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Leaders in anaesthesia and pain medicine research.

Setting the standards in CPD • Training tomorrow’s anaesthetists
• Setting the standards in quality and safety • Providing the best in medical education • Representing you in the wider community

Fellowship of ANZCA and the Faculty of Pain Medicine is an immediately recognised hallmark of specialists of the highest professional standing.

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ANZCA President Dr Lindy Roberts discusses workforce challenges facing anaesthetists.

24 The appropriate discharge of patients
Dr Peter Roessler applies ANZCA’s professional documents in a practical way in our new “what would you do?” series.
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Childhood and adolescent pain is still under-recognised, writes Dr Meredith Craigie.

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Doctors can improve the delivery of healthcare services by getting involved, says Churchill Fellowship winner, Dr Tracey Tay.

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ANZCA’s new indigenous health podcast series will help Fellows working in indigenous communities.
In 2012, I was fortunate to visit every Australian region and New Zealand to participate in regional events. I plan to do so again in 2013. These visits highlight to me not only the breadth of activities that are undertaken by Fellows and trainees in each region and country, but also the importance of these for the future of our College. They also demonstrate the quality of support provided by ANZCA staff (see article in the ANZCA Bulletin, December 2012). I’d like to pay tribute to those who lead and contribute to this work around Australia and New Zealand.

Australian regional committees and regional offices
Each Australian region has a regional committee, elected by the fellowship every two years. The Fellows who chair these committees – Alison Corbett (WA), Thien Le Cong (SA/NT), Carmel McInerney (ACT), Craig Noonan (Victoria), Greg O’Sullivan (NSW), Richard Waldron (Tasmania) and Mark Young (Qld) – provide leadership for the work of their committees. They are ably supported by staff in each region.

Australian regional activities
These include:
• CME events: the annual scientific meeting (ASM), on a rotational basis, as well as more regular meetings and workshops. Many of these are run collaboratively with the Australian Society of Anaesthetists (ASA), often through combined CME committees.
• Training activities, including examinations, hospital accreditation visits, accreditation of training rotations, appointments of supervisors, short and long examination courses, supervisor workshops and training and formal project approval.
• FPM regional committees and events.
• Trainee committees and events.
• Providing local input to publications such as e-newsletters, the Bulletin and Australasian Anaesthesia.
The New Zealand National Committee

The NZNC, under its chair, Geoff Long (Waikato), has input from anaesthetists and specialist pain medicine physicians from throughout the country and meets regularly at the national office in Wellington. The national committee and office have a broad focus, taking a leading role on issues that relate specifically to New Zealand and reporting to ANZCA Council on ANZCA affairs in New Zealand. New Zealand staff members have broad capability in many areas including policy, communication, media and government liaison.

New Zealand activities

The NZNC and New Zealand office agenda includes:

- Advocacy, consultation with and providing advice to external agencies such as the Medical Council of New Zealand (MCNZ), Health Workforce New Zealand, the Ministry of Health and other government and national agencies. This includes advice about international medical graduate specialists to the MCNZ and overseeing workplace-based assessments (WBAs). The focus is on ensuring that the New Zealand health system and environment for Fellows and trainees meets patient and anaesthesia team needs.
- Nominations of Fellows and trainees for ANZCA projects, events and awards – for example, nominees to the annual new Fellows conference, representatives to external organisations and meetings, and the award of the ANZCA Council citation.
- Liaison with the ASA, particularly through joint CME events and support for ASA committees in some regions.
- Quality and safety: providing feedback on professional standards, notifying ANZCA of safety alerts and contributing to mortality and morbidity reporting.
- Responding to legislative and other requirements specific to New Zealand, for example, the current review of the Health Practitioners Competence Assurance Act.
- Support for the training program through supervisor training and support; trainee services such as the part 3 course, examinations and pre-examination courses and formal project approval.
- Awarding scholarships such as the BWT Richie prize, the annual registrar meeting prize and the undergraduate anaesthesia prize.
- Continuing professional development (CPD) opportunities such as the New Zealand ASM, visiting lecturerships, resources to help Fellows meet regulatory requirements, and co-ordinating a branch of the ANZCA library in New Zealand. CME activities are coordinated by the New Zealand Anesthesia Education Committee (NZAEC), a joint initiative of the NZNC and the New Zealand Society of Anaesthetists (NZSA).
- Engagement with other colleges through the Committee of Medical Colleges.
- Liaison with other professional groups such as the NZSA, the New Zealand Medical Association and the New Zealand Anaesthetic Technicians Society.
- Support for the FPM NZNC and the College of Intensive Care (CICM) NZNC.
- Publications specifically for NZ Fellows and trainees, including Geshag and New Zealand Trainee Committee newsletters, along with New Zealand contributions to broader ANZCA publications.
- New Zealand media work to ensure an ANZCA has effective voice in workforce debates as well as to promote the skills and training of anaesthetists.
- Addressing quality and safety issues via mortality review committees, disaster response and safety alerts.

Strengthening connections between the regions and the central College

ANZCA’s president, vice-president and chief executive officer hold regular meetings with the chairs of the Australian regional committees and the New Zealand National Committee. This provides an opportunity for the ANZCA Council to communicate to the regions, as well as for the chairs to report on developments within their areas and raise issues of concern to Fellows and trainees directly with the council and the chief executive officer.

One of the key aspects of the ANZCA Council’s vision for our College is to strengthen the connections between its different parts. This means support for the regional and national committees and offices so that they continue to provide relevant services for Fellows and trainees. Over the past few years, this investment has increased so that about one in six of our staff is now located in the regional and national offices.

Rollout of the revised curriculum

The regional and national committees and staff have been integral to the rollout of the revised curriculum. I wish particularly to acknowledge the work of our education and deputy education officers – Indu Kapoor (NZ), Simon Robertson (ACT), Natalie Smith and Nicole Phillips (NSW), Jeneen Thatcher, Mark Gibb and Emile Kurukuchi (Qld), Margaret Wiese (SA/NT), Colin Chilvers (Tas), Rick Horton (Vic) and Jodi Graham and Jay Bruce (WA), along with the rotational supervisors, supervision of training and the WBA champions in both countries.

How to get involved

Any Fellow can nominate for their regional or national committee. This is an important way to have your voice heard as well as to contribute to our profession. For more information, contact your office or committee via the ANZCA website (see links to each region along the bottom of each page).
Also included in the roadmap are initiatives that contribute to ANZCA’s organisational sustainability. Developing and delivering the roadmap has involved collaboration with all levels of the College. We received feedback from the ANZCA Council and several committees, and held workshops and meetings with staff on information and technology systems to ensure that all business units had input.

The ANZCA Strategic Plan 2013-2017 principles have been used to inform all aspects of the roadmap.

Drivers for the IM/IT Roadmap include:
- A good experience for Fellows and trainees is central to the design of services and change implementation.
- Information will be valued as an asset. Fellows and trainees will be provided with tools/systems to manage their own information.
- Online services will be provided where possible ensuring they will be available to Fellows and trainees at any time, from any place and via multiple channels. ANZCA will provide easy-to-use processes and tools, which enable self-service.
- The policies, processes and systems that support and deliver each ANZCA/FPM function will be consistent across the organisation.
- Information will be collected once, and shared as required with minimal manual processing.
- Preference will be to use existing systems to meet newly identified needs. Buying “off the shelf” will be favoured over custom solutions.

As we move through 2013, I hope you will start to see the results of our efforts to make interactions with the College easier and more streamlined.
7

The prize comprises a certificate and
book voucher.

The 2012 prize winners are:
Gregory Brogan
The University of Sydney
Keembiyage De Silva
The University of Queensland
Danielle Gelbart
University of Otago, Christchurch
Harry Laughlin
University of Tasmania
Karen Lollo
James Cook University, Townsville
Walston Martis
University of Auckland
Ben McDonald
Flinders University, SA
Goran Mitric
The University of Queensland
Joy Wu
University of Otago, Christchurch

The professional documents of ANZCA and
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quality and safety of patient care for
those undergoing anaesthesia for surgical
and other procedures, and for patients
with pain. They define the requirements
for training and for hospitals providing
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define policies, and serve other purposes
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Professional documents are also referred
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Professional documents are subject
to regular review and are amended in
accordance with changes in knowledge,
practice and technology.

As a consequence of regulation 38’s
promulgation, professional document
TE11 Policy on the Formal Project has been
reissued with minor amendments.

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

The complete range of ANZCA
professional documents is available via

Faculty of Pain Medicine professional
documents can be accessed via the FPM

ANZCA is delighted to present College
Conversations, our new audio CD
that provides a more “mobile” way of
informing anaesthetists and specialist
pain medicine physicians about topics
of interest.

College Conversations, to be inserted
in each edition of the Bulletin this year,
includes interviews on professional
matters and issues of wider interest, such
as financial and legal advice.

In this first edition, ANZCA President
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importance of clinicians playing a greater
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Associate Professor Roger Goucke
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Essay Prize, talks about having a child
with cerebral palsy.

The Bongiorno National Network,
proud sponsors of the CD, offer advice
on buying property and self-managed
superannuation funds, while College
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Victorian Premier Steve Bracks talks
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The CD can be listened to at home,
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We hope you enjoy College
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College Conversations – anywhere, anytime

Professional documents – update

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ANZCA undergraduate
prizes in anaesthesia

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teaching of anaesthesia, its related
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and to raise awareness of the specialty
among medical students and recent
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of their clinical curriculum.

The prize comprises a certificate and
book voucher.

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Walston Martis
University of Auckland
Ben McDonald
Flinders University, SA
Goran Mitric
The University of Queensland
Joy Wu
University of Otago, Christchurch
Dr Alan William Duncan (WA) was appointed as a Member of the Order of Australia (AM) for significant service to medicine in the field of paediatric intensive care as a clinician and educator.

Professor Ben Marosszeky (NSW) was appointed as a Member of the Order of Australia (AM) for significant service to rehabilitation medicine and through contributions to people with arthritis.

Thanks for the memories

Dear Editor

Having reached the age of 80, I find myself looking back over my career and remembering the most rewarding experiences during those years.

As a result of those reminiscences I am writing to thank the College for providing one of the highlights of my professional life, an invitation to speak at the annual meeting in Melbourne, and also to speak at departments of anaesthesia in Auckland, Adelaide and Sydney.

The hospitality was incredible everywhere I went, and I developed life-long friendships along the way.

Of course, the frosting on the cake was being made a member of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons, now the Australian and New Zealand College of Anaesthetists. This was an unexpected honour and one of which I am (and always will be) extremely proud. I thank the College for this honour, and thank the many members who were so kind to me and who made my Australian and New Zealand experience so memorable.

Alon P. Winnie, FANZCA

Illinois, US
Advancing CPD: the College prepares for a changing regulatory environment

Why review continuing professional development?

There is growing pressure from external bodies for colleges to strengthen continuing professional development (CPD) standards. This is driven by the need to ensure safe patient care. They require all anaesthetists and specialist pain medicine physicians to unambiguously demonstrate their ability to practice at this level.

In November 2012, the Medical Board of Australia announced that it was starting a discussion about revalidation in Australia (see www.medicalboard.gov.au/News/2012-11-26-Communique-from-the-Board.aspx). They cited international trends and a focus on support for patient safety by ensuring doctors are fit to practice medicine.

The Medical Council of New Zealand insists that from June 2013, every registered clinician will undertake a compulsory audit of medical practice relevant to personal practice. They already refer to CPD as part of recertification to renew practising certificates.

It is likely that as a result, regulatory authorities in both countries will significantly increase the requirements on Fellows and other CPD participants for re-registration. The College must proactively address these challenges to ensure that the profession has meaningful input to any new requirements and is flexible enough to respond in a changing regulatory environment.

The regulatory requirements include a greater emphasis on practice evaluation and a steady move towards revalidation in some form, albeit slowly, at the moment. We need to be ready for this and, as a result, the College is revising its CPD standard and program. The new standard contains all the elements required by the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ). The standard is accredited by the AMC and the MCNZ and applies to all anaesthetists and specialist pain medicine physicians regardless of which program they participate in.

Advancing CPD Project

This CPD revision is being undertaken by the ANZCA CPD Committee, which I chair, the staff of the College and with significant input from Fellows in Australia and New Zealand. There are two project streams, one responsible for revising the program in light of the new standards and the second a “tech-savvy” group who are in charge of making the final product easy to use and “smart”.

We have benchmarked against other Colleges, other jurisdictions and international organisations to come up with something that will be really simple to comprehend and use, meet the requirements of the medical council/board and be focused towards patient outcomes.

Have your say

We will be working with respective committees, feedback forums and Fellow surveys to gather your opinion over the coming months. Your feedback into this development is welcomed and will ensure that we deliver a CPD program of the highest standard in a seamless fashion.

The CPD Committee – Vanessa Beavis (chair), Penny Briscoe, Sarah Green, Kerry Gunn, Rod Mitchell, Peter Roessler and Lindy Roberts – and the techy group – Kerry Gunn (chair), Chris Jones, Richard Lea, Martin Minehan, Martin Misur and Mark Williams – look forward to your feedback and comments on a greatly advanced and improved program.

Dr Vanessa Beavis
Chair, CPD Committee
ANZCA, in a proud partnership with the Bongiorno National Network, would like to introduce the College Conversations Business Essentials audio series. Recorded quarterly, these CDs will be included in the ANZCA Bulletin and are tailored specifically to anaesthetists and pain medicine specialists.

The recordings will cover topical anaesthetic issues as well as a full range of financial topics that will be highly relevant to all anaesthetists and pain medicine specialists, regardless of where they are at in their professional career. Topics may include:

- Investment strategies
- The current state of the market
- Up-to-date information on tax laws
- Superannuation and ensuring you have enough money to retire
- Risk Insurance
- The property market

You’ll learn invaluable insights and business strategies and discover new ways to grow and maximise your wealth.

The Bongiorno National Network is one of Australia’s leading financial services organisations. With over 49 years’ experience in the industry, we are the preferred choice for medical and dental professionals.

Our Business Essentials tools for the Royal Australasian College of Surgeons (RACS) and Royal Australian College of General Practitioners (RACGP) have been incredibly successful.

Keep your eyes out for the CDs which will be included in each edition of the ANZCA Bulletin throughout 2013 or visit the following website in your state to download the recordings:

Bongiorno Group (VIC)
www.bongiorno.com.au

Bongiorno & Partners (NSW)
www.bongiorno.net.au

Bartons (SA)
www.bartons.com.au

Smith Coffey (WA)
www.smithcoffey.com.au

Walshs (QLD)
www.walshs.com.au

ANZCA
www.anzca.edu.au
or
www.anzca.edu.au/communications/anzca-bulletin

Our National Network of specialist advisers ensure you get the right personalised financial advice regardless of your location. So no matter where you are around Australia, our National Network has you covered.

make every day a good day
ANZCA in the news

Since December last year, ANZCA has generated:

- 12 print stories
- 20 online stories
- 5 radio reports
- 20 TV reports

News about ANZCA and the Faculty of Pain Medicine has been accessed by a potential cumulative audience of more than 2.8 million people since December. Four media releases have been released, generating 57 media reports.

The Geoffrey Kaye Museum of Anaesthetic History was promoted as part of the International Symposium on the History of Anaesthesia, with the museum’s Honorary Curator, Dr Rod Westhorpe, doing several radio interviews, some broadcast nationally, about the museum’s collection and the history of anaesthesia.

ANZCA President, Dr Lindy Roberts, defended anaesthetists’ skills, training and professionalism in a debate about workforce issues that appeared in the Sunday Age and Age newspapers. Dr Roberts was also interviewed about the revised curriculum in an article that appeared in the Medical Journal of Australia.

Other highlights included ANZCA Fellow and member of the Research Committee and Trials Group, Professor David Story, talking at length about anaesthesia on Melbourne radio station RRR, and Quality and Safety Committee Chairman, Associate Professor David Scott, responding to the shortage of morphine sulfate.

Pain medicine has also been in the news, with FPM board member, Dr Ray Garrick, appearing on A Current Affair to talk about migraines; FPM Fellows and gynaecologists, Dr Susan Evans and Dr Thierry Vancaillie, discussing pelvic pain in Fairfax papers; and former FPM Dean, Dr David Jones, highlighting in the media the recognition of pain medicine as its own scope of practice in New Zealand.

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ANZCA Media Award

Former Australian journalist, Christine Jackman, won the 2012 ANZCA Media Award for “World of pain”, a compelling and informative story about chronic pain. Her article, which appeared in the Weekend Australian Magazine in March last year, described how many patients continue to suffer pain long after any initial cause has been treated.

“Many patients expect a story with a problem and a solution – and it was vital to communicate that chronic pain is not a simple condition with one simple cure, while maintaining their interest,” Ms Jackman said.

“My central aim here was to introduce readers to a new way of thinking about a very old problem, one that is often dismissed as ‘malingering’ or ‘hypochondria’.

Ms Jackman found compelling case studies to illustrate the story, including young, outgoing and active people who live with persistent pain, to shatter the stereotypes of chronic pain sufferers. Her article was one of 15 entries for the award and was judged the best news story or feature about anaesthesia or pain medicine that appeared in the Australian or New Zealand media in 2012.

The award was judged by ANZCA Bulletin Medical Editor and ANZCA councillor, Dr Michelle Mulligan; former ABC journalist, lecturer and media training expert, Doug Weller; and former Age health editor and communications expert, Tom Noble. They said:

“‘World of pain’ took us on a journey. It was interesting, comprehensive, well written, well researched and informative. It included a very important message about pain which is important to get across to patients and the community. Ms Jackson produced a body of work that was outstanding in its clarity and fact.”

The winning entry can be viewed at www.anzca.edu.au/communications/Media.

Meaghan Shaw
Media Manager, ANZCA

Media releases distributed by ANZCA since December

College and Interplast help world’s poor manage pain better (February 25)
Christine Jackman wins 2012 ANZCA Media Award for pain story (February 14)
Rare anaesthesia artefacts on display for world symposium (January 23)
Patients to benefit from ANZCA research projects (December 18)

All media releases can be found at www.anzca.edu.au/communications/Media
Jobs in anaesthesia

Workforce, a hot topic: what is the College doing?

In just about every forum I attend these days, not surprisingly, the hot topic is health workforce, innovation and reform. New Fellows and trainees express particular concerns about declining opportunities for public hospital positions in Australian east-coast metropolitan centres. Cuts to Australian health department budgets have impacted on demand with cutbacks in elective operating lists and senior public hospital employment opportunities. Post-GFC caution and the impact on superannuation funds have no doubt also altered plans of some anaesthetists nearing retirement.

In contrast, colleagues in regional centres express optimism as job advertisements now receive FANZCA applicants. Those in rural and remote areas, who have suffered from workforce maldistribution, maintain guarded optimism that this situation may have a positive impact on them and their communities. This is welcomed, given chronic shortages and reduced access to specialist care in regional and rural Australia and New Zealand.

The complexity of the situation is exacerbated by long-standing workforce shortages and maldistribution in New Zealand, and the trend for a net flow of anaesthetists to Australia. Add to this the significant reliance in both countries on international medical graduate specialists (IMGS), many of whom have provided long years of service to areas of need and made substantial contributions as Fellows.

The recent unprecedented growth in Australian medical school graduates provides challenges, exemplified by recent intern place shortages. This pipeline effect will hit the vocational sector in a couple of years, meaning that more posts and supervisors will be required. Fellows and trainees will be aware that, from 2004, ANZCA decided to deregulate training and accredit departments rather than posts. This was done in the interests of transparency and equity to ensure that doctors undertaking largely identical positions could count these in their training – thus employers (Australian state and territory jurisdictions, district health boards and hospitals) determine training numbers.

Changing workforce patterns add further complexity. Many of us want more flexible hours, to work part-time or intermittently for personal and family reasons. Scopes of practice are expanding into pain medicine, perioperative medicine, "outside areas" (or "off-floor activities"), as well as services such as retrieval medicine, simulation, clinical leadership, research and teaching.

All this is set against a background of debate about workforce reform across the health sector, concerns about unsustainability of current workforce models, rising health costs as a proportion of gross domestic product, and pessimism about keeping up with the demands of our ageing populations and more technologically complex healthcare. We face a complex and challenging future.

What is the College doing?
The most common question I am asked is "What is ANZCA doing about this?" The answer is "A lot, as it is vitally important to Fellows and trainees at the coalface, so I thought it would be helpful to outline some of our workforce activities."

A clearer picture is needed Much better data is needed about the situation in both countries. The College has provided data to Health Workforce Australia (HWA) for modelling of anaesthesia workforce in Health Workforce 2025: Medical Specialties Volume 3, released November 2012 (see www.hwa.gov.au/health-workforce-2025). Workforce modeling is potentially unreliable and I welcome plans by HWA to regularly update their modelling over coming years. In New Zealand, the College undertook and published The demand for and supply of anaesthesia services in New Zealand 2010-2030 (see www.anzca.org.nz/publications) in 2010. This report is publicly available to decision makers and is used in our advocacy with government and Health Workforce New Zealand (HWNZ).

Policy and advocacy The College has strengthened its policy and advocacy role with governments and organisations such as HWA and HWNZ (see article by ANZCA General Manager, Policy, John Biviano on page 16). We welcome opportunities to increase co-ordination within the medical training pathway, particularly given the complex factors at play and the involvement of multiple bodies in the workforce demand-supply equation. HWA has released a consultation document on a National Medical Training Advisory Network (NMTAN), aimed at co-ordinating workforce planning in Australia. ANZCA will make a strong and detailed submission about this. Individuals are encouraged to do likewise.

Promoting innovation but not at the expense of safety and quality With an increasingly unsustainable rise in health spending, health economists, the productivity commission and health workforce organisations in both countries propose innovation and change, and investigate new models of care. The College works hard to maintain a strong voice in this debate, in line with our mission to maintain the quality and safety of care for our communities.
ANZCA is developing a position statement on workforce roles in anaesthesia care delivery that can be used to promote the College’s position and inform our policy submissions to governments and others. Change is inevitable but should not occur at the cost of safety and quality of patient care. The College is involved in initiatives that address maldistribution, to increase access of rural and regional communities to anaesthesia care. ANZCA’s involvement in the Specialist Training Program (STP) is substantially about positions in regional centres and other expanded settings. Recent examples include the Royal Flying Doctor Service in Western Australia, the North Queensland Persistent Pain Service with outreach to isolated communities, and positions in Toowoomba and Tamworth.

Employers can advertise job vacancies on the College website – see www.anzca.edu.au/resources/anaesthesia-job-vacancies.

What can Fellows and trainees do?
• Respond and contribute to surveys; this ensures that data collected by the College and others provide an accurate picture. This strengthens the impact of any survey about workforce issues.
• When interacting with patients, every Fellow and trainee can, as opportunities arise, advocate for our profession (and its professionalism). This improves understanding of the specialty in the general community.
• Consider your own role in health leadership and decisions addressing workforce supply and demand. Advocate or act (for those in leadership positions) on issues that you can influence.

Dr Lindy Roberts
ANZCA President

• Recognise where the controls in this situation reside: employment decisions are beyond the scope of the College.
• Support the College in its attempts to advocate for considered policy decision-making that ensures access to high quality healthcare for all Australians and New Zealanders.

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It is vitally important that ANZCA has a strong and influential voice on behalf of its members and safe and high quality patient care.
Rewards and challenges of overseas fellowship

Trainees and Fellows develop valuable skills by working overseas but it may not give them the advantage they need to enter the Australian jobs market.

The fellowship year is a time where trainees are at their peak of knowledge and experience in a breadth of anaesthesia sub-specialties. For a trainee or newly appointed Fellow, it is a crucial time to develop further skills both clinically and in preparation for employment as a staff anaesthetist.

Going abroad for a fellowship can be rewarding but the process is often met with challenges, which will be outlined here.

I am approaching my 17th month in Canada, having spent 12 months doing a fellowship in Vancouver in transplant and regional anesthesia, and now as a postgraduate Fellow/staff anaesthetist working in pediatric anaesthesia in Calgary.

When I left Australia after obtaining my FANZCA in August 2011, I was told that going abroad and “gaining skills you can bring back” would assure me a strong possibility of a position in an academic department.

I returned to Melbourne last July, a few publications under my belt including abstracts presented at international conferences, to discover that many of the colleagues who had graduated before and after me had barely scraped a day or two of appointments. They had faced months of uncertainty despite having surpassed the hustle of the training program. And the word on the street was that there were no jobs.

I also was told that being away had left me at a slight disadvantage. Eventually I returned to Canada to practice. This was not an easy process, but I had little choice. I thought it would be pertinent to address this problem, so trainees preparing to go abroad appreciate the implications of an overseas fellowship.

Getting there
This takes about a year or two before leaving Australia, when the application process begins. Shortlisting for most North American fellowships typically occur 12 months before the job starts, so there is a long time between applying and finding out if you get an interview.

Once offered a job, the tedious process of paperwork begins, and most departments are organised about this process. The longest step is verification of credentials which occurs via the ECFMG (Education Commission for Foreign Medical Graduates) International Credentialing Services (EICS), takes six to nine months, is costly (around $US800), and involves tracing medical qualifications back to university and obtaining signatures from all prior clinical rotations in residency. Without this verification, provincial licensure for practice cannot be obtained.

The visa and immigration requirements take a few months, and the current cost for a medical exam is $A450, excluding the visa, which costs $US75-80. Other incidental costs include certificates of conduct from professional bodies in Australia (AHPRA etc).

Therefore trainees thinking of going abroad should prepare to spend hours and dollars to complete various steps to move out.

I have not mentioned personal organisation – I had a property and belongings I had to store, which again cost me a significant amount of money and time.

Pros
Once you get past the first step, and arrive in your country of choice and job, it can be the beginning of an amazing experience.

In addition to travelling and making new friends or learning how to ski, you learn how to “skin a cat differently” as the old adage says. There is opportunity to gain a sub-speciality interest and/or develop a niche of practice. Being a Fellow invites rewarding research and learning opportunities.

There is potential to develop work practices outside comfort zones and you...
It is important for trainees to appreciate that the job market in Australian metropolitan teaching hospitals is not great and being away can pose a disadvantage in terms of knowing what positions are coming up. Trainees must have specific fellowship goals; mentorship plays a crucial role. Before you go away, review what skills departments are seeking so you can go abroad and obtain them. This will give you the best chance of standing ahead in a job interview.

Being abroad for longer than a year can lead to the “out of sight, out of mind” phenomenon, so it is important that trainees or Fellows maintain connections with colleagues at home to stay up to date with employment and College news. I hope this encourages overseas fellows to maintain a connection with the Australian job market. It is important for trainees to continue to go abroad and return with skills to enhance their practice and foster international networks for the betterment of our specialty.

Perhaps a focus group for Fellows working abroad could be developed so there is a support network and leadership group keeping us connected to the College and the anaesthesia community.

Dr Balvindar Kaur, FANZCA
Alberta Children’s Hospital,
Calgary, Canada

“Going abroad for a fellowship can be rewarding but the process is often met with challenges.”
Meanwhile, the Policy Unit is co-ordinating and supporting two working groups to explore the general practitioner anaesthetist role and develop a position statement on alternative providers in anaesthesia respectively.

ANZCA, via the president, also has set up a working group to explore workforce issues and to review the College’s role in advocating for improved education and training within health services, on behalf of Fellows and trainees. A graduate outcomes survey is planned to help the College understand the experience of new Fellows in the workplace.

