaford was also a 2014 Archibald Prize finalist with a portrait of former ANZCA President, Professor Kate Leslie).

While always considered a gem, in the years that followed, its high profile location was also heavily sunlit and framing had been done without the benefit of conservation glass. The reproduction continued to fade and discolor until it began to look more like a ghostly apparition than a copy of an oil painting.

As part of ANZCA’s recent project to relocate the Geoffrey Kaye Museum of Anaesthetic History, it was decided the ASA would be asked to help arrange a new reproduction. The ASA agreed, the artist provided written permission to reproduce his work and the Sydney-based digital reproduction company provided excellent service, complete with postage to Melbourne.

A local framer was able to remove the frame, the glass was reused, conservation glass was added and the College made a solemn vow not to place the work in direct sunlight ever again. The portrait now resides in the gentle light of the foyer of ANZCA’s historic Ultimo building.

Dr Kester Brown
Melbourne, Victoria

Kester Brown has been involved in teaching and promoting the history of anaesthesia for 50 years.

Below from left: Dr Christine Ball; Dr Kester Brown; Brazilian anaesthesiologist and equipment developer Kentaro Takaoa and Carlos Parade – past president of WBFA and the only Latin American Honorary Fellow of ANZCA; masks and artifacts.

The Geoffrey Kaye Legacy

This year, Dr Christine Ball celebrates 25 years of involvement with ANZCA. She was appointed assistant honorary curator of the Geoffrey Kaye Museum of Anaesthetic History in 1989 and is now the honorary curator.

All historians must receive the spark of interest from somebody or somewhere to initiate their interest. Maybe it is a visit to the museum, such as Dr Rod Lidwill’s, which encouraged since at least 1966. It is fortunate that Dr Christine Ball was inspired to participate and help Dr Westhorpe with the Geoffrey Kaye Museum of Anaesthetic History since 1989. They prepared photographs of items from the collection to illustrate the front cover of Anaesthesia and Intensive Care and wrote cover notes for them. This was a major task requiring research on each subject for every issue for 22 years. It culminated in the publication of a beautiful book Historical Notes on Anaesthesia and Intensive Care (1982). Chris made a major contribution to this work.

Dr Ball has made a major study and created a web page of one of the early greats of anaesthesia, Joseph Clover, imagining the excitement when they found a whole diary of Clover’s from 1868-51 in a frame they thought contained a couple of pages of faded notes in the Geoffrey Kaye museum collection. Apparently this was gifted by Professor Robert Macnott (Oxford) to Geoffrey Kaye. This sparked an intense interest for Dr Ball who pursued in Britain and the US. She has met Joseph Clover’s great grandson in England and was awarded a Paul M. Wood Scholarship to research four of Clover’s diaries (1850-52 and 1867) and lecture notes from 1869 at the other major anaesthetic history collection in the Wood Library Museum in Park Ridge, Illinois (Chicago).

The local diary shows his beautiful hand written notes which illustrate the work of a close observer of the early days of anaesthesia.
The Medical Education Special Interest Group (SIG) convened the 2014 Combined SIG meeting, “Bridging the gap”, in Kingscliff, NSW on September 19-21. Professor Lambert Schuwirth, the first keynote speaker, spoke informatively on “bridging the gap between novice and expert”, and “bridging the gap between learning and testing” in an entertaining and engaging manner.

The second keynote speaker was Mr Hugh Mackay. A prominent social researcher and author of several books, most recently *A good life*, Mackay spoke on “Generation Y: what did we expect?” and “Why people don’t listen?” Both presentations stimulated interesting discussion and were enthusiastically received. Lessons learned for many attendees extended beyond clinical practice and into personal lives, with several anaesthetists remarking they now had a new understanding of their children!

This year the newest special interest group, Communication in Anaesthesia SIG was welcomed to the meeting. The chair of the SIG, Dr Allan Cyna, was a busy man; he ran the very popular workshop “practical hypotheses for the busy anaesthetist”, gave plenty talks and chaired communication sessions. Speakers organised by the Communication SIG were Dr Francis Lannigan and Dr David Sainsbury who work together to teach non technical skills. Their talk was “Foams R Us – safer Australian surgical teamwork”, which created lively audience participation on communication between surgeons and anaesthetists.

