Top stories:

SPECIAL REPORT – HEALTH REFORM AND ANAESTHESIA IN NEW SOUTH WALES

FELLOWSHIP SURVEY – NEXT STEPS

WORKFORCE: PHYSICIAN ASSISTANTS – THE WAY OF THE FUTURE?

WHAT’S NEW IN PAIN: SMOKE AND MIRRORS?
A winning combination.
Contents

10 Special report: Health reform and anaesthesia developments in NSW
In a new series looking at healthcare in state jurisdictions, we explore the latest developments in the New South Wales healthcare system and what this means for anaesthetists.

20 Fellowship survey – next steps
ANZCA’s response to the recent Fellowship survey findings.

92 What’s new in pain: Smoke and mirrors?
Pain is much more than sensory perception of tissue injury. Dr Eric Visser explores what’s new in pain and its multidimensional nature.

24 Workforce: Physician Assistants – way of the future?
New Zealand’s pilot program to evaluate the role of physician assistants is under way.

32 Satellite accreditation of Gove and Katherine hospitals

50 Continuing Professional Development

60 Funding research in cognition and anaesthesia

70 The legacy of Konrad Jamrozik, The Master Trial and contemporary clinical research in anaesthesia
Bill Clinton (and Julia Gillard) said “The people have spoken, but it’s going to take a little while to determine exactly what they said”. Mercifully, ANZCA is not in that position. The ANZCA Fellowship Survey has delivered some very clear messages about what our Fellows expect of their College, and what they are engaged in their professional lives as anaesthetists and pain medicine specialists. In this issue of the ANZCA Bulletin, we have mapped out our response to your feedback and our plan to increase the value of an ANZCA/FPM Fellowship for all our Fellows.

The Fellowship Survey
To briefly recap, ANZCA Council identified engagement of Fellows as a key strategic priority for 2010-12 and seeking the views of Fellows was seen as an important element in achieving that objective. The Fellowship Affairs Committee, chaired by Dr Michelle Mulligan, and ANZCA management, led by CEO Dr Mike Richards and Director of Communications, Mr Nigel Henham, planned the survey and commissioned independent research company ANOP to analyse the results. The survey was distributed to Fellows in March-April 2010 and focus groups were held at the Annual Scientific Meeting in May 2010. The response rate of the survey was nearly 50 per cent and the Executive Summary was published in the June ANZCA Bulletin. Some highlights of the results were:

- There was a good level of satisfaction with ANZCA overall with 71 per cent of respondents giving ANZCA scores of seven to 10 out of 10.
- ANZCA was perceived as being professional, credible and reputable (although sometimes a bit bureaucratic and remote).

In New Zealand, Fellows are required to advise the Medical Council annually as part of the application for registration of their participation in an approved CPD program (ANZCA’s CPD program is the only one approved for anaesthetists) and ANZCA confirms participation for those whose returns are audited by the Medical Council. In Australia, the specific rules for maintenance of specialist registration are under development. MBA Consultation Paper #5 maps out the Board’s current proposals (see ANZCA’s response at http://www.anzca.edu.au/news/submissions-to-government). Their plan is to require specialists to meet the standards for CPD set by the relevant Australian Medical Council (AMC) accredited College in order to maintain specialist registration. For our Fellows, this will mean participation in the ANZCA CPD program or another program approved by the College. In addition, the MBA plans to obtain information from the College about participation in CPD.

ANZCA has also separately mandated CPD for all active Fellows. As the end of this triennium of the ANZCA CPD program approaches, I encourage all Fellows to review their CPD plan, enter their activity data and obtain their CPD certificate as they will require this to maintain good standing with both the College and their Medical Council or Board. More information is available at http://www.anzca.edu.au/fellows/cpd including contact details for the staff in our CPD unit.

Making ANZCA’s CPD program easier to access and use
To be effective, CPD must be tailored to the practice needs of the individual practitioner and be presented in a format that best suits them. While the overall level of satisfaction with the CPD program was reasonable (7.2 out of 10), nearly four out of 10 respondents to the survey commented that they had difficulties with the program in terms of the ease of access and navigation of the website. Furthermore, the focus groups revealed that some Fellows wanted more guidance from the CPD printed materials and website about planning a CPD program, self-assessing the activities, logging them with the College and obtaining a certificate. As Council has recently resolved that advice about CPD point allocation for activities will no longer be provided prospectively, improved guidance about self-assessment is timely.

To that end, the College is planning a comprehensive review of the CPD section of the ANZCA website. This is part of an overall revamp of the website being undertaken by the Communications, IT and CPD units.

Advocate quality and safety
- 136 Fellows completed Advanced Level Clinical Teacher courses so far in 2010 and 197 Fellows registered for future Foundation Level courses.
- 81 per cent participation rate in ANZCA’s CPD program.
- 50 per cent response to the ANZCA Fellowship Survey.

Give your support
- Overseas Aid Committee and Indigenous Health Working Group established.
- 69 donations to the Foundation for 2010.
- 50 Fellows engaged in the ANZCA Curriculum Redesign project.
- 136 Fellows completed Advanced Level Clinical Teacher courses so far in 2010 and 197 Fellows registered for future Foundation Level courses.

President
Professor Kate Leslie
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G:
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September 2010
September 2010
2
3
President’s message

How are we going with ENGAGE?

Embrace new training environments
- 25 anaesthetic training positions in private and rural settings short-listed for the Australian Federal Government’s Specialist Training Program (STP) funding.

Negotiate and influence people
- 46 submissions to government (28 in Australia and 18 in New Zealand) so far this year.

Get involved
- 81 per cent participation rate in ANZCA’s CPD program.
- 50 per cent response to the ANZCA Fellowship Survey.

Advocate quality and safety
- 15 hospitals participating in the pilot program for Webairs – the online bi-national incident monitoring project supported by ANZCA, the ASA and the NSGA.

Give your support
- Overseas Aid Committee and Indigenous Health Working Group established.
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Pain in the Pacific project

ANZCA President Professor Kate Leslie accepted a cheque for a $20,000 donation from the trustees of the Ronald Geoffrey Arnott Foundation, managed by Perpetual Trustee Company Limited, in support of a Pain in the Pacific project within the Faculty of Pain Medicine.

Project sponsor, Dr Roger Goucke, former Dean of the Faculty of Pain Medicine, has written about essential pain management in the Pacific Islands and Papua New Guinea and his article can be found on page 100.

Supporting medical research

Since 2007, Mundipharma has given considerable untied annual funding to the Anaesthesia and Pain Medicine Foundation (formerly the ANZCA Foundation) to support the College’s medical research and education programs. Each year, we recognize Mundipharma’s support with an award that is presented at the Annual Scientific Meeting. The Mundipharma ANZCA Research Fellowship for 2010 was awarded to Dr Paul Wrigley for his project “Regional changes in cerebral perfusion associated with persistent spinal cord injury neuropathic pain”.

News

New Fellow on Council

Dr Justin Burke is the New Fellow on the ANZCA Council. Dr Burke obtained his Fellowship in 2009. He trained in Victoria before completing his provisional Fellowship in Darwin in the Northern Territory. He is currently a Staff Anaesthetist at The Alfred Hospital, Melbourne. His clinical interests include ENT, vascular and remote anaesthesia. He is also interested in legal issues in medicine. Justin hopes to provide Council with the perspective of new Fellows and promote the issues faced by anaesthetists early in their careers.

ANZCA Foundation changes its name

The ANZCA Foundation has been renamed the Anaesthesia and Pain Medicine Foundation. ANZCA Council approved the change following the recommendation of the ANZCA Foundation Board. The rationale behind the change is to increase awareness in the wider community of what the foundation is and its purpose (see page 70 for further details).

International Pain Summit

On September 3 more than 250 clinicians, health ministers, senior health administrators, the World Health Organization and other organisations representing healthcare, not-for-profit and human rights organisations, met in Montreal at the first global meeting about crucial aspects of pain management, with a focus on advocacy and assistance for all countries to develop national pain strategies. The International Pain Summit was chaired by Professor Michael Cousins, who chaired the inaugural National Pain Summit in Canberra earlier this year (see page 91).

2011 Research Grants

ANZCA has made $757,000 available for 2011 grant funding for Project and Novice Grants. This represents a 25 per cent increase on the level of funds available last year. Academic Enhancement Grants, Simulation Education Grants and Lennard Travels Professorships are funded separately. The following applications for grants have been received:

- 17 Project grant applications ($693,837 requested)
- Two Academic Enhancement grant applications ($179,927 requested)
- Three Lennard Travels Professorships ($53,332 requested)

The Research Committee meeting for the final determination of grants was held in mid-September from which the final recommendations will be made at the October ANZCA Council meeting.

Applications for CPD grants for rural specialists

Applications are now open under the Australian Government’s Rural Health Continuing Education Program for grants for rural practitioners to further their individual continuing professional development (CPD) needs. Grants are also available for CPD projects. Applications require endorsement by ANZCA and should be forwarded to John Biviano via email to jbiviano@anzca.edu.au by September 24, 2010. Further information is available on the ANZCA website.

ANZCA website redesign

ANZCA’s website is undergoing a comprehensive redesign to improve navigability and ease of use. While 74 per cent of Fellows in the College’s recent Fellows survey indicated they found the website easy to navigate and use, the survey and focus groups identified areas for improvement. The redesign, which is being led by ANZCA’s communications unit, is expected to be completed in early 2011. If you have any ideas or suggestions in relation to the ANZCA website redesign please send them to rhenham@anzca.edu.au.

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Although DM sits on the ANZCA Council, all decisions regarding grants are made by the Research Committee. If you have any ideas or suggestions in relation to the ANZCA website redesign please send them to rhenham@anzca.edu.au.
People and events

2010 Rural Special Interest Group meeting

The Rural Special Interest Group (SIG) held its third annual meeting on Hamilton Island from July 4-6 with the theme “The Jack of All Trades”. The meeting was well supported with more than 100 delegates, and a larger number of trade displays than in previous years, proving the concept of an annual meeting with a rural focus has support among Fellows of the College as well as GP anaesthetists, who accounted for almost a third of the delegates.

The three-day event covered a wide variety of topics, which for some in metropolitan practice are a daily or weekly occurrence but for a rural practitioner may crop up less than monthly. The first day covered pre-operative assessment with talks on pacemakers by Dr John Moloney, coronary stents and antiplatelet drugs by Dr Jenny Stevens, an audit of ECG abnormalities in pre-admission clinic from Quentin Tibbals, paediatrics by Dr Neil Paterson, diabetes by Dr Judith Killian and sleep apnoea by Dr Deb Gardiner. Day two had an intra-operative focus with talks on paediatric dental and ENT anaesthetics by Dr Neil Paterson, 10 tips for ophthalmic anaesthesia by Dr Lindy Caas, anaesthesia for urology by Dr Gay Clery, the fractured NOF from Dr Matthew Griffiths, shoulder surgery from Dr Dougal Miller and DVT Prophylaxis from Dr Steve O’Mara. The final morning had a pain focus with talks on post-operative nausea and vomiting from Dr Rod Martin, multi-modal analgesia by Dr David Rowe, intrathecal opioids for chronic pain by Dr Mathew Griffiths, shoulder surgery from Dr Dougal Miller and DVT Prophylaxis from Dr Steve O’Mara.

Annual Advanced Airway Management Refresher Course 2010

The second Annual Airway Management Refresher Course was held at the Australian Centre for Health Innovation at The Alfred hospital with 40 participants and 20 experienced airway instructors from around Australasia. There was a wealth of experience from many specialist groups, rural GP anaesthetists, intensivists and emergency physicians and anaesthetists. The course featured hands-on training in clinical airway skills in small groups with a very high instructor to participant ratio, and expert advice that was designed to go beyond the ASA and DAS algorithms of difficult airway management.

The video laryngoscope session featured an overview by Dr Rishi Mehra, followed by an interactive session. Dr Chris Acott and Dr Joel Symons were on hand to offer practical advice on the different ways of using the devices. Dr Maryanne Balkin wrapped up the session with an objective review of literature. Dr Reny Segal and Dr Paul Muszala ran the dexterity training with the Storz fibrescopes on Dexter mannequins. Airway trainers Dr Jon Graham and Dr Balan Sivasubramaniam extensively covered the Topicalisation and Aintree conversion stations. Dr Andrew Heards team from Perth and The Alfred helped facilitate the participants’ learning of the new approach to surgical airway management for anaesthetists in the “can’t intubate, can’t oxygenate” scenario. Finally, the prospect of being exposed to some good adrenaline-provoking simulated difficult-airway situations drew positive comments. Dr Stuart Marshall and emergency physician Dr Peter Fitz developed scenarios that related strongly to current practice and potential situations.
Death Under Anaesthesia meeting

Death Under Anaesthesia, a conference commemorating 50 Years of the Special Committee Investigating Deaths Under Anaesthesia (SCIDUA), was held at the Hilton Sydney Hotel on August 14. Co-hosted by the NSW Anesthesia Continuing Education Committee and the NSW Clinical Excellence Committee, the meeting attracted more than 350 delegates from across Australia and New Zealand. The theme of the conference addressed mortality and related topics. Keynote speakers Professor Ross Holland, Dr Neville Gibbs and Professor Jan Davies presented talks on the history, trends and international practice of mortality reporting. Keynote speaker Professor Alan Merry presented on the World Health Organization Surgical Safety Checklist. Other lectures addressed mortality among anaesthetists from addiction, risk-associated with transfusion and safety of home births. Group learning sessions addressed safe practice in high-risk areas that have been identified by SCIDUA such as endoscopy, orthopaedics and obstetrics. Workshops addressed the topics of breaking news to a patient’s relative of an unexpected death and advanced life support.

Progression in Pain Day

The Faculty of Pain Medicine, in conjunction with the Royal Australian College of General Practitioners, hosted a continuing medical education day “Progression in Pain – From Hospital to Home” at the National Wine Centre of Australia, Adelaide, in May. Invited speakers Dr Michael Predickison (Anaesthetist, Auckland) and Dr Malcolm Dobbin (public health physician, senior medical advisor on alcohol and drugs to Mental Health and Drugs Division, Victorian Department of Health) led the program.
RESPONSE AND RESTRUCTURE

Response to the Garling Report has been widespread and enthusiastic. Recommendations are wide-ranging and cover areas of micro (albeit much needed) reform such as the mandating of name badges worn by all staff at chest height, and visible posters advertising the responsible “nurse/midwife in charge” for each ward area – to larger scale clinical improvements.

GARLING IMPLEMENTATION AND IMPLICATIONS FOR ANAESTHETISTS

1. Deteriorating Patients (Recommendation 91) and “Between the Flags” Program (BTF) – The BTF program, in order to provide a safety net for the early detection and management of the deteriorating patient predated the Garling Inquiry. The analogy used is the red and yellow flags of Surf Lifesaving Australia. Like the surf lifesavers, hospital staff aim to closely observe patients, and keep them in safe zones “between the flags”. Standard criteria were developed, underpinned by a standard chart (Standard Adult General Observation Chart-SAGIC chart, colour coded with yellow “at risk”, and red “danger” zones), and a state-wide standardised response system promulgated to enable appropriate escalation and rapid response to the deteriorating patient. Widespread team training for nursing and medical staff was also introduced (“DETECT” training- Detecting Deterioration, Evaluation, Escalation and Communication in Teams). The DETECT program was developed by Sydney anaesthetist/intensivist Associate Professor Theresa Jacques. Many other anaesthetists have led and may need to consider the need to modify or “sign off” variances from prescribed limits where appropriate and safe.

2. Handover (Recommendation 56) – Garling identified issues and areas for improvement in handover processes at every level in the New South Wales public hospital system. Many anaesthetists act as MO supervisors (Directors of Pre-Vocational Education and Training), or are otherwise well placed to observe the function of a

NSW PUBLIC HOSPITALS AND ANAESTHESIA POST GARLING

In previous editions of the ANZCA Bulletin ANZCA interviewed Australian and New Zealand Ministers for Health regarding some of the key issues facing both countries’ health systems and, in particular, anaesthetists and pain medicine specialists and the wider profession. In this special series, commencing with New South Wales, we look at some of the developments and challenges occurring in various state and regional jurisdictions. In this issue we look at what is happening in New South Wales post the Garling Report which found major deficiencies in New South Wales’ health and hospital system.

DR JOANNA SUTHERLAND
DIRECTOR, ANAESTHETIC SERVICES,
COFFS-CLARENCE NETWORK

BACKGROUND

Vanessa Anderson, aged 16, died in 2005 in a ward of a major New South Wales public hospital, from a closed head injury, having been struck by a golf ball. Following the coronial investigation into Vanessa Anderson’s death, the New South Wales government established the “Special Commission of Inquiry into Acute Care in NSW Public Hospitals” led by Peter Garling, SC (the “Garling Commission”). This was certainly not the first wide-ranging inquiry into the practices and outcomes of care in New South Wales public hospitals, but it appears to be having a far greater impact than any previous investigation.

THE REPORT AND RECOMMENDATIONS

The Garling Report was released in November 2008. It is a massive document, containing 139 recommendations, many of which refer to a subset of other recommendations, and this response has been subject to external audit. For his part, Mr Garling recommended that restructure of delivery of care in NSW should be underpinned by four “pillars”:

1. The pre-existing Clinical Excellence Commission (CEC), which aims to build capacity in quality and safety improvements.
2. A newly formed Agency for Clinical Innovation (ACI), which will be clinician led, and drive innovation and reform (recommendation 67).
3. A new Bureau of Health Information (BHI), to provide high quality data around the performance of the health system, and

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hospital as a whole, and to recognise deficiencies in the system. JMO handover is one area which is undergoing innovation and improvement currently. Anaesthetists are also actively involved in patient handover. For example, the requirement to hand over trauma patients from day to day for non-elective scheduling, handover to ward staff of cases completed or finishing after hours, and appropriate handover of information arising from pre-admission assessment to procedural anaesthetists. These are areas where improvements in our handover procedures could substantially enhance patient safety and improve quality of care.