Submissions
ANZCA continues to advocate on behalf of Fellows, providing submissions to government and health stakeholders in a variety of areas. ANZCA recently made submissions and/or representations to:

- Clinical Excellence Commission of NSW Health on the NSW Peripheral Intravascular Cannulation Policy.
- The Department of Health and Ageing on the review of Australian government health workforce programs.
- Australian Medical Council on the proposed Intern Training Framework in the national registration and accreditation scheme.
- Pharmaceutical Benefits Advisory Committee on the status of electronic recording and reporting of controlled drugs.
- NSW Health on the composition of the Medical Council of NSW.
- NSW Health on the accreditation of specialist medical training sites project.

The Medical Education and Planning Group of the Victorian Department of Health has been established to improve planning for increased numbers and appropriate mix of intern and other postgraduate training places in Victorian hospitals. ANZCA has been invited to join the group, along with stakeholders including other colleges, major hospitals, universities and related industry organisations. The Victorian Regional Committee is being consulted on strategies consistent with local needs and educational imperatives. The planning is aligned to Health Workforce Australia’s work in this area to ensure consistency of workforce data and modelling. Local adjustments will be made where applicable.

ANZCA welcomes the opportunity to work with the health jurisdictions, health providers and related bodies to improve education and training in anaesthesia and pain medicine, which benefits our Fellows, trainees and the community.

**Policy development**

The Policy Unit has been working with ANZCA units and committees to revise all regulations following the release of the revised curriculum. Regulation 38, specific to the affiliated training regions, was released in January. The complementary ANZCA Handbook for Training and Accreditation in the Affiliated Training Regions is being developed.

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or deeds of variation and negotiations are under way. The dates for the 2014 Specialist Training Program application round will be announced soon and interested hospitals should understand that this may be the last opportunity to apply for funding under this program because the government will reach their anticipated 900 training positions by next year. DoHA usually provides a short turnaround time to submit applications, so those interested in applying for funding should start the process as soon as possible.

Further information is available at: www.anzca.edu.au/training/rotations-training-sites/specialist-training-program.html

For further information about the Specialist Training Program, please contact Donna Fahie (Manager, STP) on +61 3 9093 4953 or stp@anzca.edu.au.

College accreditation update
The College and the Faculty of Pain Medicine were granted accreditation by the Australian Medical Council (AMC) on December 17 to continue training programs in anaesthesia and pain medicine, and to run continuing professional development programs for another six years until December 31, 2018. The College and Faculty provided comprehensive submissions to the AMC and the Medical Council of New Zealand (MCNZ) in April last year. ANZCA is now working on a progress report, which will be provided to the AMC in March. The AMC has provided a copy of the report to the MCNZ for its consideration.

ANZCA's past submissions, including the College's accreditation submission to the Australian Medical Council and significant submissions developed by the New Zealand National Committee can be found on the website at: www.anzca.edu.au/communications/submissions.

Regulatory framework for the Australian and New Zealand Therapeutic Products Agency (ANZTPA)
In June 2011, the Australian and New Zealand governments announced they would proceed with a joint scheme to regulate therapeutic goods on both sides of the Tasman. The first step in sector consultation is a high-level policy paper outlining a possible regulatory framework for the scheme.

The proposed scheme would cover the standards, manufacture and product approvals of medicines, medical devices, blood and blood components. It provides for the provision of information on products, exemptions, promotion of therapeutic products and provision of expert advice.

ANZCA has responded to the paper and will continue to engage with the ANZTPA team as work progresses.

Australian government grants – Specialist Training Program
The College has finalised a variation to our contract with the Department of Health and Ageing (DoHA) to extend the Specialist Training Program (STP) to the end of 2015. All participating hospitals have received new funding agreements or deeds of variation and negotiations are under way. The dates for the 2014 Specialist Training Program application round will be announced soon and interested hospitals should understand that this may be the last opportunity to apply for funding under this program because the government will reach their anticipated 900 training positions by next year. DoHA usually provides a short turnaround time to submit applications, so those interested in applying for funding should start the process as soon as possible.

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New Zealand
Pharmac continues to consult on the contents of its preferred medicines list (PML), a nationally consistent list of pharmaceuticals that will be available in all district health boards. The New Zealand National Committee has been actively involved in commenting on various categories of drugs. Recent submissions include recommendations on the inclusion of and indications for sugammadex, and proposed preferred medicines list inclusions for dermatological, endocrine and central nervous system drugs.

Other recent submissions have included comment on a proposed expanded scope of practice for anaesthetic technicians in New Zealand, including insertion of PICC lines and working in a post-anesthesia care unit.

John Biviano
General Manager, Policy
ANZCA
e-Learning – valuable resources at your fingertips

Susan Batur, e-Learning Project Officer, ANZCA

ANCZAs e-learning resources and programs provide a rich, interactive learning experience for Fellows and trainees using cutting-edge learning technology tools. Fellows and trainees have contributed towards the development of more than 50 podcasts and the College regularly facilitates educational webinars.

The e-learning section of the College website has been revamped to make it easier to navigate the growing number of online resources for trainees and Fellows. The mini-site is divided into four areas: podcasts, interactive webinars, preparation for final exam and teacher training. These resources can be found at www.anzca.edu.au/resources/e-learning.

“The new podcast section has been categorised according to the overarching subject area so that trainees and Fellows can easily locate the content that is most relevant to their learning needs.”

Susan Batur, e-Learning Project Officer
Keen to appear in podcasts?

Plans are under way to develop new podcasts for trainees and Fellows to assist with more areas of the revised curriculum, CPD and research topics. The range of webinars will also broaden to allow trainees and Fellows to discuss the topics covered in podcasts with the expert presenter. Fellows who would like to present an area of their expertise to be made available as a podcast are encouraged to contact the College at education@anzca.edu.au.

Video podcasts – helping you to learn

Video podcasts provide a visually stimulating learning experience to help learners understand new concepts and revise topics of anaesthesia, the ANZCA Roles in Practice and educational developments. The use of podcasts has grown significantly in education and training and ANZCA has embraced this online tool to enhance the delivery of teaching to our trainees and Fellows. Podcasts are easily accessible and can be viewed in the trainee’s own time. Grants supporting the development have allowed the College to record presentations locally and in the regions to create a range of high quality presentations delivered by content experts.

ANZCA has the technical capability and in-house skills to develop high quality educational resources, which are available to trainees, international medical graduate specialists and Fellows irrespective of their geographical location. This positions us well to be at the forefront of educational technology into the future. To view the podcast videos, supporting slides and presentations please visit: www.anzca.edu.au/resources/e-learning.

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Fellows who would like to present an area of their expertise to be made available as a podcast are encouraged to contact the College at education@anzca.edu.au.

Social learning in our real-time webinars

An increase in the diversity of educational resources thanks to advances in internet speed and web technology means communication is now possible in real-time. A webinar (also commonly referred to as a web conference) is a meeting or online tutorial that takes place over the internet. At the College, webinars give trainees an opportunity to ask Fellows questions about their podcasts in real time. Features of a webinar used to encourage interaction may include:

• Sharing slides and images to assist with case-based discussions and to work through short-answer questions.
• Live streaming of video so participants can see each other (replicating the feeling associated with face-to-face teaching).
• An interactive whiteboard to draw and annotate concepts visually.
• On-the-spot polls to reinforce knowledge acquisition.

(continued next page)
The current model involves each module being undertaken by a group of participants over two weeks with the whole course to be completed over 16 weeks. It is estimated that each module will take two to four hours to complete. While the group approach is designed to promote a learning community, plans for the future will enable an individual learning journey.

Further information can be found on the ANZCA website at www.anzca.edu.au/resources/e-learning/teacher-course or email education@anzca.edu.au.

The online Foundation Teacher Course

Maurice Hennessy, Manager, Education Development and Training, ANZCA

Mark Robertson, e-Learning Manager, ANZCA

This course shares the same learning outcomes as the face-to-face program and is facilitated by providing theoretical concepts online and encouraging participants to apply the principles in practice in their own working environment. Participants are expected to share their experiences with other learners through online forums, webinars and quizzes.

The course is now accessible through android tablet devices and can be used on an iPad through Puffin, a web browser that supports Flash. Smart phone accessibility is being developed.

Awareness about the online Foundation Teacher Course, which is made possible through funding from the Specialist Training Program (STP), is growing. The STP incorporates the continuation and development of e-learning resources and teacher training development. The online course provides a viable alternative for specialists and senior trainees in remote areas who wish to improve their teaching and learning capabilities.

Currently it is running as a pilot with a strong emphasis on evaluation of usability, structure and content for improvement. All modules are due for completion before the ANZCA annual scientific meeting in May.

Feedback about the pilot course has been positive.

“Being an ATY 1, I found it particularly useful – encouraging me to explore what type of teaching I respond to best, strategies I can employ to become a more effective teacher and most importantly to utilise these in my everyday practice. Realising that every interaction, procedure and case we perform has endless possibilities for learning as well as teaching has been fantastic. Thoroughly recommended.”

Dr Emma Ford

“The online course provides a platform for participants to engage with theoretical content and are facilitated to apply the theory in their real world setting and share their experiences and receive feedback.”

Maurice Hennessy, Education Training and Development Manager, ANZCA
At the end of 2012, the College launched the training portfolio system (TPS), which acts as the hub for training activity for the revised curriculum. Emphasis has been on delivery, ease of use, engagement, collaboration and portability and this has resulted in significant interest in technology-enabled solutions within ANZCA’s community.

This year will see the revised curriculum become bedded in to departments in Australia and New Zealand. In the first months of the year, the general manager, education development and the training portfolio system team visited local trainee inductions and supervisor of training events to teach departments how to use the training portfolio system and to learn more about the training program. The training portfolio system and curriculum are live in all locations and the College will support departments throughout the year by providing information, guidance and support.

**Becoming familiar with the training portfolio system**

A series of training portfolio system user guides have been published and are available on the ANZCA website at: www.anzca.edu.au/training/2013-training-program/recording-training

Updates and enhancement have been made since the introduction of the training portfolio system following feedback from trainees and Fellows. Updates will continue to be made until March and the College will manage feedback to prioritise these updates based on users’ needs.

**Structure teaching – resources to help you**

Dr Kate Hames, Qld, former member of the Curriculum Redesign Steering Group

The College has developed teaching and learning cases as teaching resources integral to the revised curriculum. A selection of teaching and learning cases are available on the ANZCA website and the library will increase over time: www.anzca.edu.au/training/2013-training-program

Teaching and learning cases are not compulsory but have been designed to fulfil a number of functions and are available to trainees, consultants and supervisors to assist them in the delivery of the 2013 curriculum. Each case is accompanied by facilitator notes to assist in understanding the direction of the case, focus the discussion on areas of importance and provide guidance on the depth of the answers expected for the trainee’s level training.

References and resources have been identified for each case to assist the trainee and facilitator to address areas where their knowledge, experience or understanding may be insufficient or as an aide memoir. These evolving case scenarios are clinically based and are presented in a format to encourage discussion and reflection rather than didactic teaching. They are clearly linked to the learning outcomes in the curriculum and demonstrate the way these outcomes underpin the knowledge, skills and attitudes necessary for clinical practice.

Dr Kate Hames is a former member of the Curriculum Redesign Steering Group and has led the development of teaching and learning cases. The College welcomes feedback, ideas and volunteers to contribute towards new teaching and learning cases. Please email education@anzca.edu.au.

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**ACECC**

The Anaesthesia Continuing Education Coordinating Committee (ACECC)

- Local and international anaesthesia-related events
- 17 Special Interest Groups open to members
- Great resources for to organise or promote anaesthesia-related events.

www.acecc.org.au
The ANZCA Indigenous Health Committee is pleased to launch the College’s indigenous health podcast series. The series, which was funded by the Department of Health and Ageing under the Rural Health Continuing Education program, includes nine short independent learning podcast modules that focus on the needs of rural and remote anaesthesia and pain medicine specialists working with indigenous patients and communities in Australia. The modules are now available on the e-learning section of the ANZCA website (www.anzca.edu.au/resources/e-learning/podcasts).

The podcasts were developed by ANZCA and FPM Fellows, doctors with experience in indigenous health, Aboriginal liaison officers and an Aboriginal doctor, to share the experiences of working in indigenous health and provide information specific to the needs of specialist anaesthetists and pain medicine physicians.

The series aims to improve communication between clinicians and Indigenous patients, thus facilitating quality and safe healthcare. Communication is a theme recurrent throughout the series and is also the focus of one of the podcasts. Informed consent also is discussed as it applies to Indigenous patients. Other topics include pain management, culture, culture shock, the preoperative visit, traditional parenting, interactions with Indigenous patients with Indigenous and non-Indigenous heritage and diffusing anger.

The indigenous health podcast series adds an important resource to the College’s electronic learning programs and is available for all Fellows, trainees and international medical graduate specialists.

In the future, the series will be available to specialists from Australian medical colleges through the Network for Indigenous Cultural and Health Education (NICHE). The NICHE web portal is an inter-college initiative designed to provide a central location for rural and remote specialists seeking indigenous health resources. It will be launched this year.

The ANZCA Indigenous Health Committee recognises that the disease burden of Indigenous, Torres Strait Islanders, Maori and Pacific Islanders is disproportionately greater than for other Australians and New Zealanders. The College has identified the provision of support for indigenous health as an important component of its 2013-17 strategic plan (http://www.anzca.edu.au/about-anzca/structure-and-governance/pdfs/ANZCA%20Strategic%20Plan%202013-2017.pdf).

The strategic aims of the Indigenous Health Committee are to improve quality and safety in healthcare, improve access of mainstream healthcare by Indigenous patients, facilitate Indigenous role models and advocate on behalf of the Indigenous community. The following initiatives are being developed:

- Incorporate education on Indigenous health and cultural competency into the revised ANZCA curriculum. The Indigenous Health Committee acknowledges the work of Dr Elizabeth Gooch in this endeavour.
- Promote anaesthesia as a career to Indigenous medical students.
- Support Indigenous trainees and Fellows through mentoring programs.
- Develop podcasts exploring various themes in Indigenous health.
- Collaborate with the Council of Presidents of the Medical Colleges to advocate on behalf of Indigenous communities.

For further information on the work of the Indigenous Health Committee please contact Paul Cargill, Policy Officer, Community Development at pcargill@anzca.edu.au or +61 3 8517 5393.

This project was funded by the Department of Health and Ageing under the Rural Health Continuing Education sub-program (RHCE) Stream One, which is managed by the Committee of Presidents of Medical Colleges.

The Australian and New Zealand College of Anaesthetists is solely responsible for the content of, and views expressed in any material associated with this project.

Dr Rod Mitchell
Chair, ANZCA Indigenous Committee
PBS Information: This product is not listed on the PBS

Before prescribing please refer to Product Information. Product Information is available from MSD or from www.msdinfo.com.au/bridionpi

The appropriate discharge of patients

At the preoperative visit on the morning of surgery, a patient scheduled for a day-stay procedure, replies to your query about discharge transport by stating “I’m going home by taxi”.

On further questioning you discover that there will be a responsible adult at home, but not until some hours later. The facility either does not have the capacity or refuses to extend the patient’s stay for several hours.

What do you do in such cases? There are two issues. One is the appropriateness of taxi transport after a day-stay procedure and the other is the presence of a responsible adult to care for the patient on arrival and overnight.

These questions have been the source of numerous inquiries from nursing staff and facility administrators. ANZCA professional documents PS15 Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery addresses this issue. Section 7 ‘Discharge of the Patient from the Day Care Unit’ specifies the following requirements:

7.2.8 A responsible adult to take the patient home. For some patients it may be important to have an adult escort as well as the vehicle driver.

7.2.9 Discharge should be authorised by an appropriate staff member after discharge criteria have been satisfied.

7.2.10 Written and verbal instructions for all relevant aspects of post-anaesthetic and surgical care must be given to the patient and the accompanying adult. A contact place and telephone number for emergency medical care must be included.

In addition, sections 3.1, 3.2, and 3.3 apply as below.

3.1 A responsible person able to transport the patient home in a suitable vehicle. A train or bus is usually not suitable.

3.2 A responsible person staying at least overnight following discharge from the unit. This person must be physically and mentally able to make decisions for the patient’s welfare when necessary.

3.3 Ensuring that the patient and/or responsible person understands the requirements for post-anaesthetic care and intends to comply with these requirements particularly with regard to public safety.

When is it OK to leave the hospital after handover to post-anaesthesia care unit? Another matter that has recently been the source of frequent inquiry from nursing staff, hospital administrators and jurisdictional authorities is in regard to how long anaesthetists should remain at a facility after handing over to post-anaesthesia care unit (PACU) staff.

This issue is addressed within PS63 Statement on the Handover Responsibilities of the Anaesthetist. Section 3.2 is particularly relevant as problems often arise as a result of poor or inadequate communication. Effective communication between anaesthetist and PACU nurses will often avoid issues.

3.2 Care of and responsibility for the patient following sedation, major regional analgesia or anaesthesia is shared between the nursing staff, the anaesthetist and with the practitioner performing the procedure. There must be effective communication between all health professionals sharing care of the patient.

Section 4.4 addresses the requirement for availability after the handover.

4.4 The anaesthetist must be readily available to deal with any unexpected problems or alternatively ensure that another nominated anaesthetist or other suitably qualified medical practitioner is available and has access to the necessary information about the patient.

Dr Peter Roessler
ANZCA Director of Professional Affairs (Professional Documents)
Airway Management and Trauma SIG Meeting
“Airway management in trauma”
Saturday June 29, 2013
The Langham Hotel, Melbourne
Meeting to coincide with the Australian Wallabies versus British and Irish Lions rugby match
Conference runs from 8.30am to 4.15pm followed by the welcome reception
For further information, please contact the conference organiser:
Hannah Burnell
T: +61 3 8517 5392
E: hburnell@anzca.edu.au
www.anzca.edu.au/events/sig-events

Rural SIG Meeting
“Obstetric anaesthesia for the bush”
July 12-14, 2013
Millennium Hotel Rotorua, New Zealand
Partners and family program available
For further information, please contact the conference organiser:
Hannah Burnell
T: +61 3 8517 5392
E: hburnell@anzca.edu.au
www.anzca.edu.au/events/sig-events
Many have served in Afghanistan, working in two-to-four month rotations as anaesthetists or intensivists at the NATO hospital in Tarin Kot in Uruzgan province where the Australian Defence Force is based. Other deployments for many College reservists have included East Timor, Bougainville, the Solomon Islands, Bosnia, Kosovo, Rwanda, and Banda Aceh following the 2004 tsunami.

Tarin Kot is an isolated outpost in the middle of Afghanistan, with the nearest city and major medical facility in Kandahar, about 200 kilometres away. It experiences a huge variance in temperatures between day and night, and summer and winter, with forces during the summer fighting season facing temperatures climbing to the high 40s, while in winter the base can be iced over. The small military hospital at the Tarin Kot base is built within armoured walls designed to withstand small-arms fire, rockets and mortars. It has two operating theatres, an intensive care unit and several resuscitation bays.

The anaesthetic and surgical team provide initial resuscitation, life-saving treatment and damage-control surgery, with casualties requiring extensive and prolonged management evacuated to the coalition military hospital in Kandahar. The hospital’s primary role is to tend to soldiers wounded in combat, including suspected Taliban fighters. However, most patients are civilians injured as bystanders to the conflict. Sadly, about 70 per cent are children, many injured by playing with unexploded ordnance or in roadside bombings, or targeted by the Taliban because they go to school or are suspected of sympathising with the coalition forces.

“The Taliban are absolutely indiscriminate and absolutely ruthless in their attacks on civilians,” says navy anaesthetist Commander Paul Luckin, who is responsible for all the navy’s anaesthetists, intensivists and emergency medicine specialists, and who served in Afghanistan in 2009. “It’s very challenging looking after civilians, particularly children, with the type of blast wound and high velocity injury that you would expect to get in soldiers.”

Air force anaesthetist Group Captain David M. Scott, the Director of the Air Force Health Reserve in Queensland, was in Afghanistan for two months in 2008 when he ran the operating theatre and intensive care unit alone, and estimated he dealt with about 170 traumas during that time – two-thirds involving local Afghans and half of those children.

“Thank God! I’m nearly home.” One of the greatest rewards for air force reservist and anaesthetist Wing Commander Alex Douglas when repatriating soldiers injured in Afghanistan is hearing their relief once they know they’re in safe hands and heading home. As an aeromedical retriever, often she’s the first person outside the wounded soldiers’ warzone they have encountered, talking in a familiar Australian accent, and reassuring them they are going to be safe.

“They can see you’re a doctor and you’re going to take them home,” she says. “And that sense of relief and, ‘Wow, I’m nearly back’ is very touching ... It’s a gift I get and I’m very fortunate to have it.”

Dr Douglas is one of about 75 anaesthetists in Australia and New Zealand who are involved in the defence forces, ready to assist in conflicts and disasters. Despite serving in often harrowing and dangerous conditions, their shared experiences reveal the rewards of service to their country, enhanced and improved clinical skills, and strong bonds of friendship and teamwork.
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Dr Scott is now back in Afghanistan where the number of civilians being treated at the hospital is slowing as the local authorities boost their own capability and capacity in preparation for the handover of control to the Afghan people, with the Afghan national army running their own hospital in Kandahar with three intensive care beds.

But the defence force is mindful of maintaining its surgical capability, and over the past two years has set up a full-time military surgical team working at the Royal Brisbane and Women’s Hospital comprising a general/trauma surgeon, anaesthetist, intensive care physician and emergency physician, who are capable of being deployed as a team at short notice.

Many advances in medical treatment have come out of recent conflicts, such as damage control resuscitation and surgery, including minimal debridement of ballistic wounds with frequent returns to theatre, massive blood transfusion protocols, the intravenous delivery of blood and fluids, and the development of novel haemostatic agents, dressings and tourniquets.

Army anaesthetist Colonel Peter (Toby) Thomas says the damage control protocols were developed through necessity in war zones. Fewer operating tables and tight time pressures mean clinicians were able to do only the minimal amount of surgery necessary, which turned out to have better outcomes for patients.

“The importance of avoiding hypothermia and coagulopathy and acidosis in trauma patients is never more evident than when you’re resuscitating somebody that’s had both his legs blown off,” Dr Thomas explains.

“Penetrating trauma management is something that’s very cutting edge and massive wounding and massive transfusion trauma management is something you get to do par excellence when you go to those countries.”

“Sexual trauma management is something that’s very cutting edge and massive wounding and massive transfusion trauma management is something you get to do par excellence when you go to those countries.”

“Or it was just routine car crashes, irrigation canal bank collapses, rural and agricultural types of injuries and burns – little kids getting burnt when they pour boiling water on themselves. So it was a real mix of that sort of stuff.”

The opportunity to deal with rarely encountered injuries, such as blast wounds, multiple gunshot wounds and blast fragmentation wounds, benefits anaesthetists’ clinical practice on their return home.

“I saw more gunshot wounds in two months than I had for the previous 20 years of my medical career,” Dr Scott says. “Penetrating trauma management is something that’s very cutting edge and massive wounding and massive transfusion trauma management is something you get to do par excellence when you go to those countries.

“It gives you a skill set when you come back home to your own country ... You go at it harder, you get more aggressive at managing the bleeding early and the outcomes for our patients, our civilian patients, are actually more positive.

“I had a motorcycle rider up here in Lismore a couple of months ago who almost amputated his arm and his leg in a crash and I just went back to how we managed things like that in Afghanistan ... And the guy did really well, kept both his limbs, and he only had a short time in intensive care. Now I’m not sure I would have been so calm and so much under control with that sort of situation had I not had those experiences.”

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“The importance of avoiding hypothermia and coagulopathy and acidosis in trauma patients is never more evident than when you’re resuscitating somebody that’s had both his legs blown off,” Dr Thomas explains.

“In Afghanistan, we only had one operating theatre, so you have to get patients in and out quickly, you have to triage which patients need to go into the operating theatre first, and so you have to move quickly. What is required is a very high level of co-operation between the surgeon and the anaesthetist.”

Army anaesthetist Major Marty Graves, who has just finished his FANZCA training, recalls one experience that highlights the level of co-operation that can take place.

“At one stage with one casualty we had five different surgical teams of two surgeons each working on the casualty at the same time: one team on each leg, one on a limb, and one team in the belly. It’s rare to see such co-operation amongst our surgical colleagues,” Dr Graves says.

“Even the use of whole and fractionated blood is truly cutting edge and Australian healthcare is now gaining from this experience with the changes in massive transfusion protocols here in Australia.”

(continued next page)
LIFE ON THE FRONTLINE CONTINUED

ANZCA is involved in the development of frozen blood platelet technology, supporting through a research grant the work of Lieutenant Colonel Michael Reade, who has served as an anaesthetist in Afghanistan, and can take up to two years of short courses and weekend training to ensure clinicians are clinically competent and safe in a military environment. The air force tends to have the shortest training time, with the army and navy providing more training for logistical requirements including, for the navy, helicopter underwater escape training.

There is also a military anaesthesia course run in Brisbane, using resources at both the Royal Brisbane and Women’s Hospital and Ipswich Hospital, which teaches anaesthesia in austere environments, managing battle casualties and their complications, and includes using old-fashioned draw-over vaporisers. It emphasises improvisation and a return to basic skills.

Military involvement requires a change in mind-set for many anaesthetists, who need to accept any deployment is to support a military mission set by government policy, which determines which patients are treated. There also is a hierarchy and different rules and regulations to contend with.

Dr Sharpe, who joined the NZ army three years ago and has done several training missions setting up a mobile hospital in Tovalu, Vava’u and Samoa, says it has taken him some time to get used to giving orders.

“Once I was getting someone to do something and one of the NCO’s whispered in my ear, ‘Don’t ask them, Sir. Tell them,’” he recalls.

Dr Thomas says there have been many improvements to defence force support and logistics since his first deployment to Rwanda in 1994, when he was part of the first surgical team on the ground.

“There was abundant evidence of the mass killings, there were still bodies that hadn’t been removed, there was an unbelievable smell due to dead bodies,” he says.

It was his first exposure to patients injured by landmines and machetes, as well as a population where 30 per cent of the people were HIV positive, and many had AIDS-related illnesses such as tuberculosis complications.

“When I arrived back in Australia from Rwanda, I had one day off with my wife and family, and went back to work the next day. Now, everybody coming out of these areas have to be interviewed by psychologists, and debriefed about their experiences and given an opportunity to identify any particular difficulties.”

These days people are better prepared before going, and there has been a steady improvement in equipment and supplies, especially access to clean water, light and power, which are needed for any operating theatre set-up.

A similarly bleak scene confronted Dr Scott and Dr Luckin in Banda Aceh, when they were part of the first western medical team to arrive in the Indonesian provincial capital four days after the devastating 2004 tsunami, which killed 160,000 in that province alone.

“There is nothing that prepares anybody, teachs you how to be a doctor, for a place where there are bodies lying in the gutters everywhere,” Dr Luckin says.

“The stench of decay in Banda Aceh was awful. From the moment you arrived until long after you left, the smell was on your skin and in your nose and was just awful. I think for all of us the magnitude of Banda Aceh, the sheer scale of devastation and death was very hard to cope with.”

The pair had limited drugs, essentially no equipment and half a cylinder of oxygen, and they took over an operating theatre in a so-called military hospital where they dealt with the very worst of casualties, who were all classified as ASA4-E or ASA5-E.

“In Banda Aceh, all of our patients had severe penetrating trauma, they all had grossly infected wounds, most of them had septicemia, they all had aspiration pneumonia, they had lungs full of mucus, secretions, often blood, often pus,” Dr Luckin says.