In the Welfare session, Dr Robin Youngson, who is an anaesthetist as well as the co-founder of Hearts in Healthcare movement, spoke on burnout in mid career. He also facilitated an insightful “reawakening purpose” workshop.

In the Management session, topics were focused on the gap between the roles in the operating room. Ms Ruth Melville, the President of ACORN, spoke on the role of anaesthetic nursing, and Dr Peter Roessler from ANZCA spoke about the training and expectations of the anaesthetic assistant.

The 2015 Combined SIG meeting will be organised by the Anaesthetists in Management SIG and will be held in Noosa Qld on September 25-27. The theme is “Innovation – Leadership – Accountability”. We look forward to seeing you in Noosa next year.

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**Perioperative Medicine Special Interest Group meeting**

The Perioperative Medicine Special Interest Group (SIG) held its annual meeting at the Outrigger Resort and Spa Little Hastings Street, Noosa Qld, from September 12-13. This year the SIG held the meeting in conjunction with the College of Intensive Care Medicine (CICM) Perioperative SIG and was entitled “Futile surgery: Avoiding unnecessary harm”. The meeting was well supported with close to 150 delegates in attendance.

Invited speakers included Dr Julie Mundy (cardiothoracic surgeon) and Mr Mohammed Ballal (general surgeon), who examined the concept of futile surgery from their perspectives. Dr Paul Lane (intensive care) and Dr Michael Purt (respiratory physician/intensivist) examined preoperative evaluation and futility in intensive care treatment. Other topics covered included perioperative stroke prevention, perioperative glucose control, palliative care for futile patients, and functional recovery from surgery.

This year the meeting offered a perioperative simulation training workshop, which was very well received by delegates.

A big thank you to the Perioperative Executive Committee and all our wonderful speakers who give their time freely to make the event possible.

Dr Dick Ongley, Co-convenor and Chair, Perioperative Medicine SIG
Dr Siva Senthuran, Co-convenor Chair, CICM Perioperative Medicine SIG
Dr Nic Randall, Co-convenor
Events hit the right note
Recent events held in New Zealand have been well subscribed and well received. The Foundation Teacher Course, held in Wellington September 17-19, attracted the maximum 38 participants keen to learn more about the role of the educator, planning effective teaching and learning, feedback to enhance learning, interactive learning and teaching, teaching in the clinical setting, teaching practical skills, authentic assessment and clinical supervision.

In 2015, there will be a Foundation Teacher Course in Auckland. A 2 day course (September 7-9), online courses starting on March 16 and July 23, and courses also in Adelaide, Hobart, Sydney and Perth. Registration is open for all courses as of February 27. See the ANZCA website for more information.

The New Zealand Education Sub-Committee workshop for supervisors of training on October 20 drew around 30 attendees, with every training site in the country represented. Both the workshop and meeting that followed gave them plenty of opportunity to discuss various issues in depth, with the training portfolio system (TPS) dominating. Attendees found it valuable to have access to head office staff. An Education Director Dr Brian Graham (via Skype) speaking about the vision and opportunities for ANZCA from a New Zealand perspective; General Manager Education Oliver Jones (in person) specifically addressing concerns about the 2013 curriculum and TPS; and General Manager Training & Assessments Lee-Anne Pollard (by phone) outlining three key training and assessment updates including applications for Provisional Fellowship, exam remediation interviews and expectations around trainees recording time in the TPS. The NZ National Committee’s decision to re-establish a forum for clinical directors of New Zealand’s anaesthesia departments to connect with each other and the College proved popular, with more than 30 delegates participating.

Five visiting lecturers available for 2015
The NZ Anaesthesia Education Committee has approved five visiting lecturers for 2015 under its NZ Anaesthesia Visiting Lectureship program. Those awarded lecturerships are:

• Dr Doug Campbell, Auckland DHB, “Changing practice with large trials”, a presentation that looks at outcomes research through vignettes of current and future clinical trials addressing simple questions on depth of anaesthesia, maintenance oxygen therapy and intra-operative haemodynamic management.

• Dr Ben Griffiths, Auckland City Hospital, “Emergency laparotomy perioperative outcome and quality improvement pathways: a United Kingdom and New Zealand perspective”, a talk that utilises Dr Griffiths’ experience in being a clinical lead for the design and implementation of an emergency laparotomy quality improvement project, when he was working as a consultant anaesthetist in the UK.