3. Clinical Supervision

It is well recognised by anaesthetists that there is a nexus between workplace-based training, and workforce activity and contribution. The common thread is clinical supervision. Garling has referred to the need for improvement in the mentoring, training and supervision of junior medical staff, and has made quite specific recommendations around clinical supervision of junior staff undertaking surgery (although not anaesthesia). Included in the recommendations is the requirement that New South Wales Health “define supervision” for all junior medical staff, and also define the “objectives and content of supervision” (recommendation 45).

With its document “Guideline for the Structured Assessment of Trainee Competence Prior to Supervision Beyond Level One,” ANZCA has developed precisely the type of resource which Garling has foreshadowed in his recommendations, and which NSW Health is seeking. It is also worth noting that recommendation 33 of the Garling Report suggests that “all clinicians engaged in teaching and/or supervision of post-graduate clinical staff should complete courses provided by the Institute of Clinical Education and Training.” Garling’s view appears to be that CETI will be the principle organisation responsible for “training the trainers.” It will be interesting to see how CETI incorporates or reflects the role and contribution of the specialist Colleges, including ANZCA.

4. Hand Hygiene

At recommendation 88, Garling describes an “enforcement regime” to promote compliance with hand hygiene. This regime escalating from counselling, through education to disciplinary action for failure to comply with hand hygiene policies. There is no doubt Garling and NSW Health consider compliance with hand hygiene policies to be of the utmost importance in maintaining a safe work environment. In reducing the incidence of hospital acquired infections by patients, and reducing the likelihood of outbreaks of multi-resistant organisms in public (and other) hospitals. The Clinical Excellence Commission is developing considerable resources currently to the widespread education and counselling of senior doctors (including anaesthetists) throughout NSW regarding hand hygiene, including audits of the compliance of senior doctors with the requirement to appropriately observe the “5 Moments of Hand Hygiene.”

Anaesthetists should expect to be challenged by these auditors, who may ask us why we are not conforming to the accepted hand hygiene protocols.

5. Clinical records and IT

(Recommendation 51)

Garling recommends that within four years (from 2008) NSW Health will complete the current transition to an electronic medical record. For anaesthetists, work has been underway for many years to build a state-wide database to enable an electronic pre-admission document including pre-anaesthetic assessment, planning, consent and recommendations. The working party for the development of this document has been led by Sydney anaesthetist, Dr Roger Traill, and is incorporating input from current active users of the system. It is anticipated that the electronic pre-admission assessment document will be rolled out to all NSW hospitals.

6. Rural Recommendations and Training Issues

Recommendation 12 of the Garling Report states that NSW Health should consider “compulsory rural training terms” for junior medical officers beyond early training. He also links training in a rural environment with development of rural workforce, and suggests “formalised structures” to facilitate transition of clinicians between metropolitan and rural environments. ANZCA NSW has given some consideration to this issue and is progressing towards the alignment of rural positions with metropolitan-based training schemes, and mandating rural rotations for all trainees. With this realignment of training positions, a larger number of trainees will be able to complete their training in a timely fashion, with equality of access to sub-speciality modules. Additionally, workforce development will be enhanced in areas of current short supply.

FUTURE DIRECTIONS

One of Garling’s four pillars, The Agency for Clinical Innovation, was launched at Westmead Hospital on August 10. The ACI will grow from the work done over the last eight years by the GMMC (Greater Metropolitan Clinical Taskforce). For anaesthetists, the timing of the launch of the ACI is propitious. The most recent clinical network to be developed and incorporated is the “Anaesthetic and Peri-operative Care” Network, co-chaired by Sydney anaesthetist Dr Su-Jen Yap. This network will provide interested clinical anaesthetists with the opportunity to lead and contribute to innovative models and systems of care, make recommendations regarding workforce development and training, and providing advice regarding new opportunities for improving patient outcomes. This network has identified key priority areas (see page 13).

Garling’s report came at a time of real crisis within NSW public hospitals. Although some of the changes proposed by Garling were already underway or planned there is no doubt that the urgency and exposure generated by Garling has given considerable impetus to the process of reform. Increased resourceing could potentially accelerate this reform process. There is currently a significant amount of activity addressing Garling’s many recommendations, and in many hospitals a sense that alongside clinical change and improvement will come the real structural change that is so desperately needed at all levels within the hospital system in New South Wales.

Above right: Westmead Hospital.
THE NSW AGENCY OF CLINICAL INNOVATION – AN ANAESTHESIA PERIOPERATIVE CARE NETWORK

DR MICHAEL AMOS
IMMEDIATE PAST CHAIRMAN,
NSW REGIONAL COMMITTEE

The New South Wales Agency for Clinical Innovation (ACI) was established by the NSW Government in January 2010 as a board-governed statutory health corporation, in direct response to the Final Report of the Special Commission of Inquiry into Acute Care in NSW Public Hospitals by Peter Garling SC. Building on the valuable work carried out by the Greater Metropolitan Clinical Taskforce (GMCT) and its predecessors over the past nine years, the ACI uses the expertise of its clinical networks to collaborate with doctors, nurses, allied health professionals and consumers to develop evidence-based standards or “models of care” for the treatment of patients. It supports NSW Area Health Services and other public health organisations – including the soon to be established Local Hospital Networks (LHNs) – to implement these standards across the public health system in NSW. The ACI reports to both the NSW Minister for Health and the Director-General of NSW Health.

The newest clinical network to be formed under the ACI umbrella is the Anaesthesia Perioperative Care Network. It is comprised of anaesthetists, perioperative nurses, anaesthesia technicians, other medical, nursing and allied health professionals with an interest and consumers from hospitals and local communities from across New South Wales.

The Anaesthesia Perioperative Care Network is one of 23 ACI clinical networks that was established to recommend improvements to anaesthesia and perioperative services in NSW public hospitals. Dr Su-Jen Yap, a staff specialist anaesthetist at Prince of Wales Hospital and Sydney Children’s Hospital, is the medical Co-Chair of the Network and will include seven other anaesthetists (Dr Michael Amos, Dr Jo Sutherland, Dr Tracey Tay, Dr Roger Traill, Dr Ross Kerridge, Dr Darrick Scott and Dr Scott Finlay), consumers, nursing and allied health professionals and managers from the ACI. The aims of the network are to:

- establish a network including doctors, nurses and allied health professionals from across NSW Area Health Services and consumers from the NSW community that is best placed to represent a consensus view for service planning and development for anaesthesia and perioperative services. This network will include consumer participation and incorporate consumer input in all functions of the network;
- address equity of access and outcome issues and determine priority areas for anaesthesia and perioperative services across NSW;
- develop and promulgate evidence based or consensus driven models of care to address priority areas;
- be the peak source of advice on clinical matters relating to anaesthesia and perioperative care services to the NSW Department of Health and other NSW Health organisations; and
- ensure the network and any subcommittee/working groups have measurable and documented outcomes which will facilitate better patient outcomes.

Areas for Review by Network

The Anaesthesia Perioperative Care Network Executive will initially focus on the following areas:

- Safe sedation practices.
- Assistants to anaesthetists.
- Perioperative care – shared guidelines for the management of patients’ intercurrent medical conditions.
- Perioperative systems – perioperative units and other emerging models of care (day-only, extended day-only, day of surgery admissions), pre-admission clinics, acute pain management, recovery room care and high dependency units.
- Rural and remote anaesthesia and perioperative care.
- Metropolitan non-tertiary referral hospital anaesthesia and perioperative care.
- Paediatric anaesthesia and perioperative care.
- Anaesthesia perioperative care outcomes.
- Indigenous and diversity health.
- Consumer priorities.
- Education.
- Information systems.

Dr Michael Amos (left), Dr Su-Jen Yap (right) and Dr Jo Sutherland (not pictured). The Executive has now met three times, including a meeting hosted by Dr Scott Finlay in Moree. This is an exciting project for our specialty as it utilises multi-disciplinary consultation and discussion to facilitate improved outcomes for our patients. It allows a clinician’s voice into the planning of anaesthetic services and should allow anaesthetic issues to be more effectively communicated to government.

It also enables communication to other health groups about the expanded roles anaesthetists are taking outside the operating room. Finally, it is a wonderful opportunity to raise the profile of anaesthesia as a specialty in a forum side by side with all other areas of medicine.
This year we conducted a survey of CME preferences, the results of which have encouraged us to pilot a series of evening CME meetings. The first of these was held in May to coincide with a regional visit by Professor Tailleux Egan, a keynote speaker at the 2010 ANZCA Annual Scientific Meeting. Held over two nights and venues (Westmead Hospital and Royal North Shore Hospital), Professor Egan and local anaesthetists Adam Rothak and Paul Sinclair delivered a series of talks and workshops on the theme in pharmacovigilance and total intravenous anaesthesia. We plan to run at least one of this style of meeting every year, probably in the Sydney CBD.

Providing access and relevant CME for regional anaesthetists has been another goal in recent years. This is beginning to pay dividends in the form of good quality education. Establishing some form of a podcasting component to CME delivery should be considered. However, podcasting is expensive and does not provide the level of interaction that anaesthetists seek.

Attracting trainees to the CME meetings is also a challenge that we have partly addressed by offering discount rates and encouraging participation as workshop facilitators. We continue to work on this.

The relationship developed with appropriately skilled to escalate care in anaesthetists within our region has already created benefits. Access to good quality education is always difficult but it seems this model of delivering training is a by-product of this process, an example of innovation by clinicians as the former Commissioner Garling attested to.

Continuing professional development within New South Wales is overseen by the NSW Anaesthesia Continuing Education Committee (NSWACE). Jointly hosted by the NSW ANZCA Regional Committee and NSW Section of the Australian Society of Anaesthetists and administered by the NSW Regional Committee secretariat, the committee comprises 12 volunteer specialist anaesthetists from a range of metropolitan and regional hospitals within NSW.

The main aim of the NSWACE is to support CME activities for anaesthetists. To this end, every year the committee convenes two one-day Winter meeting held at the Hilton Hotel in Sydney, and a weekend meeting held in a regional centre in late Spring. After some experimentation we have settled on a format that suits both represents the participants which includes, along with lectures, a large component of concurrent small group interactive workshops, either “group learning” sessions for up to 30 people or workshops providing a facilitator: participant ratio of 6:1.

We have conducted detailed post seminar appraisals for many years and this approach appears to provide the optimal mix of learning formats that is able to be delivered to large numbers of delegates. ACE also coordinates the anatomy workshop, held annually at the University of Sydney and convened by anaesthetists Joe McGuinness and Liz O’Callaghan, along with a team of long serving anaesthetists with special expertise in this area. While our seminars have always been popular with specialists anaesthetists we have witnessed an increase in attendance over the last two years, possibly coinciding with the new ANZCA CPD program.

This year’s Winter meeting held on August 14 entitled “Death under Anaesthesia – 50 years of the Special Committee Investigating Deaths Under Anaesthesia” focused on anaesthesia mortality reporting to coincide with the “golden jubilee” of the SCIDA, which undertakes peer review of all deaths occurring within 24 hours of anaesthesia or sedation. Data obtained by SCIDA has substantially contributed to mortality reporting internationally. The level of interest in this meeting (350 delegates) is a testament to the commitment anaesthetists have for patient safety.

Upcoming events include NSWACE’s summer regional meeting entitled “Future Direction in Anaesthesia – where to next?”, which is scheduled to be held in Port Macquarie on the weekend of November 20-21, 2010. Ongoing challenges we face include attracting ANZCA trainees; improving access and relevance for regional anaesthetists; and scheduling CME activities to suit the variable schedules of metropolitan anaesthetists, particularly those working in the private sector.

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Attracting trainees to the CME meetings is also a challenge that we have partly addressed by offering discount rates and encouraging participation as workshop facilitators. We continue to work on this.

The relationship developed with appropriately skilled to escalate care in anaesthetists within our region has already created benefits. Access to good quality education is always difficult but it seems this model of delivering training is a by-product of this process, an example of innovation by clinicians as the former Commissioner Garling attested to.

There are other rural objectives for the ACI network in the short-term including a rural perioperative workforce survey for NSW, developing support for a rural general anaesthetic training path and further developing the already strong association between GP anaesthetists and ANZCA. Well trained and supported GP anaesthetists can inject hard core medical skills into rural settings that can benefit whole communities.

References:
WHERE TO FROM HERE?

There is no doubt that many non-anaesthetists and health managers remain unenlightened regarding the sedation continuum, and the implications of potentially unsafe sedation practices for adverse patient outcomes. A sedation working party under the auspices of the ACI has recommended to NSW Health that PS9 be implemented as a minimum standard for safe sedation practice throughout NSW. The next step will be to examine the extent to which PS9 is currently being appropriately applied in terms of staffing, patient assessment, monitoring and governance of sedation practice. Anaesthetists view PS9 as a valuable “risk management” tool. It will therefore be necessary to collect high-quality data around sedation practices. It will be essential that any such audit be viewed as a means to support clinical practice, and improve patient safety and outcomes.

OTHER GROUPS INVOLVED IN SEDATION PRACTICE

Apart from the specialist groups who have already signed up to PS9 as a conjoint document, there are many other groups who regularly administer sedation. Such other groups include dentists, cardiologists, paediatricians and haematologists. ANZCA Council is optimistic that PS9 will be the benchmark document to provide a framework around safe sedation practice that will meet the needs of each of these groups. Discussion with these groups is ongoing.

CLINICAL EXCELLENCE COMMISSION REPORT – MIDAZOLAM

In early 2009 the CEC published a focus report on the use of midazolam in NSW public hospitals. This report analysed 915 IIMS reports, of which 377 were considered to be clinical incidents relating to the use of midazolam. The CEC made a number of recommendations, including the recommendation that hospitals should ensure that sedation is covered by an organisational policy, and that overall responsibility for sedation practice is assigned to a senior clinician (e.g., an anaesthetist). It is not known whether this recommendation has been widely implemented.

HEALTH REFORM IN NSW

• Local Health Networks (LHN) to comprise a single hospital or group of hospitals and other health services that are geographically or functionally linked and increase local decision-making.

• 17 Local Health Networks will be created across NSW.

• The LHNs are Central Coast, Sydney, Nepean Blue Mountains, Northern Sydney, South East Sydney, South West Sydney, Western Sydney, Illawarra, Central West, Far West, Hunter New England, Southern NSW, Mid North Coast, Murrumbidgee, Northern NSW, and Specialist Networks (the Sydney Children’s Hospitals Network at Randwick and Westmead) and the Forensic Mental Health Network.

• LHNs will be given decision-making authority and a range of governance and management functions. This will include emergency care, surgery, outpatients, medical services, critical care, anaesthesiology and a range of other services.

• Clinical Councils to strengthen clinician involvement will continue. Some clinicians on Clinical Councils may also seek appointment to their local Governing Council.

• Key criteria for establishing LHN boundaries include: the new networks must be built around principal referral or specialist hospitals; metropolitan networks should have coverage of a population of 500,000; networks need to be self-sufficient in a number of services of high level complexity; economies of scale to ensure administrative overheads are not excessive; maintain existing clinical service network; the networks need to cater for growth.

• The State Government will be responsible for system-wide public hospital planning, hospital-wide performance, capital planning and purchasing of hospital services. It will make and amend Service Agreements with LHNs regarding funding.


Above from left: Royal North Shore Hospital; Sydney Hospital.

ANAESTHESIA IN NSW CONTINUED

SEDITION PRACTICES IN NEW SOUTH WALES PUBLIC HOSPITALS

Prince Alfred Hospital, Sydney, in March 2010, under the auspices of GMCT (Greater Metropolitan Clinical Taskforce – now incorporated in the Agency for Clinical Innovation). Dr Tracey Tay discussed the background to PS9, and implications for practice. Dr Joanna Sutherland presented the pharmacology of commonly used sedation drugs, and a review of the evidence base covering complications and poor outcomes from sedation in radiology. Dr Greg O’Sullivan discussed the “difficult to sedate” patient. The evening was well attended, with more than 120 registrants. Some concern was expressed regarding the resource implications around full compliance with PS9. There was general agreement that PS9 addresses the concerns of this group, particularly the nursing staff who have felt unsupported regarding sedation decisions and practices in radiology suites for some time.

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WHERE TO FROM HERE?

There is no doubt that many non-anaesthetists and health managers remain unenlightened regarding the sedation continuum, and the implications of potentially unsafe sedation practices for adverse patient outcomes.
Enhancing engagement of Fellows with the College has been identified as a key strategic priority for ANZCA. Seeking the views of the Fellowship is an important element in achieving that objective. In the June edition of the ANZCA Bulletin we published the results of the ANZCA Fellowship survey conducted this year by leading research company ANOP Research Services. ANOP’s executive summary, which was reproduced in full, shed light on a number of key areas.

The survey was completed by 50 per cent of Fellows. ANOP notes that this is a strong response that allows valid conclusions to be drawn from the data. It showed that the College is performing well in a number of areas with overall levels of satisfaction by Fellows with the College at high levels. ANOP Research Services, which has more than 30 years experience conducting research for state and federal governments and many leading companies, educational institutions and membership organisations, reported that the survey results represent a strong outcome, with the College performing favourably across a number of areas when compared to comparable organisations.

While the satisfaction ratings are pleasingly high, the results indicate that there is still work to be done to improve the level and quality of services that the College provides to its Fellows. The College Council has reviewed the findings and in this issue of the ANZCA Bulletin, we outline the steps the College will take to address the issues identified in the survey.