“They were desperately ill patients and Dave and I anaesthetised them with very little in the way of drugs or equipment.”

As a small nation, Australia uses a tri-service model for surgical deployments, with expressions of interest sought from military anaesthetists when need arises. This means navy, air force and army anaesthetists find themselves working side by side for military operations, such as Afghanistan, and during peacetime disasters.

New Zealand has not sent a surgical team to Afghanistan, although some anaesthetists have worked with the Canadian surgical team, which had been providing service to New Zealand troops. New Zealand anaesthetists can join the forward surgical team of the Royal New Zealand Army Medical Corps or can become part of the Civilian Volunteer Health Service, which can be sent to disasters and around the Pacific.

Despite the tri-service set-up, the different services do maintain specialist roles. The air force is mostly involved in long-distance aeromedical retrievals, while the navy can move a hospital ship and anchor it offshore, such as it did during the Solomon Islands conflict.
The army provides Australia’s only field hospital and expects its doctors to develop combat, logistic and administrative expertise alongside their clinical roles.

Dr Douglas, who was awarded the Medal for Gallantry for her service in Rwanda, nominates as her most memorable retrievals accompanying seven Australian soldiers who were shot in Afghanistan in 2011 when they travelled home from a staging post in Germany, and repatriating a large number of burns patients injured during an explosion on an asylum seeker boat off Ashmore Reef.

The Ashmore Reef explosion represented a logistical challenge to co-ordinate the concurrent movement of critically ill patients from Darwin hospital to the Royal Brisbane and Women’s Hospital. It involved six ambulances in convoy, a police escort that cleared intersections for the party, and special access on to the airfield.

Other aeromedical retrievals from overseas can be a challenge because of the 24 to 36 hours it can take to get home, all the while continuing the level of care that would be expected in a hospital for critically wounded patients, which often includes intubation and ventilation.

Dr Douglas says this is compounded by the hazards of aircraft, such as electrical shocks, loud aircraft noise that can drown out alarms, the necessity to be seated during take-off and landing, and the different air pressure levels that affect physiology.

“There are enormous considerations – trapped gases, the fact that vibration disturbs clots, a patient who’s traumatised will probably bleed, it’s colder at altitude, it’s noisy, fatigue, lots of things to think about,” she says.

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“Then when you’re at altitude, whilst you might know what the issues are, your capability to act on all of them is not as good as it would be on the ground, therefore making it even more adverse for you.”

Despite the challenges, Dr Douglas describes it as “fun”, “it’s absolutely awesome. I get really quite animated when I think, yeah, I do this stuff and I love it.”

Other College reservists share a similar enthusiasm for the rewards of service, despite the dangers involved in some deployments and the separation and anxiety from family.

Dr Graves says it is well worth joining up. “It might seem you’re delaying your career or hurting your career, but the benefits you get out of the military far outweigh any of the negatives,” he says.

Professor Beade says his attitude to teamwork has changed due to his military involvement, and his deployments have made him more tolerant of circumstances at home that he cannot change.

“If there was a lesson, it was that all you can do as a doctor is the best you can do, and I apply that to my civilian practice now as well,” he says. “The rewards have been to work with a very close-knit and co-operative team of people who are focused on one job. You end up forming a real bond with the team members you’re there with. And you do get the sense that you are actually achieving some good.”

Dr Thomas says it is professionally rewarding to provide high quality surgery and anaesthesia to coalition soldiers and civilians and it is hard not to be tempted to help whenever possible, despite the strain it places on his very supportive family.

“My youngest son was at law school when I went to Iraq and he said if I ever did another deployment, he was going to take me to court and sue me for mental stress or something,” Dr Thomas recalls with a laugh. “I think he was joking.”

While the dangers of service in the Middle East are always present, the surgical team is relatively safe due to the hospital and sleeping accommodation housed in armoured plated containers.

“Life on a two-way shooting range is a bit of a challenge always,” Dr Scott says with understatement. “But you just knuckle down and do your job. You don’t really notice that sort of stuff.”

He says the support given to the surgical team is overwhelming and, in some cases, unexpected.

He recalls a particularly hellish period at the end of his last rotation in 2008 when he helped repatriate to Australia wounded soldiers who had been ambushed by the Taliban. He survived on minimal sleep over several days.

He returned to his room, which he was sharing with an army colonel, whom he hadn’t yet met.

“And I get back to find that my bags had all been opened, all the dirty clothes had been taken out, washed and dried and folded,” Dr Scott recalls.

“This guy was an army colonel, I didn’t know him from a bar of soap, I said, ‘Wow, why did you do that?’ And he said, ‘I’m an intelligence officer and I know what you guys have been up to in the last 48 hours, I thought you might appreciate it’.

“There’s not many places in the world where that would happen, is there?”

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Involving clinicians in healthcare reform

When applying for a Churchill Fellowship, Newcastle anaesthetist Dr Tracey Tay had to make a two-minute pitch to a room full of unidentified people. With no knowledge of their backgrounds, skill sets or professions, she had to assume they had no understanding of the healthcare system and her spiel had to go to the heart of how her research project would make Australia a better community.

“My essential pitch was if you’re not consistently happy with healthcare in Australia, either for yourself or your community at large, and you were to redesign it, who would you want on the team?” she asks. “And currently there isn’t a strong representation from clinicians in it at that high level.”

Dr Tay works part-time as a senior staff specialist anaesthetist at John Hunter Hospital and Royal Newcastle Centre and her research last year has led to her working part-time at the NSW Agency for Clinical Innovation.

Her Churchill Fellowship investigated how highly performing organisations support clinician involvement in decision-making and leading change.

“I’ve always been interested in working out how doctors in particular can get a stronger voice into decision-making about priority setting and resource allocation in health at every level from hospital level and health service level all the way up to government and how we influence policy makers,” she says.

Her research from late November to January last year took her to the UK, Denmark, Sweden and the US, and involved 35 interviews with 60 health experts.

In the UK, an interview with the Chief Executive of the Academy of Medical Royal Colleges, Mr Alastair Henderson, revealed...
the historical background of how doctors and nurses ran hospitals with boards of management until a review by the Thatcher government recommended involving people with more specialised management and financial experience.

As a result, there was a backlash by doctors who feel management structures in the UK, and Australia and New Zealand followed suit, leaving very few health services run by clinician CEOs.

But more recently, another review of the National Health Service in the UK identified a lot of waste in the system and problems with equity of access. Dr Tay says the resulting recommendations were for the involvement of senior clinicians in management positions. Now all Strategic Health Authorities in the UK have a medical director. “They’re starting to say without doctors heavily involved at the beginning they’re not going to get the reforms they need to see,” she says.

In Australia too, the National Health and Hospital Reform process, instigated by former prime minister Kevin Rudd, recommended doctors have a much stronger role and voice in decision-making to ensure the most effective use of the health dollar.

Dr Tay’s report shows the barriers to greater involvement by clinicians in management and management training and, especially for doctors, a lack of financial reward and prestige for taking on the extra responsibility. But she views things differently and has found an emerging interest from clinicians wanting to get more involved.

“One of the things I’ve found around the world is a renewed desire to step up and make a difference in terms of the community that people want to live in,” she says. “I think there are people who care enough, and for them it’s not all about making large amounts of money.”

Dr Tay says people who get involved get a sense of transparency and fairness about the distribution of health dollars.

“I talk about being a citizen of the healthcare system, not a victim of it,” she says. “And I think a lot of people … talk and act as though they are victims of the system, rather than a part of it. So that sense of belonging and sense of being part of a system that gives good healthcare overall is also a reward for getting involved.”

Anaesthetists, in particular, are often found in the leadership arena, Dr Tay notes. “It seems that we are people who are whole-of-system thinkers. Because in anaesthesia we’re essentially a service specialty … we learn how to work across specialties, we learn what the challenges are across specialties, we work very much as a team.

“So when it comes to understand whole of system, we’re pretty good and I think we’re over represented at that leadership and management level. Managers tend to see us as largely sensible, calm people, which I think means we get a voice.”

In Denmark and Sweden, Dr Tay found a more egalitarian, bottom management structure, with clinicians more engaged in the needs of the whole hospital rather than just their departments.

She says Denmark mandates leadership and management training for all clinicians and provides quarantined time for training activities. The UK also has developed a Medical Leadership Competency Framework, which mandates the same management curriculum for all medical schools, specialty training and deaneries (for pre-vocational training).

In Sweden, she visited Qulturum, a purpose-built facility within the grounds of the Ryhov County Hospital, where individuals or teams can spend six months or a year doing projects to redesign aspects of healthcare.

Similarly, the Kaiser Permanente’s Sidney R. Garfield Innovation Centre in San Francisco is a giant warehouse with mock healthcare environments for working up new ideas and ways of doing things. The doctor-led organisation looks holistically at healthcare, building gardens and parks near communities struggling with obesity and running farmer’s markets to encourage better eating as a way to influence the social determinants of health.

Dr Tay also visited the Institute for Healthcare Improvement in Boston, which developed the “Triple Aim” framework, which has three simultaneous objectives: improve the patient’s experience of care, improve the health of the whole population and control costs.

Based on her research, Dr Tay makes four recommendations in her report, which are in summary:

• That all clinical education contains leadership and management training.
• That government and other health services include clinicians in planning, priority setting and resource allocation.
• That opportunities are created, particularly for junior doctors, for experiential learning in leadership and management.
• That healthcare organisations support clinicians to share responsibility and accountability for health outcomes, quality and cost with managers.

Dr Tay says the architect of the UK’s management curriculum framework, King’s Fund Senior Fellow, Mr John Clark, is now advising Health Workforce Australia on developing a similar national curriculum.

Western Australia and Victoria already have training programs in place for junior doctors to do a term attached to a service improvement project and there is strong interest from New South Wales to do something similar.

Dr Tay would also like to see clinicians and managers share key performance indicators so, for example, clinicians would be accountable for costs, and managers for education outcomes.

“Clinicians have to realise that we have to work with managers,” she says. “The team that will change healthcare will consist of clinicians and managers. We both need each other to make change. So the sooner we understand managers and the sooner managers understand us, the quicker we’ll get change.”

• Dr Tay encourages any anaesthetist with a passion for something to consider applying for the Churchill Fellowship, which considers a broad range of issues. “It’s a wonderful opportunity and most Fellows find that it is a life-changing experience, as it was for me.” She’s happy to be contacted at Tracey.Tay@hnehealth.nsw.gov.au. Further information is available at www.churchilltrust.com.au.

• To hear more about Dr Tay’s experiences, listen to the College Conversations CD with this edition of the ANZCA Bulletin.
Ultrasound, chai and the Himalayas

A teaching week in Nepal delivers learning and enrichment for everyone involved, writes Dr Anthony Hull.

In spring 2012 I spent a week with the welcoming anaesthetic team at Dhulikhel Hospital, Dhulikhel, Nepal, teaching ultrasound-guided regional techniques. Having been in contact with the anaesthetists there, it was apparent that ultrasound-guided regional anaesthesia (and ultrasound-guided vascular access) was an area they were deficient in and were keen to develop. It seems that only two or three other anaesthetists in Nepal (who are in Kathmandu), are using ultrasound-guidance for regional blocks. Access to instruction or exposure to such techniques is extremely limited in Nepal, even more so outside of the capital.

Dhulikhel Hospital (www.dhulikhelhospital.org) is a unique health enterprise in Nepal. Founded by Dr Ram Makaju Shrestha, a local who obtained his medical degree in Vienna, Dhulikhel Hospital is a non-profit community hospital whose mission is to provide affordable, accessible and high quality healthcare. It has an all comers “service first, pay later” ethos, and runs quite differently to how a Nepali government hospital runs. Many patients can’t afford to pay, and a significant amount of free treatment is funded out of a charity kitty. It receives no financial support from the Nepali government, but is funded by donor input and the re-investment of what fees are charged. The dedicated doctors and nurses are paid modestly. It’s a busy place, with a happy, efficient and “can do” atmosphere.

It operates as an effective teaching hospital, in concert with the Kathmandu University Medical School, and also has a new and extensive dental school. The hospital covers a population of approximately 1.9 million people, though has already provided services to 50 out of 78 districts of the country.

Otherwise, apart from Nepal’s government-funded public medical system, there is a growing private medical system that provides for the small minority who are able to pay high prices. The private system has an effect of draining more experienced medical staff from the public hospitals.

In Dhulikhel Hospital theatre, the default approach to regional LA blocks had been via stimlocation, using pre-loved and re-sterilised stimulating needles, performed pre or post-operatively. It was not unusual for the injection end-point to be that of neurological symptoms, particularly when there had been failure to evoke a motor response. The incidence of symptoms associated with systemic LA toxicity ranged between 4 to 10 per cent based on individual anaesthetist’s estimations. Neurological manifestations were treated with benzodiazepines.

There were no reports of progression to cardiovascular sequelae. Patients who received regional blocks had no routine follow up after departure from theatre, and catheter techniques had not been used.

There was a reasonable case for the introduction of ultrasound guidance into the local armamentarium, and teaching proceeded via hands-on practice and instruction. An ultrasound machine luckily lives in, and is allocated for, theatre use. The schedule was flexible to allow the busy theatre workload to continue unimpeded. The presence of nurse anaesthetic assistants enabled good attendance by the anaesthetists. The sessions initially focused on systematic sonographic imaging of plexuses and nerves on willing subjects, and progressed to performance of regional blocks on appropriate patients in the pre or post-operative setting. Also included were TAP blocks for sub-umbilical or full abdominal midline incisions.
We demonstrated how to achieve successful blocks by injection into neurofascial planes, with a margin of safety between needle and nerve. We discussed planning to avoid possible delays to theatre turnover with the use of a new technique.

The most readily available, inexpensive, and functional disposables (such as 22g quincke needles for TAP blocks) were determined. Some of the more generic aspects of regional anaesthesia were discussed selectively, including appropriate patient selection, day one post-operative reviews, LA dosing, and LA adjuvants.

An intralipid therapy flow chart was provided for copying and distribution to procedure areas where blocks occur, and intralipid availability was confirmed. A hard copy ultrasound-guided blocks resource is also now available for further self-guided progress.

The routine for central venous line placement at Dhulikhel Hospital was via the landmark guided subclavian approach. We covered imaging of, and CVC access via, the internal jugular vein route.

A week spent introducing a new method of performing regional anaesthesia is just a start. Just as the transition to ultrasound-guided regional anaesthesia practice among Australian anaesthetic departments took time, it also will be a gradual process in Nepal. There are also major resource and educational impediments to consider.

There are distinct benefits to be gained by incorporating this new technique into the routine of Dhulikhel Hospital anaesthetics department. Since I left Dhulikhel, there have been material improvements in block performance. The department has also managed (amazingly) to source another, more portable and user friendly ultrasound machine. They hope to conduct an ultrasound regional block workshop, planned for early-mid 2013, at Dhulikhel Hospital, to be run by another anaesthetist from abroad.

I also gained distinct benefits while at Dhulikhel, among them the morning cups of Nepali chai overlooking the distant Himalayan range, being involved in an inspiring institution, and meeting a great bunch of Nepali doctors, nurses, and patients.

Dr Anthony Hull, FANZCA
New South Wales

“Just as the transition to ultrasound-guided regional anaesthesia practice among Australian anaesthetic departments took time, it also will be a gradual process in Nepal.”
Studies in neonates and young children suggest there are long-term ripple effects on somatosensory perception from pain during early development but the implications are not clear yet. What we do know is that chronic pain in later childhood and adolescence is common. The landmark study by Perquin et al. found that chronic pain affected 25 to 35 per cent of children with a significant rise during adolescence. More than 50 per cent of children reported recurrent pain in the previous three months, more than half in multiple sites and 25 per cent fulfilled the definition of chronic pain. It was more frequent in 12 to 15-year-old girls. Approximately 5 per cent had moderate to severe pain. More recently, a systematic review of studies of pain prevalence by King et al., found that there were widely inconsistent findings (Table 2). They suggested that at least some types of pain may become chronic in childhood and be predictive of pain persisting into adulthood. Contributing factors included socioeconomic status, parental education, mental health status and time spent watching television. They concluded that there was a need for better studies of prevalence to understand the developmental trajectories, which may then allow identification of children at risk and early intervention. Prevalence studies have not been done in Australia and New Zealand.

### Table 1: Membership of IASP Pain in Childhood SIG, 2010

<table>
<thead>
<tr>
<th>Country</th>
<th>Members</th>
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</thead>
<tbody>
<tr>
<td>USA</td>
<td>79</td>
</tr>
<tr>
<td>Canada</td>
<td>42</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>20</td>
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<td>Australia</td>
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<tr>
<td>Brazil</td>
<td>11</td>
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<td>Netherlands</td>
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<td>Sweden, Germany</td>
<td>7</td>
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<tr>
<td>France</td>
<td>6</td>
</tr>
<tr>
<td>Japan, India</td>
<td>5</td>
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<td>New Zealand, Italy, Norway, Spain</td>
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</tr>
<tr>
<td>Thailand</td>
<td>3</td>
</tr>
<tr>
<td>Belgium, Switzerland, Portugal, Mexico, Denmark, Israel</td>
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</tr>
<tr>
<td>Finland, Ukraine, Costa Rica, Pakistan, Taiwan, Ireland, Kenya, South Africa, Bosnia &amp; Herzegovina, Austria, Singapore</td>
<td>1</td>
</tr>
</tbody>
</table>

Adapted from the latest information available on IASP website.

### Table 2: Summary of prevalence rates and age differences by pain type.

<table>
<thead>
<tr>
<th>Pain type</th>
<th>Prevalence range</th>
<th>Age differences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>8.8-82%</td>
<td>Older &gt; younger</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>3.8-53.4%</td>
<td>Younger &gt; older</td>
</tr>
<tr>
<td>Back pain</td>
<td>13.5-24%</td>
<td>Older &gt; younger</td>
</tr>
<tr>
<td>Musculo-skeletal/limb pain</td>
<td>3.9-42%</td>
<td>Older &gt; younger</td>
</tr>
<tr>
<td>Multiple pains</td>
<td>3.6-48.8%</td>
<td>Unclear</td>
</tr>
<tr>
<td>Other/general pain</td>
<td>5.8-89%</td>
<td>Unclear</td>
</tr>
</tbody>
</table>

Adapted from King et al. (2011).

Studies in neonates and young children suggest there are long-term ripple effects on somatosensory perception from pain during early development but the implications are not clear yet. What we do know is that chronic pain in later childhood and adolescence is common. The landmark study by Perquin et al. found that chronic pain affected 25 to 35 per cent of children with a significant rise during adolescence. More than 50 per cent of children reported recurrent pain in the previous three months, more than half in multiple sites and 25 per cent fulfilled the definition of chronic pain. It was more frequent in 12 to 15-year-old girls. Approximately 5 per cent had moderate to severe pain. More recently, a systematic review of studies of pain prevalence by King et al., found that there were widely inconsistent findings. They suggested that at least some types of pain may become chronic in childhood and be predictive of pain persisting into adulthood. Contributing factors included socioeconomic status, parental education, mental health status and time spent watching television. They concluded that there was a need for better studies of prevalence to understand the developmental trajectories, which may then allow identification of children at risk and early intervention. Prevalence studies have not been done in Australia and New Zealand.
In the clinic setting, complex regional pain syndrome, headache, abdominal pain and fibromyalgia dominate presentations. Girls present more frequently than boys, similar to the community incidence. A study published by Walker et al. this year investigated the predictors of long term outcomes for 843 children experiencing functional gastrointestinal disorders with associated chronic pain and psychiatric comorbidities in adolescence and adulthood. They performed cluster analysis and found a cohort of children who had evidence of central sensitisation that could be identified at baseline assessment. This has clinical and public health significance because it was these children who were at significantly higher risk of poor outcomes and therefore, should receive intensive specialised treatment.

However, it is not clear what constitutes the ideal treatment in many instances. Adult practices are often extrapolated to paediatric practice with limited evidence of efficacy. New slants on the traditional multidisciplinary approach are being tried with some promising results. However, studies on treatment programs are few and the cost of persistent pain in childhood is high. In 2004, in the United Kingdom, Sleed et al. identified the costs for adolescents attending a pain management clinic with those attending a rheumatology clinic. They estimated the average overall cost of pain to be around £8000 (approximately $A12,500) per adolescent per year. However, the costs for adolescents in pain were three times more than the rheumatology group. Parents and siblings required additional healthcare services secondary to the impact of the adolescent’s pain problem on the wider family, adding to the costs. Estimates of lost earnings were up to £7,250. This extrapolated to a national economic burden of approximately £680 million per year. Amazingly, there has not been any further update on these estimates despite some major international pain initiatives recently. Neither the 2011 Institute of Medicine blueprint from the US nor the Australian National Pain Strategy provides any cost analysis of the impact of persistent pain in children and adolescents.

Dedicated funding for all paediatric pain services across Australia and New Zealand remains elusive. The Faculty of Pain Medicine acknowledged children as a special group and established the Paediatric Pain Working Party but only 5 per cent of Faculty Fellows work in this field with three recognised training positions in paediatric pain medicine. (continued next page)

This page: Images of a 10 year old girl with Complex Regional Pain Syndrome (CRPS) following a minor trauma of her foot being shut in a car door and a subsequent re-injury playing netball.
Raising the profile of pediatric pain continued

This year, the Australian Pain Society established the Pain in Children SIG, drawing together the small number of practitioners from the various paediatric medical, nursing and allied health disciplines. Hopefully pooling resources will benefit all. Research output mostly comes from the established groups in Sydney and Melbourne plus some from Auckland. Recent publications include articles on service provision of acute pain management for children, the emerging issue of children on long-term opioids and putting some science into paediatric pharmacology.18-20.

Despite recent advances, pain in childhood and adolescence remains under recognised, under estimated, under treated and under researched. More translational research from animals to humans and from children to adults is desperately needed to understand when and how to intervene. Strong advocacy is required both for improved access to multidisciplinary pain management services for children and adolescents as well as research funding. Most important of all, though, is raising the profile of pain in childhood within the healthcare professions as well as the broader community to enable better understanding, early intervention and better outcomes for children and their families.

Dr Meredith Craigie, FANZCA, FFPMANZCA Chair, Faculty of Pain Medicine Paediatric Pain Working Party Faculty of Pain Medicine Pain Working Board member Chair Faculty of Pain Medicine Examination Committee

References:
And what is your idea?

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In August 2012, I travelled to Vanuatu for a week with funding provided by the ANZCA Overseas Aid Trainee scholarship under the supervision of Dr Matthew Howes, a staff specialist from the Mater Mothers’ Hospital in Brisbane. We were based at the Vila Central Hospital in Port Vila, the capital city on the island of Efate, providing relief anaesthetic services during the Pacific Society of Anaesthetists conference in Fiji. Vanuatu is a south Pacific nation comprising some 80 islands approximately 2400 kilometres east of Cairns. The islands are tropical and located in a region of active tectonic plate movement known as the “Paciﬁc ring of ﬁre”. Earthquakes and volcanic activity are common and we experienced a quake measuring 5.1 on the Richter scale during our stay.

Vanuatu is country of contrasts; luxury cruisers moor in the harbour while a few streets away families live in very humble circumstances. Despite the poverty, it has been dubbed “the happiest country on earth” and the national people (known as Ni-Vanuatu or Ni-Van) greet you with a happy “hello” and a bright smile.

Due to geographical and linguistic separation, the islands display an amazing diversity of culture. Residents speak more than 100 distinct languages and there are many dialects. The ofﬁcial languages are French, English and Bislama (or Vanuatu pidgin English). Most hospital staff spoke English, but for many patients Bislama was the common tongue. It was interesting to discover that the term “anaesthetist” is not only a mouthful in English but also in Bislama. While the surgeon is known as the “katem man” (the cutting man), there are several variations for “anaesthetist”. For example, I could be called “dokta blong makem man i silip guf” (the doctor who makes you have a good sleep) or this could be expanded to “dokta we i stikim man o i givim gas blong makem bodi i ded blong dokta i save katem” (loosely translated as “the doctor who either sticks you [for example, spinal] or gives you gas so that look dead in order for you to be operated on”).

The hospital at Port Vila was once located on a small island in the harbour, a ﬁve-minute boat ride from the mainland. Today the island is home to the Iririki resort, however, if you look carefully you can see what remains of the former hospital. More than 30 years ago it was decided to move the hospital to the mainland, which by all accounts was a good idea. The current Vila Central Hospital comprises several single-storey buildings with separate wings for medical, surgical, obstetric and paediatric patients. The hospital is in a particularly poor area with many slum dwellings nearby. There are always groups of people milling around and kids kick a football on the open grassed area near the entrance. Immediately it is evident that this is like no hospital I have worked in before.

Resource limitations don’t slow the medical staff – or the babies – at Vila Central Hospital.

The two operating theatres are old and patched up. Everything from the beds, lights, diathermy, drapes and gowns appear to be from a bygone era and bring back fond childhood memories of watching M*A*S*H. There is a distinct lack of order and the meticulous sterility we are accustomed to in western hospitals. The anaesthetic machines seem more cluttered. The ampoules are hard to read and even harder to break; a ﬁle beside the anaesthetic machine is used for this purpose. There are no colour-coded drug stickers and multi-dosing of drugs is common to avoid wasting scarce resources. There are sharps everywhere, no needleless injection systems. Sharps bins are makeshift containers, such as used water bottles or cardboard boxes. Many “single use” items are recycled, including Hudson masks and oxygen tubing. The ward charts, drug charts and anaesthetic records are bland and there
is no comprehensive correct-site surgical procedure. Many patients do not know their date of birth and it is not uncommon to see numerous variations of names on a patient’s chart.

Despite the obstacles and shortcomings everyone works well together to get the job done. The hospital staff are delightful and the patients are tough, tolerant and very grateful. By necessity, the junior doctors are much more hands-on than in Australia. It is not out of place for an intern under supervision to remove an appendix or perform a tubal ligation.

The clinical work was interesting and challenging. The caseload included a large number of paediatric and obstetric cases. During the week there were 77 births at the hospital – a lot considering there were only two midwives on duty! These deliveries included four emergency caesareans (no elective caesareans) and one vaginal delivery in the operating theatre (just saved from the scalpel). Two perineal tears also were sutured in theatre. Interestingly, there are no labour epidurals. Actually, there seems to be no pharmaco-analgesia for labour at all.

As well as the clinical aspects, I was able to attend one of the newly established obstetric morbidity and mortality meetings. The obstetric department recently established a high-risk obstetric clinic, which means there are fewer obstetric anaesthetic “surprises”. I was also involved in running an interactive, clinically based teaching session for junior doctors on the topic of obstetric emergencies. Our time in Vanuatu also provided much needed support and shared experience with the two hard-working anaesthetic assistants — Michael Kalotrip and Joseline Phatu.

Overall, I found my time in Vanuatu to be of great value. The work was varied, challenging and rewarding. The hospital staff and patients were a delight to work with and care for. It was interesting to use different anaesthetic agents and techniques and I was left with a greater appreciation of our own medical system and the responsibility we have to use our resources wisely.

Dr Stephen Smith, FANZCA
Cairns Base Hospital, Cairns
ANZCA Overseas Aid Trainee
scholarship winner

The ANZCA Overseas Aid Trainee Scholarship was established to support a final-year ANZCA trainee to develop their understanding of the challenges of providing anaesthesia and/or pain medicine in developing countries. Further information about the scholarship is available on the ANZCA website or by contacting overseasaid@anzca.edu.au.