• Dr Jeanette Scott, Middlemore Hospital, “What is new in difficult and failed airway algorithms”, a presentation that builds on Dr Scott’s airway fellowship in Canada and subsequent work on the Canadian Airway Focus Group guidelines for difficult airway management, as well as her international teaching experience in airway management and airway skills.

• James Cameron, Hutt Valley DHB, “Simple steps to a safer block”, a presentation in which Dr Cameron shares knowledge he acquired during his recent fellowship studying regional anaesthesia in Canada.

• Dr Emma Patrick, Taranaki Base Hospital, with the topic “Life of a regional anaesthetist” and “Things I wish I had known”. The informal atmosphere encouraged trainees and specialists alike to share information, and the breaks and dinner that followed provided good networking opportunities.

By the end of November, there were 40 registrants for the inaugural ANZCA NZ Anaesthesia Research Workshop being held at Auckland City Hospital on December 4. The workshop brings together internationally recognised New Zealand researchers in anaesthesia to provide a guide for specialists, trainees and research nurses on how to become involved with and develop quality research. It will also provide an opportunity for novices to seek guidance and to network with research peers. In the afternoon, there will be a “Dragon’s Den”-type session, where participants present their research or ideas to a panel of experts to critique.

New Minister of Health
Dr Jonathan Coleman has been appointed Minister for Health following the resignation of Tony Ryall at the September election. Dr Coleman took his medical degree at Auckland University and has worked as a doctor in New Zealand, the UK and Australia. He obtained an MBA in London in 2000 and returned to New Zealand, working as a consultant on health sector issues and as a part-time general practitioner in South Auckland. Dr Coleman has been the MP for the Northcote seat since 2005, and has been in the National Government since 2008, serving in the cabinet since then in various roles, including as associate health minister (2008-11).

South Island-wide systems rolling out in 2015
The South Island Alliance, which consists of the five South Island district health boards, is moving closer to a single repository for clinical records and has been given ministerial approval for the introduction of a single patient information system to all South Island hospitals.

The South Island clinical workstation within the Canterbury, South Canterbury and West Coast district health boards. The system will provide clinicians with access to results, reports and encounters, and they will be able to search and display clinical documentation as well as laboratory results from one regionally accessible interface. Health Connect South will aggregate information that is currently stored in many different systems and present it in a single view for clinicians. The system is expected to make it easier for patients and district health board staff to move around the region.

Announcing the new patient IT system, then Health Minister Tony Ryall said the South Island Patient Information Care System would connect hospitals and health services in the South Island so that health professionals could share information securely and provide patients with better care. It will mean each district health board’s patient information system is replaced with a single regional system. It will also be able to manage patient appointments, admissions, discharges, and transfers.

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The First Flinders Resuscitation Refresher Course for Anaesthetic Specialists

The first Resuscitation Refresher Course for anaesthetists was held at the Women’s and Children’s Hospital in Hobart on September 29. The last meeting of the 2014 evening meeting series was well attended with 85 locals and 25 from remote sites Alice Springs, Darwin and Mount Gambier hospitals. Guest speaker Dr Debbie Knight, FANZCA, spent five years in the air force as a squadron doctor, including missions to Bougainville, East Timor, Singapore and Baghdad. She studied anaesthetics in Adelaide and Darwin and now works as a full-time partner in private practice. Dr Knight delivered an excellent presentation, opening with a historical story of Frances Burney, an 18th century English novelist’s personal account of having a breast surgically removed without anaesthetic due to suspected breast cancer. Burney was later able to describe the operation in detail, since she was conscious through most of it as it took place before the development of anaesthetics. Despite advances in anaesthesia, which in a 2007 BMJ poll was voted the third greatest advance in medicine after sanitation and antibiotics, a hauntingly familiar tale was told. Dr Knight went on to discuss more recent accounts of accidental awareness under anaesthesia, relevant studies and their outcomes.

The SA & NT CME Committee would like to thank all of the contributing speakers and corporate supporters over the 2014 CME series, as without their valuable support these important medical education meetings could not go ahead.

FPM pre-exam short course

This three-day course was held in Brisbane from September 19-21. A record 43 people attended this course which was again held in Brisbane for the fourth consecutive year. The FPM Queensland Regional Committee would like to thank the many course presenters together with the VIVA examiners, course convenors Dr Richard Pendleton and Dr Frank Thomas and Faculty staff for their commitment in bringing this course together over this period.