Key findings of the survey

The Fellows’ survey found:

• A high level of satisfaction by Fellows with ANZCA overall (71 per cent satisfaction score).
• Strong usage of many of ANZCA’s services indicating the College’s relevance and value to the profession.
• A high level of satisfaction with College staff (77 per cent satisfaction score).
• Six in 10 Fellows regard the annual subscription fee as reasonable or at least acceptable.
• The College’s most important roles are seen to be quality and safety, professional standards setting, as well as education and training.
• More than half the Fellowship – 55 per cent of respondents - report undertaking pro bono roles and nearly eight in 10 – 78 per cent - are involved in teaching roles.
• Fellows see particular strengths in the College’s professional documents, the Annual Scientific Meeting, the library, publications and communications.
• Slightly lower levels of satisfaction were evident in survey responses relating to the College’s CPD program, and ANZCA’s role as the professional voice of anaesthetists.
• There is a reasonable level of satisfaction among Fellows with the ANZCA website.
• There is scope to improve the ease of access and use of ANZCA’s CPD program.
• There was relatively low understanding among Fellows of the roles and responsibilities of officer holders in the College, and low awareness of the ANZCA Foundation, particularly among new Fellows.

Key implications

ANOP has advised that there are a number of implications that arise from the survey:

• ANZCA’s core roles are quality and safety standards setting as well as education and training. Fellows are committed to high standards and quality and the maintenance of world-class standards is central to ANZCA’s standing and the profession.
• The CPD program needs further fine-tuning and streamlining. While there is a good level of satisfaction with the CPD program, it emerges as one of ANZCA’s more important services and its ranking in terms of satisfaction lags behind its importance ranking.

Next steps

ANZCA’s Fellowship Affairs Committee and the College Council have approved a number of actions that will be implemented over six to 12 months. They include:

• A comprehensive review of the navigation of Continuing Professional Development (CPD) on the ANZCA website, as part of a wider website redesign, which will be completed by early 2011.
• An improved highlight of information for the CPD program that will make the program easier for Fellows to understand.
• Expanded coverage of CPD clinical activities and opportunities in the ANZCA Bulletin and ANZCA E-newsletter.
• Continuing to increase the College’s support and training for Fellows who provide teaching to ANZCA trainees, such as the recently introduced ANZCA Teacher Course, which is designed to support supervisors of training, module supervisors and anyone involved in the clinical teaching of ANZCA trainees.

ANOP has advised that there are a number of implications that arise from the survey:

• Publications and communications need to continue to cater for a variety of delivery and content preferences. While there are no major issues with specific publications, the priority is on “important to know” information. The College also needs to cater for differing levels of computer proficiency by making publications available in print and online.
• Fellows see an important role for ANZCA in representing the profession. ANZCA’s representations to government and the jurisdictions, and its role as the voice of anaesthetists needs to be enhanced. The professional standing and public profile of anaesthetists’ roles and responsibilities needs to be strengthened.
• There is a desire for greater recognition of pro bono contributions by Fellows and for more assistance in carrying out these roles.
• There is a desire for greater speed, responsiveness and further streamlining of College administrative processes.
• Comprehensive redesign of the ANZCA website with an emphasis on enhanced functions, navigation and editorial content.

• The development of special new multimedia “mini” sites for Quality and Safety, Continuing Professional Development, Special Interest Groups and the Faculty of Pain Medicine with improved navigation and content.

• Redesign and improvements to ANZCA’s New Zealand publications with the appointment in July 2010 of a communications specialist in the New Zealand office.

• Greater focus on government programs and associated funding opportunities, a stronger public advocacy role and improved communication of ANZCA government submissions and representations.

• Clarification and improved communication to Fellows regarding ANZCA’s annual subscription fee.

• Improved information setting out more clearly the rules of Council and committees, and outlining how Fellows can participate and engage more fully in College affairs.

• Improved communication for new Fellows about the role and purpose of the Anaesthesia and Pain Medicine Foundation (formerly the ANZCA Foundation) and its fundraising activities.

• Further streamlining of College processes such as the new online in-training assessment process (ITA) and online registration.

The Fellowship survey, which will be repeated on a three-yearly cycle, will serve as an important base by which to measure progress and continuously improve all that we do to meet Fellows’ needs. The points above represent some key actions the College will be taking over the short to medium term to address the issues Fellows identified. Updates will be included in future College publications.

The College appreciates the contribution made by the Fellowship in participating in the survey, and is committed to taking the action indicated above to address the issues identified. Feedback about the survey, the results and the steps being taken to address issues identified in the survey is very welcome and can be directed to the Chair of the Fellowship Affairs Committee, Dr Michelle Mulligan, at communication@anzca.edu.au; or by writing to the Director of Communications, Nigel Henham, at nhenham@anzca.edu.au.

Annual Subscription Fee

The ANZCA Annual Subscription Fee is $400, which includes Conference fees, New Zealand publications, Professional indemnity insurance and all College publications. Fellows who are members of the Council or committee pay $315.

Fellows on leave on Long Service Leave (LSL) are charged the same as non-members.

Fellows returning from LSL are only required to pay $100 extra to catch up with the Annual Subscription Fee.

Fellows on leave on Maternity Leave (ML) are exempt from paying the Annual Subscription Fee.

Primary Refresher Course 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 first part of 2011. The first week will cover mainly Physiology topics and the second week Pharmacology topics. Applications close on Friday, October 1, 2010 (if not filled prior)

Date: Monday, October 18 – Friday, October 22, 2010 (Physiology)
Monday, October 25 – Friday, October 29, 2010 (Pharmacology)
Venue: Large Conference Room, Kerry Packer Education Centre
Royal Prince Alfred Hospital
Missenden Road, Camperdown, NSW 2050
Fee: $880 (including GST) (2 weeks)
$440 (including GST) (1 week)
In addition, a comprehensive set of supplementary notes, lectures notes and CD will be given to each participant at the commencement of the course.

For information contact:
Tina Papadopoulos
ANZCA New South Wales Regional Committee
117 Alexander Street, Crows Nest NSW 2065
Phone: (02) 9966 9085
Fax: (02) 9966 9087

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Overseas, Physician Assistants are seen to be operating at a mid-level and are able to fill a distinct, complementary role within the multidisciplinary health team. One of the reasons for undertaking a pilot in New Zealand is to see how a Physician Assistant role might relate to, and fit with, existing health care roles like doctors and nurses.

They see the career of PAs as appealing to people who obtain undergraduate degrees in the biomedical and health sciences and to those who complete undergraduate year one but are not accepted for medicine.

ANZCA’s response was expressed, the training and clinical experience for our medical students, junior doctors and their teachers – our senior doctors, if some of their current scope is removed”. Consequently, the pilot needed to be evaluated rigorously, the CMC said. Patient safety should also be considered in evaluation. This evaluation should be subject to peer review and involve comment from all Colleges,” CMC said.

To improving New Zealand’s ability to train, recruit and retain the health workforce.

On September 6, two physician assistants recruited from the United States commenced work in the Department of General Surgery at Middlemore Hospital in South Auckland, which comes under the ambit of the Counties Manukau District Health Board (CMDHB).

The CMC said the pilot was the first step of a wider regional pilot of the PA role. Once it is up and running, consideration will be given to pilots in other DHBs and other specialties in the Northern Region.

The overall project is a joint initiative between Health Workforce New Zealand (HWNZ), which has provided the funding, the four DHBs and the University of Auckland’s Faculty of Medical and Health Sciences.

HWNZ is responsible for leading and coordinating the planning and development of New Zealand’s health and disability workforce to meet future health needs and housed within the Ministry of Health, it reports directly to the Minister of Health, advising on health workforce developments, and, as the provider of funding for clinical training, it wields considerable power. Its aim is to provide a single, coordinated response to improving New Zealand’s ability to train, recruit and retain the health workforce.

The Chair of its Board and former head of the School of Medicine at Auckland University, Professor Des Gorman, has had several discussions with ANZCA this year, both directly and in the College’s capacity as a constituent of the Council of Medical Colleges of New Zealand (CMC). His comments have made it clear that HWNZ is looking keenly at alternative staffing options for meeting an expected massive increase in demand for health services coupled with health workforce shortages.

At the July meeting of ANZCA’s New Zealand National Committee (NZNC) Professor Gorman said that with health workforce demand expected to double in 10 years, retaining the status quo for models of service and care was not an option. Current spending on health was tracking more than three to four times faster than GDP and was not sustainable.

**Government objectives**

New Zealand’s Minister of Health, Tony Ryall, sees the PA role as having the potential to relieve house surgeons of some of the tasks that do not require a medical degree (see ANZCA Bulletin, March 2010, interview with then ANZCA President Dr Uma Wilson).

Briefing documents in relation to the pilot that was announced last December indicate that HWNZ had been liaising with the DHBs in relation to pilots of different models of care and/or different scopes of practice for health workers.

Accordingly, there is an urgent need to look at new types of health workers and new configurations of the health workforce for elective surgery.

Overseas experience suggests that Physician Assistants may be one of the potential new scopes of practice that have the potential to address some of these unmet health issues in the USA. They point to a study that showed that Physician Assistants in general surgery and surgery subspecialties.

In relation to the question: if the pilot was successful, would Physician Assistants replace doctors and nurses? The FAQ material supplied as part of the background information on the pilot states: “It is becoming clear that current and projected health workforce shortages cannot be addressed simply by training more doctors and nurses.

Overseas, Physician Assistants are seen to be operating at a mid-level and are able to fill a distinct, complementary role within the multidisciplinary health team. One of the reasons for undertaking a pilot in New Zealand is to see how a Physician Assistant role might relate to, and fit with, existing health care roles like doctors and nurses.

They see the career of PAs as appealing to people who obtain undergraduate degrees in the biomedical and health sciences and to those who complete undergraduate year one but are not accepted for medicine.

**The pilot**

The New Zealand pilot involves having two USA-trained PAs work at CMDHB for 12 months in a mid-level role under the delegated authority and supervision of a Senior Medical Officer (SMO) and within the SMO’s scope of practice.

The CMDHB are working according to a locally developed scope of practice. Each PA’s role is defined further in an individualised practical plan agreed with their supervising surgeons and a Clinical Governance Committee has been established to monitor the pilot.

According to the New Zealand Government’s plan to establish 20 more operating theatres for elective surgery, for which a significant number of extra staff would be required.

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ANZCA’s response was expressed, that additional pressure on our medical students, junior doctors and their teachers – our senior doctors, if some of their current scope is removed”. Consequently, the pilot needed to be evaluated rigorously, the CMC said.

“The evaluation should incorporate an analysis of the impact on medical student training, experience and supervision. Patient safety should also be considered in evaluation. This evaluation should be subject to peer review and involve comment from all Colleges,” CMC said.

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**Workforce: Physician Assistants – way of the future? continued**

The meeting will involve clinicians, health administrators, educators and representatives from bodies such as the Australian Health Professionals Regulatory Authority (AHPRA), Health Workforce Australia, the Australian Medical Council and various medical colleges. ANZCA and the Australian Society of Anaesthetists will be represented.

"It is a pretty broad nationally representative group," he says. "The aim is to get a good understanding of some of the opportunities and challenges of that sort of model."

Last year, ANZCA’s then President Dr Leona Wilson noted (in a letter responding to a call for input into Victoria’s Workforce Redesign project) that the profession does not technically exist yet in Australia and that the role of attending physicians, residents, and PAs, they can reduce overall salary costs for inpatient staffing while preserving adequate levels of medical care." However, they also note that PAs work far fewer hours than resident doctors.

Asked where graduates expected to find employment, the university referred to the Queensland PA trial and said: "Once the trial/report is complete, we will have a better idea of where PAs are going to fit in the health system. So far, the trial results are very favourable but we need to wait until the final results are published before we can say with certainty that PAs will be able to work in Queensland."

The spokesperson went on to say that although it was early days for the PA profession in Australia, with details still to be clarified, "we are confident that the PA profession will grow, but it will take time."

James Cook University in Townsville is also developing a three-year (two years instructional, one year clinical) PA course, due to commence in February 2012. The University of Queensland offers a Graduate Certificate in Physician Assistant Studies (one year, part time) and a Master of Physician Assistant Studies (1.5 years, full time), for which the certificate course is a prerequisite. (For details of these courses, see www.uq.edu.au/study/studyarea.html#area-phys. The first cohort of 17 students is due to graduate in July next year with a second cohort of 9 students also taking the course.

Although initially employed in general family practice, in the 1990s their work expanded into the hospital arena, where PAs have assumed tasks commonly performed by resident physicians because of their skills in clinical assessment, diagnostic acumen, medical and pharmacologic management, and procedural skills, Physicians Assistants says. Whereas in 1984, nearly 56 per cent of PAs worked in primary care, now over 57 per cent work in non-primary care.

The authors of Physicians Assistants also note "It is no coincidence that the period of rapid growth of employment of PAs, beginning in the early 1980s, closely parallels the time when hospitals were coming under increasing pressure to contain costs."

The PA house officer salary is approximately twice that of intern and resident doctors, the authors say it is far below that of a fully licensed physician. Physicians Assistants states: "Hospitals have found that by adjusting the mix of attending physicians, residents, and PAs, they can reduce overall salary costs for inpatient staffing while preserving adequate levels of medical care." However, they also note that PAs work far fewer hours than resident doctors.

Today, the number of clinically active PAs in the US is more than 75,000 and PA graduates number more than one-quarter the number of physician graduates each year. They are able to practice in every US state. The cost of PA education is approximately one-fifth of physician education, and PAs graduate in 26 months compared with nine years of education and training for doctors, the book’s foreword says.

The New Zealand pilot does not directly involve anaesthesia practice, but ANZCA NZ is watching with interest because of the potential for it to lead to the introduction of the PA role generally. As mentioned above, the NZNC is open to innovative ways of addressing workforce shortages and to new models of delivering health services. However, it stresses the need to evaluate very carefully what those needs might be, how they should be addressed and, most particularly, any potential impact on the current workforce, especially the training of junior doctors.

Following her visit to see the pilot program at the Royal Adelaide Hospital in action last year (a visit made in her capacity as Director of Anaesthesia for the Auckland District Health Board), NZNC Chair, Dr Vanessa Beavis, recommended that the concept of introducing PA roles to New Zealand should be advanced or at the very least supported.

"It seems that the perioperative and post-surgical settings would be an ideal place to employ PAs. The post-operative care of patients is an area which ANZCA has identified as an area of our interest and for expansion of anaesthesia’s role in some formalised way," Dr Beavis said.

"Clearly, not every task needs the expertise and skills of a ‘FANZCA’, so a PA would be the ideal enhancement to the perioperative ‘care team’,

Dr Beavis said much consultation would be required, with a process allowing education and dispensing of the abundant mythology that surrounds the role.

“The mantra that it is cheap and efficient is patently untrue but is becoming part of the mythology and has been repeated so many times, no one is questioning it any more. Further, there needs to be careful consideration as to the effect general establishment of such a role could have on the training opportunities for junior doctors.”

Dr Vanessa Beavis, Director of Anaesthesia for the Auckland District Health Board, NZNC Chair.
Workforce: Physician Assistants – way of the future? continued

Speaking as NZNC Chair, she has said PAs could make a useful contribution to the clinical team, including as an anaesthesia assistants.

“The concept does need to be explored – to improve patient care in areas that currently have gaps.”

However, ANZCA NZ’s chief concern was standards of patient safety and maintenance of a high quality of practice, Dr Beavis says.

She also noted “the mantra that it is cheap and efficient is patently untrue but is becoming part of the mythology and has been repeated so many times, no one is questioning it any more.

“Further, there needs to be careful consideration as to the effect general establishment of such a role could have on the training opportunities for junior doctors.”

Dr Leona Wilson says the key issue for anaesthetists is the standard of care.

“The anaesthesia team has to be led by a fully qualified anaesthetist but, having said that, we are open to innovation in the team, as long as the standard of care is at least maintained and preferably improved.

“It is also very important that any innovation is properly described and evaluated before it becomes gospel,” she says.

Responding to a HWNI request that the NZ Society of Anaesthetists consider how PAs could be used in anaesthesia, a joint NZSA/ANZCA Workforce Committee has been established. Its Co-Chair Dr Andrew Reid, FANZCA, speaking in a personal capacity for the purposes of this article, says the questions that need to be addressed are:

• What are the problems we are trying to solve?
• What solutions are best for the problems identified?
• What tasks do New Zealand anaesthetists consider could be delegated?

Dr Reid considers there are potential risks associated with introducing allied health professionals such as PAs into the anaesthetist’s realm and says that any such move must be made very carefully so as not to create resistance among the existing workforce.

He also has reservations as to how much PAs could alleviate the workforce shortages in health, considering that they, like other medical specialists, will ultimately be attracted away by much higher remuneration overseas.

He says there is an urgent need to debate the topic of healthcare workforce composition and sustainability in New Zealand – citing the factors of the loss of personnel in Australia, the ageing population/reducing workforce demographics and the New Zealand Government’s aim of getting more output from the workforce with a particular focus on elective surgery.

HWNI has discussed these staffing issues with various clinical groups, including anaesthesia, and has suggested that PAs might be a solution.

Dr Reid says the NZSA/ANZCA joint working group is understandably cautious on the matter as this would represent a significant departure from current practice.

He believes widespread consultation with the anaesthesia community and debate is needed now to establish the best way forward.

“The joint working group is hoping to commence a national roadshow on this matter shortly with a view to getting an interim report on the matter written by Christmas. It is hoped that engagement with the workforce will give the matter energy and the attention that it needs to solve the challenging problem in front of us.”

Referring to the pilot at Middlemore, Dr Reid says: “We will watch with interest as to any insights that can be gained.”

This article was researched and written by ANZCA New Zealand Communications Manager, Susan Ewart, who interviewed a number of clinicians and government personnel.

References

ANZCA research notices

Research awards for 2013

Applications are invited from Departments of Anaesthesiology and Pain Medicine Centres, Fellows, and registered trainees of ANZCA and/or the Faculty of Pain Medicine for research awards for projects related to anaesthesia, resuscitation, peri-operative medicine or pain medicine. In general, the work must be carried out in Australia, New Zealand, Hong Kong, Malaysia or Singapore, however, ANZCA Fellows or Trainees who are temporarily working in other countries for research experience may also be considered.