“I could be called “dokta blong makem man i silip gud” (the doctor who makes you have a good sleep) or this could be expanded to “dokta we i stikim man o i givim gas blong makem bodi i ded blong dokta i save katem” (loosely translated as “the doctor who either sticks you [for example, spinal] or gives you gas so that you look dead in order for you to be operated on.”

Opposite page from left: Vila Central Hospital;
Public health message: “Breast milk from mother is the best number one food for your baby.”

This page from left: Some of the hospital’s theatre staff on our last day; Theatre 1: Arch bars to fractured mandible.
To resuscitate or not to resuscitate?

Anaesthetists have a duty to intervene when a patient has an adverse reaction to anaesthesia. But what if the patient requests otherwise? It is increasingly common for patients with significant chronic disease to participate in advanced care planning, which is a process whereby a patient, in consultation with healthcare providers, family members and important others, makes decisions about his or her future healthcare, should he or she become incapable of participating in medical treatment decisions. Such programs have demonstrated a positive impact on the quality of end of life care.

A frequent component of advanced care planning is a “not for resuscitation” (NFR) order (also known as a do not attempt resuscitation order), which may be documented in the hospital records of patients whose underlying medical condition is severely compromising their quality of life, or is so debilitating as to make resuscitation attempts futile.

If the order is at the patient’s request, attempting to resuscitate the patient from an imminent or established cardiorespiratory arrest related to their underlying disease would be against the patient’s wishes, and could subject them to a loss of dignity and privacy that they had actively sought to avoid. It would not comply with the Good Medical Practice requirements (or guidelines of the Medical Board of Australia or the Medical Council of New Zealand). Moreover, in the unlikely event that the resuscitation was unsuccessful, it may cause harm or prolong or increase the patient’s suffering. For these reasons, all clinicians involved in the patient’s care should respect an NFR order.

But what if the cardiorespiratory arrest (or imminent cardiorespiratory arrest) was not directly related to the patient’s underlying medical condition? What if it were instead related to a recognised and reversible side effect of a drug administered for an unrelated condition? Or worse, what if the wrong dose of the drug – or even the wrong drug – had been administered? What if the patient already had intravenous access, airway protection and monitoring in place, and was likely to respond rapidly to resuscitative efforts without loss of privacy or dignity?

Should resuscitation be withheld in these circumstances?

Providing anaesthesia for patients with NFR orders in place raises these and other questions. Several professional societies and organisations have guidelines on the decision to suspend or modify NFR orders in the perioperative period and the issue has been discussed in recent articles and editorials. Various health departments and hospitals also publish guidelines to which anaesthetists can refer. However, the issue is complex and there are ethical and legal implications and it can be difficult for anaesthetists to know how to proceed.

This article simplifies the complex issues. It is not a comprehensive review, but a summary of common features found in the guidelines. It offers a framework for compassionate and responsible care.

Most guidelines on this issue highlight the importance of communication, which can be considered under the headings: explanation, clarification, informed consent, reassurance and documentation. Others focus on the importance of “re-evaluation” or “required reconsideration” of NFR orders, which also would involve these steps.

Explanation

While the patient’s wishes must be respected, allowing a reversible side effect of an anaesthetic drug to hasten death is not an option for any anaesthetist. Therefore, to relieve anxiety and avoid misconceptions, it is essential to explain what anaesthesia entails. Patients (or their next of kin or legal guardian if they are not competent to provide informed consent) should be advised that general anaesthesia requires intravenous access, airway protection and the administration of intravenous fluids and/or drugs that may be required to counteract the known dose-related haemodynamic and ventilatory side effects of anaesthetic agents.

Major regional anaesthesia and heavy sedation require similar safety interventions. It is important to emphasize that managing these side effects is a part of anaesthesia and cannot be neglected or abrogated without a severe risk to the patient. If, at the request of a patient, an anaesthetist does not reverse a known haemodynamic or ventilatory side effect of an anaesthetic agent, the result could be fatal and may constitute assisted suicide. Moreover, there is the rare possibility of a more severe adverse reaction to anaesthesia, which may require cardiopulmonary resuscitation (for example, anaphylaxis, high neuraxial block). The anaesthetist would feel required to treat any anaesthetic-caused adverse reaction of this nature from the induction of anaesthesia to discharge from the post-anaesthesia care unit.

There is another view that patients are entitled to refuse treatment even for iatrogenic complications and that treatment decisions should be “defined in terms of patients’ clinical goals and preferences”. In the authors’ opinion, this should not extend to reversible anaesthetic side effects and complications.

On the other hand, it should be explained to the patient that the management of most side effects of anaesthesia is typically rapid, effective and painless, and usually involves only the administration of vasocactive agents and/or intravenous fluids by their anaesthetist. Even chest compressions and defibrillation can be done in a controlled manner. A resuscitation team is not required to apply additional monitoring or insert extra lines without detailed knowledge of the patient’s condition and wishes.

The point of contention, however, will be the differentiation between a major cardiovascular or respiratory event (including cardiorespiratory arrest) related to anaesthesia, and an event that is attributed to the patient’s underlying condition. If there were any doubt, the anaesthetist would be required to attempt resuscitation until an anaesthetic cause had been excluded. If the arrest was due to the patient’s underlying condition rather than an anaesthetic side effect, resuscitation would be much less likely to be successful; causes related to the patient’s underlying condition would in most cases soon declare themselves.

Prolonged resuscitation attempts would not be justified, irrespective of the cause of the adverse event, due to the patient’s previously expressed wishes and the futility, given the patient’s reduced cardiopulmonary reserve and/or poor prognosis.
Clarification
In the event that consideration is being given to maintain any aspect of the NFR orders during the perioperative period in which the patient is under the influence of an anaesthetic drug, the anaesthetist must first clarify the following:
1. Has the patient provided written informed consent to the NFR order and is he or she competent to confirm their preference for NFR orders in relation to their underlying condition to continue during the perioperative period?
2. If the NFR order is part of an advanced care directive, did the advanced directive have provision for the possibility of unforeseen circumstances such as the need for surgery and anaesthesia?
3. Is the patient’s medical condition or prognosis the same as or worse than at the time of their signing of the NFR order?

If the answer to any of the above questions is yes or is not known, then it will not be possible to ensure that the patient’s wishes are current in relation to surgery and anaesthesia.

Informed consent
Before proceeding with anaesthesia, the patient (or their next of kin or legal guardian if they are not competent to provide informed consent), as for all patients, must be made aware of the risks of anaesthesia and the measures that will be undertaken to minimise these risks. They should be informed that the risks are almost certainly increased by their patient’s underlying condition, and that death may occur despite optimum management. Nevertheless, consenting to anaesthesia should include consent to the management of reversible anaesthetic side effects and adverse reactions. Once informed, the patient, if competent, must then declare their wishes in relation to resuscitation for non-anaesthetic causes of cardiorespiratory arrest. Patient preferences for limitations on resuscitation from any cause (including anaesthetic causes) of cardiorespiratory arrest should also be documented, such as declining postoperative ventilation, haemodynamic support or intensive care. A purpose-designed form may be useful in this situation.

While there should be a separate consent form for the surgery or procedure, ideally the surgeon or proceduralist and the anaesthetist should meet with the patient together, so that all parties are aware of the risks and options, and the management plan and the patient’s wishes are clear to all.

Reassurance
As for all patients, patients with NFR orders should be reassured that their anaesthesia will be as safe as possible and that they will receive adequate pain relief following their procedure and optimal management of anaesthetic side effects. In addition they should be reassured that their wishes in relation to NFR orders will be respected. If they have provided informed consent to have the NFR orders maintained throughout the perioperative period, then any attempts at resuscitation will be limited to the management of adverse effects known (or suspected) to be caused by anaesthesia. They will NOT receive resuscitation from a cardiorespiratory arrest considered to be unrelated to the anaesthesia or surgery. They should also be reassured that regardless of cause, resuscitation attempts will not be prolonged into the postoperative period, such that they would require postoperative ventilation, haemodynamic support or intensive care, counter to their requests.

Documentation
In addition to the written informed consent, a brief summary of the discussion with the patient or their next of kin should be documented in the patient’s medical record.

In most cases this process is likely to be satisfactory to all parties. In the event that the patient (or the next of kin or legal guardian if the patient cannot provide informed consent) refuses any form of resuscitation despite the explanation and reassurance provided, then it may not be possible to provide anaesthesia for the procedure. Making stipulations on the extent of resuscitation (for example, procedure specific), such as no chest compressions or no defibrillation, may place an anaesthetist in a difficult position if they must attempt to reverse an inadvertent iatrogenic cause of a cardiorespiratory arrest, which if untreated could lead to an anaesthesia-related death. Treatment decisions should be based on the likely cause of the arrest while emphasising that, irrespective of cause, resuscitation attempts will not persist postoperatively against the patient’s wishes. Hospitals or departments could develop guidelines to assist in this process.

In summary, NFR orders should not be automatically suspended during anaesthesia, but patients should still receive the safest possible anaesthesia, including the treatment of common anaesthetic side effects and rare adverse reactions. There should be extensive explanation and reassurance to allay patients’ anxiety about inappropriate resuscitation and clarification and documentation of patients’ wishes. Attention should then focus on providing the safest possible anaesthesia and ensuring that the patient is as comfortable and pain free as possible in the postoperative period.

In summary, NFR orders should not be automatically suspended during anaesthesia, but patients should still receive the safest possible anaesthesia, including the treatment of common anaesthetic side effects and rare adverse reactions. There should be extensive explanation and reassurance to allay patients’ anxiety about inappropriate resuscitation and clarification and documentation of patients’ wishes. Attention should then focus on providing the safest possible anaesthesia and ensuring that the patient is as comfortable and pain free as possible in the postoperative period.

Professor Neville Gibbs, FANZCA, MD, Chair of the ANZCA Mortality Sub-Committee
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(continued next page)
Quality and safety

To resuscitate or not to resuscitate? continued

References


AURORA – a clinical registry

The concept of a registry is simple – it is a place where records are kept. Clinical registries systematically and uniformly collect information from people who undergo a procedure, are diagnosed with a disease or use a healthcare resource. The American Heart Association defines a clinical registry as a prospective observational database of a clinical condition, procedure, therapy or population, in which there are no registry mandated approaches to therapy and relatively few inclusion and exclusion criteria. This is very different to the conduct of a controlled-clinical trial where rigid filters in the form of inclusion and exclusion criteria are often applied before sampling can occur. This process of exclusion generates internal validity but may limit application of results to a broader population.

Despite these limitations, the randomised controlled trial (RCT) is the gold standard for determining if a therapy is efficacious. The focus of clinical registries is to capture real-world clinical practice, for example native hospital behaviour, in large patient populations independent of the environment of a controlled clinical trial. Clinical registries are important for monitoring and benchmarking the quality of clinical care and are critical for clinical practice improvement. Clinical registries can serve multiple functions such as public health surveillance and for performance assessment. They can be used as vehicles for quality improvement, to evaluate trends in clinical practice and to monitor the safety and efficacy of a drug or device in phase four studies. Determining if best practice and evidence-based guidelines are being adhered to or if the results of RCTs apply in routine practice (effectiveness study) are further valid uses.

There are many examples of successful clinical registries or databases from surgery,8 intensive care,4 and internal medicine. The Australian and New Zealand Registry (AURORA) is an example of a clinical registry established to determine the quality and safety of our contemporary practice of peripheral regional anaesthesia. The project began in 2006 during a period in which regional anaesthesia was evolving because of increased use of peripheral regional anaesthesia and ultrasound-guided techniques.

In previous studies peripheral nerve blocks (PNB) were performed using nerve stimulator technology and therefore the results did not apply to a new clinical technique. Existing literature included studies using self-reporting methodologies that were considered inadequate to guide risk disclosure. Monitoring the quality and safety of regional anaesthesia is important for informed patient consent, clinical decision making and because regional anaesthesia is an alternative anaesthetic technique by many patients and anaesthesiologists.

The public perception of risk associated with anaesthesia is primarily related to the extremely rare risk of death due to general anaesthesia. Overall, the risks of general anaesthesia tend
to be more easily understood and thus accepted by patients. An anaesthetist may recommend regional anaesthesia but a patient’s preconceptions may influence how receptive they are to an alternative technique. An additional burden is therefore placed on the clinician wishing to perform a regional technique when new potential benefits and complications are provided to patients.

**AURORA results**

**Detailed methodology, outcome definitions, follow-up pathway and preliminary results of this project were published in 2009.**

During 2006-2012, approximately 35,000 peripheral nerve blocks (PNB) have been captured to the registry. Ultrasound-technology was used in 81 per cent of peripheral nerve blocks during this period. Peripheral nerve block was an effective technique for enhancing early postoperative recovery with the median pain scores in post anaesthesia care unit (PACU) being zero in all peripheral nerve block categories except for trunk.

Overall 65 per cent of patients required no analgesia, 23 per cent intravenous opioid analgesia and 8 per cent oral analgesia respectively. A total of 48 per cent of patients were ready to disport the PACU within 30 minutes.

Patient-rated outcomes indicate that patients were satisfied with the information provided to them and interactions with their anaesthetist. However, there is room for improvement because a significant proportion of patients reported moderate or severe pain following recession of peripheral regional anaesthesia.

During the study period of January 2007 to May 2012 inclusive, there were 22 episodes of local anaesthetic systemic toxicity (LAST) (3 minor, eight major and one cardiac arrest) from 25,336 peripheral nerve block. Overall, the incidence of LAST was 0.67 per 1000 peripheral nerve blocks. AURORA has demonstrated that ultrasound guidance may be protective for LAST. When peripheral nerve block was performed with ultrasound technology the incidence of LAST was reduced compared to techniques not using ultrasound. This finding was consistent using multiple analytical techniques and may represent the first statistical evidence that ultrasound guidance improves safety during peripheral nerve blocks.

The incidences of late and long-term peripheral nerve block-related nerve injury were 0.6 and 0.30 per 1000 peripheral nerve blocks regardless of technology used. These incidences were calculated from a denominator comprising the total number of brachial plexus, femoral and sciatic nerve blocks. Fortunately, in most cases the long-term outcome for these patients was favourable.

In this study there was no significant difference in the incidence of late or long-term peripheral nerve block-related nerve injury when peripheral nerve block performed with ultrasound was compared with no ultrasound. Many observers would consider it plausible that peripheral nerve block-related nerve injury would be reduced when ultrasound-guided techniques were compared with techniques not employing ultrasound technology.

The major value and use of ultrasound-guided peripheral nerve block includes dynamic visualisation of needle placement and avoidance of physical trauma there are other potential mechanisms including direct local anaesthetic toxicity. A randomised controlled trial comparing ultrasound-guidance with techniques not employing ultrasound would require a prohibitively large number of patients if permanent nerve injury were the primary outcome.

The AURORA results indicate that if a difference in nerve injury truly exists when ultrasound guidance is compared with non-ultrasound techniques a sample of at least 30,000 per group would be required. It is now accepted that ultrasound guidance has not reduced the incidence of nerve injury caused by peripheral nerve block. Even if a larger registry had an appropriate sample size, it would be very unlikely to contain a large cohort of peripheral nerve block not performed using ultrasound technology. Furthermore, the clinical presentation of nerve injury its impossible to be absolutely confident of the cause. Distinguishing anaesthetic, patient and surgical causes of nerve injury are notoriously difficult, if not impossible in some instances.

Some consider that regional anaesthesia introduces a non-essential procedural risk into the already complex perioperative environment. The AURORA results clearly demonstrate that the incidence of serious complications attributable to peripheral nerve block is extremely low. When the infrequency of serious complications documented in this study is combined with the proven efficacy of ultrasound-guided peripheral nerve block, it is difficult not to promote its routine use for peripheral nerve block. The evidence for the efficacy of ultrasound-guided peripheral nerve block is robust for commonly performed upper and lower extremity peripheral nerve block, but less definitive for trunk blocks.

(continued next page)
The future

Fortunately, serious complications associated with regional anaesthesia are infrequent or rare. This, however, introduces the first challenge – the requirement for large sample sizes. The second challenge is to distinguish outcomes directly attributable to peripheral nerve blocks from other causes.

The development of a clinical registry with well-defined outcomes provided a framework for assessment of quality and safety of contemporary peripheral nerve block. This registry and its collaborative infrastructure provide an opportunity to develop what this author has described as a virtual department of anaesthesiology.1 If large enough, this entity would comprise centres with distinctly differing practice patterns providing the basis for a pseudo-randomised clinical trial. Ideally these practice patterns would include some of the almost continuous stream of newly described techniques. As creative and innovative as these new techniques often are, they should be tested for clinical effectiveness and safety before their widespread use is promoted. Registries provide an important mechanism to do this. Other industries routinely do so to stay competitive – continually monitor its products for quality and take steps to improve when indicated. Some experts have called for a registry for every medical condition and invasive procedure.2 AURORA is a registry for peripheral nerve block. In anaesthesia, we should be looking for efficient mechanisms to add value to our daily professional activities. Recording and reporting outcomes from routine care is one method of doing so. Competition from alternative anaesthesia providers and modes of local anaesthetic delivery3 should prompt us to examine ways of adding value to what we do. A significant proportion of our population requires anaesthesia services every year and therefore we should treat anaesthesia as a public health issue. Collecting data from routine care and collaborating in multi-centre registries as virtual departments of anaesthesiology provide us with an opportunity to extend our repertoire and become public health physicians. Registries provide an infrastructure for measuring and reporting key outcomes crucial to any improvement. This registry provides both a template for such a research infrastructure and demonstrates a low incidence of serious morbidity that others can benchmark their practice against in virtual departments of anaesthesiology. Because, this project now collects outcome data from Australia, New Zealand, Malaysia and the United States, it has been renamed the International Registry of Regional Anaesthesia. The collaborators and hospitals that have contributed to this project are located at www.regionalanaesthesia.wordpress.com/collaborators.

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References:
Preoperative care – a “consumer’s perspective”

The following is an edited extract from a letter to the ANZCA chief executive officer by an informed patient. The letter details her preoperative experience and highlights difficulties that may be faced by patients attempting to communicate with their anaesthetist prior to surgery. The issue is more common in the public health sector. Of course similar frustration is often also felt by the anaesthetist, who may not have the chance to adequately assess preoperatively a patient with a complex medical history.

Dear Ms Sorrell,

I am writing to you to outline a gap I have become aware of in how anaesthetists relate to consumers.

The gap emerged from my own experience of having an anaesthetist attend me for two operations. I have multiple chronic conditions so any operation causes concern and raises questions such as “is it going to upset my conditions which are stable at the moment?” I wanted to play an equal part with my health team in ensuring that my outcome was as good as it could be. People in the health environment say having the consumer at the centre of care benefits all and this is what I wanted.

I visited the specialist members of my health team who manage my chronic conditions and asked them to speak with the surgeon, which happened and that worked very well, but I could not access the anaesthetist for the same preoperative consultation. I was given an appointment for a pre-admission clinic a week before surgery and I saw an anaesthetist, but not the specialist who was going to give my anaesthetic. He tried to answer my questions but it was not very satisfactory because he was not the doctor attending the operation. He suggested I phone a number 24 hours before my operation to speak with the anaesthetist rostered to my surgery, but I wanted my questions answered before deciding whether I would have the operation. The anaesthetist did not have rooms so was unavailable until the morning of the operation. I eventually left a message and the anaesthetist phoned me at home on a Sunday and we began working together as a team.

The surgeon, the anaesthetist and I made up a team and they changed the way they did things to give me a better outcome. I was happy with the contract we drew up among us to manage my situation. I had an incredible outcome, the operations were successful and there was no change in my chronic conditions.

The health system encourages people to be more involved in their care and to play an active role in making health decisions. Consumers can only do this if we have easy access to the doctors and some knowledge that will help us make the right decisions for our care.

I am sure that anaesthetists would be willing to answer consumers’ questions but I believe that consumers are unaware of how they can arrange a consultation prior to surgery. The increase in day-surgery procedures means consumers may not be seen by the anaesthetist before the day of their operation. This limits their ability to make informed decisions about whether to have an operation.

At the pre-admission clinic, I did not want to consent to the operation until I had my questions answered by the anaesthetist who was to give my anaesthetic, but I was expected to do so anyway. This was difficult for all involved. I did not give up and I was happy with the outcome.

Could there be discussion on how the interface between anaesthetists and consumers can be improved to provide a preoperative consultation process? Can we ensure that consumers know how to connect with their anaesthetist to assist them to make informed decisions?

This may be a new way of thinking about the relationship between consumers and anaesthetists, but the health system continues to say “put the patient at the centre of the care”. By encouraging consumers to become knowledgeable and skilled at self-managing their chronic conditions, we also encourage them to ask questions and to contribute to decisions about their healthcare.

Regards,

(Name withheld)

Of note, the author does not at any stage refer to herself as a patient but as a “consumer”. She reflects on the “contract” that exists between herself and her treating physicians. These are terms that we are not familiar with using in medicine but are no longer the sole domain of business and law.

Gratifyingly, she recognises the importance of the anaesthetist in optimising her outcome and the potential impact of anaesthesia and surgery on her underlying chronic conditions. She also has an acute understanding of the importance of a healthcare team. However, her experience was not optimal and serves to highlight the challenges of delivering patient centered care in a health system under significant fiscal constraints.

Whilst “easy access to doctors” providing the primary care is always going to be problematic in the public sector, staffing preoperative clinics with physicians who are able to comprehensively answer questions based on potential anesthetic plans should allow the patient to give informed consent for a procedure. Consideration needs to be given to the best way of establishing lines of communication with the primary anaesthetist. Meeting consumer demands for more comprehensive information about anaesthesia and perioperative management should be attainable.

The College has developed two relevant professional documents, PSSay Recommendations for the Pre-Anaesthesia Consultation and PSSay Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery. These reinforce that the intention of the medical team should always be to “put the patient at the centre of the care”. This is not a new concept but the inevitable increase in day of surgery admissions and day surgery procedures in higher risk patients provides ongoing challenges. We must be aware of the increasing pressures and develop strategies to address them.

Dr Phillipa Hore, FANZCA
Communication and Liaison Portfolio
Quality and Safety Committee
Our past and present shape our future and the 2013 ANZCA Annual Scientific Meeting (ASM), “Superstition, dogma and science”, aims to provoke discussion around this concept. Melbourne is bold. So we invite you to be brave, share our passion for inquiry and discuss the choices you make every day. Discover if you are a creature of habit or a practitioner open to critical evaluation?

Melbourne is also dark and mysterious. Our laneways are alive with vibrant street art and the aroma of freshly brewed coffee wafts from bustling cafes. A cultural mix of hip inner-city style is interwoven with business efficiency and structured academia. It is an exciting city.

We are a community of innovators. In 1938, the Australian Red Cross Blood Transfusion Service, established in Melbourne, was the first organisation in the world not to give money to blood donors. In 1984 we delivered the world’s first frozen embryo baby. The National Gallery of Victoria has the world’s largest stained glass ceiling. It measures 51-metres long by 15-metres wide. Even the ubiquitous McDonalds was manipulated to satisfy our citizens. A world-first McCafe was established at the Swanston Street store. Are you able to incorporate new information and innovate?

The scientific meeting venue, Melbourne Convention and Exhibition Centre has not just a five-star rating signifying Australian excellence but a world-first six-star rating, meaning it sets new global standards for a convention centre.

The invited speakers
The Australian and New Zealand College of Anaesthetists is fortunate to have engaged world leaders in anaesthesia to stimulate our anaesthesia community’s spirit of exploration and self-examination.

Professor Kevin Tempe is an intriguing combination of chemical engineer, anesthesiologist, safety analyst and advocate for improved patient outcomes. He was invited to give the keynote address, the Emery A. Roverine Memorial Lecture, at the American Society of Anesthesiologists national meeting in 2010. He is a sought-after speaker at national and international academic centres for his work on optimising information systems to improve patient outcomes.
Professor Edzard Ernst is a physician with an MD and PhD who has sharp insight into the explosive topic of complementary medicine. He has been quoted as saying only 5 per cent of alternative medicine is backed by evidence, with the remainder being either insufficiently studied or backed by evidence showing lack of efficacy. His convincing views are certain to stimulate debate and his lecture in Plenary Session One (“The prince and I”) with its royal intrigue is not to be missed.

Associate Professor Timothy Short is head of the ANZCA Trials Group and brings local expertise along with Professor Colin Royce. Their diverse interests in patient outcomes combined with a practical sense developed in clinical anaesthesia complement our international speakers.

Cultures aligned with the night sky believe a shooting star means a man has died. Professor James Bagian is a multi-talented MD, engineer and former NASA astronaut who logged more than 300 hours of space flight on two missions. His broad reaching perceptions on prevention of patient harm will enlighten us all. He is the perfect man to debate science and shooting stars.

Professor Paul White has public and professional experience in the debate surrounding ethics. He will challenge us to examine in detail the rules that govern our actions in every aspect of our practice.

Workshops and problem-based learning
Our workshops focus on the acquisition of practical skills. Many of the workshops allow access to equipment that might otherwise be unavailable to anaesthetists due to financial or geographical constraint. Simulation, advanced airway management and echocardiography sessions will allow participants to test their skills in a stress-free environment. Our workshop team has worked hard to bring innovative techniques within the grasp of those bold enough to sign up.

The problem-based learning discussions encourage evaluation in an interactive format. Participants always express strong feelings around the topics and this generates improved active learning experiences. “Caffeination: Savour the brew, enjoy with the coffee...” brings the unique culture of Melbourne back into the mix.

The anaesthetised, animal wet lab workshop at the Werribee Veterinary School is a standout. We remain sensitive to the eth-crit white providing an excellent opportunity to acquire life-saving skills in people.

Melbourne will bring our belief systems around our anaesthesia practice to the fore. Our meeting will challenge participants to explore all the options, examine the evidence, and evaluate the superstition and dogma before relying on best available science. Be bold, challenge yourself and enjoy the experiences Melbourne has to offer.

Our masquerade ball will give you an opportunity to relax with friends and believe in the magic of mysterious Melbourne. We welcome your participation in “Superstition, dogma and science”, the 2013 ANZCA ASM.

Dr Debra Devonshire
Convenor, 2013 Annual Scientific Meeting
Look out for these high-profile contributors:

In addition to our invited speakers and experts from within our fellowship we have many guest contributors to the ASM program. There are specialists from other medical disciplines including intensive care, surgery, neurology, cardiology, haematology, immunology, retrieval and respiratory medicine. The view is further broadened by the inclusion of non-medical experts in ethics, law, politics and informatics. All are leaders in their respective fields and part of our exciting program.

Dr Joanna Flynn AM is a general practitioner and current chair of the Medical Board of Australia. Her career of service to the medical profession includes previous roles as the president of the Australian Medical Council and chair of the Post Graduate Medical Council of Victoria.

Ms Loretta Marron is a two-time winner of the Australian Skeptic of the Year award and chief executive officer of Friends of Science in Medicine, an organisation dedicated to challenging pseudo-science and quackery in healthcare.

Professor Rinaldo Bellomo is an intensive care specialist, author of more than 700 papers and 120 book chapters and current editor of the journal Critical Care and Resuscitation. He has been a key contributor to many landmark trials that have changed our understanding of critical care medicine and is a highly entertaining and forthright speaker.