We understand the course format will change in line with the new curriculum and be hosted by another state.

Queensland weekend residential primary viva course

This course was held mid-September in the Queensland office. The number of candidates accepted into the course is limited by the number of doctors available as examiners. The course offers intensive Viva practice to regional candidates who have been invited to sit a VIVA in Melbourne. Initial regional applications are accepted from Queensland and then from other state’s regional areas if examiners are available. The other aim is to provide more time for formal feedback on presentation skills, which is rostered into the timetable.

The course is held over one and a half days and is broken into three sessions with some examiners opting to attend the full day and with some attending a single session and we are grateful for all assistance.

I would like to invite examiners to assist in 2015. The dates set for this course are:

March 28 and 29.
September 12 and 13.

Email: qldevents@panzca.edu.au

Dr Helen Davies
Course Convenor

Unique airway workshop in Hobart

For the first time in Tasmania, Hobart-based otorlaryngologists and anaesthetists came together to present a multi-disciplinary workshop on the “Management of the difficult airway”.

There was high demand, with the workshop being fully subscribed. The thirty registrants included anaesthetists, surgeons and intensivists from all states of Australia, as well as New Zealand.

Held at the impressive Medical Science Precinct in Hobart, the day commenced with lectures on identifying and managing the difficult airway from both a surgical and anaesthetic perspective. This was followed by hands-on workstations using cadaveric specimens to help hone practical skills. These stations focused on topics such as surgical anatomy, video laryngoscopy/direct laryngoscopy; fibre-optic intubation/ rigid bronchoscopy; jet ventilation; as well as emergency cricothyrotomy and tracheostomy. Following lunch there was a scenario-based workshop organised for anaesthetists.

A similar airway workshop, purely for anaesthetists will be held as part of the Tasmanian 2015 ASM on February 21 and 22. Dr Mike Challis greatly appreciated the time and effort contributed by the entire faculty. He explained that lessons learnt from this first workshop would help ensure that the February workshop will be just as positive for all participants.

Participants valued the small workshops that allowed plenty of individual hands-on learning; the opportunity to learn in a multi-disciplinary environment, and the opportunity to practice airway techniques on cadavers.

Feedback was very positive. Participants valued the small workshops that allowed plenty of individual hands-on learning; the opportunity to learn in a multi-disciplinary environment, and the opportunity to practice airway techniques on cadavers.

The course was jointly convened by Dr Michael Challis, anaesthetist and Dr Ana Nusa Naiman, otorlaryngologist, both based at the Royal Hobart Hospital. Dr Naiman said that the workshop provided a great pre-laryngology conference opportunity for surgical registrars to gain hands on experience.
Updates in Anaesthesia meeting
Sir Charles Gairdner Hospital and the WA Continuing Education Committee welcomed 140 delegates to beautiful Bunker Bay for the ANZCA/ASA WA Updates in Anaesthesia Meeting in October. The topic of “Crisis management” was chosen to complement the “Emergency response” component of the ANZCA CPD Program. In keeping with the ANZCA/PFM mission statement, “...serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine”, we are striving to ensure we remain up to date.

The “Emergency responses” CPD category ensures regular education in core emergency responses which may be encountered infrequently but remain essential to safe anaesthesia practice. The four areas, CICO, ALS, anaphylaxis, and massive blood loss were all covered by approved workshops and PBLs within this meeting. Additionally, presentations from local experts throughout the weekend encouraged the delegates to consider planning and preparing for crises, and provide updates on the management of crises in various clinical contexts, including adult, paediatric, obstetric and outside areas.

The WA office would like to thank the speakers and workshop facilitators for sharing their expertise and for committing their time and effort to another outstanding meeting. We are grateful to ANZCA President, Dr Genevieve Goulding who travelled from Brisbane to attend and present at the conference.

Other news
On November 14 Professor Britta Regli-von Ungern-Sternberg and Professor Michael Faech conducted the prize viva to determine the 2014 recipient of the ANZCA/ASA Gilbert Troup Prize in Anaesthetics. The successful candidate was Ms Natalie Smith.

The Faculty of Pain Medicine Exam was held on November 7, the Final ASA Committee Meeting was held on November 17 and the final ANZCA Regional Committee meeting was held on November 24. The CME Committee met on November 24 to discuss the upcoming Autumn Scientific Meeting and to discuss feedback from the Country Conference.