Support is provided for proposals encompassing broad areas of research; details of initial area(s) of investigation need to be outlined.

The ANZCA Research Policy, which provides full details on the ANZCA Grant Program, is available on the College website and should be considered in detail by all applicants.

Two types of research awards are offered:

1. Research Project Grants

Awarded to support the salary of a research assistant and/or to assist in the purchase of research equipment. Projects that will be considered may be in the field of basic scientific research, clinical investigation or epidemiological research. Grants are usually awarded for one year; however, consideration will be given to the provision of 2 or 3 year Grants for applications under special conditions.

2. Research Fellowships/Scholarships

Awarded to Fellows or registered Trainees for salaries to support full-time or part-time research in a recognised university or medical research institute in Australia, New Zealand, Hong Kong, Malaysia or Singapore. Scholarships are available to individuals enrolled in either the Master of Science degree or a related discipline at a university in Australia, New Zealand, Hong Kong, Malaysia or Singapore. They are available for up to three years, subject to category of award made and subject to satisfactory reports.

Applications are also encouraged to apply for NHMRC, NZ HRC or equivalent funding. Any applicant gaining such funding will be considered by ANZCA for “top up” funding.

The stipend and allowances are similar to those provided by the NHMRC. The basic stipend is approximately $40,000 inclusive of allowances.

Applications will only be accepted on the prescribed forms. The ANZCA Research Policy, which provides detailed information on the criteria for applications, is available from the College website www.anzca.edu.au on 1 December 2010.

Simulation/education grant

Applications are invited from Fellows and registered Trainees for the Simulation/ Education Grants for 2012. Projects that will be considered may be in the field of medical simulation and education of relevance to anaesthesia, intensive care or pain medicine.

An Application Guide and Form will be available from the College website (www.anzca.edu.au) from 1 December 2010.

Academic enhancement grant

ANZCA provides enhancement grants, which aim to foster the advancement of the academic disciplines of Anaesthesia, Intensive Care Medicine and/or Pain Medicine.

Support is provided for proposals encompassing broad areas of research; details of initial area(s) of investigation need to be outlined.

Thus the grant aims to enhance foci of research activity.

Applicants must have University status at level of Professor/ Clinical Professor or Associate Professor/ Clinical Associate Professor but do not have to have administrative responsibility for a clinical department.

Research foci eligible for support include: a new Chair; an existing Chair with new incumbent; an existing Chair pursuing a new research direction; a second Chair in an existing department; a Professor/Associate Professor or Clinical Professor/Associate Professor who heads a research group. Reapplication by a previously successful applicant within 5 years will receive a lower priority unless exceptional circumstances exist for the reapplication.

Applications must be made on the application form for Academic Enhancement Grant.

ANZCA Research Policy, which provides full details on the ANZCA Grant Program, is available on the College website (www.anzca.edu.au) from 1 December 2010.

Novice research grant applicants

This is a major goal of the College and it is our duty to encourage and foster novice investigators. Writing research applications can be a daunting task for the uninitiated. The ANZCA Research Committee therefore invites novice investigators to apply for mentoring during the application process.

Novice investigators may apply by email for mentoring. Once the application for mentoring is approved, the College must receive a complete grant application from the novice investigator for the chosen grant opportunity. A Mentor must then be appointed by the Research Committee. This mentor will assist the applicant in providing a strong application. The applicant must then resubmit their application to the College by the closing date. Without the application being complete the application will not be accepted. All mentoring provided to the applicant will be confidential and not available to the Research Committee.

For the purposes of this process, a novice is an investigator who: 1) has not been awarded a peer-reviewed research grant in the past, and 2) has not published more than 5 research papers in the 3 years prior to the year of application, and 3) does not have an experienced investigator as a co-investigator or associate investigator on the proposed grant.

Applications will only be accepted on the prescribed forms. The ANZCA Research Policy, which provides full details on the criteria for applications, is available from the College website www.anzca.edu.au on 1 December 2010.

Further information contact

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with me – they keep me on my toes when they ask questions and I have to justify why we do the things we do. It keeps everyone honest.”

“That was amazing because they had never done hearts at the hospital,” Dr Griggs said. “We had a trial run a week beforehand – even to the extent of having a surgical registrar as the patient. It was lucky we did – we found we had no defibrillator paddles!”

The first procedure – a coronary artery bypass – was fairly straightforward and successful. Later on in the 1990s, echocardiography became popular as another monitoring device for cardiac anaesthesia and Dr Griggs recognised the importance of upgrading her skills in this area, travelling to Baltimore in the US to gain initial echo knowledge. Later she began studying at Melbourne University for her postgraduate diploma in perioperative and critical care echocardiography, which she completed at the end of 2006.

“There was an awareness among surgeons that it is important to have a good cardiac anaesthetic service,” Dr Griggs said. “But it wasn’t structured – the service was based on the anaesthetist who was available.”

Later in 2006, she decided to specialise in cardiac anaesthesia and worked with surgeons George Westlake and then Jim Tatoulis. “I think I like the procedural part of it. It’s technical and also it had a lot of clinical work and physiology, she said. Dr Griggs said she had been lucky to land the St George’s job soon after the hospital had appointed its first female consultant anaesthetist who married and moved to the USA a month later. “See, you can’t trust females,” she said.

Dr Griggs had several strong female mentors in the early years at the Royal Melbourne including Dr Patricia Mackay (who eventually became the head of anaesthesia at the Royal Melbourne) and Dr Nancye Edwards.

“When I had my child, Dr Mackay was very supportive and insist I return,” Dr Griggs said. “I was wondering when would be a good time to come back and Dr Mackay rang after six months.”

At 63, Dr Griggs said she was slowing down a little now and felt she would probably retire within the next two to three years.

“You need to do a certain number of cardiac anaesthetics otherwise you really wouldn’t maintain your expertise,” she said. “It’s like a footballer – you’re better to go out when you’re at your peak and not be asked to leave.”

Dr Griggs said she would be leaving the specialty in a healthy state. “Anaesthesia is now held in higher esteem than it has been by the community and the doctors coming through the Royal Melbourne are probably better trained than I was – so I will be leaving it a better place.”

Royal Melbourne colleague and ANZCA President, Professor Kate Leslie, said the examination had been tough. “Margaret is greatly admired by anaesthetists and surgeons in Melbourne and maintains a very high level of practice and skill,” Professor Leslie said. “She’s a great example of a senior anaesthetist still at the top of her game.”

For many years Dr Griggs has been on the Victorian Consultative Council on Anaesthetic Mortality and Morbidity which looks at all deaths due to or under anaesthesia. She sees this as playing a vital role in assisting learning processes and preventing deaths or adverse events in future.

Indeed, Dr Griggs is a good example of a woman who has forged a strong career in anaesthesia and still has a life beyond the walls of a hospital. She and Professor Judson have a 25-year-old daughter, Elizabeth (who is also a doctor planning to specialise in radiology) and she and her husband enjoyed hunting with hounds (they bought a horse back from England) for many years and are both keen skiers.

She said she had never seen herself as a role model. “But it is nice when female anaesthetists say ‘you’re one of the reasons I did it because I can see that you maintain some kind of reasonable lifestyle,” Dr Griggs said.
Satellite accreditation of Gove and Katherine hospitals
By Professor Kate Leslie, Training Accreditation Committee

Accreditation and re-accreditation of training facilities is core business for the College. Our mission is to ensure that high-quality training environments are available for ANZCA trainees and that specialists are properly supported in their clinical, teaching and administrative roles.

Recently, the Training Accreditation Committee introduced “satellite accreditation” for training sites that provide sub-specialty experience for module completion or a broader range of training opportunities (such as sub-speciality, rural or remote, or private hospitals). Trainees may be rotated to these sites on a list-by-list or other limited basis. Supervision is usually one-on-one but may be remote in special circumstances. The satellite relies on the parent hospital to fulfil many of the requirements of an approved training department (such as educational programs and formal supervision of training functions). In essence, the satellite may be considered as a distant set of anaesthesia locations of the parent hospital. Time spent at the satellite counts as part of the maximum time in clinical anaesthesia that may be spent at the parent hospital.

The Department of Health and Families of the Northern Territory Government funds five hospitals (Royal Darwin Hospital, Katherine District Hospital, Tennant Creek Hospital, Alice Springs Hospital and Gove District Hospital). In their recent routine inspection of the Royal Darwin Hospital, Professor Kate Leslie, Dr Frank Moloney and Dr Thien LeCong were invited to visit the Gove District and Katherine District Hospitals with a view to satellite accreditation.

The Gove District Hospital is located in the town of Nhulunbuy and serves the East Arnhem region. Nhulunbuy is 2,000 kilometres east of Darwin on the Gulf of Carpentaria and is accessed via commercial flights from Darwin and Cairns, charter aircraft and sea. It is inaccessible by road during the wet season (December to April). The hospital is a 32-bed acute-care facility providing medical, surgical, paediatric, respiratory and maternity services. There are 15 remote community clinics that refer patients to the hospital, which also provides a district medical officer service to the region.

The Katherine District Hospital is a 60-bed medical, surgical, paediatric and maternity facility. The hospital services the Katherine region and remote areas, covering an area of approximately 340,000 square kilometres between the Western Australian and Queensland borders. The population of the Katherine region is approximately 9,000 with an annual tourist presence of more than 500,000 visitor nights. Katherine is 330 kilometres south of Darwin and is accessible by road and air.

Both Gove District and Katherine District hospitals are staffed by procedural and non-procedural general practitioners, aided by visiting specialists from Darwin and elsewhere. Approximately 50 percent of the patients at each hospital are children. The Australian Government intervention (“Closing the Gap”) has resulted in an increase in procedures among indigenous children at both sites. Specialist anaesthesia services for these lists are provided by the Department of Anaesthesia at the Royal Darwin Hospital and occasionally by visiting groups from John James Foundation in Canberra and Westmead in Sydney.

Dr Brian Spain, Director of Anaesthesia at the Royal Darwin Hospital, says: “We saw the paediatric ENT and dental lists at the Gove District and Katherine District hospitals as a great opportunity for our trainees to complete their paediatric module and also to gain exposure to indigenous healthcare and remote medicine. The trainees will rotate to the satellites in one-week blocks and will be able to log six to eight paediatric sessions during each visit. This will add to the substantial paediatric experience they gain at the Royal Darwin Hospital. The visits also present a great opportunity to liaise with and upskill the GP anaesthetists.”

For more information about the South Australian Northern Territory Rotational Anaesthesia Training Scheme (SANTRATS) or the Royal Darwin Hospital, please contact Dr Brian Spain (brian.spain@nt.gov.au). For more information on ANZCA’s accreditation processes, please visit the accreditation pages at www.anzca.edu.au/trainees/hospital-accreditation or contact Treena Murphy on +61 3 8517 5325 or tmurphy@anzca.edu.au.
The Professional documents of ANZCA and the Faculty of Pain Medicine are an important resource for promoting the quality and safety of patient care for those undertaking anaesthesia for surgical and other procedures, and for patients with pain. They are used to define the requirements for training and for hospitals providing such training, to provide guidance to the FPM on standards of anaesthetic and pain medicine practice, to define policies, and for other purposes that the College deems appropriate. Professional Documents are also referred to by government and other bodies, particularly with regard to accreditation of healthcare facilities. Professional Documents are subject to regular review and are amended in accordance with changes in knowledge, practice and technology.

A new professional document, TDA (Equipment to Manage a Difficult Airway During Anaesthesia), has been promulgated, and is accompanied by a background paper. Revised versions of the following have also been promulgated:
- ADP1 Professional Documents
- PS1 Essential Training for Rural General Practitioners Proposing to Administer Anaesthesia
- T3 Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice
- TE1 Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia
- TE14 Policy for the In-Training Assessment (ITA) Process
- TE18 Policy for Assisting Trainees in Difficulty

Please note that TE14, TE18 and ADP1 are now accompanied by background papers. Queries or feedback regarding these or other professional documents can be directed to profdocs@anzca.edu.au. The complete range of ANZCA professional documents is available via the ANZCA website: www.anzca.edu.au/resources/professional-documents. The Faculty of Pain Medicine professional documents can be accessed via the FPM website: www.anzca.edu.au/fpm/resources/professional-documents.

There have been highs and lows in the JCCA journey. On the positive side, training and assessment of rural GPs who wish to provide anaesthesia services, supported by post-training continuing professional development, has been provided throughout Australia. This has allowed rural GPs to provide a much-needed anaesthesia service in rural and remote areas. We have accredited non-ANZCA training hospitals to engage in training (for example, Goulburn, Bega and Bathurst in New South Wales), but there are many major hospitals involved as well (for example Darwin, Cairns, Townsville, Lyell McEwin, Joondalup Health Campus and, more recently, the Northern Hospital and Barwon Health).

What are the problems then? The JCCA is a loan operation that relies on the pre-bono contributions of a widely distributed and somewhat fragmented network of trainers and supervisors, and occasionally lack of consistency in teaching and assessments may arise. The JCCA is working to improve networking and consistency and also to ensure that ANZCA and non-ANZCA training hospitals are aligned in their understanding of the goals of JCCA. ANZCA and the JCCA are working to ensure that trainees are provided with an anaesthesia service required in rural and remote Australia and to improve the collaboration with specialist standards.

I have received enquiries from many sources, around “let’s have a DA (Diploma of Anaesthesia)”… A formal DA may solve some of the assessment incoherencies of the current system, but it would introduce other questions regarding the cost to the developer of the program (college and universities) and the increased chance that a formal qualification may allow diplomats to move into urban practice rather than into much-needed roles in rural and remote areas. All these factors would need careful consideration.

The JCCA is also asked to consider the credentials of GPs who have been practising anaesthesia in their own practice and who want to do locums that include provision of anaesthesia services. JCCA approval is a jurisdictional requirement. The JCCA requires that these GPs complete a placement in a suitable hospital with a supporting letter from the mentor and success in the JCCA exam. We are often asked to recognise prior learning and do so as appropriate, but insist on workplace-based assessment and the exam.

In summary, ANZCA is proud to be involved in standard setting and training for rural GPs who wish to provide anaesthesia services, but there are many challenges. I believe that the current system delivers a suitably trained and adequately assessed workforce for rural and remote Australia. However, we need to move with the times and I am urging the RACGP and ACCRM to join with ANZCA in exploring more uniform training and assessment, and increased appreciation by city anaesthetists of the realities of medical care in the bush.

Dr Frank Moloney
Chair JCCA
ANZCA Councillor
ANZCA Rural Officer

Combined Education, Simulation, Welfare and Management SIGs present:

2010 Combined Special Interest Group Meeting
Achieving our best

Sheraton Mirage, Port Douglas, Queensland
September 24–26, 2010

The meeting will follow the successful format of previous years that includes sessions and workshops under the four Special Interest Group areas. A number of concurrent sessions will be run to allow a mix of workshops and themed presentations. In addition, breakfast sessions and free paper sessions will be included in the program.

Following the success of past meetings where speakers from areas of interest outside the field of anaesthesia presented, Sheila Heen and John Richardson, Founder and Senior Consultant at Triad, will be the main speakers in 2010. Triad are world-renowned experts in negotiation techniques and communication training.

Pre-meeting workshops will be held on September 23-24, as well as workshops within the meeting main program. Numbers in the workshops are limited and places will be allocated on a first-come, first-served basis.

The Sheraton Mirage, Port Douglas is situated on Four Mile Beach. It is an easy distance to the centre of Port Douglas and a good base for visiting the Great Barrier Reef and the Daintree Rainforest.

For program and registration details, and to access the Sheraton online booking link, visit the Combined SIG web page www.anzca.edu.au/fellows/sig/medical-education-sig

Hannah Burnell, ANZCA Continuing Professional Development
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34 ANZCA Bulletin September 2010
35 ANZCA Bulletin September 2010
Quality and safety

Profile: Adjunct Professor Martin Culwick

I am Medical Director of the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC). ANZTADC was formed in 2006 and is the joint initiative of ANZCA, the ASA and the NZSA, to capture, analyse and disseminate information relating to anaesthetic incidents. Prior to my appointment to ANZTADC in November 2007, I had served on the ANZCA “Integrated Approach to Quality and Safety” Taskforce in 2005 and had provided advice to ANZTADC relating to data collection and analysis as an invited guest at two meetings.

In order to capture the information relating to anaesthetic incidents it had been decided to use a web-based system to record the data, which would be provided to members of the Tripartite Group free of charge. During 2008, the specifications for the system were completed as well as ethics approval and also approval for data protection by the Australian and New Zealand governments. The system was built and tested during early 2009 and the first incidents recorded by one of the pilot hospitals in September 2009. Since then, a further 12 hospitals have joined the pilot scheme and 232 incidents have been recorded from 206 cases at the time this article was written. Registration with ANZTADC to use the system is now open to all hospitals in Australia and New Zealand (see accompanying article “The ANZTADC project” on page 39).

My experience in private practice and as a senior specialist at Royal Brisbane and Women’s Hospital, has been tremendously helpful in managing the ANZTADC project.

I am currently an Adjunct Professor in the discipline of Information Systems, in the Faculty of Science and Technology, at Queensland University of Technology (QUT) and I am grateful for the assistance we have had with program development from research students at QUT.

Family time is also very important. My wife, my two sons and I enjoy sailing, golf and music together.

I have very much enjoyed working with other members of ANZTADC and the Quality and Safety Committee of ANZCA. I hope that our methods will be effective in bringing demonstrable improvements in quality and safety during anaesthesia and the perioperative period.