Dr Jodi Sherman, MD is an assistant professor of anaesthesiology and environmental compliance officer at the Yale University School of Medicine. She is an internationally recognised speaker and author in the emerging field of sustainability in anaesthesia.
Along with a great scientific program the forthcoming ASM has much more on offer. Here are just some of the highlights...

SOCIAL HIGHLIGHTS

Set in the prestigious Plaza Ballroom, this year’s College Ceremony Cocktail Reception will be held in a venue reminiscent of a 19th Century European ballroom. Come celebrate this memorable night with our New Fellows and colleagues, whilst enjoying Victoria’s fine wines and food.

The ASM 2013 Gala Dinner is about ....

...immersing in a SUPERSTITION inspired ambience, embracing the DOGMA of having a good time celebrating Melbourne’s success in gastronomical SCIENCE

OPTIONAL TOURS HIGHLIGHTS

...join us for a round of golf

Join your fellow delegates for a day of golf at one of Melbourne’s prestige golf courses, Sanctuary Lakes. As his first Melbourne project, Greg Norman’s design at Sanctuary Lakes capitalises on the natural beauty of the site with a classic links style course.

Explore Melbourne is celebrated as Australia’s home of the arts, sport and shopping. Yet, just one hour’s drive takes delegates to a world away... visit local vineyards, world-class golf courses, stunning surf coasts to wildlife sanctuaries. Book in to one of the optional activities and really explore Victoria!

Voted the world’s most liveable city in 2012, Melbourne has something for everyone!

WHAT’S HAPPENING IN MELBOURNE

This year, Melbourne has already welcomed the Melbourne Food and Wine Festival, the Grand Prix, Melbourne International Flower Show, French film festival, Melbourne International Comedy Festival AND the L’Oreal Melbourne Fashion week. But don’t think that it all stops there! In May, the city will host the St Kilda Film Festival, Monet’s Garden at the National Gallery of Victoria, Melbourne Jazz Fringe Festival and the Melbourne International Coffee Expo.

For further information please visit www.anzca2013.com
Tribute to
Dr Patricia Mackay

The inaugural meeting of the Quality and Safety Committee of the Australian and New Zealand College of Anaesthetists was held on Sunday May 4 in 2006. Dr Patricia (Pat) Mackay, retired anaesthetist and Emeritus Consultant to the Victorian Consultative Council for Anaesthetic Mortality and Morbidity, was one of 11 participants. The committee was the outcome of the combined recommendations of two taskforces established by Professor Michael Cousins during his presidency: the Data Taskforce (chaired by Dr Michelle Joseph) and the Integrated Approach to Quality and Safety Taskforces (chaired by Pat). Thus Pat was not only present from the beginning of the Quality and Safety Committee, she was substantially responsible for its creation.

During the six-and-a-half years that she served on the committee, Pat’s astute mind, practical focus, encyclopaedic knowledge of matters medical, and consistent willingness to accept tasks however onerous, have made an enormous direct contribution to the committee’s activities. In addition, Pat has made a substantial and very positive contribution to the collegial and effective way in which the committee has functioned. During its first year, Pat argued strongly that an experienced and senior administrator would be essential if the committee were to succeed. Pauline Berryman was appointed (followed by Giselle Collins and now by Karen Gordon-Clark). Pat’s wisdom has been very evident through the contributions of Pauline and Giselle. Fellows, notably Pat, contribute a great deal of their time to the College pro bono. Competent support from College staff is absolutely essential if the considerable value of that time is to be realised. This is perhaps better understood today than it was in 2006 and, in this, as in so many things, Pat was characteristically forward thinking.

The Quality and Safety Committee has placed considerable emphasis from the outset on communication. Pat took on the communication portfolio and established the quality and safety section within the College Bulletin that has now become a keynote feature of this publication. Although various Fellows have contributed, it has been Pat’s energy, commitment, and editorial skill that has made the quality and safety section the widely read and important part of the Bulletin that it has become. Pat was also very quick to capitalise on the opportunities offered by the College’s e-newsletter.

Patricia Mackay was born in New Zealand. She graduated from Otago University, Dunedin, in 1949 and her postgraduate training in anaesthesia was undertaken in New Zealand, Australia and the UK. She was appointed to the Department of Anaesthesia at the Royal Melbourne Hospital in 1954 and since then has pursued an outstanding career in Australia, in anaesthesia, intensive care and pain medicine (Pat established the first acute pain service in Victoria). She became Director of the Department of Anaesthesia at the Royal Melbourne Hospital in 1984, and held this position until 1992.
Pat brought all of these attributes to the committee, and a great deal more. In thanking her, Associate Professor David Scott, the chair, emphasised that this was her last official contribution. There can be little doubt that calls will continue to be made on Pat’s unrivalled knowledge, expertise and wisdom.

Professor Alan Merry
Former Chair, Quality and Safety Committee

At the same time as achieving all of these things, Pat, with her husband Ian (an immunologist), raised five children. It is not surprising that, in 2002, she was made Woman Doctor of the Year by the Australian Medical Association. Pat is an outstanding role model for all doctors (not just anaesthetists) in Australia and New Zealand – both men and women.

On Friday November 9, 2012, Pat attended her last meeting of the Quality and Safety Committee. Quality and safety in anaesthesia can only be built on the foundation of sound clinical expertise and experience, and through effective administrative and organisational skills.

Pat’s considerable organisational and administrative abilities were underpinned by a commitment to the promotion of research and teaching. In the ASA she has held the roles of secretary and treasurer, and was president from 1966 to 1968. She has been an examiner for the Faculty of Anaesthetists and made many contributions to ANZCA, including membership of the well-loved anaesthetists group, and culminating in her outstanding service on the Quality and Safety Committee.

In 1991, Pat was appointed by the Victorian Minister of Health to the position of Chair of the Victorian Consultative Council for Anaesthetic Mortality and Morbidity (VCCAMM). Her work on this council has promoted the highest standards of anaesthesia and peri-operative care through adverse event reporting and systems improvement, and this has reaped benefit locally, nationally and internationally. Pat’s tireless and effective pursuit of patient safety has continued to this day, and has earned her an international reputation and the respect of all who have had the privilege of working with her. She has published more than two dozen papers in peer reviewed journals (several under her maiden name of Wilson) and has been a frequent invited speaker at national and international scientific meetings.

Pat has been recognised as a foundation member of the Australian Patient Safety Foundation and as a life member of the World Federation of Anaesthesiologists. In 2000 she was awarded the ANZCA Medal (pictured above right), in 2001 the Centenary Medal of the Order of Australia and in 2008 an OAM.

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Anaesthetists can lead the way in surgical safety practice

Anaesthetists can lead the way by using the WHO surgical safety checklist in operating theatres, the Chair of New Zealand’s Health Quality & Safety Commission (HQSC), Professor Alan Merry, says.

“Anaesthetists are integral to ensuring safety in theatre, and we’re looking to them to help ensure the checklist is used to best effect,” Professor Merry says. “It’s about making sure the basics are right so the skill and expertise that characterises our surgery, anaesthesia and nursing is not wasted.”

The surgical checklist provides a list of crucial checks that have serious consequences if missed, but also encourages members of clinical teams to introduce themselves, and to discuss the operative plan and any concerns they have before starting a procedure.

“Overseas studies suggest this initial conversation can make a difference if a member of the team subsequently notices something amiss while an operation is under way, and is debating whether to speak up.”

Mistakes such as wrong-site surgery are still reported but should never happen, says Professor Merry, and the checklist helps to prevent such errors. It should stimulate discussion within the theatre team, rather than being used as a simple tick-list.

Professor Merry says just over 300,000 publicly-funded surgical operations are carried out annually in New Zealand.

The commission will be working with the sector to help teams use the checklist effectively and get the most out of this tool.

Each year, the HQSC releases a report on serious and sentinel events’ (SSEs) in district health board hospitals, most recently in November. The reports aim to encourage transparency and a just culture.

“It gives us a picture of where things are going wrong, and enables us to put in place systems to reduce harm,” Professor Merry says. “But it is also much more than that. It is a promise to patients that these tragic events will be robustly reviewed, to ensure appropriate care and treatment was provided, and where indicated, to improve systems and processes of care.”

Reporting also provides a safeguard for clinicians.

“By identifying and fixing systems failures, we give clinicians greater confidence that they will be supported by the systems around them to practise safely.”

For the 2011/12 year, district health boards (DHBs) reported 360 serious and sentinel events. Ninety-one patients died (86 in 2010/11), although not necessarily as a result of the adverse event. Serious and sentinel events included 170 falls, a 13 per cent decrease from the 195 falls reported the previous year; 111 clinical management events, up from 103 in 2010/11; 18 medication errors, down from 25 the previous year; and 17 suspected in-patient suicides.

There was an overall decrease in serious and sentinel events, specifically falls, for 2011/12.

“This decrease is very good news,” says Professor Merry. “It represents a lot of hard work by DHBs to both report and prevent adverse events. However, we have seen an increase in the number of cases of delayed treatment and suspected in-patient suicides.”

He says that in 2011/12, DHBs reported 17 suspected in-patient suicides. The commission has looked at the DHB reviews of these deaths and found there is no clear trend evident – either in terms of whether numbers are increasing, or common factors.

“Each of these suicides has been subject to a robust process of review to ensure appropriate care and treatment was provided, and to improve systems and processes of care to reduce the chances of such a tragedy occurring again,” he says.

In 2011/12, 17 cases were reported to the commission describing events in which system failures resulted in delays in the diagnosis of cancer or in a similar serious outcome. There were 13 such events in 2010/11, eight in 2009/10, nine in 2008/09 and seven in 2007/08 – indicating a likely increasing trend.

Professor Merry says the HQSC will look at measures to reduce the likelihood of these events.

1. “The importance of following up needs to be top-of-mind for clinicians at all times.”

He says a national reportable events policy has introduced a change to the way serious and sentinel events are reported to the commission.

“Previously, there was no requirement for DHBs to report the outcome of a review to the commission, meaning lessons from events were often not shared. There is now a requirement for organisations to report to the commission the key findings and recommendations of reviews of events that occurred from July 1, 2012. Future SSE reports will be able to discuss in greater detail issues such as contributory causes and what has been learnt from the events.”

Serious and sentinel event results for individual DHBs are posted on DHB websites. For a copy of the full report, summary document, and questions and answers about serious and sentinel events, visit www.hqsc.govt.nz.

Susan Ewart
NZ Communications Manager, ANZCA

Reference:
1. A serious adverse event is one that leads to significant additional treatment but is not life-threatening, and has not resulted in a major loss of function. A sentinel adverse event is life-threatening or has led to an unexpected death or major loss of function.
See the bigger picture in goal-directed therapy with the hemodynamic management system from Edwards Lifesciences.

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For professional use. CAUTION: Federal (United States) law restricts this device to sale by or on the order of the physician. See instructions for use for full prescribing information, including indications, contraindications, warnings, precautions and adverse events.
The Faculty of Pain Medicine has begun 2013 with a focus on the activities that also finished 2012. The year’s agenda has been firmly established with 2013 shaping as the year of the curriculum redesign. The planned introduction of our revised curriculum in 2015 will entail great commitment and a sustained effort over the next two years.

The guiding principles of the curriculum redesign are based on the outcomes of the “blueprinting” process the Faculty conducted over the past two years. The blueprinting process documented the core skills and attributes unique and essential to a specialist pain medicine physician. The revised training scheme will ensure our trainees are taught and examined in a way that will deliver the quality specialist we need for the future.

This year has begun with a successful series of meetings across New Zealand and each Australian state. The information evenings allowed the Faculty to explain early proposals for the new curriculum and gave Fellows an opportunity to provide critical and constructive feedback. The rigorous debate that occurred during these visits has strengthened the basis of the new curriculum.

This project is the Faculty’s most significant and ambitious undertaking since the curriculum was developed 15 years ago. It will require active input from Fellows to be successful, especially those who have direct contact with trainees.

The proposed changes will affect all Faculty Fellows in teaching hospitals and all future trainees. It is essential that Fellows have an early, accurate and thorough understanding of the proposed new curriculum, associated fee structures and training implications.

In the most basic sense, a profession is defined by the sacrifices required during training and examinations to obtain the qualifications of that profession. The introduction of training and examinations for pain medicine in the late 1990s gave definition to the Faculty and to the qualification of FFPMANZCA. This qualification has grown in prestige over 15 years to its current state of recognition as a standalone speciality in Australia and New Zealand. The review and redesign of our training curriculum will continue to define our specialty and to maintain the quality of our fellowship.

The recent publication of a report into the administration of the National Health Service (NHS) in a region of the UK serves to remind us of the importance of the third pillar of our five-year strategic plan: “Build Advocacy and Access”.

Eminent US opinion leader Dr Daniel Carr has published his foreboding insights on this topic, in a series of articles and addresses themed “When bad evidence happens to good medicine”. Dr Carr warns of the increasing political misrepresentation of medical statistics and meta-analysis to improperly justify drastic limitations on health expenditure. He warns that the ambitious, clinical agenda to achieve an evidence-based medicine approach frequently is improperly represented to limit health funding where politically convenient.

In today’s political context of necessary austerity we need to be – more than ever – aware of misrepresentation of evidence and deliberate undermining of our professional and clinical requirements to justify politically driven cost cutting.

In this regard, our plight is international. The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, published in February, was damning in its condemnation of the “saving-at-all-costs agenda of the Mid Staffordshire NHS Foundation Trust”.

The inquiry was empowered to investigate the serious failings of the foundation trust, whose mandate was delivery of healthcare in that region of the UK.

In the words of the report, “the story it tells is first and foremost of appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider trust board”. It makes further reference to “tolerance of poor standards and disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care”.

In Australia and New Zealand, we must all be vigilant and firm in our advocacy for patient care, when the motives of hospital administrators may lead them to be reckless with the interest of good healthcare in order to meet targets based solely or primarily on their fiscal performance.

We look forward with optimism to both the challenges and potential achievements of the year ahead.

Associate Professor Brendan Moore
Dean, Faculty of Pain Medicine

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Admission to fellowship of the Faculty of Pain Medicine
By examination:
December 5, 2012
Dr Tipu Aamir, MRCPsych, NZ
Dr Jayne Berryman, FANZCA, Qld
Dr Jenny Jin, FAFRM (RACP), NSW
December 26, 2012
David Louis Sommerfield, PCARCSI, Vic
January 21, 2013
Andrew Douglas Powell, FANZCA, NSW
This takes the total number of Fellows admitted to 337.

2013 FPM board elections
The Faculty of Pain Medicine has received two nominations to fill the single vacancy on the Faculty of Pain Medicine Board, which means there will be a formal ballot. Faculty regulations require the vacancy to be filled by a Faculty Fellow with FRANZCP. Ballot papers have been circulated. The ballot closes at 5pm on Wednesday April 8.

2013 Pre-Exam Short Course
The 2013 Pre-Exam Short Course will be held from September 13-15 at the ANZCA Queensland Regional Office, West End Corporate Park, River Tower, 20 Pidgeon Close, West End Qld 4101.

ANZCA and FPM have been saddened by the untimely death of James Strong who was the chairman of Painaustralia since its establishment in 2011. Mr Strong had a long association with College and the Faculty, having been an inaugural member of the board of the ANZCA Foundation (as it was then called) in May 2005 and contributing to its change into the Anaesthesia and Pain Medicine Foundation in March 2011 before resigning to take up the chairmanship of Painaustralia.

The College and the Faculty are integral members of Painaustralia, the not-for-profit non-Government organisation established to pursue implementation of the Australian National Pain Strategy as articulated at the National Pain Summit in March 2010. Mr Strong contributed his considerable experience and skill to the establishment of Painaustralia and to its impressive advocacy work to date in a difficult climate. He was a champion of the plight of people in pain and did much to bring this to the attention of policymakers and the philanthropic community. His expertise, charm and insight will be missed.

Mr Strong was a prominent businessman in Australian circles, having been a board member and chief executive officer of Qantas, chairman of Woolworths Limited and of Insurance Australia Group as well as of other well-known companies. He was also a devotee and supporter of the arts, being at one time chairman of the Australia Business Arts Foundation and the Sydney Theatre Company.

We extend to James Strong’s family our condolences and warmest thanks for his contributions to “our” world.

Associate Professor Milton Cohen
Director of Professional Affairs, FPM
ANZCA/FPM representative, Painaustralia

Vale James Strong AO
FACULTY OF PAIN MEDICINE
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

INTERNAL PAIN IS NOT ETERNAL PAIN

OCTOBER 25-27, 2013
BYRON AT BYRON RESORT AND SPA, BYRON BAY, NSW

CONVENOR’S INVITATION
On behalf of the Faculty of Pain Medicine and the organizing committee of the 2013 Spring Meeting, we would like to invite you to this exciting three day event. 2013 is the IASP Global Year Against Visceral Pain and the meeting, “Internal pain is not eternal pain” will focus on visceral pain syndromes. The meeting is scheduled to be held at the beautiful Byron at Byron Resort and Spa from October 25 to 27, 2013.
For further information, please contact the conference organizer, Lana Lachyani on +61 3 8517 5318 or llachyani@anzca.edu.au.
We look forward to welcoming you to Byron Bay.
Dr Michael Vagg, Convenor
Associate Professor Brendan Moore, Convenor and Dean, Faculty of Pain Medicine
FEbruary 2013

Report following the meeting of the Faculty of Pain Medicine Board held on February 25

The president-elect of the Australian Pain Society, Dr Malcolm Hogg, met with the board in February to discuss areas of co-operation and collaboration.

Dean-elect: Associate Professor Brendan Moore was re-elected unopposed as dean-elect.

Honours and awards

The board noted with pleasure that the following were appointed members of the Order of Australia in the Australia Day honours list in recognition of distinguished contributions to their disciplines:

• Professor Jono (Ben) Manasseh, FAFRM(RACP), FFPMANZCA (NSW).
• Dr Alan Duncan, FANZCA, FCICM (WA).

Build fellowship and the Faculty

2013 board election: Nominations closed on February 1 for the one vacancy on the Faculty board. There being two nominations, a formal ballot will proceed. The ballot closes at 5pm on April 8.

FFPMANZCA logo: The board has approved a FFPMANZCA logo for professional use by Fellows on business cards, letterhead, slide presentations and email. This will be distributed in a CD format by mail and will also be downloadable from the FPM website.

Health Workforce 2022, Medical Specialities – Volume 3: The board noted that this document influences the changing landscape of medicine and will seek opportunities for pain medicine to be included in future iterations. The exclusion of pain medicine in the 2019 dataset was based on absences rather than modelling. The board noted that this is a restricted number of more than 100 members. The Faculty has subsequently highlighted to Health Workforce Australia (HWA) our expanding numbers and offered co-operation. HWA has been receptive to this offer and has sought information on the Faculty fellowship. The Faculty is considering a survey of Fellows to assist in providing information.

Terms of reference: An additional clause on financial reporting and planning has been added to all FPM committee terms of reference.

ANZCA museum: Pain medicine is to be represented within ANZCA’s Geoffrey-Kaye Museum and items or paraphernalia of historical interest will be sought.

Acknowledgement of past board members and deans: Academic dress for past FPM board members and deans is to be modified as a means of identifying individuals who have stood in high office in the Faculty. During their term of office, board members will wear badges of office, which will be relinquished upon retirement from the board.

Assessor

New Fellows: The following are congratulated on their admission to FPM fellowship. All new Fellows will be invited to present during the College Ceremony at the 2013 annual scientific meeting in Melbourne.

• Dr Michael J Kent, FFRM(RACP), FFPMANZCA (NSW).
• Dr Jenny Gao-Ge Adams, FANZCA, NSW.

International medical graduate specialists (IMGs): The board has approved guidelines for the accreditation of positions for substantially comparable and partially comparable IMGs applicants. It is proposed that suitable employment opportunities will not be restricted to Faculty accredited training units for those required to undertake a period of clinical practice under supervision.

The board is reviewing all pathways to fellowship in order to align the standards required for trainees, Australian and New Zealand specialists and international medical graduate specialists.

Fellowship

Election to fellowship: Dr Michael J Kent, FANZCA (WA) and Dr Kym Boon, FRANZCP (NSW) were elected to fellowship of the Faculty of Pain Medicine.

Professional documents

Pain Management Training Sites Project: The Faculty has approved a response to the Accreditation of Specialist Medical Training Sites Project interim report of December 2012. This project is looking at accreditation processes to see if a streamlined approach to accreditation can be developed across the colleges. A final report is anticipated by February.

Resources

2013 budget: ANZCA Council has approved the Faculty’s 2013 budget to provide adequate funding to meet the requirements of expanding Faculty activities, including support for the Curriculum Redesign Project.

Build curriculum and knowledge

Education

Mentoring program: Subsequent to the development of the FPM Mentoring Program in May 2012, the board has endorsed mentoring guidelines for mentees and mentors. A mentoring database was also approved for publication on the website, and will be accessible by Fellows and trainees. It will list Fellows who have volunteered to be mentors with a short background on each, and their contact details. Fellows and trainees seeking a mentor will go to the database to select a mentor and make initial contact. Ongoing mentoring activities will be conducted in a manner that is at the discretion and privacy of the mentor and mentees. The program will be monitored every six months for quality assurance.

Trainee exit questionnaire: Faculty regulations have been amended to require trainees to submit an exit questionnaire for each individual unit at which the trainee has undertaken accredited training. The aim is to gain a longitudinal perspective and provide an independent means of bringing information back to board, an Australian Medical Council requirement.

Supervisor of training ratification: Dr Anton Wan was appointed supervisor of training for the Barbara Walker Pain Centre for Pain Management. Dr Andrew Powell was appointed supervisor of training for the Hunter Integrated Pain Service.

Curriculum Redesign Project: Consultation and communication for phase one of the Faculty’s Curriculum Redesign Project (CRP) began in December. Members of the Curriculum Redesign Project Steering Group were involved in making five short videos to inform Fellows and trainees about the new curriculum framework and program, which will be introduced in 2015. The videos and the program overview document are available on the Faculty website.

Regional face-to-face forums were held from late January to mid February to provide an opportunity for Fellows and trainees to clarify points and give feedback on the proposed curriculum framework. These forums provided valuable input.

A Curriculum Redesign Project e-newsletter has been developed to keep Fellows and trainees informed of developments.

Examination report: The 2013 Examination Report is available on the FPM website. This report has been restructured to provide more feedback to prospective examination candidates on what is expected of them. It includes instructions on what should be covered in a neurological examination for the long case.

Sensory testing guidelines: The board has approved guidelines (known as POST) developed by the Examination Committee, to outline standardised terminology, equipment and techniques for Pain Oriented Sensory Testing during clinical examination for trainees.

(continued next page)
The Faculty has made a submission to Bupa Health Foundation seeking funding for online education for Allied Health Pain Management in Primary Care, building on the joint initiative with the RACP. An initiative of co-operation from allied health groups and the Australian Pain Society was included with the submission. A response is expected in April.

Continuing professional development

Scientific meetings
2013 ASM and FPM Refresher Course
Day and ASM – May 3 and May 4 – Melbourne.
Sofitel on Collins, Melbourne. Theme: Selling pain science – communication and cultural competency. Scientific convenor: Dr Michael Vagg.
2013 Spring meeting – October 25-27, Byron at Byron Resort and Spa, Byron Bay. Theme: ‘Internal pain is not eternal pain’. Scientific convenor: Dr Michael Vagg.
2016 annual scientific meeting, Auckland Dr Jane Thomas, FANZCA, FFPMANZCA has been appointed as the Faculty’s 2016 scientific convenor.

Research
Electronic persistent pain outcomes collaboration (ePPOC): Negotiations are well advanced between NSW Health, the Agency for Clinical Innovation (ACI) and Australian Health Services Research Institute (AHSRI), University of Wollongong. A three-year contract will see Professor Kathy Fagor and team from ACI providing ePPOC manage statistical support and also high-level strategic input. Key deliverables will include piloting the benchmarking process in NSW and simultaneously working on a business case for expansion of the program across Australia and New Zealand.

Pain device implant registry: The dean met with ANZCA’s Director Policy, John Riviano, to commence development of a high-level business plan as a basis for seeking industry funding to support the proposed pain device implant registry.

Steps to be taken include:
- Development of a business plan for industry funding.
- Professional management to develop product literature and PowerPoint presentations for hospital and clinician orientation and initiative.
- Establishment of a pilot in three hospitals. It will be important to make this fit with both the RACS and New Zealand concept and New Zealand interest also be sought.
- Lobby for perpetual funding (beyond the pilot phase) for a national register, including project management costs.

Development of this initiative by the Faculty would be a world first for an independent body to hold and control an implant register for pain.

Build advocacy and access

Relationships
Australian Faculty of Rehabilitation Medicine: The AFRM, including a request for the FPM to articulate a guideline on FPM professional document PMO: Principles regarding the use of opioid analgesics in patients with chronic non-cancer pain. A follow-up meeting is anticipated in June, once PBAC has reviewed

Australian Medical Council (AMC) re-accreditation: The board discussed its role in advocating for positions in pain medicine to be filled by appropriately qualified specialist pain medicine physicians. The board will advocate strongly to employing authorities and health departments that FPMANZCA is the only qualification recognised by the Medical Board of Australia for registration as a specialist pain medicine physician and that FPM training is the only one with a clinical basis. The use of the terminology of “specialist pain medicine physician” will be encouraged in all new appointments.

Painaustralia had been asked to respond to the NSW Legislative Council General Purpose Standing Committee No 4 Inquiry into the safety and efficacy of cannabis for medical purposes. A measured response was provided to avoid any inference of support. The Faculty does not currently have a position on this issue and there is potential for this to be considered.

Submissions:
The Faculty contributed to the following submissions soon to be available on the ANZCA website:
- Australian and New Zealand Therapeutic Products Agency regulatory framework
- Department of Health and Ageing – Pediatric pharmaceuticals prescribing resource project
- Cancer Council Australia – Cancer pain management guidelines
- Health Workforce Australia – Draft Health Professionals Prescribing Pathway.

Essential Pain Management Sub-Committee:
The College has established this sub-committee to improve pain management worldwide by working with health workers at a local level. The new sub-committees, which will report to the ANZCA Overseas Aid Committee, includes international members from the UK, Malaysia and Honduras to help advise on the best global approach to managing pain.

Fellows’ publications:
The board noted the following publications:
- Australian and New Zealand Journal of Obstetrics and Gynaecology
- Stacey et al Persistent pelvic pain: rising to the challenge.
- Evans, Editorial. Chronic pelvic pain in Australia and New Zealand.
- New Zealand Medical Journal
- Shipton, E.A. Recognition of the vocational training in the profession of pain medicine in New Zealand

National Pain Strategy:
Painaustralia has been asked to respond to the NSW Legislative Council General Purpose Standing Committee No 4 Inquiry into the safety and efficacy of cannabis for medical purposes. A measured response was provided to avoid any inference of support. The Faculty does not currently have a position on this issue and there is potential for this to be considered.

Employment of specialist pain medicine physicians:
The board discussed its role in advocating for positions in pain medicine to be filled by appropriately qualified specialist pain medicine physicians. The board will advocate strongly to employing authorities and health departments that FPMANZCA is the only qualification recognised by the Medical Board of Australia for registration as a specialist pain medicine physician and that FPM training is the only one with a clinical basis. The use of the terminology of “specialist pain medicine physician” will be encouraged in all new appointments.