Please place the following dates in your calendars for next year: Autumn Scientific Meeting – March 14, 2015 held at the University Club and convened by Dr Lip Yang Ng. Winter Scientific Meeting – July 4, 2015 held at the University Club and convened by Dr Michela Salvadore. Country Conference – October 26-28, 2015 held at Pullman Resort, Bunker Bay and convened by Dr Sam Hilliard.

GASACT Part 3 course was held on November 29 for all ANZCA/ASA trainees; we thank the sponsors for their support and hope the trainees enjoyed the session.

The meeting was made possible by the professionalism and dedication of College administrative staff.

I look forward to future quality assurance meetings in the coming year.

Dr Shiva Malekzadeh
Convenor, Victorian Regional Committee

Victorian quality assurance meeting
The final quality assurance meeting for the year run by the Victorian Regional Committee for Victorian anaesthetists was held at ANZCA House on Saturday October 18.

The meeting began with four interesting presentations by four remarkable facilitators, Dr Balvinder Kaur, Dr Raymond Hu, Dr Geoff Steele and Dr Laurence Weinberg. Thirty-five anaesthetists with a broad range of experience attended the meeting, contributing their personal cases for discussion. The cases were all interesting and engaging. Once again ethical dilemmas, and resource allocation issues were prominent.

The meeting was made possible by the professionalism and dedication of College administrative staff.

I look forward to future quality assurance meetings in the coming year.

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Australian Medical Association careers day

Members of the ANZCA NSW Regional Committee and Trainee Committee attended the NSW Australian Medical Association careers day on August 30 at the Sydney Olympic Park.

The event was designed to introduce the various careers available to junior doctors and around 200 junior doctors and medical students attended.

The NSW ANZCA table was well attended and questions ranged from “How do I become an anaesthetist?” to “How do I pass the primary exam?” and “How do I get a trainee job?”. Highlight of the day was the retrieval demonstration by Careflight, who flew in to extricate an injured child from a mock-up playground accident.

This generated great interest in attendees when it was revealed that anaesthetists are part of the retrieval team. Many thanks to NSW ANZCA staff and doctors who gave up their Saturday to talk about anaesthetics.

“Are you aware?” meeting

The “Are you aware?” meeting was held at the Crowne Plaza Terrigal from November 1-2. The meeting attracted Anaesthetists from across Australia and New Zealand and was very well received.

Some of the topics that the keynote lectures covered were: NAP5; ACE-I – the pre-operative dilemma; a survival guide for pulmonary hypertension; Buccal oxygen delivery and dyannaesthesia.

The PBLDs and workshops were a great success and addressed new techniques and equipment facilitated by expert presenters. A highlight of the workshops was the massed CICO workshop run by Dr Andrew Heard.

We congratulate the NSW ACE committee, convenors and NSW ANZCA staff on the success of this event. They are already planning for next year.
But it was in his extra curricular activities that Stephen really excelled. Whether it was mountaineering in Nepal, competing in international Frisbee competitions, or participating in the royal Hobart Hospital's Global Outreach, Stephen's passion and dedication were evident.

While Stephen had a conventional, team-oriented career, his personal life was filled with adventure. He had the ability to calmly diffuse tense situations – in 1999 he found himself in the middle of a significant disturbance in the main market in Honiara. Despite having arrived in the Solomon Islands just a day earlier, he deftly negotiated safe passage through the riot using local politics and rugby as discussion points.

Stephen's outdoor adventures took him far and wide, from Federation Peak in south-west Tasmania to the Annapurna Circuit in the Himalayas. With his daughter, he would often go on hiking trips, and even when giving commentary on a single malt whiskey or a red wine he'd carried in and shared. He was a true Renaissance man.

While Stephen could be an imposing figure, he had a warm and caring nature. His students and colleagues were always touched by his kindness and generosity. He was a true mentor, and many will have their own stories about working with him in and out of the operating theatre. And it was a real pleasure to work with him on his overseas teaching trips. His contributions included voluntary work at the Citizens Advice Bureau, the Blood Bank and the South Auckland Hospice, as well as delivering Meals on Wheels.

Throughout his career, his kindness and compassion shone through. He was a true friend and mentor, and his legacy will live on in the lives of those he touched.

We mourn his passing, but we are richer for having known him. Vale Stephen.