Adjunct Professor Martin Culwick
Medical Director of the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC)

Recommended reading

Patient safety: time for a transformational change in medical education – William B. Runciman
MJA Volume 193 Number 1, July 5, 2010

The article concerns the role of junior doctors in initiating and sustaining clinical change and improvement. Runciman argues that in support of junior doctors in such a role, they will need not only an awareness of quality and safety issues, but also the tools to enable them to act as agents for change. In particular, Runciman mentions training in areas such as “graded assertiveness” and “situational awareness”.

Dr Joanna Sutherland
Director, Anaesthetic Services, Coffs-Clarence Network

Patient Blood Management Guidelines: an update

Associate Professor Larry McNicol, ANZCA representative on the Expert Working Group for the Patient Blood Management Guidelines Review.
Chairman of the Clinical Reference Group for Critical Bleeding/Massive Transfusion and Perioperative Modules (Phase 1) of the PBM Guidelines Review.

A comprehensive review and update of the 2001 Clinical Practice Guidelines for the Use of Blood Components is currently underway steered by the National Health and Medical Research Council (NHMRC), Australia New Zealand Society of Blood Transfusion (ANZSBT) and National Blood Authority (NBA).

The guidelines have a clinical management rather than blood product focus. A series of six modules of evidence-based Patient Blood Management Guidelines will be progressively developed: critical bleeding/massive transfusion, perioperative (elective surgery), intensive care, medical, obstetric and paediatric/neonatal populations. Patient blood management optimises the use of donor blood and reduces transfusion associated risk.

An Expert Working Group, which included representation from clinical colleges and societies, defined the scope of the new guidelines and constructed six generic questions, to be applied to each population. These questions included whether anaemia was an independent risk factor for adverse outcomes, the effect of transfusion of red cells and components, the thresholds at which blood components should be transfused and the use of non transfusion measures to improve haemoglobin. In addition, a number of specific questions for each population will also be addressed.

Using the formulated research protocol, systematic reviews of the relevant literature are being undertaken with the results synthesised to produce a series of evidence statements and evidence-based recommendations to guide clinical practice. In many situations where guidance is necessary, good quality evidence has been found to be lacking. In these situations, practice points, based upon consensus among the Clinical Reference Group members, are being developed.

A NHMRC Guidelines Assessment Register expert ensures the systematic review and processes comply with NHMRC standards. A comprehensive communication strategy has been developed to ensure that the clinical community is kept informed and involved in the guideline development and to facilitate dissemination and implementation.

Due to the scope and extent of the work, the development process is necessarily prolonged, having begun in mid-2007. The Critical Bleeding/Massive Transfusion module is pending final approval by the NHMRC, the draft perioperative module is shortly to be released for public consultation and the systematic literature review for the intensive care and medical modules has recently commenced.

Associate Professor Larry McNicol

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Associate Professor Larry McNicol
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In a notice letter posted by the UK Medicines and Healthcare Products Regulatory Agency (MHRA), Draeger states that blood pressure measurements taken using the above cuffs may produce artificially high readings. Blood pressure readings generated using these cuffs may be 450 per cent higher than the actual blood pressure, potentially resulting in the neonatal patient being given the wrong medication. Draeger states that it has received no reports of patient injury related to this problem.

Action needed: Verify that you have received the June 2010 Important Safety Notice letter from Draeger. Identify, isolate, and discontinue use of any affected product in your inventory. Determine the software version of affected product by checking the screen display on page 1 of the letter. Regardless of whether you have affected product, complete the confirmation form and return it to Smiths using the information on the form. Upon receipt of the form, Smiths will process an upgrade kit order automatically for any systems running obsolete software indicated on the form. The upgrade kit will contain instructions on how to upgrade the software. After performing the software update, return the completed software upgrade test form on page 3 of the instructions so that your pump service records can be updated. Alternatively, arrange to return your pumps to Smiths for the upgrade.

Draeger—Neonatal Noninvasive Blood Pressure Cuffs: May Produce Artificially High Readings

**Product identifier:** Neonatal Noninvasive Blood Pressure Cuffs

**Sizes:** 1 through 5; Part Nos.: MP00901, MP00902, MP00903, MP00904, MP00905.

**Units distributed between January 12 and June 12, 2010.**

**Manufacturer:** Draeger Medical AG & Co KG [17044], Moltzinger Allee 57-55, Postfach 1339, D-23542 Luebeck, Germany.

**Problem:** In a June 22, 2010, Urgent Medical Device Correction Notice letter submitted by an ECRI Institute member hospital, Smiths states that if the above pumps are running obsolete software, they may continue to run beyond the set volume limit if all of the following conditions occur:

- The “volume over time” delivery method is used.
- The volume over time mode is reached through the “Recall Last Settings” function.
- The syringe is overfilled (for example, the syringe is filled for > 1 infusion dose).

Overfilling the syringe can result in overdelivery of infusion, which could lead to patient injury or death depending on the administration route, fluid delivered, and patient condition. Smiths has received no reports of serious patient injury or death related to this problem.

**Action needed:** Identify and isolate any affected product in your inventory. Determine the software version of affected product by checking the screen display when powering on the pump (refer to the illustration on page 1 of the letter). Regardless of whether you have affected product, complete the confirmation form and return it to Smiths using the information on the form. Upon receipt of the form, Smiths will process an upgrade kit order automatically for any systems running obsolete software indicated on the form. The upgrade kit will contain instructions on how to upgrade the software. After performing the software update, return the completed software upgrade test form on page 3 of the instructions so that your pump service records can be updated. Alternatively, arrange to return your pumps to Smiths for the upgrade.

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**Professor John Russell**

Member of the Quality and Safety Committee’s Editorial Advisory Body

**ECRI Safety Alerts**

**Smiths—Model 3010 and Model 3010a Medfusion Syringe Infusion Pumps: May Overinfluence If Software is Obsolete**

**Product identifier:** Medfusion Syringe Infusion Pumps: (1) Model 3010, (2) Model 3010a (Capital Equipment)

**Software Versions:** 2.0.2, 2.0.3, 2.0.4.

**Manufacturer:** Smiths Medical MD Inc [410772], 1265 Grey Fox Rd, St Paul, MN 55112-6967, United States.

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**The ANZTADC project**

**The Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) is a joint endeavour and jointly funded by ANZCA, the ASA and the NZSA. This data committee has developed a system for recording anaesthetic incidents that has been in the pilot phase since September 2009. Over the past year, six hospitals in New Zealand and seven hospitals in Australia have joined the pilot phase. The chart (right) shows the way in which the pilot users of the program have coded the main categories. The three highest categories are Medication, Medical Device/Equipment and Respiratory/Airway. These three groups account for approximately 60 per cent of all of the incidents. ANZTADC is currently analysing and confirming this coding. This will involve drilling down to provide further sub categorisation and development of strategies to try to prevent similar events from happening in the future. The confirmed results will be published as a series of articles in future issues of the ANZCA Bulletin as well as the ANZTADC project.**

**ADJUNCT TO THE ANZTADC PROJECT**

Ann and Rachel are completing their post stabilization program. The role of the program is to assess the patient for signs of shock in order to provide appropriate treatment. The program is funded by the Commonwealth Government and is available to all hospitals in metropolitan areas.

**User coding by pilot sites 1/9/09 – 14/7/10**

**Analysed as a series of articles in future issues of the ANZCA Bulletin as well as the ANZTADC project. The ANZTADC program is provided at no cost to Fellows of ANZCA, members of the ASA or members of the NZSA. We wish to thank all of the pilot sites for taking part in the ANZTADC project and for the useful feedback provided regarding the pilot version of the program. We are about to undertake a review of the dataset collected and we will release pilot results in the next issue of the ANZCA Bulletin as well as the ASA and NZSA’s publications and newsletters.**

**Adjunct Professor Martin Culwick, Medical Director ANZTADC**
We arrived at Narita Airport from Australia at about 7pm. In the process of departing the plane I was overtaken by severe breathlessness and could take no more than a few steps at a time. A wheelchair was obtained, enabling me to traverse the airport, negotiate the customs and immigration formalities and board a limousine bus bound for the Tokyo railway station, near where our pre-booked hotel was located. We checked in, still needing a wheelchair. The next morning I was no better.

What was to be done? Because I was quite comfortable when sitting or lying and was unsure of a diagnosis we decided to continue on with our rail travel. As we continued to travel east, the symptoms began to ease, but the possibility of a pulmonary embolus was not abandoned. I decided to visit the Niigata University Hospital, in the city of Niigata, a provincial capital 300km north west of Tokyo. Niigata is on the Sea of Japan coastline of Honshu, the largest of the Japanese islands. The population is more than 800,000, and it serves as a major port, with commercial dependence on fishing and cultivation of rice. Niigata has few tourist attractions and western visitors are few. Little English is spoken and street and bus signs are predominantly in Japanese, all offset (for us at least) by a remarkable helpfulness of the city dwellers to bewildered foreigners.

It all happened in the Japanese city of Niigata, a provincial capital 300km north west of Tokyo. Niigata is on the Sea of Japan coastline of Honshu, the largest of the Japanese islands. The population is more than 800,000, and it serves as a major port, with commercial dependence on fishing and cultivation of rice. Niigata has few tourist attractions and western visitors are few. Little English is spoken and street and bus signs are predominantly in Japanese, all offset (for us at least) by a remarkable helpfulness of the city dwellers to bewildered foreigners.

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The emergency admission room was a large, well-equipped procedural area. It was populated with what seemed a veritable army of medical personnel (all very interested in my particular case), but the only identifiable figures to me were the emergency and intensive care unit physicians. Within minutes, intravenous and arterial lines had been inserted, and blood sent for multiple biochemical tests and blood gas analysis. The blood gas and electrolyte results were rapidly available (within 30 minutes) and displayed prominently on large wall monitors. These and the chest X-ray appearances all pointed to a pulmonary embolism. Transthoracic echocardiography was performed by one of the emergency staff and demonstrated severe pulmonary hypertension. Other imaging suggested probable venous thromboses in both lower legs. By now any hope I had of returning to my comfortable hotel bed had dissipated rapidly – on the contrary, I was informed that I would be admitted to ICU that evening and could expect to be in hospital for at least three weeks!

My arrival in the ICU was an “eye-opener”. It seemed so large yet so quiet that my first thought was that I was the only occupant. I soon learnt that this was not the case, but rather that each cubicle was partially separated and for each there was a dedicated nurse with computer at the bedside. All information collected on site was entered and stored electronically and immediately accessible. What was notable was the relative lack of noise apart from an occasional monitor, quite a contrast to the continuous forensic and noisy activity that seems to characterize ICUs elsewhere. Subsequently I found that a tranquil ambience was likewise a feature of all of the hospital wards and departments of the Niigata University Hospital. On the morning after admission to the ICU, the diagnosis of venous thromboembolism was confirmed by further echocardiography by highly trained departmental staff, and a CT technetium lung scan that demonstrated not one but three separate areas of embolism. Many investigations were performed which I could read off on my monitor, and anti-coagulant treatment was started. I had the feeling that I was in safe hands. The main downside of my stay in the ICU was the incredibly hard mattress and pillow, perhaps more bearable to Japanese than Western patients.

After three days in the intensive care unit I was transferred to a busy surgical ward and installed in a private room best described as a mini-suite, comprising two rooms, a sitting area, a mini kitchen, cupboards and bathroom. Instead of proceeding to Europe, here I was to remain, following my early rapid improvement, for two weeks before returning to Melbourne. Fortunately my attending cardiologist was English speaking, having just returned from a two-year post-doctoral stay in Manchester, UK. The other medical staff had limited English, but were always attentive and thoughtful. I was even provided with a continuous water heater so that I could have a respite from the lukewarm green tea served at every meal, and with DVDs, as there was not an English channel on the TV in my room and I had long tired of the Japanese sports channels. The nurses were very devoted and cheerful, despite an almost complete lack of English, although they did have a phrase book which was used with much enthusiasm and merriment. The safety aspects of my care were naturally of great interest to me, and once I was mobile I was able to examine details of the ward-management system as well as the overall facilities for patients and relatives. Each ward had a very large central staffed with a bank of computers that could accommodate all the nurses and doctors on duty at any one time. All ascertained data and information were entered directly by the nurses at the bedside on a Personal Digital Assistant (PDA) as they performed their routine four-hourly observations. Thus continuous cardiac monitoring, blood pressure, temperature and pulse oximetry were transmitted directly to the central computers from the bedside. Each nurse also had their own mini-pulse oximeter. Results of all blood biochemistry tests, INR and others, were entered into the computer

A leaf out of their book
A personal experience of illness in Japan by Dr Pat Mackay OAM
A leaf out of their book continued

system within 30 minutes, so that when the physician was at the bedside of the patient. I departed the appointed time, with no waiting indefinitely in corridors or holding bays, as I have personally experienced during in-patient sojourns in Melbourne public and private hospitals. The investigational procedures were performed expeditiously, with a prompt relay of all results and scans to the ward computers. Another feature was the electronic management of drugs with bar coding corresponding to the bar code on my wristband, which was reassuring as I could not recognise my own name in Japanese script. In addition, parental drugs were double checked by nursing staff. An alarm conveyed to the central ward computer indicated when the syringe pump containing anticoagulant was non-functional. While I could not deny I received the same ‘demarcation of duties’ as in Australian hospitals. Orderlies were employed for trolley transfer, always by the registered nurse. Meal trays were delivered and removed either by

The Department of Cardiology wisely insisted that en route oxygen should be available. It was required by the special transfer of cylinders from Australia to Tokyo and even the provision of a dedicated business-class seat beside me (at some cost!) to accommodate "Mr Cylinder" all the way back to Australia! In the event, transport from the Niigata Hospital to Melbourne by taxi, train and airplane was seamless thanks to the highly efficient Japanese rail system, which made a wheel chair available at every transit from the Niigata station to the Qantas Lounge at Narita airport. Qantas staff were extremely helpful, and the trip was made all the more comfortable by a less than crowded aircraft. Although it was not needed, I felt I had to use some of my expensive oxygen during the night flight in preparation for the transfer to a Melbourne flight at the usually chaotic Sydney airport. So, instead of proceeding with our carefully planned and much-anticipated European sojourn, and to the relief of our family, I arrived back in Melbourne at midday on Mother's Day. I have experienced personal care in both public and leading private hospitals in Australia, and now in Japan. I am left with the overall impression that the use of sophisticated electronic patient systems in Japan not only contributes to additional safety but improves direct contact of patients with medical and nursing staff, and provides for a pleasing degree of serenity in a busy surgical ward. I recovered, and in so doing found that we in Australia could still take a leaf or two out of their book in critical and general medical care.

Dnr Pat Mackay OAM Communication/Liaison Portfolio Manager, ANZCA (Quality and Safety Committee

I would like to acknowledge the expert clinical and technological care provided by Professor Yoshifusa Aizawa, Head of Cardiology, Dr Takeshi Kashimura, Cardiologist, and the senior nursing staff of the Niigata University Hospital. Professor Katsumi Hatakeyama, Dr Yosichi Hara and Dr Nobuyoshi Satoh of the Niigata University School of Medicine, Department of Surgery kindly interacted with the hospital on my behalf. Professor Hiroi Ishibashi assiduously facilitated my admission to the hospital and expert advice was offered by Dr Eric Heimbach and Dr David Dr Tr D 1968 UC, Davis, California. I am also most grateful to Mrs Akiko Ishibashi and Mrs Kaori Maeda, who flew from Kochi City to Niigata Hospital to Melbourne by taxi, train and airplane was seamless thanks to the highly efficient Japanese rail system, which made a wheel chair available at every transit from the Niigata station to the Qantas Lounge at Narita airport. Qantas staff were extremely helpful, and the trip was made all the more comfortable by a less than crowded aircraft. Although it was not needed, I felt I had to use some of my expensive oxygen during the night flight in preparation for the transfer to a Melbourne flight at the usually chaotic Sydney airport. So, instead of proceeding with our carefully planned and much-anticipated European sojourn, and to the relief of our family, I arrived back in Melbourne at midday on Mother's Day. I have experienced personal care in both public and leading private hospitals in Australia, and now in Japan. I am left with the overall impression that the use of sophisticated electronic patient systems in Japan not only contributes to additional safety but improves direct contact of patients with medical and nursing staff, and provides for a pleasing degree of serenity in a busy surgical ward. I recovered, and in so doing found that we in Australia could still take a leaf or two out of their book in critical and general medical care.

Dr Pat Mackay OAM

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2. Remove the antiseptic solution container and associated swabs from the sterile set up.

3. Prepare medication for epidural injection using aseptic technique. The prescriber must:

- select each medication,
- prepare the medication for administration

4. Insert the epidural catheter

5. Inject the epidural medication

6. Record administration

Drugs used for epidural anesthesia or analgesia must be handled in a manner that avoids inadvertent administration of the wrong drug (including skin preparation solutions). During the initiation of epidural anesthesia or analgesia, the same person must select each medication, prepare the medication administration, administer the medication and record its administration. Receptacles containing skin preparation solution should be removed from the sterile setup following application of the solution to the skin. Intermediate steps in drug handling, such as decanting, local anaesthetic solutions into unlabelled containers on sterile setup, should be avoided.

Position Statement, August 2010

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Australians and New Zealand anaesthetists have a long track record participating in projects that have improved the quality and safety of anaesthesia. The New South Wales Special Committee Investigating Deaths under Anaesthesia, for example, has led to major changes in practice. The Australian Incident Monitoring Study and the WHO Surgical Safety Checklist are examples.

Recently, the importance of clinical registers as tools for systematically measuring outcomes in anaesthesia has been highlighted. Clinical registers monitor and benchmark the quality and safety of routine clinical care and are critical for improving clinical practice. Actively measuring, benchmarking and reporting results can identify problems early, potentially preventing sub-standard care from developing.