Communications:
A schedule for Faculty publications in 2015 is available on the Faculty website.
FACULTY OF PAIN MEDICINE
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

SELLING PAIN SCIENCE

COMMUNICATION & CULTURAL COMPETITION

Selling Pain Science
Refresher Course Day and Faculty Dinner
Sofitel Melbourne on Collins
Friday May 3, 2013

The program is headlined by international guests Professor Edzard Ernst and Professor Fabrizio Benedetti and will include speakers from medical and non-medical backgrounds with expertise in all facets of communication, from the consulting room to the internet and other forms of mass media.

The meeting will be of value for Fellows, trainees and practitioners with an interest in pain medicine. It will precede the ANZCA/Faculty of Pain Medicine annual scientific meeting.

Keynote Speakers:
Professor Edzard Ernst - Professor of Complementary Medicine, Peninsula Medical School, UK.
Professor Fabrizio Benedetti - Professor of Physiology and Neuroscience, University of Turin Medical School, Italy.

Provisional Program:
Session 1: The neuroscience of the doctor-patient relationship.
Session 2: Pop culture and pain - the challenges.
Session 3: Standing up for the evidence.
Session 4: Putting the pain medicine message out there.

FPM Annual Dinner:
Eureka 89, Riverside Quay, Southbank

Registration:
Registration brochures are now available for download from www.anzca.edu.au/fpm.
Alternatively, contact the Faculty office:
P: +61 3 8517 5337
E: painmed@anzca.edu.au
International visitors journey into the past at Geoffrey Kaye Symposium

The Geoffrey Kaye Symposium held at the College in Melbourne in January attracted many prominent and international guests. They saw the world famous Geoffrey Kaye Museum of Anaesthetic History collection firsthand and enjoyed a fascinating program, including a tour of Melbourne University’s medical collections.

The museum hosted the Geoffrey Kaye Symposium as a satellite meeting to the 8th International Symposium on the History of Anaesthesia held in Sydney and gave many international anaesthesia historians their first opportunity to visit the College and the collection.

Geoffrey Kaye was an avid collector. When he established a teaching department at Melbourne University in the mid 1940s, he displayed his collection of anaesthesia devices to ensure that medical graduates received a firm grounding in anaesthesia. This collection became the core of the Geoffrey Kaye Museum, which now holds some 8000 objects. Geoffrey Kaye’s display also included items of his own design and a range of equipment he had expertly sectioned for the benefit of his students.

The Geoffrey Kaye Symposium also gave an opportunity for the museum’s honorary curators and staff to upgrade the permanent display and mount a temporary display in the boardroom. A new state-of-the-art display case was installed in the foyer of ANZCA House to showcase Geoffrey Kaye as an inventor, engineer and teacher.

The temporary display showed the depth of the museum’s collection, with more than 80 mask inhalers on display. Designed for use with ether, chloroform or ethyl chloride, almost all dated from the 19th century.

Also on display were three significant books. Joseph Clover’s casebook, from 1846-1854, an original copy of the Illustrated London News of January 9, 1847, showing the diagram of the ether inhaler that was copied by both William Pugh in Launceston and John Bellsario in Sydney, when they administered the first anaesthetics in Australia in June 1847.

One of the College’s Corporate Collection treasures, a 23rd century Latin copy of Hippocrates, also was on display along with a selection of 2000-year-old Roman surgical instruments. The donor of the Hippocrates book, Professor Bernard Brandstater FANZCA, had brought the ancient instruments from his home in Loma Linda, especially for the occasion.

The existing permanent exhibition also is available for Fellows, trainees and their families and friends to visit during business hours. We invite Fellows and trainees attending the forthcoming annual scientific meeting in Melbourne to visit the Geoffrey Kaye Museum. In addition to the anaesthesia timeline, the central part of the display focuses on developments in pain medicine and monitoring, two areas in which anaesthesia has made great advances.

Dr Rod Westhorpe
Honorary Curator
Dr Christine Ball
Honorary Curator
Maria Drossos
Museum Collection Officer

All inquiries, please contact Maria at museum@anzca.edu.au

This page clockwise from top left: Dr Jan Hofland, Dr Joan Allison, Dr Rod Westhorpe and Dr Joseph Rupreht; Dr Jean Bernard Cazalaa, Dr Dominique Tjinon, Dr Jacques Hotton, Dr Margaretta Zimmer and Dr Rod Westhorpe; Dr Christine Ball, Dr David Wilkinson, Dr Wulf Stratling, Dr Rod Westhorpe, Dr Joseph Rupreht and Dr Marten van Wyhe; Professor Bernard Brandstater, Mrs Ramona Bause, Dr George Bause and Dr Susan Vassallo and Ms Karen Bierman.

Opposite page clockwise from top left: Dr Michael Cooper, Dr John Paul and Dr Des O’Brien; Dr Rod Westhorpe, Mrs Mimi Westhorpe and Professor John Severinghaus; Mrs Jean Goulden, Dr Paul Goulden, Professor Barry Baker and Dr Anthony Kovac; Dr David Wilkinson, Dr Christine Ball and Dr Wulf Stratling.
Second Pugh Day Lecture:

“Walking from Hobart to Launceston with Dr Pugh in 1836.”

SPEAKER: Dr John Paull MB BS, Dip Ed, FANZCA, consultant anaesthesitst (retired). University Associate, School of Humanities, University of Tasmania, Launceston, Tasmania

VENUE: Meeting Room, Queen Victoria Museum and Art Gallery, Inveresk, Launceston Tasmania.

DATE AND TIME: Sunday June 16, 2pm.

SUMMARY: After a four-month voyage from England, Dr William Russ Pugh arrived in Hobart in December 1835. He visited Sydney and, after returning to Hobart, began a month-long walk to his ultimate home, Launceston, at the height of summer in February 1836. Bushrangers were a hazard along the dirt road and his diary describes the people he met and the conversations he had. Several of the homesteads are still owned by descendants of the families he stayed with. Despite repeated advice from his hosts to abandon medicine and take up sheep farming, Dr Pugh reached Launceston and proposed to the woman he had met on the voyage from England. Pictures of the characters and their properties, then and now, illustrate the talk.

SPONSORSHIP: This lecture, which commemorates Dr Pugh’s administration of ether for a surgical procedure for the first time in Australia on June 7, 1847, is jointly sponsored by the Launceston Historical Society and the Launceston General Hospital Historical Committee and Department of Anaesthetics.
Teaching change: the development of training in anaesthesia

The first anaesthetic registrars meeting was held at the Royal Children’s Hospital in Melbourne in 1971. Forty years later, Kester Brown opened ANZCA’s registrars meeting in 2011, presenting a fascinating look at how specialty training has changed over time.

When Dr Kester Brown arrived in Australia in 1966, there was a paucity of teaching in Melbourne hospitals. If they managed to get time off from their clinical duties, registrars might attend basic science lectures at the University of Melbourne or the Faculty of Anaesthetists. It was very different to Dr Brown’s own training in Vancouver, where anaesthesia residents had time set aside, free of clinical duties, for their teaching program.

In 1968, Dr Brown arranged a weekly half-day release for registrar tutorials at the Royal Children’s Hospital, where he worked as an anaesthetist. The following year he began monthly meetings in the anaesthesia department. In 1970, as the Victorian education officer in the Faculty of Anaesthetists, Dr Brown came up with the idea of a registrars meeting and it was from these beginnings that a tutorial system emerged in Melbourne hospitals.

The first registrars meeting in July 1971 was planned for the Saturday following the Part II Course so that interstate doctors could attend. Registrars at the time were paid less than $10,000 a year so funds were obtained from companies marketing new drugs – Parke Davis (ketamine) and Abbott (methoxyflurane) – to support travel for interstate presenters. Hospitals were asked to arrange for a staff anaesthetist to cover emergencies for the day so that the registrars could attend.

The meeting was also well attended by specialist anaesthetists – there were few meetings in those days – and attendance was about 120.

The director of anaesthesia who had introduced registrar training to the Royal Children’s Hospital in 1953, Dr Margaret McClelland, opened the inaugural meeting.

Dr Margaret McClelland
Dr McClelland had been a founding Fellow of the Faculty of Anaesthetists and president of the Australian Society of Anaesthetists and her handwritten notes deliver a valuable insight into the development of anaesthesia training over time.

“It is a truism to say that the years of our youth are spent looking forward and with advancing age our thoughts often turn to the past,” Dr McClelland said.

“I can look back a long way – 40 years. In those days there were no anaesthetic registrars. All doctors were expected to give anaesthetics. The standard anaesthetic was an ethyl chloride induction followed by ether dropped on to a gauze-covered mask. This was not an easy anaesthetic to administer. The standard anaesthetic was an ethyl chloride induction followed by ether dropped on to a gauze-covered mask. It was not an easy anaesthetic to administer. It was feared and disliked by the patients, was an ethyl chloride induction followed by ether dropped on to a gauze-covered mask. This was not an easy anaesthetic to administer. It was feared and disliked by the patients, with experienced anaesthetists the surgeons were given reasonable working conditions. However, many anaesthesias were given by resident medical officers, with experienced anaesthetists the surgeons were given reasonable working conditions. However, many anaesthesias were given by resident medical officers, including those recently qualified.

“Teaching and supervision was frequently inadequate so that it is not surprising that some anaesthetics were stormy and increased the hazards of anaesthesia. Preparations of the patient left much to be desired. There was no blood bank and often, particularly at night, we were expected to collect and cross match blood if it was considered necessary.

“Equipment was almost non-existant. Machines, if any, were very primitive. There were no piped gases, suction was not readily available to anaesthetists and anaesthetic deaths were considered bad luck even though nearly half of them were due to inhalation of vomitus.”

Dr McClelland mentioned the first Australian surgical anaesthetic by Pugh in Launceston on June 7, 1847, less than eight months after Morton’s demonstration in Boston.

She discussed Edward Henry Embley, the first anaesthetist appointed to the Melbourne Hospital, who undertook what was one of the most comprehensive research projects at the turn of the last century – 286 experiments in dogs, done at weekends, which showed, among other information, that death with chloroform was due to cardiac and not respiratory causes.

The Hyderabad Commissions in India concluded that death was primarily respiratory. Results, published in three papers in the British Medical Journal in 1902, took up 20 pages.

E.H. Embley
In the collection of ANZCA’s Geoffrey Kaye Museum of Anaesthetic History, there is a certificate signed by Embley indicating that the student had undertaken six anaesthetics and achieved proficiency in administering anaesthesia.

According to Dr McClelland, those who wished to practise modern techniques in the immediate post-war years were frustrated by the difficulty in obtaining drugs, equipment and machines.

“Teaching and training became an important issue. The examinations for the Diploma of Anaesthetics started in 1948 in Melbourne and Sydney. The Faculty of Anaesthetists was founded in 1952.”

By the time Dr Brown joined the anaesthesia department at the Royal Children’s Hospital in 1957, much had changed.
Deaths associated with anaesthesia were uncommon. Recovery rooms had been introduced. Patients were usually seen the night before surgery and received pre-medication. Thiopentone (1934), muscle relaxants, IPPR, machines and anaesthetic assistants had come into being. By today’s standards, monitoring would be regarded as simple but anaesthetists were skilled at clinical monitoring and assessment.

In the 1960s and 1970s, intensive care was in its infancy. Prolonged nasotracheal intubation began in Beirut, Adelaide, Melbourne, Toronto and Gotenberg in the early 1960s and led to the development of intensive care. Much of what is taken for granted today had to be learned. Nasotracheal tubes bypass the humidifying mechanism in the nose so humidifiers were introduced. Which were more suitable – humidifiers or nebulisers, which produce minute water particles? Humidifiers eventually won.

In 1970, deep hypothermia to 18 degrees Celsius and then circulatory arrest was introduced for repair of congenital heart disease in infants. Before that, infants below 10kg had palliative surgery until they were big enough for corrective surgery.

More recently, new drugs, equipment and monitoring have improved medical practise and our affluent world has enabled surgery to progress to the standards we expect and deliver today. Training also has improved and registrars are fortunate to be training under one of the best systems in the world.

Many of those who contributed to these early registrar meetings have gone on to make significant contributions to our specialty, among them Dr Chris Evans, who won the prize at the first meeting. Dr Evans later became president of the New Zealand Society of Anaesthetists.

Dr Kester Brown, FANZCA
Former Director of Anaesthesia, Royal Children’s Hospital, Melbourne
Neuroanaesthesia SIG Meeting
July 19-21, 2013
Millennium Hotel Queenstown, New Zealand

Sessions to run from 7.30am-midday; afternoons free for skiing and visiting the beautiful surroundings.

For further information, please contact the conference organiser:
Sarah Chezan
T: +61 3 9093 4982
E: schezan@anzca.edu.au
www.anzca.edu.au/events/sig-events

The Cardiothoracic, Vascular and Perfusion Special Interest Group meeting
June 30 – July 5, 2013
Pullman Port Douglas Sea Temple Resort & Spa, Port Douglas, North Queensland

For further information, please contact the conference organiser:
Lana Lachyani
T: +61 3 8377 5318
E: llachyani@anzca.edu.au
www.anzca.edu.au/events/sig-events
Scientific meetings. Presentation at a trials group research workshop at an early stage of development is strongly encouraged. The study may be conducted in association with one or more collaborating institutions or research groups.

Proposals will be endorsed on merit and take into account the ANZCA Trials Group terms of reference, any relevant trials group research policies, the research strategy and the research capacity of the trials group.

The process for endorsement involves at least two reviews of the study where at least one reviewer will be a voting member of the trials group executive. Once endorsed by the trials group executive, the study management committee is responsible for obtaining resources and conducting the proposed study in accordance with the trials group terms of reference and relevant policies.

Studies must be conducted with high professional standards and in compliance with codes of research conduct such as the National Health and Medical Research Council Australian Code for the Responsible Conduct of Research.

A study update must be presented at least once per year, preferably by presentation at a trials group meeting. Results of the primary study must be presented at a trials group or ANZCA scientific meeting. Presentation at a trials group research workshop at an early stage of development is strongly encouraged. The study may be conducted in association with one or more collaborating institutions or research groups.

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A copy of the guidelines for ANZCA Trials Group presentations and endorsement is available from trialsgroup@anzca.edu.au.

**Introducing Anna Parker**

Anna Parker joined the ANZCA Trials Group in November 2012, and is based at the Department of Epidemiology and Preventive Medicine, Monash University, Alfred campus. Her primary role is the coordination of the POISE-2 study, but she assists with all the trials group activities including the new studies in 2013, the RELIEF and Balanced Anaesthesia studies.

Anna is an experienced research administrator who has worked in the healthcare sector for many years. She holds a master of bioethics degree from Monash University and a master of arts from the University of Melbourne.

Before joining the ANZCA Trials Group, Anna was employed by the Research and Ethics Unit of Alfred Health, assisting researchers through the life of their project from submission preparation and monitoring of research conduct through to final reports and archiving.

A key aspect of her Alfred role has involved ensuring that research projects are adequately resourced, designed to achieve their research outcomes in a manner that is respectful and appropriate for the participant group and comply with necessary legislative and regulatory requirements, such as the Australian Code for Responsible Research Conduct and ICH/GCP.

Anna also has developed governance tools such as training, policies and communications to support the research goals. Prior to working at Alfred Health, Anna spent several years conducting educational research for a non-profit organisation, developing new qualifications and curriculum. Her early career was as an archaeologist working on excavations in Turkey, Syria and Jordan.

**Guidelines for ANZCA Trials Group presentations and endorsement**

The ANZCA Trials Group aims to promote, support, design and conduct multicentre collaborative research in anaesthesia, perioperative medicine and pain medicine. In keeping with these aims, the trials group has developed guidelines to assist researchers seeking formal trials group endorsement for their research studies.

The purpose of trials group endorsement is to ensure a consistently high standard of study design, conduct, analysis and dissemination and that research capacity and study feasibility are optimised.

Further, engagement with the trials group research community is an essential component of the endorsement process. To be eligible for endorsement, new and revised study proposals must be presented at trials group and/or ANZCA scientific meetings. Presentation at a trials group research workshop at an early stage of development is strongly encouraged. The study may be conducted in association with one or more collaborating institutions or research groups.

Proposals will be endorsed on merit and take into account the ANZCA Trials Group terms of reference, any relevant trials group research policies, the research strategy and the research capacity of the trials group.

The process for endorsement involves at least two reviews of the study where at least one reviewer will be a voting member of the trials group executive. Once endorsed by the trials group executive, the study management committee is responsible for obtaining resources and conducting the proposed study in accordance with the trials group terms of reference and relevant policies. Studies must be conducted with high professional standards and in compliance with codes of research conduct such as the National Health and Medical Research Council Australian Code for the Responsible Conduct of Research.

A study update must be presented at least once per year, preferably by presentation at a trials group meeting. Results of the primary study must be presented at a trials group or ANZCA scientific meeting, and it is preferred that this is the first presentation outside of the study investigators.

The guidelines also include a publication policy as well as information and requirements for submitting proposals to the trials group research workshops.

A copy of the guidelines for ANZCA Trials Group presentations and endorsement is available from trialsgroup@anzca.edu.au.
ANZCA Trials Group
5th Annual Strategic Research Workshop

The 5th Annual Strategic Research Workshop of the ANZCA Trials Group returns to the Sea Temple Resort at Palm Cove this year and registrations are now open.

We are delighted to welcome Professor PJ Devereaux to the meeting. Professor Devereaux, who is from McMaster University Ontario, Canada, is well known to many in Australia as the lead investigator on Perioperative ischemic evaluation study-1 and Perioperative ischemic evaluation study-2 (POISE) trials. In addition, our popular statistical sessions are included in the program.

The workshops bring together experienced researchers as well as new and emerging researchers from Australia, New Zealand and Hong Kong. The meeting aims to present, mentor and encourage new ideas for multicentre research in anaesthesia, perioperative and pain medicine. Updates are also given of existing research activity, and participants are encouraged to engage in current multicentre trials. Submit your ideas for future multicentre research projects to the event co-ordinator: spoustie@anzca.edu.au

Anaesthesia research nurses and co-ordinators are encouraged to attend. More information about the meeting can be found at: www.anzca.edu.au/fellows/Research/anztca-trials-group-events.html

New publications


Survey research

In 2013 the ANZCA Trials Group developed a council-endorsed survey research policy, improved its participant sampling methods and updated its web pages on survey research on the ANZCA website. It considered 23 applications for survey research in 2012, representing an increase of 76 per cent in applications. More than 10 of these were reviewed, approved and facilitated electronically by the trials group; some are still being reviewed. The response rates for electronically facilitated survey research remains low; at worse it can be as low as 29 per cent while the highest response rate in 2012 was 49 per cent. The trials group strongly encourages Fellows and trainees to participate in survey research that they receive from the trials group. The trials group endeavours to review and assist survey researchers to ensure their research meets publishable standards before a survey is facilitated. 

Extra expertise is available to trainees. Further information can be found at: www.anzca.edu.au/fellows/Research/trials-group/survey-research.html

Stephanie Poustie
ANZCA Trials Group Co-ordinator
14th Biannual Ultrasound Guided Regional Anaesthesia Workshop
August 10th & 11th, 2013 in Perth, Western Australia

Two Day Hands-On Workshop with Unique Teaching Structure
This “No Snooze” Multi Screen Multimedia Setup, Makes You Participate Actively & Learn
For Details About Workshop, CME Credits & To Register Visit: www.Nerveblocks.org

Below Is The Unique Teaching Structure Developed By Our Course Director:
Prof. Krishna Boddu MBBS, MD, DNB, FANZCA


Noted Reviews : “Probably The Best Regional Anesthesia Workshop In The World”; “I have never seen anything like this”; “Much Better Than ASRA Workshops”

Limited Spaces! First Come First Serve! GP Anaesthetists Are Welcome

Workshop Coordinator: Ms. Susan Chinnery
Department of Anaesthesia & Pain Medicine, 4th Floor North Block, Royal Perth Hospital, 197 Wellington St, Perth, WA 6000, Australia
Phone: +61892241038  Fax: +61892241111
USA Phone: 7138559971  
Susan.Chinnery@Health.WA.Gov.Au

Visit www.nerveblocks.org to Register to attend, to teach, to volunteer, donate & sponsor our national & international educational activities

Our Thanks to: University of Western Australia & Global Medicine Ltd
Anaesthesia and Pain Medicine Foundation

Becoming a patron now simpler and more rewarding

When it was established in 2009, the Anaesthesia and Pain Medicine Foundation’s Patrons Program was designed to allow donors to make planned annual donations to support anaesthesia and pain medicine research and education, while offering visible recognition of donors’ generosity. Joining required donors to commit to donations of $5000, $25,000 or $100,000 over a five-year term.

Last year the foundation simplified the program to make it easier to join. The five-year commitment is no longer needed – a new patron only needs to commit to give $1000 or more each year.

The recognition levels were retained, except that rather than commit to a predetermined level up-front, patrons are now recognised as follows whenever total giving reaches these levels:

- $5000 Presidents patron.
- $25,000 Life patron.
- $100,000 Governor.

Patrons continue to be recognised in the December issue of the ANZCA Bulletin and on the foundation pages of the ANZCA website.

From time to time patrons will also be invited to special events held to recognise the foundation’s most committed supporters. A reception is being planned to coincide with the annual scientific meeting in Melbourne in May for donors from across Australia and New Zealand. Future events will be held in the regions and in New Zealand starting at ANZCA House in April.

December appeal

An appeal promoting the foundation was inserted with the subscriptions mailing in December. The response to date has been encouraging with almost $60,000 received, compared to just over $26,000 the previous year. This is an important boost to our capacity to fund research and overseas aid. Thank you to everyone who so generously donated.

Patron profile: Dr John Boyd Craig

In 1987, Dr John Boyd Craig donated $100,000 to generate future income to provide perpetual annual research grants for Fellows, especially for Western Australia-based pain medicine research.

In 2010, Dr Craig was made the inaugural governor of the then-ANZCA Foundation, in recognition of his financial contribution to research in the field of pain medicine and his strong commitment to the foundation’s work to increase support for research and education in the specialties.

Rather than make a donation to support a single project, Dr Craig’s vision was for the funds to be invested, producing earnings to fund research projects in perpetuity. Increasing capital growth would produce ever-increasing funding for research over the long term. This vision was consistent with the objective of the Patrons Program, which is to allow committed supporters to make regular annual gifts to build the broader foundation corpus, thereby contributing to the total funds available to grant to Fellows for research and education projects each year.

Another important motivation behind Dr Craig’s gift was to encourage others to make similar donations to increase the funding for research. With uncertainty around the level of future research funding available from other sources, his desire was to demonstrate that a growing corpus can provide a protected and secure source of funding for the research required by ANZCA Fellows to remain at the forefront of innovation in anaesthesia and pain medicine.

To honour Dr Craig’s contribution, ANZCA created the annual John Boyd Craig Research Award, which is awarded each year by the ANZCA Research Committee to the chief investigator submitting the most suitable, highly ranked research project grant application.

After graduating in medicine from the University of Melbourne in 1942, Dr Craig served as a staff officer in aviation medicine with the Royal Australian Air Force focusing on anaesthesia until 1960. He subsequently practiced in Perth as a specialist anaesthetist before retiring in 1986.

Dr Craig’s keen interest in pain medicine was influenced by his father, a Gallipoli veteran whose leg amputation left him with phantom pain and sciatic neuralgia.

The foundation acknowledges and thanks all those Fellows who have given generously.

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

MDA National understands the risks of practising medicine and that contracting a communicable disease may have a significant impact on you. Our Communicable Disease Cover is automatic and at no additional cost.* Another good reason to contact MDA National for a quote today!

Give your current indemnity provider a health check.

*Effective July 2012, MDA National’s communicable disease cover is subject to terms and conditions of the Professional Indemnity Insurance Policy. Insurance products are underwritten by MDA National Insurance Pty Ltd (MDA National Insurance) ABN 56 058 271 417, a wholly owned subsidiary of MDA National Limited ABN 67 055 801 771. With limited exceptions, they are available only to MDA National Members. Before making a decision to buy or hold any products issued by MDA National Insurance, please consider your own circumstances, read the Product Disclosure Statement and Policy wording available at www.mdanational.com.au. DIP064
Library update

New titles


Greater access to e-books

Greater access to e-books

Fellows and trainees who have accessed online books such as Miller’s Anesthesia and Anesthesia Secrets through MDConsult will be pleased to learn that the ANZCA Library now provides full unlimited access to all the subscribed resources, plus chapter PDF downloads for offline use.

Cambridge Books Online recently upgraded to a user-friendly platform that provides html and PDF access to the specialised anaesthesia collection, as well as other tools such as RSS feeds and improved accessibility.

A growing collection of online books can be accessed through the ANZCA Library website: www.anzca.edu.au/resources/library/online-textbooks

Watch this space as an exciting new collection of resources soon will be available to all ANZCA Fellows and trainees.

Do you know the value of your College or hospital library?

It’s official – your health library can help with professional development, health outcomes, innovation and due diligence. Health Libraries Inc (HLI) and the Australian Library and Information Association (ALIA) have produced a joint report, Questions of life and death, describing the value of health library and information services in Australia.

The report is based on surveys carried out in August and September 2012, with responses from 250 library staff and users across the nation. The report shows how people use health library and information services and the impact this has on their work and study. Library and information service users were asked how they believed their use of the service over the past year had helped them. The report can be downloaded from the HLI (www.hlinc.org.au) and ALIA (www.alia.org.au) websites. For more information, please call Laura Foley, HLI, +61 6 8517 5305 or Sue McKerracher, ALIA, +61 404 456 749.
New journal in the ANZCA Library

The ANZCA Library recently added the Journal of Continuing Education in the Health Professions to the online collection. Journal of Continuing Education in the Health Professions is the official journal of the Alliance for Continuing Education in the Health Professions, the Society for Academic Continuing Medical Education, and the Council on CME, the Association for Hospital Medical Education. It is a quarterly journal publishing articles relevant to theory, practice and policy development for continuing education in the health sciences. The journal presents original research and essays on subjects involving the lifelong learning of professionals, with a focus on continuous quality improvement, competency assessment and knowledge translation. It provides thoughtful advice to those who develop, conduct and evaluate continuing education programs.

Ask an expert ... for search assistance

Need updated information on a topic for an unusual case, presentation or paper and don’t know where to start? The ANZCA Library has the expertise to perform literature searches and share the search strategy and results with you. The Medline and Embase databases now have the functionality to allow the library staff to email the search strategy to you so you can continue or make changes to the search. The library also has EndNote bibliographic software on hand and can send results in a format that can go straight into your EndNote library.

Contact the library to discuss your information needs: library@anzca.edu.au

New ECRI publications

Health Devices, Vol. 42, No. 1, January 2013
- A tool for addressing the top 10 technology hazards

Operating Room Risk Management
- Refusal of blood transfusions on religious grounds.
- Employee radiation exposure.
- Health literacy.
- Culturally and linguistically competent care.

Latest anaesthesia and pain medicine research

All articles can be sourced in full text from the library’s online journal list: www.anzca.edu.au/resources/library/journals


Online textbooks can be accessed via the ANZCA Library website: www.anzca.edu.au/resources/library/online-textbooks

Contact the ANZCA Library
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A PATCH A WEEK FOR ACTIVE LIVING

For moderate to severe chronic osteoarthritic pain and back pain

OPIOID THERAPY SHOULD ONLY BE PRESCRIBED AS PART OF A MULTIMODAL PAIN MANAGEMENT PLAN. NORSPAN® TRANSDERMAL PATCH MINIMUM PRODUCT INFORMATION

NAME OF THE MEDICINE
Buprenorphine.

INDICATIONS
Management of moderate to severe pain.

CONTRAINDICATIONS
Hypersensitivity to buprenorphine or patch components, respiratory depression, or history of drug abuse.

PRECAUTIONS
Use with caution in convulsive disorders, head injury, shock, reduced level of consciousness of uncertain origin, intracranial lesions or increased intracranial pressure, severe hepatic impairment, hypothyroidism, valvular heart disease, carcinoid, inflammatory bowel disease, or severe renal impairment. Concurrent use of non-selective MAO inhibitors (or within 14 days of their administration) is contraindicated.

INTERACTIONS WITH OTHER MEDICINES
Contraindicated in patients concurrently receiving non-selective MAO inhibitors or within 14 days of stopping treatment. Caution is advised with selective MAO inhibitors. CNS depressants (sedatives, hypnotics, general anaesthetics, opioids, phenothiazines, antihistamines) could lead to increased clearance and reduced efficacy. Buprenorphine has also been shown to be a CYP2D6 inhibitor in vitro. INR levels may potentially increase with concurrent use of warfarin.*

ADVERSE EFFECTS
Adverse reactions are similar to those observed with other opioid analgesics and tend to reduce over time except for constipation. Very common (≥10%) adverse reactions include application site reaction (includes erythema, oedema, pruritus or rash at application site), constipation, dizziness, dry mouth, headache, nausea, pruritus, somnolence and vomiting. Common (≥1% to <10%) adverse reactions include abdominal pain, anorexia, anxiety, asthenic conditions (including muscle weakness, lethargy, fatigue and malaise), chest pain, confusion, depression, diarrhoea, dysgeusia, exanthema, insomnia, nervousness, pain, paresthesia, psychological reactions, rash, sweating, tiredness, vasodilatation.

DOSAGE AND ADMINISTRATION
Adults: For transdermal use only over 7 days. The initial dose is 5 μg/hr, especially in opioid-naïve patients. During conversion from other opioids (up to 90 mg oral morphine-equivalents/day and combination analgesics), patients should be started on a low dose of NORSPAN® patch. Titrate until adequate analgesia and improvement in function is achieved, continuing supplemental analgesics as required. Do not increase dose more than once every 3 days. To convert to a higher strength patch or combination of patches at a different site, the current site should not be used for 3-4 weeks. Refer to PBS Schedule for full Authority Required Information.


Please review Product Information and State and Federal regulations before prescribing. Product information for NORSPAN® patches can be accessed at www.mundipharma.com.au/Products.aspx

PBS Information: Restricted benefit. Chronic severe disabling pain not responding to non-narcotic analgesics. Authority required for increased maximum quantities and/or repeats. Refer to PBS Schedule for full Authority Required Information.
**Do you need a Specialist Anaesthetist Locum?**

You may be eligible for the Rural Obstetric and Anaesthetic Locum Scheme (ROALS) if you work in rural and remote Australia (ASGC-RA 2 to 5).

*No fees to the host specialist for using ROALS; ROALS pays the host specialist a subsidy; $1100 per day (up to $15,400 for 14 days), plus locum travel costs.*

**INTERESTED......NEED MORE INFORMATION?**

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Melissa (03) 9412 2912 or Angie (03) 9412 2971
E: roals@anzcog.edu.au  W: www.roals.org.au

*ROALS is funded by the Australian Government*

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Are systemic treatments the only choice for your patients with localised neuropathic pain associated with post herpetic neuralgia (PHN)?

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Dunedin 2013

**Welcome to springtime in Middle Earth**

*New Zealand Anaesthesia ASM 6 – 9 November*

NOVEMBER 2013

**www.nzadunedin2013.com**

**www.newzealand.com**
People and events

New Zealand news

Singapore visit
Earlier this year, Dr Lindy Roberts (ANZCA President), Dr Genevieve Goulding (ANZCA Vice-President), Dr Mark Reeves (Chair, Training and Accreditation Committee) and Dr Kerry Brandis (ANZCA councillor) visited ANZCA-accredited hospitals in Singapore and Malaysia where they met with ANZCA trainees, supervisors of training and the Singaporean and Malaysian Regional Training Committees to support ANZCA training in these countries until mid-2019.

Above: Members of the 2013 NZ Trainee Committee, from left: Dr Richard Walsh, Dr Julia Foley, Dr Chang Kim, Dr Kathryn Hagen, Dr Rochelle Barron (chair) Dr Sheila Barnett (outgoing chair), Dr Michael Hamilton, Dr Laura Kwan and Dr Lizi Edmonds.

Above from top: Standing from left: Dr Ashokka Balakrishnan, Dr Tiong Ing Hua, Dr Nikan Loganathan, Dr Rohit Agrawal, Dr Deborah Khoo, Associate Professor Raymond Gay, Dr Swajna Thampi and Dr Terry Pan from the National University Hospital, Singapore. Sitting from left: Dr Lindy Roberts (ANZCA President) and Dr Kerry Brandis (ANZCA councillor).

Standing from left: Members of the Singapore Regional Training Committee Professor Lee Tat Leang, Dr Terry Pan, Dr Guh Meng Huat, Associate Professor Eugene Liu with ANZCA councillor Dr Kerry Brandis. Sitting from left: Dr Mark Reeves (TRC Chair), Dr Lindy Roberts (ANZCA President), Dr Uma Shridhar, Dr Genevieve Goulding (ANZCA Vice-President), Dr Lim Suan Ling.

NZ Trainee Committee
December’s New Zealand Trainee Committee meeting saw the incoming members of the 2013 committee join the 2012 members to ensure a smooth transition.

The meeting was held on the eve of New Zealand going live with ANZCA’s 2013 curriculum and training portfolio system, the first region to do so, ensuring keen anticipation and an obvious area of discussion.

The valued contribution of the outgoing committee members (Dr Jonathan Taylor, Dr Rachel Dempsey, Dr Matt Levine, Dr Sarah Sew Hoy and chair Dr Sheila Barnett) was acknowledged and the new members were welcomed. The 2013 committee is Dr Olivia Albert (Auckland), Dr Rochelle Barron (chair, Wellington), Dr Ruth Breen (deputy chair, Christchurch), Dr Liz Edmonds (Nelson), Dr Julia Foley (Auckland), Dr Michael Hamilton (Dunedin), Dr Chang Kim (Auckland), Dr Laura Kwan (Wellington), Dr Ghassan Talab (Auckland) and Dr Richard Walsh (Hamilton), with Dr Catherine Purdy (co-opted, Auckland) and Dr Kathryn Hagen (NZ Society of Anaesthetists’ representative).

One of the committee’s projects for this year is updating the Anaesthesia Training in NZ Made Easy handbook. Its focus will be on the experience of training to become an anaesthetist in New Zealand, rather than curriculum advice or duplicating information that is available on the ANZCA website.

The committee has already begun work on establishing a trainee welfare system. The welfare system will provide trainees with support by way of nominated welfare officers. Trainees will be able to contact a welfare officer in times of increased stress, if they are having difficulties or are feeling overwhelmed either in or outside the workplace. The recent survey as to what support already exists drew a 50 per cent response rate and those responses are now being analysed.

Above: Members of the 2013 NZ Trainee Committee, from left: Dr Richard Walsh, Dr Julia Foley, Dr Chang Kim, Dr Kathryn Hagen, Dr Rochelle Barron (chair) Dr Sheila Barnett (outgoing chair), Dr Michael Hamilton, Dr Laura Kwan and Dr Liz Edmonds.
England.

Six-week ocean voyage required to reach quite an adventure for a South Canterbury Tommy Ritchie. He attended St John’s team and first XI cricket team. Head boy and captained the first XV rugby at Timaru Boys’ High School, where he was educated. His secondary school education was at The Pines in Timaru, a five-mile pony ride to and from school. His secondary school education was at Timaru Boys’ High School, where he was head boy and captained the first XV rugby team and first XI cricket team.

Following in his father’s footsteps, Brian William Thomas ‘Tommy’ Ritchie was born in South Canterbury in 1915. His early education was at The Pines in Timaru, a five-mile pony ride to and from school. His secondary school education was at Timaru Boys’ High School, where he was head boy and captained the first XV rugby team and first XI cricket team.

He graduated in 1938 with a bachelor of arts with honours in natural sciences. While at Cambridge, Tommy Ritchie studied physics under Lord Rutherford, and was introduced to Albert Einstein while on a rugby tour to the United States (sponsored by Philip Morris cigarettes!). He captained the St John’s College rugby XV, tennis VI and the university XV on its US tour. During the latter, he may have been responsible (neither confirm nor deny) for blackening John F Kennedy’s eye in the scrum when they overwhelmed Harvard 50-0.

After graduating, Tommy Ritchie studied clinical medicine at St Thomas’ Hospital, London, qualifying MB BS in 1941. Various house appointments during the war led to the position of resident anaesthetist at St Thomas’.

The formation of the BWT Ritchie Scholarship for medical students has been due partly to the fact that in those days no stipend was paid until a specialist was fully qualified; laundry facilities were provided but young doctors were expected to use ‘private means’ to survive.

Tommy Ritchie wrote: “The Second World War made our clinical studies somewhat abnormal as the bombing disrupted the functioning of the hospital with numerous evacuations to Surrey and the Home Counties. I often acted as chauffeur to the senior obstetric and gynaecological consultant while attending classes out of London and he would teach me while we weaved our way in and out of London during or after a blitz.”

In 1944, the Emergency Medical Service (EMS) sent Dr Ritchie to the north of England, where he was appointed consultant anaesthetist at the Royal Victoria Infirmary in Newcastle as well as at Shieltybridge Hospital, Freeman Hospital and as a clinical tutor at Newcastle University.

Rugby and cricket continued during the war: he captained St Thomas’ Hospital XV and XI, the London United Hospitals XV and XI, played for the Barbarians and captained the North of England XV against Charlie Saxton’s New Zealand Expeditionary Force XV.

While in the north-east, he met his future wife, Jesse Gilbert Carter, who was in the Women’s Auxiliary Air Force as a senior cipher officer. They married in Oxford in 1946 in an ‘austere’ wedding due to rationing. After returning to New Zealand with his new wife, Dr Ritchie decided there were greater opportunities in England so returned to the north-east.

Simon (1948) and Julia (1950) were born before Jessie died in an automobile accident in 1951. A nanny, Miss Prue Blackley, was dispatched from New Zealand to assist with the young children and soon became Mrs Prue Ritchie. Jonathan (1956) and James (1959) followed.

When Dr Ritchie retired from the National Health Service in 1981, the couple returned to New Zealand and lived in Masterton. Tommy died in 1992, Prue in 1993. Both were predeceased by Julia, who died in a boating tragedy in Taiwan in 1990.

Dr Ritchie set up the BWT Ritchie Scholarship in 1991 with a $220,000 gift to a trust for that purpose—the capital to be retained with the net income on the capital to be used to fund the scholarships. Jonathan Ritchie has been an advisory trustee since the trust’s inception, as were his parents until they died.

The first recipient was Dr Charles Minto of Christchurch, who undertook a provisional fellowship year at Stanford University. Records are not complete but at least 21 doctors have received scholarships since then and have studied mainly in the UK and USA, but also in Canada, Australia and South Africa.

Dr Ritchie clearly considered there were benefits in having New Zealand anaesthetists study overseas and returning to practice in New Zealand. The trust deed establishing the scholarship stipulates that the grant is intended to enable overseas experience but with the scholar expected to return to New Zealand for at least three years to work in anaesthesia or intensive care. At the time, intensive care training was overseen by ANZCA.

For information on the scholarship, see www.anaesthesia.org.nz (click the NZAEC link) or email nzaec@anaesthesia.org.nz.
NZ Anaesthesia ASM
Registration has opened for this year’s NZ Anaesthesia Annual Scientific Meeting. The conference, co-hosted by ANZCA’s New Zealand National Committee and the NZ Society of Anaesthetists, will be held in Dunedin, November 6-9.

Dr Campion Read as convenor and Dr Hansjoerg Waibel as scientific convenor lead a committee drawn from Dunedin Hospital’s Anaesthesia and Intensive Care Department, which is putting together the conference programs.

A range of Australasian speakers will address the theme “Best practice: Aiming for excellence” in plenary presentations, workshops, panel sessions and problem-based learning discussions. Professor Mark Warner, from the Mayo Clinic in the US, Professor Eric Jacobsohn, who heads the anaesthesia department at the Canada’s University of Manitoba, and Professor Jamie Sleigh, from the University of Auckland, are the keynote speakers.

There will be a welcome reception amid a healthcare industry exhibition, a morning run, “A toast to the arts” casual evening at the highly regarded Dunedin Art Gallery and a conference dinner at Larnach’s Castle.

With many New Zealanders having undertaken their medical degrees in Dunedin at the University of Otago, home of New Zealand’s first medical school, the conference presents an ideal opportunity for anaesthetists to revisit their old stamping ground while updating their knowledge and networking with colleagues.

Dunedin is the gateway to New Zealand’s most spectacular scenery and attractions in Central Otago as well as having a wide range of attractions itself, adding to the appeal of a spring visit to New Zealanders and those from overseas.

Abstract submission is open until August 31. For more information and to register, see www.nzadunedin2013.com.

Part 3 course again of value
Following on from the success of the inaugural course in 2011, the second Anaesthesia Part 3 course was held on December 8 at Middlemore Hospital’s Ko Awatea Centre. Once again, the course was fully subscribed.

The day aimed to provide senior trainees from around the country with a better understanding of life as a senior medical officer (SMO) in New Zealand. It was also a chance to meet, discuss and exchange ideas, issues and experiences relevant to their stage of training. The small group format, informal atmosphere and high-quality speakers provided an excellent educational opportunity and the day concluded with a complimentary social function.

The day was split into three sessions, the first of which was a workshop on CV writing and interview techniques. Trainees had an opportunity to critique example CVs and ask those involved with interview selection a range of questions about how to get an SMO job.

The day progressed with interactive presentations, discussions and question-and-answer sessions. Speakers provided thoughts and advice on a number of SMO professional roles. Topics included medico-legal issues, personal branding and persuasion at interviews, academic anaesthesia and research, roles for SMOS within ANZCA, working part time, managerial roles for SMOS, working in rural centres, private medical practice, contract negotiations, dealing with trainees, being on call, work-life balance, managing continuing professional development and a variety of other ‘warts and all’ experiences of SMO life.

Some examples of feedback received about the 2012 course are:
• “A great chance to get second opinion on my CV. Much appreciated.”
• “The course provided a mix of formal and informal opportunities to ask questions.”
• “The presentations were honest and down to earth.”
• “The course provided a more detailed perspective of the non-clinical role one can engage in when a consultant.”

ANZCA’s New Zealand National Committee and the NZ Society of Anaesthetists supported the Part 3 course, which will be held again this year.

Above: Participants in the 2012 Part 3 Course held in Auckland in December.
Patient safety campaign

Research shows that simple changes in clinical practice can lead to big reductions in harm. New Zealand’s Health Quality & Safety Commission (HQSC) has said as it prepares to launch a national patient safety campaign. The campaign will begin in a few months.

In a December update, the commission said that the campaign’s goals were to save lives, prevent adverse events and save money so it could be spent on other areas of health care. It will align and work with existing patient safety initiatives, with a phased approach to reducing harm in four areas: falls, healthcare associated infections, medication and surgery.

The campaign will support the development of national, regional and local clinical leaders and consumer champions. It will have:

• Strong branding to provide national visibility and connection between campaign work occurring around the country.
• Resources, guidelines and advice, and a dedicated website that will also link to other regional patient safety websites.
• Leadership training and capability building.
• Comprehensive evaluation.

The commission has met with more than 20 sector groups and 200 individuals to discuss what they hope the campaign will achieve.

It said that a 25 to 30 per cent reduction in falls and healthcare-associated infections alone would mean 25 to 30 deaths avoided annually and generate up to NZ$2.5 million in savings. This was a fraction of the harm that could be prevented, and the savings that could be made.

There will be a four-pronged evaluation approach:

• Change of outcome – saved lives and costs, reduced harm (quality and safety markers).
• Change of process – district health boards implementing changes known to reduce harm (quality and safety markers).
• Process of change – the effect of elements of the campaign (awareness, response).
• Infrastructure – have we increased skills, knowledge and networks to sustain and expand improvement?

For further updates and to register your interest in the campaign, visit www.hqsc.govt.nz.

Staying alive after surgery

Early bird registration closes on May 15 for the inaugural workshop of New Zealand’s Perioperative Mortality Review Committee (POMRC). The workshop, titled “Staying alive after surgery”, is being held on Thursday June 13, 2013 (9am-5pm) at Te Papa in Wellington. It will feature:

• Presenting New Zealand’s first national perioperative mortality data, including: elective/waiting list admissions (ASA 1 & 2), postoperative mortality in those 80 years and older, pulmonary embolus and cholecystectomy.
• Auditing surgical mortality.
• Perioperative information, informed consent and the consumer.

Speakers include two former ANZCA presidents – Professor Kate Leslie and POMRC Chair Dr Leona Wilson – as well as ANZCA Councillor Professor Alan Merry, who chairs New Zealand’s Health Quality & Safety Commission. Other speakers are Professor Cliff Hughes (CEO, NSW Clinical Excellence Commission and a cardiothoracic surgeon) and Dr Cathy Ferguson (POMRC’s Deputy-Chair).

Further details and a link to register can be found at www.safersurgery.co.nz.

Also, the Perinatal and Maternal Mortality Review Committee is holding its workshop, “Safer beginnings”, the day before, on Wednesday June 12, 2013 (same venue as above). Its early bird registration also closes on May 15.

Participants who register for both workshops can save more than 20 per cent on the cost of each. For more information, contact info@hqsc.govt.nz.
Keynote Speakers

Vincent Chan
Ontario, Canada

Mark Newman
North Carolina, USA

Steve Shafer
New York, USA

Lee Fleisher
Pennsylvania, USA

Warwick Ngan Kee
Hong Kong

Admir Hadžić
New York, USA

Paul Myles
Melbourne, Australia

Ban Tsui
Alberta, Canada

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21-25 February, Auckland, New Zealand

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The i-gel is a unique second generation supraglottic airway device with a gel-like, anatomically shaped, non-inflatable cuff and integrated gastric channel.
Mark Gibbs honoured with Australia Day Achievement Award

The Queensland Department of Health has recognised 13 individuals and teams for their significant contribution to the improvement and delivery of health services in Queensland as part of Australia Day celebrations. In ceremony held on January 25, Dr Mark Gibbs received an Australia Day Achievement Award from the Director General of the Department of Health, Dr Tony O’Connell.

Dr Gibbs was awarded for his “dedication and commitment to improving the standard, quality and capacity of anaesthetic services in rural facilities across Queensland”.

In his role as chair of the SWAPNET Rural and Remote Work Group, Dr Gibbs conducted a statewide review of anaesthetic service capacity involving 30 rural facilities across Queensland throughout 2010 and 2011. The review developed 18 recommendations to improve the quality and capacity of anaesthetic services in rural areas.

Dr Gibbs then established and led two major projects:

• Standardised Anaesthetic Equipment Project, which delivered anaesthetic equipment worth $3 million to 28 rural facilities last year.

• Rural Generalist Anaesthetic Introductory Program, a four-day program held in Toowoomba in the final week of January. This program provided 16 rural generalist trainees/registrars with the necessary training to enable them to be effective and less reliant on their supervisors from the day they start their anaesthetic advanced skills training/rural posting. The ultimate aim of the Rural Generalist Anaesthetic Introductory Program is to deliver high-quality GP rural generalists to rural hospitals in Queensland.

The four-day program was officially opened and recognised by the health minister on Wednesday.

Dr Gibbs is the Director of the Department of Anaesthesia & Intensive Care at Ipswich Hospital, and is a member of several ANZCA committees, including the Queensland Regional Committee, Training Accreditation Committee and the GP Anaesthesia Working Group. He is also the rotational co-ordinator for the Queensland Anaesthetic Rotational Training Scheme (QARTS) and a former regional education officer.

Congratulations Mark!

Dr Mark Young
Chair, Queensland Regional Committee

This page from top: from left, Dr Jeneen Thatcher (education officer), Dr Kerstin Wyssus (formal project officer) and Dr Masha Jukes (QARTS, southern rotational co-ordinator) at the Welcome to 2013 reception; from left, Sandy Shaw (regional manager), Dr Mark Young (regional chair), Professor Michael Steyn (regional committee member), Dr Paul Nicholas (Trainee Committee chair), Dr Genevieve Goulding (ANZCA Vice-President), Dr Charmaine Barrett (QRC secretary and treasurer) at the Welcome to 2013 reception.
Busy year planned for Queensland continuing medical education

The Queensland ANZCA-ASA CME Committee has begun the year with bold plans to continue with four events in our Evening Lecture Series and expand the annual conference to improve access to our Queensland Fellows, trainees, and interstate and overseas Fellows. The annual conference has been the centrepiece of the Queensland CME calendar for many years now, and the 37th ANZCA-ASA CME Annual Conference will be held this year on Saturday June 22.

Entitled “Together everyone achieves more – Anaesthesia in the team environment” the event focuses on the uniquely collaborative nature of anaesthesia, with a panel of invited speakers ranging across disciplines we cross paths with in our daily working lives. This includes a cardiologist, haematologist and a perioperative physician. The program will include an afternoon of stimulating workshops and small group discussions.

We have had our inaugural CME event for the year, with Dr David McCormack giving a fantastic presentation on the neuromuscular junction. New research of such a purportedly well known topic really proves that the field of medicine is ever changing and always continues to surprise.

Our committee continues to grow in size and enthusiasm with the sole focus on giving our Fellows high quality and relevant CME. With the change to the ANZCA training curriculum, we may find our events increase in popularity with our trainees who, for the first time, have a mandated CME requirement.

We always are open to ideas for meetings or extra committee members. Thanks must be given to those already working hard on the committee and to the administrative support provided by Ailsa Brown, ANZCA Queensland regional office. Without such help, these events would not happen. We look forward to educating you for another year.

Dr Chris Breen
Chair, Qld ANZCA-ASA CME Committee

Dr David McCormack
Convenor, Qld ANZCA-ASA CME Annual Conference

Queensland
Faculty of Pain Medicine Queensland
CME lecture meetings 2013

<table>
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<tr>
<th>Date</th>
<th>Event Details</th>
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<tr>
<td>March 27</td>
<td>Dr Kath Cooke and Dr Richard Pendleton will discuss 'challenging case conferences'</td>
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<tr>
<td>June 11</td>
<td>Professor Gerald Holmberg will present on visceral pain. Sponsored by Janssen Cilag</td>
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<tr>
<td>July 23</td>
<td>Dr Radford Smith from the Department of Gastroenterology and Hepatology Royal Brisbane and Women's Hospital, Sponsored by Janssen Cilag</td>
</tr>
<tr>
<td>October 15</td>
<td>Dr Curtis Gray will present on sleep and pain. Sponsored by Pfizer</td>
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Australian Capital Territory

ACT meeting cancelled

The Art of Anaesthesia meeting usually held in March has been cancelled this year due to the high number of national meetings being held in Canberra this year. The ACT Regional Committee and the ACT section of the Australian Society of Anaesthetists can reassure Fellows and trainees that the popular event will return next year with usual high quality two-day program.
South Australia and Northern Territory

Part 0 orientation for new trainees
The South Australia and Northern Territory regional office held the ANZCA/Australian Society of Anaesthetists Part 0 orientation course for new trainees on January 19. The Chair of the SA and NT Trainee Committee, Vicki Pentelow, ran the informative course. There were presentations from Dr Ken Chin about rotational issues, Dr Christine Hildyard on the new ANZCA curriculum and workplace-based assessments and Olly Jones on the trainee portfolio system. Chelsea Hicks delivered a presentation about GASACT and Dr Stewart Keynes spoke about his rotation to SA’s emergency medical retrieval service, MedSTAR. Trainee welfare officer Dr Marion Andrew also gave a presentation. Ten new trainees started on the SA and NT rotational anaesthesia training scheme in late January.

Trainee dinner
Forty five trainees attended the third annual trainee dinner on November 2 with a fun night had by all. The trainee dinner gives trainees an opportunity to network, socialise and relax together after a year of hard work and exams. Dr Gareth Lyttle gave an inspirational talk about his work on the Mercy Ship. Thanks to the Trainee Committee for their work in organising the dinner – we’re already looking forward to next year’s event!

Dr Vicki Pentelow
Chair, South Australia and Northern Territory Trainee Committee
Western Australian Regional Office

The Western Australian office has had a busy start to the year. The Part 0 course was held on February 7 and 8. This year the Australian Society of Anaesthetists/GASACT held an evening event focusing on welcoming new trainees into the anaesthetic community and also invited partners. ANZCA held an afternoon event focusing on the new training program. This was a very successful course and we thank Jodi Graham, Jay Bruce, Dr Jim Miller and Dr David Jammaat for their time and effort.

The Supervisor of Training Committee met with Oliver Jones on February 7 after a long day spent attending hospital campuses with Jodi Graham to speak to those using the training portfolio system. The committee reported that while there were a couple issues relating to the system, generally all is going well. We thank Oliver and Jodi for taking the time to speak with the Western Australian trainees.

The Faculty of Pain Medicine held a teleconference on the February 12 regarding the communication and consultation period for the end of phase one of the project to develop new curriculum framework. The purpose of this forum was to ensure clear communication about the board’s plans and to enable genuine consultation.

The West Australian Trainee Committee met on February 13 and welcomed the new chair, Scott Douglas, deputy chair, Nirooshan Rooban, and the new committee. We thank Scott and Nirooshan for taking on these roles in the committee.

The West Australian Regional Committee met for the first time on February 19. Dr Nolan McDonnell has stepped down as the deputy chair and Dr Irina Kurowski was voted in. We thank Irina for taking this position on the committee.

Primary exams will be held on February 25 with two exams running simultaneously at the ANZCA/Australian Society of Anaesthetists WA office and Subiaco Hospital due to the change in curriculum. We wish the trainees well in the exams.

The Autumn Scientific Meeting will be held on March 9 at the University Club of UWA. Focusing on ‘All in a day’s work – day surgery anaesthesia’, the key speaker is Dr Ken Sleeman from Brisbane who recently became chair of the Day Care Anaesthesia Special Interest Group. We look forward to this conference.
Australian news continued

New South Wales

**New South Wales**  
**Primary refresher courses in anaesthesia**

The course is a full-time revision course run on a lecture/tutorial basis and is suitable for candidates presenting for their primary examination in the second part of 2013.

**Dates:**  
Monday June 17 – Friday June 28 and Monday October 14 – Friday October 25

**Venue:**  
Large Conference Room, Kerry Packer Education Centre Royal Prince Alfred Hospital Missenden Road Camperdown, NSW 2050

**Fee:**  
$8990 (including GST)  
A comprehensive set of supplementary notes, lectures notes and USB will be given to each participant at the start of the Course.

Applications close on Friday May 31 for the June course and Friday September 27 for the October course (if not filled prior). The number of participants will be limited. Late applications will be considered only if vacancies exist.

For information contact: Tina Papadopoulos  
ANZCA NSW Regional Committee  
117 Alexander Street, Crows Nest NSW 2065  
Email: nswcourse@anzca.edu.au  
Phone: +61 (2) 9966 9085  
Fax: +61 (2) 9966 9087

Tasmania

### Year starts with workshop

The Tasmanian Regional Committee started a busy 2013 year with the introduction of a Trainee Applied Anatomy for Anaesthetists Workshop that was held on January 15 in partnership with the University of Tasmania in Hobart. This was well attended by trainees and received very positive feedback. An additional workshop is now being planned for October 26.