The results obtained from clinical registries complement other tools of evidenced-based medicine, such as randomised controlled trials (RCTs), and importantly, clinical registers collect data from routine practice. Data is of such value that some experts have called for a registry for every medical condition. Surgical specialties have long recognised the value of registries and the Society of Thoracic Surgeons National Database and the National Surgical Quality Improvement Project are two examples of successful large clinical registries credited with reducing morbidity and mortality in the United States.

Anaesthetists can also engage in this type of quality improvement process where core data is systematically collected from every eligible patient. In 2010, serious and sentinel adverse events, such as major local anaesthetic toxicity and wrong site anaesthesia, occur infrequently following peripheral nerve blockade (PNB), however these should be reported with valid denominator data and sufficient clinical detail to help prevent their re-occurrence. However, it is not just the existence of adverse events that demand a registry of care, but the variability in outcomes including clinical effectiveness that provide the opportunity to improve the quality of care and reduce costs.

Ultrasound (US)-guided anaesthesia is a relatively new clinical technique that allows anaesthetists to image the needle trajectory, target nerves and surrounding structures; injection of local anaesthetic while adjusting real-time to improve the spread of the injection. In expert hands, US-guided PNB significantly improves outcomes compared to traditional techniques. US-guided PNB has resulted in new clinical techniques being described and performed by an ever-expanding number of enthusiastic novices.

More recently, the US focus has turned back towards the neuroaxial and paravertebral regions and it appears what we can image with US is being tested to the absolute limit. The diversity of US-guided regional anaesthesia is now substantial, its complexity increasing and although ideal, it is not feasible to perform RCTs to investigate the efficacy (let alone the effectiveness) of every technique and its permutations. US-guided regional anaesthesia is evolving at a rapid pace driven by advances in technology and equipment. For example, 4D US-guided PNB and virtual reality imaging for US-guided facet joint injections exist. Documenting the incidence of infrequent but serious complications, changes in practice and clinical effectiveness are important for any invasive procedure but especially one that is evolving.

The Australasian Regional Anaesthesia Collaboration has established the foundation for a large clinical registry by designing and implementing a web-based database and performing a prospective audit of over 7000 PNBs. AURORA is its offspring and is a prospective, outcome-based observational (cohort) study with the primary purpose of performing the quality and safety of clinical practice. AURORA has documented trends in regional anaesthesia practice—a reduced proportion of PNB performed using nerve stimulation alone from 24 per cent in 2007 to 12 per cent in 2010, and an increase in PNB performed with ultrasound (34 to 53 per cent) during 2007-10 (Figure 1). Figure 2 shows a steady increase in PNB recorded with the total number recorded in 2007 equal to the number recorded in the first half of 2010, while the proportion of lower limb PNB steadily increases. The target study population for AURORA comprises all patients receiving PNB for regional anaesthesia performed by all anaesthetists in each site. AURORA has distinctive features including: 1. Data elements that are clearly defined and collected into an online database close to the point of care facilitating ease and accuracy of data entry. 2. Data collected from individual patients so that risk-adjusted outcomes can be generated; 3. Rigorous postoperative follow-up of all patients using robust neuroaxial follow-up and investigative pathways; 4. Preservation of patient, anaesthetist and hospital anaesthetic practice; 5. An "opt out" consent process that facilitates complete (or near-complete) inclusion of all eligible patients; 6. Processes for data quality-control and project governance and 7. Training of data collectors. As a comprehensive contemporary register of procedures and outcomes AURORA is of value for clinical decision making and development of practice guidelines.

All anaesthetic groups and practices that perform PNB (regardless of technology used to locate nerves) are invited to contribute to AURORA and continue our local data collection. Contributing groups can request electronic copies of individual patient data, if required. AURORA is generously supported by an ANZCA research grant for three years commencing 2010, therefore now is the time to collaborate. Our research team consists of David Scott, Danny Liu, Michael Barrington, Rowan Thomas, Roman Kluger, Steve Watts, Michael Fredrickson, Darcy Price, Steven Fowler, Martin Culwick and Valerie Tay. The team has significant expertise in clinical research, large outcome studies, biostatistics, data management, epidemiology, information technology and neurology. AURORA provides administrative and clinical support (for example, investigation of a suspected nerve injury), reports, training of data collectors and offers assistance to collaborators. Please consider engaging with AURORA in 2010 for further information e-mail: michael.barrington@svhm.org.au.

Figure 1

- Figure 2

References

A life in patient safety: A conversation with Professor Jeff Cooper

PART TWO

Professor Jeffrey B. Cooper, PhD, is the Executive Director of the Center for Medical Simulation in Boston, Professor of Anesthesia at Harvard Medical School and co-founder of the Anesthesia Patient Safety Foundation. Professor Cooper has dedicated his career to improving patient safety and is the author of several seminal works on anaesthesia safety, his early work catalysing the formation of the Anesthesia Patient Safety Foundation and leading to the development of safety standards for anaesthesia. This is part two of an interview with Professor Cooper by Dr Cate McIntosh, Director of Simulation at the Hunter New England Skills and Simulation Centre, and Consultant Anaesthetist in the Department of Anaesthesia, Intensive Care and Pain Medicine at John Hunter Hospital in Newcastle. Part one appeared in the June edition of the ANZCA Bulletin. In part two, Professor Cooper talks about optimism and the achievements in patient safety made to date, and outlines his thoughts on what needs to be done to improve patient safety.

What has it been like being a non-physician in a world of clinicians? My relationships with physicians have run the full gamut over the years but most of it certainly has been positive. We had great cooperation from the many people who participated in the critical incident studies in the 1970s. My department Chair, Dick Kitz, was incredibly supportive. He deeply appreciated the value of multidisciplinary collaboration and assembled a department of researchers from varied backgrounds in pursuit of the many fundamental issues he sought to explore in anaesthesia. He was visionary and a model of a great leader: Supportive, loyal, appreciative, able to delegate, would back you up when times got tough. He and I are still close; he’s been one of the critical forces in shaping my life. And there were many others who gave me wise counsel and collaboration.

Yet there were a few who didn’t make it easy. Some of the anaesthesiologists resented what they saw as an intrusion of someone who wasn’t a physician. They saw me as affecting their lives, of calling for changes in their practices that I didn’t have a right to do. Yet I always felt that I was merely facilitating what the leaders or majority wanted. I felt it was simply a matter of taking questions of them and letting them decide what they felt best to do.

A few got nasty about it. Despite feeling hurt by some of what felt like attacks, I learned not to ignore them. I wanted to win them over I suppose, something of a challenge, a competition with myself of sorts. And I respected those who were critical. They were generally smart and some of the best clinicians. So I listened to what they were telling me and, although they might never have realised it, I adapted my understanding and positions based on what they were telling me. I tried not to see them as enemies, which they weren’t (perhaps there were some exceptions), but primarily as teachers. I suppose because I never saw myself as especially brilliant, I’ve always been open to learning from just about anybody when times got tough. He and I are still close; he’s been one of the critical forces in shaping my life. And there were many others who gave me wise counsel and collaboration.

The most obvious answer to this question is that anaesthesia is not itself therapeutic. Thus causing harm in the process of care can’t be rationalised as easily as in specialties for which curing the disease is the main objective. And, from the time of the first report of an anaesthetic death, it was more obvious that the anaesthetic was the cause (although there are many instances where the anaesthetist is unfairly blamed). Thus anaesthetists had more reason to pay great attention to, and take responsibility for, being the cause of direct harm directly from what they do and were more receptive to doing things to prevent harm. I have no way of testing that theory but it seems to make some sense.

I do think there also was a certain amount of good fortune that led to anaesthesia taking a lead in the modern era of safety. I ascribe that to leadership of Jeep Pierce. As President of the American Society of Anaesthesiologists, he took the risk of stressing safety as the approach to reducing escalating malpractice costs versus the more popular approach of seeking changes to the legal system. Why do you think incidents stay with, and shape, some people but not everyone? We’ve all had critical incidents but not everyone stays as focused on achieving change, why do you think that is? There are two questions embedded here. I think that most clinicians learn a lot from their mistakes. Those mistakes probably shape their practice strongly. The ones who don’t learn from those events probably find ways to blame someone else. Perhaps that’s a protective defence mechanism, but those are the people I worry about. They don’t learn and will repeat the behaviours that created the problems. I certainly have observed such clinicians. They are not the best clinicians and are likely to be the more problematic ones. Fortunately, they are the exception, not the rule.

As for why I pursued the path I did, I’m not really sure. There is no story of how I personally hurt someone or that a family member was injured by an adverse outcome. Those kinds of events often catalyse people to take on a cause. For me, it was more about following a path of curiosity and feeling that I could make a difference somewhere. And, I think I liked the idea of being a bit different, of doing something that others hadn’t done. You might call it a neurosis more than anything else. But, overall, it has seemed to work out for me and others.

What is the one most important thing you’ve done (or been involved in) that changed clinical practice to improve patient safety? I can’t point to any one thing I’ve done that is “the” important contribution. The initial work in identifying errors in anaesthesia was probably catalytic in some ways, particularly in getting people to see errors in a different light, that is not to put so much blame on individuals, but also to recognise the need for strategies versus exhortation to do better, as the solution. I have wondered if this wouldn’t have happened anyway. We can’t do that experiment. But, I suspect that by illuminating the issue in this way may have at least catalysed formation of the Anesthesia Patient Safety Foundation (www.apsf.org), which I am most proud of. For 25 years now, the APSF has maintained a single-minded devotion to preventing harm from anaesthesia. I think it’s made a difference but I can’t quantify it. The organisation itself is remarkable in that the culture of its executive committee, which does almost all of the direct work of the foundation despite having turned over completely from the start (except for me), continues to be an exceptionally dedicated team that works well together, exceptionally well. We argue, but almost always reach consensus. And, we have fun together. It’s just a great team.

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What is the one most important thing you’ve done (or been involved in) that changed clinical practice to improve patient safety? I can’t point to any one thing I’ve done that is “the” important contribution. The initial work in identifying errors in anaesthesia was probably catalytic in some ways, particularly in getting people to see errors in a different light, that is not to put so much blame on individuals, but also to recognise the need for strategies versus exhortation to do better, as the solution. I have wondered if this wouldn’t have happened anyway. We can’t do that experiment. But, I suspect that by illuminating the issue in this way may have at least catalysed formation of the Anesthesia Patient Safety Foundation (www.apsf.org), which I am most proud of. For 25 years now, the APSF has maintained a single-minded devotion to preventing harm from anaesthesia. I think it’s made a difference but I can’t quantify it. The organisation itself is remarkable in that the culture of its executive committee, which does almost all of the direct work of the foundation despite having turned over completely from the start (except for me), continues to be an exceptionally dedicated team that works well together, exceptionally well. We argue, but almost always reach consensus. And, we have fun together. It’s just a great team.

What is the thing you are most proud of? As for why I pursued the path I did, I’m not really sure. There is no story of how I personally hurt someone or that a family member was injured by an adverse outcome. Those kinds of events often catalyse people to take on a cause. For me, it was more about following a path of curiosity and feeling that I could make a difference somewhere. And, I think I liked the idea of being a bit different, of doing something that others hadn’t done. You might call it a neurosis more than anything else. But, overall, it has seemed to work out for me and others.
what they do. The Emergency Care Research Institute (now ECRI Institute) began addressing equipment safety issues in the mid-1970s. I'd like to say that the movement started with the founding of the APSF in 1985, but I think to be fair, the Emergency Care Research Institute started in the 1970s. Perhaps the most positive outlook on life. I see almost every problem now as an opportunity. I got that frame from Dick Kitz. I can recall many times setting up a meeting with him to tell him about some problem that he needed to get involved with to make things right. He is the consummate optimist. He would say, “there are no problems, just opportunities”. It used to drive me nuts. I finally came to understand that he was right. It took a long time, but now I can almost instantly begin to see opportunity in just about anything that doesn’t seem to be going the way I hoped or expected. It’s a wonderful way to approach life.

As for dealing with people who don’t seem to see things the way I do, I can’t care as much as I do about what I think is important, that just doesn’t bother me like it used to. There are so many important things in the world. We each decide what’s important to us and that’s what we take on, I can get some people to care enough to make a cause out of those things. I feel great satisfaction for mandatory reporting, and formation of organizations such as the APSF to take to safety. I think patient safety is now entrenched in healthcare organizations and education programs. I just can’t believe how many people have come to care about safety, about education, about the development of faculty. I think this is one of the best things I’ve ever done. I've learned a bit from the work of Antonio Damasio and more lately, Dan Segal.

I certainly didn't start out as an optimist and I don't see myself quite that way. I actually spent most of my life as a pessimist, worrying a lot about all that could go wrong. I could go on, but I know that many good things have happened already and we're on a good path.

How do you keep your ‘fire’ burning? Are you an optimist...and if so, how do you stay optimistic in the face of people trying to stymie progress through apathy or ignorance? I certainly didn't start out as an optimist and don't see myself quite that way. I actually spent most of my life as a pessimist, worrying a lot about all that could go wrong. I could go on, but I know that many good things have happened already and we're on a good path. We know that no matter what we do there are still risks and that we don't know quite how close we are to the limits of safety until something goes wrong. I still have a frame of thinking about how things can go wrong and try to plan or at least think about how I would act if the worst happens. Paraphrasing James Reason, “the price of safety is chronic unease”. Yet I have learned to have a fairly positive outlook on life. I see almost every problem now as an opportunity. I got that frame from Dick Kitz. I can recall many times setting up a meeting with him to tell him about some problem that he needed to get involved with to make things right. He is the consummate optimist. He would say, “there are no problems, just opportunities”. It used to drive me nuts. I finally came to understand that he was right. It took a long time, but now I can almost instantly begin to see opportunity in just about anything that doesn’t seem to be going the way I hoped or expected. It’s a wonderful way to approach life.

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Continuing Professional Development

The CPD program awaiting qualified privilege

Australia
The Maintenance of Professional Standards (MOPS) program, which predated the College's current Continuing Professional Development (CPD) program, enjoyed qualified privilege in Australia. As such, information recorded by participants was protected by an Act of Parliament from being used as evidence in a court of law. The College has been unable to secure confirmation that the current CPD program is also protected by qualified privilege.

The CPD program (as did MOPS) includes activities which benefit from candid assessment of one's own practice, and the practice of colleagues. Such activities include clinical audits, reflection notes on one's experiences, and practice peer review. Self-evaluation at the commencement and completion of each triennium allow for identification of areas requiring self-improvement, and self-analysis of whether or not learning goals have been achieved.

Given that the CPD program has not been granted qualified privilege, Australian Fellows should be aware that while the likelihood is extremely low, information recorded in the online CPD portfolio could, in theory, be used as evidence in court.

The College is continuing to negotiate with the relevant government authority for qualified privilege to be applied to the CPD program in Australia.

New Zealand
The ANZCA CPD program continues to be a Protected Quality Assurance Activity in New Zealand under the Health Practitioners Competence Assurance Act 2003.

Convenient ways to collect CPD credits

The first CPD program triennium will conclude at the end of 2010. For those of us who have not yet achieved the minimum credits required, it’s not too late.

The CPD program has been divided into four categories. A total of 10 credits are required from each of Categories 1-3 and a total of 90 credits must be achieved for each year on average. There is no minimum requirement for Category 4 (Education and Research). Articles will appear in the ANZCA Bulletin over the coming months directing Fellows to convenient places to collect CPD credits. While the motivation of this series is to assist rural doctors who may find it difficult to collect CPD credits, the resources covered are available to all Fellows of the College. All that is required to access the resources discussed in this first article will be a connection to the internet, a computer with a speaker and a logon to the College website. Having a camera on your computer will add to the number of resources available to Fellows, so keep this in mind when updating your hardware.

The aim of this first article is to direct Fellows to the current resources available to collect CPD credits from Category 1. As a reminder, Category 1 activities are defined below:

1 credit per hour: No maximum cap
Activities may include:
• Lectures
• Meetings
• Conferences (regional, national, overseas)
• Videoconferences

Documentation: In portfolio as per guidelines in Toolkit on the CPD Portfolio. Confirmation of participation.

Category 1 Level 2 – Interactive Activities: These are educational group meetings that have an objective and which emphasis audience participation and exchange of information, usually among a small number of participants. Topics may cover any of the attributes of a specialist anaesthetist.

2 credits per hour: No maximum cap
Activities may include:
• Small group discussions
• Seminars
• Workshops with no practical skills learning

Documentation: In portfolio as per guidelines in Toolkit on the CPD Portfolio. Confirmation of participation.

As of 2010, the College has begun audio taping and video taping keynote speakers from the ANZCA Annual Scientific Meeting. While currently these recordings are housed on the College’s server,冻存于an archive accessible through the College website. From the College’s home page, under the heading of Events, you will find a listing for Annual Scientific Meetings. If you click on this heading you will see a list of the past meetings by year. Clicking on the 2010 meeting, you will see subheadings, including audio.

There are 10 audio-taped speeches available to be downloaded with a cumulative time of close to 10 hours. One could nearly collect their entire year of credits for Category 1 by listening to these audio-taped speeches and documenting the times.

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ANZCA 2010 Fellowship Survey

- ANOP Executive Summary

Overall satisfaction with ANZCA

71% of Fellows are satisfied with ANZCA overall, giving scores of 1–4. The mean overall satisfaction response rate of “acceptable” (52%) or “fair and reasonable” (10%), whereas 36% are of the opinion that the fee is “too high”. This is a conservative estimation. Also not unexpectedly, concerns about value are most pronounced among those less satisfied with ANZCA overall.

ANZCA ASM 2010 audio

Saturday May 1
Professor Talmage Egan – Pharmacodynamic interactions – hypnotics and opioids.
Professor Jeffrey S Mogil – What’s wrong with animal models of pain?
Wallabies coach Robbie Deans address to graduates at the College Ceremony.

Sunday May 2
Professor Richard Rosenquist – Perineural catheter techniques for postoperative pain management at home.
Professor Michael “Monty” Mythen – Why is it easier to get doctors to the top of Mount Everest than it is to change their clinical practice?