The committee is also planning a one-day continuing medical education conference on Saturday August 3 to be held at Freycinet Lodge, with further details to be released soon. This will be in addition to the annual scientific meeting which took place on the weekend of March 15-17 at the Tram Shed in Launceston.
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Obituary

Dr Betty Brenda Spinks
1920 – 2012

I feel honoured to be asked to write an obituary for Dr Betty Brenda Spinks. Betty was born in London in March 1920 and died in Melbourne in October last year. Of particular importance was that Betty passed the inaugural final fellowship examination for the Faculty of Anaesthetists, RACS, in Melbourne in May 1956.

After schooling in Brighton, Victoria, and London, UK, Betty graduated MBBS Melbourne in 1943. She passed the part 1 DA (Melbourne) in 1946 after a residency in Hobart Tasmania, Royal Children’s Hospital (Melbourne) and Fairfield Hospital, and she started her anaesthetic training in Melbourne. Dr L Travers and Dr K McCaul were her early supervisors. Registrar training commenced in Britain at Kings College Hospital and the Hillington Hospital. She completed her training as a registrar at the Queen Victoria Hospital and the Royal Melbourne Hospital. During this time she also undertook 18 months in general practice.

I had professional contact with Betty twice. As a junior resident medical officer at Footscray and District Hospital we did a three-month anaesthetic term and Betty was often my supervisor. I remember during an open insufflation anaesthetic for Ts and As, I stated that the patient was “getting light”. Her immediate response was “get the patient deeper or the patient will vomit”.

In 1969, I became a colleague as a visiting medical officer at Footscray and District Hospital. I was now able to appreciate that Betty was a meticulous anaesthetist and was always concerned about the welfare of the patient. She continued to specialise in ear, nose and throat anaesthesia.

Department meetings were held in the homes of the six visiting medical officers and Betty rarely missed a meeting. Her opinions were always sound. Betty also gave anaesthetics at the Peter MacCallum Cancer Institute and had a small private practice.

Over recent years she suffered from ill health and, with some difficulty, attended a combined ANZCA/ASA meeting in Melbourne to be awarded a 50-year membership of the Australian Society of Anaesthetists.

Dr Ian Rechtman, FANZCA
Victoria
Future meetings 2013
Australia and New Zealand

May 3 Melbourne, Vic
FPM Refresher Course Day
Theme: “Selling pain science: Communication and cultural competition”
Venue: Sofitel Melbourne on Collins, Melbourne, Victoria
Website: www.fpm.anzca.edu.au/events/2013-refresher-course-day

May 4-8 Melbourne, Vic
ANZCA ASM 2013
Theme: “Superstition, dogma & science”
Venue: Melbourne Convention and Exhibition Centre, Melbourne, Victoria
Website: www.anzca2013.com

June 29 Melbourne, Vic
Airway Management and Trauma Special Interest Group Meeting
Theme: “Trauma and airway management”
Venue: The Langham, Melbourne, Victoria
Website: www.anzca.edu.au/fellows/special-interest-groups/trauma/airway-management-and-trauma-sig-meeting.html

June 30 – July 5 Port Douglas, Qld
Cardiothoracic, Vascular and Perfusion Special Interest Group Meeting
Venue: Sea Temple Resort and Spa, Port Douglas, Queensland

July 12-14 Rotorua, NZ
Rural Special Interest Group Conference
Theme: “Obstetric anaesthesia in the bush”
Venue: Millennium Hotel, Rotorua, New Zealand
Website: www.anzca.edu.au/fellows/special-interest-groups/rural/rural-sig-conference-2013.html

July 19-21 Queenstown, NZ
Neuroanaesthesia Special Interest Group Conference
Theme: “Neuroanaesthesia – past, present and future”
Venue: Millennium Hotel, Queenstown, New Zealand
Website: www.anzca.edu.au/events/sig-events

The meetings in this listing are ANZCA or ANZCA-affiliated meetings.
Non-ANZCA meetings are listed in the events calendar on the ANZCA website:
www.anzca.edu.au/events
Please check with conference organisers to confirm dates before arranging travel.
Future meetings 2013
Australia and New Zealand
continued

July 20
Perth, WA
Winter Scientific Meeting
Theme: “Perioperative medicine wants you”
Venue: University Club, University of Western Australia
Website: www.wa.anzca.edu.au/events

October 11-13
Bunker Bay, WA
Updates in Anaesthesia
Theme: “Enhanced recovery after surgery”
Venue: Pullman Resort, Bunker Bay, Western Australia
Website: www.wa.anzca.edu.au/events

November 6-9
Dunedin, NZ
New Zealand Anaesthesia Annual Scientific Meeting
Theme: “Best practice: Aiming for excellence”
Venue: Dunedin Centre and Town Hall, Dunedin, New Zealand
Website: www.nzadunedin2013.com

July 27
Melbourne, Vic
34th Annual ANZCA/ASA Combined CME Meeting
Theme: “Mythbusting in anaesthesia”
Venue: Sofitel Melbourne on Collins, Melbourne, Victoria
Email: vic@anzca.edu.au

October 25-27
Byron Bay, NSW
Faculty of Pain Medicine (FPM) Spring Meeting 2013
Theme: “Internal pain is not eternal pain”
Venue: Byron at Byron Resort and Spa, Byron Bay, New South Wales
Email: events@anzca.edu.au

November 23
Sydney, NSW
Anatomy for Anaesthetists
Theme: “Anaesthesia and all things obstetric/trauma”
Venue: Adelaide Convention Centre, Adelaide, South Australia
Website: www.sant.anzca.edu.au/events/cme-meetings.html

September 20-22
Noosa, Qld
Combined Education, Management, Simulation & Welfare SIG Meeting
Theme: “Mindfulness, performance and achievement”
Venue: Outrigger Little Hastings Street Resort, Noosa, Queensland
Website: www.anzca.edu.au/events/sig-events

November 2-3
Leura, NSW
NSW Spring CME
Venue: Fairmont Resort, Blue Mountains, Leura, New South Wales
Website: www.nsw.anzca.edu.au/events

November 30
Adelaide, SA
The Biennial Burnell Jose Visiting Professorship Annual Scientific Meeting 2013 and Delegate Dinner
Theme: “Anaesthesia and all things obstetric/trauma”
Venue: Adelaide Convention Centre, Adelaide, South Australia
Website: www.sant.anzca.edu.au/events/cme-meetings.html

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Dante was a major Italian poet of the Middle Ages whose masterpiece, *The Divine Comedy*, is considered the greatest literary work composed in the Italian language. Anne Gunner follows his footsteps through Florence.

Dante began *The Divine Comedy* in 1308, while exiled from his beloved Florence. The pain of this banishment surfaces in his writing: "You shall leave everything you love most, this is the arrow the bow or exile shoots first." (Paradiso, XVII). Dante never returned to his native city; even the tomb built for him in 1929 in Santa Croce remains empty. Yet were Dante to return to Florence today, much of the city would be familiar to him.

**The Baptistero San Giovanni and Duomo**

Recognizable to any medieval citizen, the Baptistero and Duomo remain the heart of Florence. Dante’s *bel San Giovanni* is one of the city’s oldest and most famous buildings. Medieval houses still line the Piazza Duomo, many still proudly displaying a stone coat of arms.

Like many Florentines of the time, Dante was baptised in the large octagonal font of the Basilica. The building itself dates back to the 4th century. The 13th century mosaics covering the ceiling show with graphic detail the horrors and glories of the Last Judgment. Dante never saw Ghiberti’s famed doors, for they would not grace the building for another century.

Construction of the Duomo began in 1296 before Dante’s exile in 1301. In the basement lie the excavations of the Palaeochristian cathedral, Santa Reparata, founded in the 6th or 7th century AD on the remains of a Roman palace. On the southern side, just before the Via dello Studio, is a stone plaque marking where the poet would sit and contemplate the construction of the cathedral. For the hardy, 463 steps lead from the floor of the Duomo and up through a labyrinth of corridors and stairwells to the top of the cupola. (The most difficult part of the climb is over the arch; there is a spot here for lovers to place a padlock and throw away the key, so declaring undying love. Hidden corners remain marks left on the brickwork by the medieval builders as they trudged these endless stairwells.) The cupola soars to the height of the neighbouring hills. The view embraces the history of Florence with many a medieval street following the course of their Roman precursors. Private palaces survive, and a few towers – or torre, outlawed in 1250 – still remain.

(continued next page)
The Via dei Calzaiuoli was the thoroughfare of the medieval city. Linking the Duomo to the Palazzo Vecchio, it runs past the all-important Guildhall of Orsanmichele. Once a grain hall, in Dante's time the Orsanmichele reflected the power wielded by the greater guilds. The statues in the niches on the outside walls were commissioned by each guild. These include the Medici e Speziali, the guild of physicians, apothecaries and painters, to which Dante belonged. (Without guild membership, a Florentine could not participate in the city's parlaments.)

A slight detour leads to the Mercato Nuovo, a popular market since the 11th century. The atmosphere alone makes it worth a visit, especially on rainy days when the portico offers shelter from the elements. The Oltrarno, or 'other side of the Arno' takes pride of place at the entrance. A slight detour leads to the Mercato Nuovo, a popular market since the 11th century. The atmosphere alone makes it worth a visit, especially on rainy days when the portico offers shelter from the elements. The Oltrarno, or 'other side of the Arno' takes pride of place at the entrance. (Without guild membership, a Florentine could not participate in the city's parlaments.)

Walking beneath the arch into the Via Santa Maria Novella leads past the 12th century Santa Maria Novella, where the poet married Gemma Donati (they were betrothed when Dante was nine). It is also where he first saw Beatrice Portinari, the woman he immortalised in his writing. Beatrice's father, Fosco Portinari, is buried here.

A few streets away is the Badia Fiorentina, whose bell, as mentioned in Paradiso (IV 97-98) regulated medieval life. Boccaccio used the Badia in 1373 to give public lectures on Dante's works. Opposite is the Bargello, the oldest seat of government surviving in Florence. It was here that Dante's banishment was proclaimed.

An archway leads from the piazza to the Via Proconsolo, where Beatrice lived. This street in turn opens onto the Corso, another Roman road, which leads to the site of the eastern gate of the Roman city; 'Florentina' was founded by Charlemagne in 786. The age of the building can be seen in the way that it lies considerably lower than the road. Beyond the Ponte Vecchio, the Via dei Neri bends as it follows the shape of the old Roman road. A small road branches off to the north of the Via dei Neri, leading to the Piazza dei Priori, renamed the Palazzo Vecchio in 1299. Dominating the Palazzo Vecchio, the Piazza della Signora has continued as the centre of political activity since the Middle Ages. Heavy traffic has been banned since 1385. The imposing façade of the Palazzo Vecchio has remained virtually unchanged since it was built (1299-1302) – Dante writes of how the houses of the Ghibelline Uberti were demolished after the triumph of the Guelfs and the new Palazzo built on their ruins. (The Piazza della Signora is itself built over Roman ruins.)

The Palazzo Vecchio still functions as the town hall. Its bell tower, once the tallest edifice in the city, summoned the (male) population to the parlamento in the square below in times of trouble. Savavarola was imprisoned in the Palazzo before being burnt at the stake in the Piazza della Signora. It was here, in 1530, the people of Florence proclaimed the return of the Medici from their own exile.

In Dante's time the Ponte Vecchio was home to butchers and grocers; since the 16th C it had been the place to shop Florence's most spectacular jewellery. The Oltrarno, or 'other side of the Arno' was, until the Grand Dukes move here in 1550, for those who could not afford a grand palazzo within the city centre. Today, it remains relatively quiet compared with the bustle of tourists in the rest of the city.
A walk of a few minutes from the Ponte Vecchio leads to Santa Felicita. A church has existed on this site since the 4th C. In the 2nd century AD some Syrian-Greek merchants settled along a busy consular road here, bringing Christianity to the city. Inside Santa Felicita are some masterpieces of 16th century Florentine painting. The Vasari corridor runs through the nave, which enabled the Medici to attend Mass unseen by the great unwashed. On the left of the church runs the Costa di San Giorgio; Galileo once lived at number nine. At the end of the road stands the Porta San Giorgio, the oldest of the surviving city gates (Florence was still a walled city in Dante’s time.) A steep walk away is perhaps the least spoilt of all the Romanesque churches in Tuscany: San Miniato al Monte. It’s classical façade of green-grey and white marble has looked down over Florence since 1018. The quiet streets of the Oltrarno are filled with artisan workshops and medieval buildings. Wandering them at leisure, perhaps with a gelato in hand, gives an insight into Florence in the time of Dante. Perhaps even better, why not imitate the locals and choose a place to enjoy a coffee with some schiacciata alla fiorentina (a Florentine carnival cake) or maybe a glass of wine and some crostini, and sit and watch the world go by?

What to eat when in Tuscany
Crostini – slices of toasted bread smeared with olive oil and spread with different toppings.
Prosciutto di cinghia – a ham made from wild boar.
Fagioli o ceci all’olio – white beans served with olive oil – simply delicious.
Papardelle alla leper – a broad pasta served with hare sauce.
Arista alla fiorentina – pork loin roasted with rosemary (dating from the 15th century).
Cacciucco di livorno – a rich fish soup served over toasted garlic bread (a Tuscan ancestor to bouillabaisse).

Ricciarelli – diamond shaped almond cakes.
Schiacciata alla fiorentina – a Florentine carnival cake.
Zuccotto – sponge cake filled with almonds, hazelnuts and chocolate and cream.

Places to stay
For a unique experience, consider a convent or monastery stay:
Casa Santo Nome di Gesu – a 15th century palace in the Piazza del Carmine, it is now a Dominican convent (I sat on my balcony overlooking the garden while a string quartet played Vivaldi on the marble steps below.)
Sanctuary b&b Firenze – An oasis of a convent in the Borgo Pinti, a few streets away from the Duomo.
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LET’S TALK
FINANCIAL HEALTH

Your personal and professional journey is unique, and there are financial considerations at every milestone. Whether you're commencing your practice, at your career peak, focusing on professional consolidation, or preparing for life after work, careful planning is required at each stage. Perpetual Private can work with you to grow and safeguard your wealth throughout that journey.

Every day we turn high income into capital, tax effectively. We open doors to investment opportunities, draft partnership agreements, and provide many more tailored services. Understanding your needs at every stage allows us to establish a sustainable plan that continually evolves to adapt to your changing personal circumstances. We’ve been on the journey, let us help you with yours.
CASE STUDY: OPTHALMOLOGIST, 61 YEARS

1. Our client initially met with us in his late thirties. His key priorities were setting up his own practice and ensuring his biggest asset, his income, was protected. We established the appropriate structures for private practice and implemented personal insurance to protect him and his family.

2. To address his high level of debt, we focused on reducing non-tax deductible debt, such as tuition fees and his first home. We established a self managed super fund to efficiently build his retirement savings and also purchase his practice property, allowing the fund to benefit from the ownership.

3. Over the years, we’ve implemented strategies to build our client’s assets. Some five years ago, we developed a business succession plan, using our deep knowledge and benchmarking analysis to ensure that the value of his practice was maximised. At the same time we commenced a transition to retirement strategy.

4. In retirement, our client’s objectives are to maintain annual income of $300,000 (roughly half of previous net taxable earnings) and pursue his active diving ambition. We continue to adjust and optimise his plan, putting in place sound strategies to build and protect his wealth. After many years of detailed attention, he is well placed to dive into life after work.
The recertification circus

CANE TOADS BE WARNED – COMPULSORY RECERTIFICATION MAY NOT BE THE ANSWER.

I recently was required to have a yearly “medical” for my driving licence – it is no secret that I have had Parkinson’s disease for more than 10 years. The public needs to be protected from incapacitated drivers. This time, I was required by law to be assessed by an occupational therapist and a driving instructor. I passed, but the process set me thinking about compulsory recertification for doctors.

My morning cost almost $400. How much will doctors be charged for half a day’s “grilling”? The occupational therapist that assessed me was capable and professional. She had to complete a moderately complex neurological assessment. At one stage she was testing touch and proprioception in upper and lower limbs. I volunteered the medical words “posterior columns” just trying to make conversation. She stopped, puzzled and asked what I meant. I replied, “oh, those are the pathways you are testing”, to which she said, “sorry, I just do the tests I am told to, I don’t know all that other stuff”. I asked did she do a Romberg’s Test as well, which also drew a blank. I did not embarrass her further by mentioning the spino-thalamic tracts, dysdiadokokinesis or anything else neurological.

Having completed the occupational therapy assessment, we were met by a driving instructor with a dual-control car. We set off through the streets of Elanora, here on the Gold Coast, driving through intersections, roundabouts, traffic lights and a section of motorway. No old ladies, children, animals or even cane toads were killed or even threatened. Towards the end of the test, I was directed down a long, empty street without traffic and asked to park the car, which I did. The occupational therapist and the instructor then told me that my driving was good but I didn’t check my rear mirrors often enough. Hello?

Forewarned, I complied as we drove the few kilometres back to the office by flicking my eyes back more often than usual on the three rear-vision mirrors and all was hunky dory. They were then satisfied, even if I had sore external ocular muscles.

The following week an old uncle died in Sydney and I drove myself down to the funeral, 1900km return trip. No old ladies, children or cane toads perished en route. However, arriving at Wahroonga then negotiating three lanes of peak-hour traffic in Sydney awakened me to the reality of STD – “Sydney traffic dystrophy”. Thirty-five years of travel on Sydney’s roads breeds a terrible survival instinct. There is so much to be aware of in front of your vehicle (and it is taken for granted that there will be some idiot too close to your tail or in your “blind spot”) that the relative luxury of constantly checking your mirrors, while theoretically nice, could lead to you running into the vehicle in front (50 per cent of collisions in our cities are this sort of accident) or, much worse, killing an old lady or a child.

The greatest fool can ask a question that the wisest man cannot answer. This is the big risk of compulsory recertification for doctors – that is, we all have gaps in our knowledge that can be twisted against us in an interview. We may have a mode of practice based on our experience that is not identical to textbook descriptions but which is perfectly safe. Bureaucrats and our political enemies can exploit differences to try to remove us for whatever reason.

In the meantime, I will still gun for the cane toads.

Dr Jim Wilkinson FANZCA bade “adieu” to anaesthetic practice in Sydney in 2006 at the tender age of 55 because of Parkinson’s Disease. Seven years on, he still writes a weekly column for doctors on medico-political matters.)
Lyrica helps control my neuropathic pain

PBS Information: Authority Required (Streamlined).
Treatment of refractory neuropathic pain not controlled by other drugs.

Before prescribing, please review full Product Information available from www.pfizer.com.au

MINIMUM PRODUCT INFORMATION
LICENCEE: Pfizer Australia Pty Ltd
MANUFACTURED: Pfizer Manufacturing Groenhout, Victoria


Contraindications: Hypersensitivity to pregabalin or its components. Pregnancy: lactation; diabetes, oedema, history of substance abuse, cognitive impairment, mental depression, alcohol, benzodiazepines, mevalonoid acid formation, See full PI. Interactions: OES, benzodiazepines, alcohol, benzodiazepines, verapamil, medications causing constipation. See full PI. Adverse effects: Most common: dizziness, somnolence, Others include: blurred vision, headache, edema, peripheral oedema, tremor, insomnia, dizziness, sedation, Postmarketing: suicidal ideation, allergic reactions, loss of co-ordination, pruritis, constipation, nausea, vomiting, diarrhea, hallucinations, See NPSA Dosage and Administration: 75 mg to 300 mg once daily given as 2 divided doses. Neurontin neuropathy pain start at 150 mg/day increase to 300 mg/day after 3 to 7 days. If needed, increase to a maximum of 600 mg/day after a further 7 days. Neurontin start at 150 mg/day, increase to 600 mg/day after 7 days. Maximum dose of 600 mg/day may be given for a further 7 days. Neurontin neuropathy dose: 300 mg/day.


*Please note changes to Product Information.
Life Moments

At night when counting sheep,
Do you hear the sound of the oximeter beep?
Happy sound of sunlit stream,
Blue tonal terror of hypoxaem?
In dreams it fills my slumber
And so I lie and I wonder,
This nocturnal visitation
Of the ticking saturation,
Steady patient, safe heart beat,
Life moments lost, in the anaesthetist’s seat?

Dr Rob Grace, FANZCA
Cairns Base Hospital
The Alfred Intensive Care
Upcoming Events Program

The profits from courses are 100% allocated to research, education, projects and equipment for The Alfred ICU.

7th Alfred Advanced Mechanical Ventilation Conference (AAMVC)
AAMVC Theme: Complications of Mechanical Ventilation. International speakers are Brian Kavanagh from Canada and Dale Needham from the USA. A full day of presentations on Thursday is complemented by the hands on Ventilation Waveforms Workshop (Wednesday).

Waveforms Workshop is now sold out, places for AAMVC & Physio Seminar are still available
AAMVC 20 June 2013 Fees $350 – $520 Early Bird $315 – $470 by 24 April 2013

Infectious Diseases & Critical Care Conference
This one day conference will present practical updates on best practice in infectious diseases and infection control in intensive care. Design for consultants, trainees, pharmacists and nursing staff, participants will be provided with updates on innovations in this exciting and rapidly progressing field. Guest speakers include Prof David Paterson, A/Prof Debbie Marriott and A/Prof Anton Peleg amongst others. Case studies will examine issues such as antibiotic selection, writing of guidelines, use of antifungals, dosing and de-escalation strategies.
15 November 2013 Fees $250 - $475 Early Bird $190 - $410 by 13 September 2013

Advanced Life Support (ALS2) Provider Course
Two day Australian Resuscitation Council accredited adult life support provider training in advanced cardiac arrest and medical emergency management for doctors, nurses and paramedics.
20 & 21 May Sold Out 22 & 23 July 28 & 29 October
2 & 3 December 2013 Fees $770 - $1550

Basic Assessment & Support in Intensive Care
Two day introduction Course for medical staff new to intensive care and the care of the critically ill.
6 & 7 May Sold Out 5 & 6 August 6 & 7 November 2013 Fees $650

Bronchoscopy for Critical Care
All you need to know about fibre optic intubation, massive pulmonary haemorrhage, bronchial lavage, foreign body removal and safe bronchoscopy in critically ill patients. Interactive and simulation based course.
21 June (Day after AAMVC) 1 November 2013 Fees $800 - $990 Early Bird $700 - $850 by 24 April or 6 September 2013

Crisis Resource Management for Intensive Care (CRM)
One day course aimed at Intensive Care Senior Registrars and Consultants, covers the principles of crisis resource management and includes a series of immersive simulations reflecting realistic critical care scenarios.
22 May 4 December 2013 Fees $900 - $1200 (Course limited to 10 places)

Critical Care Echocardiography Course
Two day course covering problem oriented approach to echocardiography in critically ill patients. Emphasis on echo guided management of the critically ill. Content tailored to suit participant’s echo experience with a favourable faculty:participant ratio providing ample hands on experience using live models & Heartworks simulators.
27 & 28 May Sold Out 9 & 10 September 2013 Fees $1750 (The CCUltrasound Course follows each Echo Course)

ICU & Perfusion Adult ECMO Course
Two day course for Doctors, Nurses & Perfusionists covering ECMO support of cardiac and respiratory failure. Optional third day for cannulation training.
2 Day Course 17 & 18 April 2013 9 & 10 October 2013 Fees $800 Course & 1 Day Cannulation 16 or 19 April 2013 8 or 11 October 2013 Fees $2300

MAQUET GETINGE GROUP

The HEaRT Course – Haemodynamic Evaluation and Related Therapies
Two day course designed for Doctors and Nurses working in all critical care areas including intensive care, theatres, coronary care & emergency, covering the physiology, measurement, monitoring & support of the cardiovascular system with practical sessions in small groups.
(Course limited to 24 places)
29 & 30 April 2013 24 & 25 October 2013 Fees $400 - $800

TOE Course (Transoesophageal Echocardiography)
High intensity TOE simulator and wet-lab based two day hands on course covering the standard TOE views and basic pathology. Aimed at advanced trainees/consultants in Anaesthesia, ICU, ED and Cardiology and covering the basics of TOE using the latest in simulator technology.
21 & 22 November 2013 Fees $1750 (Course limited to 12 places)

Critical Care Ultrasound Course (CCU)
One day course covering the practicalities of critical care ultrasound. This is a comprehensive course with tutorials and hands on sessions with models. Topics covered will include chest US, abdominal ultrasound including FAST and aortic aneurysm, DVT screening and ultrasound for procedures.
29 May Sold Out 11 September 2013 Fees $750 or $500 if purchased with ECHO held the 2 days prior.

ALS, Basic and all other workshops have limited places and will fill up quickly.

For further information or to register online www.alfredicu.org.au/courses
ALS/BASIC/CRM/TOE Contact: Cathy Oswald Ph: +61 3 9076 5397 E: c.oswald@alfred.org.au
Prices are subject to change
ALS/BASIC/CRM/TOE Contact: Kate Pearce Ph: +61 3 9076 5404 E: k.pearce@alfred.org.au

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Before prescribing, please review full product information available from Pfizer Australia Pty Ltd.

**CYKLOKAPRON** solution for injection reduces peri- and post-operative blood loss and the need for blood transfusion in adult patients undergoing cardiac surgery, or total hip or total knee arthroplasty.\(^1,2\)

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**BEFORE PRESCRIBING, PLEASE REVIEW FULL PRODUCT INFORMATION AVAILABLE FROM PFIZER AUSTRALIA PTY LTD.**

MINIMUM PRODUCT INFORMATION CYKLOKAPRON® (tranexamic acid, 1000 mg/10 mL Solution for Injection)

**Indications:** reduction of peri- and post-operative blood loss and the need for blood transfusion in adult cardiac surgery, total knee or hip arthroplasty. See full PI for complete list.

**Contraindications:** history or risk of thrombosis, active thromboembolic disease, colour vision disturbances, subarachnoid haemorrhage, hypersensitivity to tranexamic acid or other ingredients.

**Precautions:** Do not use in haematuria. Concomitantly with Factor IX Complex Concentrates or Anti-inhibitor Coagulant Concentrates, irregular menstrual bleeding, disseminated intravascular coagulation rapid injection may cause dizziness and/or hypotension. 

**Pregnancy Category B1.** Use with caution in nursing mothers. See full PI for details.

**Adverse Effects:**

- Common side effects: death, arrhythmia, cardiogenic shock, myocardial infarction, stroke, renal dysfunction/impairment, renal failure, respiratory failure, DVT
- Serious but rare side effects: convulsions. See full PI for details.

**Dosage and Administration:**

- **Adult Cardiac Surgery:** 15 mg/kg (pre-surgery), 4.5 mg/kg/hr (during surgery), 0.6 mg/kg of this infusion dose may be added to heart-lung machine.
- **Adult Total Knee (TKA) or Hip Arthroplasty (THA):** 15 mg/kg prior to tourniquet release (TKA) or prior to skin incision (THA) & repeated at 8 & 16 hours after first dose. Dosage adjustment in renal impairment, See full Product Information for dosage for other indications. The current Product Information is available at www.Pfizer.com.au. Pfizer Australia Pty Ltd. ABN 50 008 422 348. 38-42 Wharf Road, West Ryde, NSW 2114. Pfizer Medical Information 1800 675 229.

**References:**


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**PBS Information:** This product is not listed on the PBS.