Tuesday May 4
Professor Paul Myles – Stochasticity in clinical medicine.
Professor Steve Shafer – Un solved mysteries of anaesthesia.

Wednesday May 5
Professor Paul Myles – The last lecture I’ll ever give (at this meeting) – life skills, anaesthesia and philosophy.
Professor Steve Shafer – The last lecture I’ll ever give (at this meeting) – life skills, anaesthesia and philosophy.
Professor Talmage Egan – The last lecture I’ll ever give (at this meeting) – life skills, anaesthesia and philosophy.

I would encourage all Fellows who cannot attend the annual scientific meetings to make use of this valuable resource. At your own convenience, you can listen to both local and international keynote speeches and collect CPD credits the easy way.

In addition to this service, with the introduction of webinars soon to be rolled out, live speeches and workshops will soon be made available to Fellows. For more information about webinars, see the June edition of the ANZCA Bulletin.

Dr Vincent Sperando FANZCA
New South Wales
Life, by its nature, is a series of changes. Being a new Fellow does not only mark the beginning of our career, but also opens a new page in our life. We need to face numerous changes in the workplace as well as in personal life. Transition from a trainee into an independent specialist, providing supervision and training instead of being taught, increasing involvement with research, administrative work and college affairs, subspecialty training, entering marriage and parenthood, coping with the ever-changing world trends and cultures of different generations...the list simply never ends.

Changes can be both good and bad. It provides us an opportunity to evolve into a better self. However, it is invariably associated with uncertainty, fear and stress. Overcoming resistance to change demands self-realisation, motivation, planning and the courage to ‘act’ and to ‘accept failure’. Although it appears to be difficult, can we do something to better equip ourselves for the challenges?

In response to the above concern, the theme of the 2011 New Fellows Conference is “Managing the change”. Proposed sessions include:

1. **Exploring ourselves**
   - Through art jamming, we will explore our values and priorities in life. Sharing and discussion on the topic will be conducted in a pleasant and artistic atmosphere.

2. **Equipped for the change**
   - Workshop led by a clinical psychologist with emphasis on the psychological aspects of change management.

3. **A Taste of the tradition**
   - Traditional Chinese culture has a unique view on life. It stresses harmony with nature and peace of mind. Tai Chi is an internal Chinese martial art with well-known benefits on stress management and general well-being. A Tai Chi workshop consisting of a short seminar, demonstration and practical session will be held to provide participants with a taste of traditional Chinese wisdom which can be applied in our daily life as well as clinical practice.

All the workshops will be interactive in nature. Delegates will be asked to prepare a brief presentation related to the conference theme. Hopefully, through various activities, sharing and discussion, we will gain more insight into the topic and be better equipped for our future.

Our conference will be held in Hong Kong Disneyland Hotel which is located on the Lantau Island, about 15 minutes drive from the Hong Kong International Airport. Lying along the shores of the South China Sea, the hotel is surrounded by lush green lawns and the charm of Victorian elegance. With modern amenities like luxurious swimming pools, gym and spa, its close proximity to Inspiration Lake Recreational Centre and the Disneyland theme park, will surely bring you a unique, relaxing and refreshing experience in the midst of the “rush and hush” city life in Hong Kong.

We encourage all new Fellows, within eight years of Fellowship, to submit an application to their regional or national committee to attend this exciting conference by October 4, 2010. We look forward to seeing you in Hong Kong next year!

Dr Patricia Kan
Dr Timmy Chan
NFC 2011 Co-Convenors

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**“The only constant is change, continuing change, inevitable change, that is the dominant factor in society today. No sensible decision can be made any longer without taking into account not only the world as it is, but the world as it will be.”**

Isaac Asimov
In the spotlight: Teacher training in medicine

By Felicity Hutton, Education Training and Development Manager, ANZCA and Mary Lawson, Director of Education, ANZCA

Teacher training in medicine is the subject of discussion and debate across all disciplines in medicine and at all levels of medical education (including medical school, junior doctor and medical college level).

ANZCA hosted a one-day symposium in April 2010 on supervision for the Confederation of Postgraduate Medical Colleges (CPMC). Participants actively engaged in debate around the following questions:

• How can health environments support good supervision?
  
  Discussion focused on the need for structural support for medical teaching to occur, including dedicated time and resources required. It was also acknowledged that teaching needs to be recognised as core business in health environments and that this may require significant cultural change.

• How can supervisors be equipped for their task of providing effective educational supervision?
  
  It was agreed that there are very few (if any) discipline-specific medical teaching skills.

At the end of the meeting, there was broad agreement that colleges share many of the same challenges and that a generic approach to teacher training may be both efficient and desirable. This challenge has been taken up by Health Workforce Australia (HWA) through the Clinical Supervision Support Program (CSSP). HWA are working to expand capacity and improve quality of clinical supervision through the development and implementation of a National Clinical Supervision Support Strategy and Framework. ANZCA will submit a response to their consultation paper outlining the College’s strategic goals and activities related to teacher training and support.

ANZCA teacher training and support

The College is using existing knowledge and frameworks for the development work at ANZCA. All courses are mapped against the competency framework for the “Doctor as Educator” detailed in The Bridging Project. The literature on what constitutes effective supervision in medicine has been used as the starting place for development action.

With this information providing a sound base, ANZCA is taking a proactive approach to teacher training and support. There are a number of new initiatives. Existing provision has been revised, structured and standardised and is delivered equitably in all ANZCA regions and nations. This article provides a review of what is available locally.

What support is available for ANZCA teachers?

Support and training for clinical teachers has been identified as a key strategic priority of the College. ANZCA Council convened a Clinical Teacher Development Working Group (CTDWG) to oversee the review and redesign of support and training initiatives for Fellows involved in delivering clinical teaching to trainees.

The ANZCA Education Development Unit has reviewed and redesigned a suite of teacher training and support activities resulting in the development and implementation of the ANZCA teacher course.

What is the ANZCA teacher course?

Many ANZCA Fellows teach but few have received formal training and support. While they have shown passion and commitment to teaching, many have done so without formal recognition and have welcomed the introduction of a formal support program.

The ANZCA teacher course is an exciting initiative designed to support supervisors of training, module supervisors and any Fellow involved in the clinical teaching of ANZCA/Faculty of Pain Medicine trainees to develop their teaching knowledge, skills and professional behaviours. The ANZCA teacher course consists of two complementary options:

1) ANZCA teacher course: foundation level

2) ANZCA teacher course: advanced level

All courses have been developed on a set of principles that are shown in Box 1 (on page 57).
In the spotlight: Teacher training in medicine continued

Who is the ANZCA teacher course – foundation level suitable for?
The ANZCA teacher course is suitable and made available to any Fellow involved in the support and supervision of an ANZCA trainee. The foundation level is a two and a half day course. The format is currently face-to-face but an online version will be developed in the future. Participants are required to complete pre-course preparatory work, engage in a range of interactive activities and complete a post-course assessment. The foundation level course is particularly relevant to those involved in teaching ANZCA/FPM trainees who have received little or no formal training in teaching in the clinical environment. Participants do not need to hold a formal role of teaching responsibility but rather demonstrate a commitment to teaching or have shown initiative in the teaching of trainees. Importantly, the focus of the course is the application of core teaching skills to the clinical environment.

In 2010 the pilot foundation level course will be delivered in Victoria, Queensland, New Zealand and an additional course will be held in Victoria for ANZCA/FPM Fellows working in regional and rural areas as well as those in expanded settings. Applications for the foundation level course have been overwhelming with almost 300 Fellows registering their interest. Regional and national committees have been responsible for reviewing the applications and nominating suitable participants from the respective regions. This system was put in place to ensure that regional committees were able to put forward their local key teachers and those who would be actively involved into the future.

Participation in the ANZCA teacher course – foundation level is fully sponsored by the College during this pilot phase.

Who is the ANZCA teacher course advanced level suitable for?
Any Fellow can take an advanced level workshop. There are no prerequisites for participation. The advanced level course comprises of a one day face-to-face workshop. The focus of each workshop varies and regions are able to choose from a suite of medical education topics to cater for the needs of their respective Fellows. Participants are required to complete pre-course preparatory work and engage in a range of hands on and interactive activities. Importantly, the advanced level course provides an opportunity for Fellows to share experiences and challenges and develop practical strategies to apply when teaching and supervising trainees in their workplace.

In 2010, the advanced level course has been delivered to all ANZCA regions, New Zealand, Malaysia, Singapore and Hong Kong. The course is freely available to ANZCA and FPM Fellows.

Details of the ANZCA teacher course foundation level can be found on the College website: www.anzca.edu.au/edu/teacher-programme/teacher-course

Foundation level can be found on the College website: www.anzca.edu.au/edu/teacher-programme/teacher-course

What’s available to support ANZCA teachers in 2011?
College support for teacher training is growing. In 2009, more than 150 Fellows received training and this number will increase in 2010. In 2011 it is anticipated that the support and teacher training activities will increase substantially. The ANZCA teacher course foundation level will be adapted for the online environment and will enable greater access to training opportunities for ANZCA/FPM Fellows in expanded clinical settings.

There will be increased opportunities to attend the advanced level course throughout the regions/nations and the foundation level course will also be offered as part of an educational stream at the ANZCA Annual Scientific Meeting (ASM). ANZCA Council approved an educational stream at the ASM, which demonstrates the continued commitment of the College to teacher training and support.

A major emphasis of training for 2011 will be in preparing Fellows for the implementation for a formal system of workplace-based assessment (WBA) so look out for the advertising for training in your local area.

All details of the work undertaken by the CTWG can be found on the College website: www.anzca.edu.au/edu/projects/teaching-review.

References:

Box 1: ANZCA’s underlying principles for teacher training and support
In the context of an increasing number of ANZCA trainees, the clinical development, training and support activities should:

• be available in multiple delivery modes and accessible to all ANZCA trainees and Fellows.
• be aligned with the ANZCA training program.
• be recognised and resourced as a key responsibility of the College and provided on an ongoing basis.
• include core training for all clinical teachers with options for a more tailored approach to meet the needs of those who progress to increased educational responsibilities (for example, for educational leadership, scholarship, teaching and/or management).
• adopt an inclusive approach to recognition of prior learning (RPL) in terms of teacher training activity provided in other contexts and by other providers and establish clear articulation pathways for progression to other relevant programs/courses if so desired.
• be acknowledged and recognised by the College within continuing professional development (CPD) frameworks and via other appropriate mechanisms.
• reflect adult learning principles ensuring that initiatives are relevant to the interest and responsibility level of the clinical teacher.
• include active lobbying and advocacy for the importance of clinical teaching, on behalf of clinical teachers to funding, regulatory and health policy agencies.
• be continually reviewed to ensure ongoing improvement in quality, effectiveness and accountability to the College, trainees, the anaesthetic profession, patients and the wider community.

Box 2: Participant comments from ANZCA teacher course
"I found that hearing/sharing experiences of/with others – their tips and tricks to be the most beneficial aspect of the course.”
"The course provided an excellent summary of education around the topic enlarging my vocabulary/knowledge.”
"The interactive nature of the course increased learning – especially the role plays.”
"It gave me an opportunity for discussion with colleagues about my own environment and practices.”
"I found the discussion of techniques to overcome barriers to be extremely helpful.”

References:

From top left: Malaysian Fellows learn about effective clinical supervision; Felicity Hutton teaches the principles of providing effective feedback.
Call for Abstracts

The Scientific Committee cordially invites prospective authors to submit their abstracts for presentation at the Combined Scientific Meeting of the Australian and New Zealand College of Anaesthetists, the Faculty of Pain Medicine and the Hong Kong College of Anaesthetists taking place in Hong Kong from 14-17 May 2011.

All authors are requested to submit their abstracts in electronic format, online at www.csm2011.com by 5pm Hong Kong Time (7pm AEST), Friday 11 February 2011. All presentations will be in poster format except for the Gilbert Brown Prize, Formal Project Prize and FPM Dean’s Prize presentations, which will be in oral presentations.

Notification of acceptance will be sent to presenters by email in early March 2011. To ensure abstracts are included in the final programme, please register for the CSM2011 by 18 March 2011 (close of early bird registrations). Enquiries should be forwarded to abstract@csmonline.com.

CSM2011 Regional Organising Committee

Dr. Chi-Wai Cheung
Dr. Genevieve Goulding
Prof. Warwick Ngaan Kee
Dr. Annabel Orr
Dr. Phoon-Ping Chen
Dr. Simon Chan
Dr. Peggy Li
Dr. Lilly Lee
Dr. Chris Duffy
Dr. Enjiam Lim
Dr. Timmy Chan
Dr. Patricia Kan
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Workshop Convener
PRLD Co-Convener
PRLD Co-Convener
New Fellows Conference Co-Convener
New Fellows Conference Co-Convener
ANZCA ASM Officer
FPM Scientific Meeting Officer

INVITED SPEAKERS

Dr. Steve Yentis
ANZCA CSM Visitor
Steve Yentis is a Consultant Anaesthetist at the Chelsea and Westminster Hospital and Honorary Reader in Anesthesiology at Imperial College, London, UK. He trained in London apart from one year in Toronto. His main interests are in obstetric anaesthesia and anaesthesia, airway management, research methods, use of evidence, and ethics. He is an Executive Member of the Association of Anaesthetists of Great Britain & Ireland, Editor-in-Chief of the journal Anaesthesia, a Council member of the Committee on Publications Ethics (US), Central Anaesthetic Assessor for the Confidential Enquiries into Maternal Deaths, and past Honorary Secretary of the Obstetric Anaesthetists’ Association. He has published widely including the book Anaesthesia & Intensive Care A-Z and a book of medical cartoons ‘I work from the Heart’. He is also the Chair of the European Anaesthetic Association’s ‘Informed Consent’ Committee.

Assoc. Prof. David Scott
Australian Visiting Professor
David Scott is Associate Professor and Director of Anaesthesia at St. Vincent’s Hospital in Melbourne. He graduated from Monash University in 1979 and gained his fellowship in Anaesthesia in 1984. After spending two years at the Brigham and Women’s Hospital in Boston USA, he returned to Australia where he has been Director of the Acute Pain Service at St. Vincent’s since its inception in 1990. He has clinical and research interests in a wide range of areas including Regional Anaesthesia, Acute Pain management, Cardiovascular anaesthesia and the cognitive effects of anaesthesia and surgery. He has researched and published extensively in these areas including a number of books. He completed a PhD in 2004 in neuromodulation and the analgesic effects of cannabinoids and continues to be interested in managing neuropathic pain in the acute postoperative patient. He is also an ANZCA Councilor and is currently Chairman of Examinations for the College.

Prof. Catherine Bushnell
FPM CSM Visitor
Professor Bushnell of McGill University, Montreal, Canada, is the faculty of Pain Medicine ASM Visitor. She is the Harold G. Griffin Professor of Anesthesia and a Professor of Dentistry and Neurology at the McGill University. Prof. Bushnell has made significant contributions to the understanding of the neural basis of pain. She is a recognized authority in areas of somatosensory mechanisms of pain processing and cognitive modulation of pain, and the application of brain imaging and psychophysiological testing in the study of pain processing. Prof. Bushnell was awarded the Federation Keffer Award for Basic Research in Pain from the American Pain Society in 2006 and the G. E. Studdard Cancer Award from the Canadian Pain Society in 2003. Prof. Bushnell is the President-Elect of the Canadian Pain Society.

Prof. Yuen Hong Kong Visiting Professor
Hong Kong, Pain Medicine
Profusion of pain in Hong Kong, Beijing, China, is the faculty of Pain Medicine Hong Kong, Professor and the Director at the Neurosensory Research Institute at Peking University. Prof. Yuen is also the Director of the Key Laboratory for Neuroscience, Ministry of Education of China. He has published major research on the roles of ion channels and receptors on chronic pain modulation, and pain in brain in mechanisms of nociceptive analgesia. Prof. Yuen is the recipient of several national and international awards, including 2008 FSP Award for Excellence in Pain Research and Management. His contributions have also been recognized by the State Council, People’s Republic of China.

Prof. Vincent Chan
Hong Kong, Visiting Professor
Prof. Vincent Chan is Professor, Department of Anaesthesia of the University of Toronto, Ontario. Prof. Chan received a Bachelor of Science degree (Biochemistry, Honors) in 1978 and his MD degree in 1980 from McGill University, Montreal. Prof. Chan completed postgraduate training in Anaesthesiology at University of Toronto, Toronto and board certification (FRCPC) in 1986. Prof. Chan is acknowledged by his colleagues as an international leader in the fields of regional anaesthesia and pain medicine. He is currently the President of the American Society of Regional Anaesthesia and Pain Medicine. He has been awarded the gold medal award by the Canadian Anaesthesiologists’ Society, the highest personal award in recognition of his contribution to anaesthesia in Canada through excellence in teaching, research, professional practice in the field of ultrasound guided regional anaesthesia.

Prof. Spencer Liu
SAHK Visitor
Prof. Spencer Liu is the Chair of the Department of Special Surgery, New York, United States; is the Society of Anaesthesiologists of Hong Kong, Chair of the Department of Anaesthesia at Cornell University and the University of Washington, United States. Prof. Liu has focused on the role of regional techniques in anaesthesia and analgesia. He has made significant contributions to the evidence for the use of different regional techniques including brachial plexus, local anaesthetic wound infiltration and epidural analgesia, and postoperative pain management. Prof. Liu is also an active authority and advocate in acute pain management.

Prof. Mervyn Singer
SAHK Visitor
Mervyn Singer is Professor of Intensive Care Medicine at University College London. His primary research interests are sepsis and multiorgan failure, infection, shock, and haemodynamic monitoring. Funding for these activities primarily comes from the Wellcome Trust, Medical Research Council and UK National Institute for Health Research, by which he was awarded Senior Investigator status. He previously developed an oesophageal Doppler haemodynamic monitor that is now in widespread use and has authored various papers and textbooks including the Oxford Handbook of Critical Care.

Prof. Homer Yang
SAHK Visitor
Prof. Yang is the Professor and Chair at the Department of Anaesthesia, University of Ottawa. He is also the Head of Anaesthesia at the Ottawa Hospital covering the Civic, General, Civic South, Riverside South, and the Ottawa Heart Institute. Prior to his appointment at the University of Ottawa, he was the Chairman of Anaesthesia at McMaster University between 1997 and 2003. Since 1997, he has been actively conducting research on the prevention of perioperative myocardial infarction, including the use of beta-blockers. He is the Principal Investigator for the NAVS (Nolasco After Vascular Surgery) Study and one of the two Principal Investigators for the POES-US (Percutaneous Coronary Intervention Evaluation Study). His current research interest is in the use of wireless remote perioperative ECG monitoring for the prevention of perioperative cardiovascular complications.
ANZCA spoke with Associate Professor Silbert, Associate Professor David Scott (Director of the Department of Anaesthesia and Chief Investigator) and Lis Evered (Senior Scientist and Research Manager).

Cognitive changes after anaesthesia is an issue of great importance. Each year more than 2.5 million anaesthetics are administered in Australia to an increasingly ageing population. The elderly are most susceptible to cognitive change after anaesthesia and it is this group that receives the highest number of anaesthetics. Cognitive decline already represents a major health issue in the aged, but exacerbating this problem by increasing surgery and anaesthesia cannot be underestimated.

The first study by Associate Professor Brendan Silbert and his colleagues builds on previous work which documented the incidence of cognitive decline after cardiac surgery. The ANTIPODES (Australian National Trial Investigating Post-Operative Deficit, Early extubation and Survival) trial investigated the incidence of postoperative cognitive deficit after coronary artery bypass graft (CABG) surgery. The study included 350 patients aged 55 years or older who underwent CABG surgery. This trial resulted in the collection of cognitive test results from more than 320 patients.

Associate Professor Silbert says that retaining patients for the trial is very important. “If one drops out, your results become less usable because you are unsure whether you’ve lost them because they’ve lost cognition. Each one you lose takes away the strength of your result. We have included country patients, which helps contribute to the high retention rate of 94 per cent. There is a lot of travel involved for the three research assistants and it is labour intensive work, developing a rapport with the patients and spending one to two hours testing each one.”

The tests fall into two categories. One method is the traditional way of testing with pen and paper which involves a word learning test where 10 simple, unrelated words are read to the patient who responds with as many as they can remember, in any order. Mild cognitive impairment has a high rate of developing into Alzheimer’s disease. Other cognitive tests include joining the dots with a pen, which is timed and other exercises using symbols and letters, as well as a reading test. There is also an opportunity for patients and their partners to give feedback about their views on the patient’s cognitive function. The second method of testing involves a computer using software designed by Cogstate. One involves a maze task that is sensitive to executive function via finding pathways one square at a time. Reaction time is measured in milliseconds by pressing a key on the board with the number of errors automatically recorded.

Associate Professor Silbert says that it is scientifically proven that the older people get, the greater the chance and severity of their cognition falling. Research has shown that the more intelligent and better educated people are, the less likely and less severe the cognitiver falls.

Associate Professor Silbert makes evidence that suggests these may play a part in diminishing brain function. The particles are measured using a special ultrasound machine which goes on the side of the head and measures the particles that go up into the brain. The study is measuring the number of errors automatically recorded.

In August this year, Geert De Meyer of Ghent University in Belgium and colleagues in the Alzheimer’s disease Neuroimaging Initiative announced that Alzheimer’s disease can be predicted with up to 100 per cent accuracy years before patients experience symptoms of memory loss using biomarkers found in spinal fluids.

In relation to the hip surgery trial, most patients have spinal anaesthetics as a part of their surgery before they are unconscious. Associate Professor Silbert says that by chance, 18 months ago it was decided that before the spinal went in, his team would take a sample of the cerebral spinal fluid (CSF).

“An ANZCA research grant bought us the Transcranial Ultrasound Doppler machine that goes on the side of the head and measures the particles that go up into the brain. The time, we thought these bubbles caused cognitive change; the more bubbles you get, the more change. We haven’t published yet, but it looks like the bubbles may not be as ominous as we first thought. When we applied to the College for a research grant we were certain that the bubbles were going to be the problem,” Associate Professor Silbert said.

“We now have 100 samples of CSF in 100 patients who have all got cognitive results. If it works out, we will be able to correlate the CSF proteins with the cognitive results of the patients. This is purely conjecture now – not science – but the way it seems to be fitting together for us is that if patients have the Alzheimer’s CSF profile then they are probably susceptible to anaesthesia in a way that normal patients wouldn’t be,” he says.

In the future, instead of taking 20 years for the onset of the disease to occur, they’d get it in six months or a year. There’s no doubt that CSF will be universally accepted as a marker of Alzheimer’s disease – the question of whether those patients are susceptible to cognitive changes after anaesthesia will require further research.”

The study will conclude at the end of next year.
The Legacy of Konrad Jamrozik, The Master Trial and contemporary clinical research in anaesthesia

In the June issue of the ANZCA Bulletin, Dr John Rigg outlined his collaboration with the late Professor Konrad Jamrozik, which led to the publication of THE MASTER TRIAL, “The Multicentre Australian Study of Epidural Anaesthesia”. Following consultation with co-authors, Dr Rigg has written a more detailed account of the trial and Professor Jamrozik’s contribution (opposite). Dr Rigg hopes that this story will interest all Fellows, but more particularly, trainees and younger Fellows who may be involved in clinical research.

It was great to be approached in the early 1990s to become involved with the MASTER trial and we were delighted that Brendan Silbert from our Department at St Vincent’s Hospital in Melbourne could play a major role. John Rigg was first awarded a grant from ANZCA in 1994 that allowed him to start the research and later to successfully receive the largest grant that the specialty of anaesthesia had ever been awarded by the NHMRC. After nearly 10 years of hard work the MASTER trial was published in The Lancet in 2002. Publication of papers related to anaesthesia are rare in this prestigious journal, and this was a great achievement by John and his team.

The Master Trial

The Multicentre Australian Study of Epidural Anaesthesia (MASTER Trial) was the first major multicentre trial carried out predominantly in Australia. John Rigg was the driving force behind the trial that established Australia as a major player in outcome research of medical and surgical outcomes. John has detailed the history of the trial in an article in this ANZCA Bulletin. The Master Trial has been extensively studied to preserve, because it illustrates the huge amount of work, persistence and dedication required to complete such an ambitious task.

In my June obituary of Konrad Jamrozik, I referred to the role of chance in research and the notion of ‘serendipity’. As Louis Pasteur wrote 150 years ago: “Chance favours only the prepared mind”. In 1969, the Royal Australasian College of Physicians (RACP) Sydney Commonwealth Travelling Professor was the distinguished anaesthesiologist, surgeon and Editor in Chief of the ANZCA Bulletin, Blair Ritchie organised a memorable three hour meeting with himself, Campbell and me, during which we discussed my research. This was a true moment of serendipity because it led directly to an offer of a lectureship in the Faculty of Medicine at McMaster University, which I accepted.

From January 1972, Moran Campbell was the Director of Anaesthesia at St Vincent’s Hospital in Melbourne. From 1983 I began my association with Michael Davies at St Vincent’s Hospital in Melbourne. Combined regional and epidural anaesthesia was improved and respiratory failure was reduced with epidural analgesia. Although the project was subject to some criticism, the publication of the MASTER trial has led to a reappraisal of the use of epidural analgesia in this country. The great legacy of John and his colleagues was that they set the template for new multicentre trials in Australia and many have followed. The ANZCA Multicentre Trials Group was established to foster such trials and to ease the burden on future researchers who seek to emulate the achievements of John and his team.

Association Professor Michael Davies

Director of Anaesthesia
St Vincent’s Hospital, Melbourne
1984-2009

“A large multicentre trial, limited to high-risk cases, was required. We knew we needed a lot of money. We also understood that across hospitals, we needed to standardise the concept of ‘high risk’, defined to standardise organ specific definitions of pre-operative patient pathology were essential to standardise patient eligibility for entry to the study.”

It is a common misconception that research is about conducting experiments, analysing data and publishing results. Experienced and successful research scientists understand that ‘discovery’ and ‘refutation’ on the other hand are important considerations for anyone grappling with ideas and ‘hypothesis testing’. This was important to me for two reasons; first, I gained an intuitive understanding of what was needed, logistically and scientifically, to establish a study like the Master Trial, and secondly, it facilitated achieving strong original research with Konrad Jamrozik from our earliest meetings in 1989 and 1990.

Contribution to my luck in acquiring Blair Ritchie, Moran Campbell and David Sackett as mentors, there were some important experiences in clinical anaesthesia that were pivotal in leading to the Master Trial. The first was during my training in anaesthesia at the Royal Women’s Hospital in Melbourne in 1969. Advanced cervical cancer was common, often treated by Wertheim hysterectomy and radical cystectomy. Surgery could last over eight hours with radical cancer surgery in the morning and the urologist, after afternoon, fashioning an ideal bladder. The basic anaesthesia technique was intermittent epidural, however, my research project, with the notion of ‘serendipity’. As Louis Pasteur wrote 150 years ago: “Chance favours only the prepared mind”. In 1969, the Royal Australasian College of Physicians (RACP) Sydney Commonwealth Travelling Professor was the distinguished anaesthesiologist, surgeon and Editor in Chief of the ANZCA Bulletin, Blair Ritchie organised a memorable three hour meeting with himself, Campbell and me, during which we discussed my research. This was a true moment of serendipity because it led directly to an offer of a lectureship in the Faculty of Medicine at McMaster University, which I accepted.

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In 1989, David Sackett was the RACP SIMS Travelling Professor (20 years after Campbell). At a private function for Sackett in Perth, I met Konrad Jamrozik for the first time. I soon introduced him to the ideas that Michael and Brendan Davies had been discussing for the previous five to six years. We quickly established good rapport. Konrad was an anaesthesiologist with terrific clinical intuition. He was quick to recognise an important clinical question worthy of a well designed study and that I had a good background in clinical epidemiology. We soon agreed on the essential requirements for the trial and the need for NHMRC funding.

First, though, we needed credibility. Credibility required seed funding to begin studies, acquire a track record and to develop a detailed and robust protocol that could generate wide acceptance by clinicians. Coincidentally, in 1990, we had just accepted, a three-month sabbatical in the Department of Anesthesiology at Bowman Gray Medical School in Winston Salem, North Carolina. During this time, I wrote a ‘cook book’ paper, outlining the rationale and basic structure of the trial. I wrote a first draft of a NHMRC grant application and sent this to David Sackett in Canada and David Glass and Mark Yeager in New Hampshire. I followed this by visiting each institution for a couple of days of further discussion. In both cases, the discussions were invaluable and illuminating.

In returning to Western Australia, I was strongly motivated to press on with our plans. And in 1992, Konrad and I worked on the protocols and a trial instruction manual. In Perth we received excellent support and assistance from Wally Thompson, Vernon Van Heerden, Michael Pasch and later, Tim Pavy and Chris Vorkan. Vernon, in particular, found Karen Collins, an intensive care nurse who would become Master Trial co-ordinator and database manager. To Karen, the trial became her vocation. For over seven years she was a loyal, hard working and passionate supporter. Konrad and I travelled, often independently, across Australia and to New Zealand, making numerous presentations to generate support for the trial. We encountered much opposition, mainly from anaesthetists. These were mostly in one of three groups: (1) the non believers felt that the trial was a waste of time and money; (2) the believers also had their minds made up, all epidural and combined techniques were vastly superior to general anaesthesia and the only certainty was that both groups could not be right; and (3) the apathetic, just not interested, for a variety of reasons.

From 1993, through to December 1996, I was involved in the Pharmaceutica’s, Mallinckrodt Medical, ANZCA (1995 John Rigg, 1997 Phillip Peyton) and the Heart Foundation of Western Australia was critical in early enrolment of patients, particularly, in Melbourne, at the Austin and Repatriation Medical Centre (Phillip Peyton and Stephanie Poulter), The Alfred (Paul Myles, Jenny Hunt and Helen Fletcher) and St Vincents (Brendan Silbert and Carolyn Blyth). NHMRC funding began in January 1997 and finished in December 2001 (1997-9, $506,000; 2000 $140,887 and 2001, $70,000). For nearly seven years, Konrad and Karen Collins shared equal responsibility for carrying a mobile phone, 24 hours a day, seven days a week, dedicated to ensuring patients to the Master Trial. Konrad randomised patients in the early morning on the Swan River early in the morning, during lectures and even from his hospital bed recovering from an anaesthetic!

In 1997, I was invited to write a review paper in Current Opinion of Anaesthesiology, a European journal, and which was published in 1998 with Konrad as co-author. We published it with three paragraphs, much of which bears repeating here:

“Demonstrating clinically important real improvements in anaesthetic and perioperative management well designed multicentre trials. Other wise we cannot hope to identify moderate differences in treatment that are worth knowing about. The last Master Trial patient was randomised in May 2001. Richard Parsons and Karen Collins conducted the full primary analysis and presented the results to Konrad and myself. Because of the international and interest in the results of the trial, we agreed to keep the findings secret until after the acceptance of the paper for publication or the presentation to the American Society of Anaesthesiologists in New Orleans. As it turned out, the manuscript was accepted for publication in the LANCET within seven days of that ASA presentation. This meeting was held five weeks after the 9/11 terrorist attack in New York. Instantaneous and the usual 6,000 plus registrations, fewer than 500 registrants registered. In a special panel convened to discuss regional block, organised by David Glass, I had the privilege of being joined by anaesthesiologists attended presentations by Mark Yeager, Paul Myles and myself. Konrad, Karen, Stephanie and Jenny travelled to New Orleans to hear our presentations.

In February 2002, Konrad moved from the University of Western Australia to Imperial College London, then to the University of Queensland and finally to the University of Adelaide as Head of the School of Population Health and Clinical Practice where he died in March this year, aged 54.

I met five years ago, Konrad extended his collaborations with Master Trial colleagues and other clinical anaesthesia researchers. His influence on all of us was huge. He generated a transformational shift in the way that anaesthetists thought about and tackled clinical research projects. His legacy to our specialty will extend for decades after his passing. Anaesthetists in research today recognize his legacy in the ANZCA Trials Group, the award to Paul Myles in 2003 of the prestigious NHMRC Clinical Practitioner Fellowship and his collaboration with many colleagues and important influence in subsequent multicentre trials such as Enigma I and II, Reason, Antipodes, ATACAS, and B Aware. It is impossible to exaggerate the importance of Konrad Jamrozik to the advance of clinical research in anaesthesia in Australia over the past 20 years.

In 2002, Konrad moved from the University of Western Australia to Imperial College London.
Introducing the only opioid analgesic that helps prevent opioid-induced constipation

Why are TARGIN® tablets different?
Until now, effective management of persistent pain with opioids has only often been compromised by the debilitating effects of opioid-induced bowel dysfunction.1 The introduction of TARGIN® tablets can help change this.

TARGIN® tablets are a fixed combination of oxycodone, which provides effective analgesia, and naloxone, which helps prevent the opioid-induced constipation (OIC) that often accompanies opioid therapy.14 Patients who require an opioid as part of a multimodal treatment plan to manage persistent moderate to severe pain in conditions such as osteoarthritis, back, neuropathic and cancer conditions may benefit from TARGIN® tablets.1,14

How can TARGIN® tablets help prevent opioid-induced constipation?
OIC is a debilitating and prevalent side effect of opioid treatment that can reduce patients’ health-related quality of life.15 OIC is primarily caused by the opioid’s effect on the mu-opioid receptors in the gut,16 which results in decreased fluid secretions and motility, and increased fluid absorption and transit time. Whilst laxatives are a recommended component of a patient’s care plan, they may often be ineffective14,16,17 and are associated with a range of gastrointestinal side effects, and fail to address the underlying cause of OIC.1,14

With TARGIN® tablets, the naloxone component prevents the opioid binding to the mu receptors in the gut, providing therapy and prophylaxis of OIC.1,14

How do TARGIN® tablets work?
TARGIN® tablets provide central analgesia and peripheral bowel benefits. In the gut, naloxone binds competitively to opioid receptors and with a higher binding affinity than oxycodone. This prevents the oxycodone from binding to these receptors.1,14

As naloxone is absorbed into the circulation, it is transported to the liver where it undergoes extensive first pass metabolism. Naloxone has a low oral bioavailability, with more than 97% of the naloxone metabolised in the healthy liver.1 Opioid oxycodone follows a similar path to the liver, however oxycodone has a high bioavailability and up to 87% passes into the circulation intact. The oxycodone part of TARGIN® tablets reaches the CNS where it exerts an analgesic effect equivalent to that of controlled release oxycodone alone.1

Do TARGIN® tablets provide effective analgesia as well as bowel function benefit?
In randomised double-blind studies it was demonstrated that there was no statistically significant difference between the analgesic efficacy of TARGIN® tablets compared with oxycodone during 12 weeks of treatment,1,14 and a 12-month extension of one of these studies demonstrated that mean pain scores remained low and stable.15

When patients were switched from oxycodone alone to TARGIN® tablets, there was a clinically meaningful improvement in patients’ mean Bowel Function Index scores from the first week, and Bowel Function Index scores continued to improve over 12 weeks.1

Your patients can now experience the benefits of TARGIN® tablets – the opioid analgesia you expect from oxycodone, but with reduced opioid-induced constipation.1,14

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

Before prescribing, please refer to Product Information and to State and Federal regulations. Product Information available from Mundipharma Pty Limited.
An essential component of any large multicentre research is the establishment of functioning committees that review and monitor data safety, and data quality. These are two distinct entities with separate charters, committee membership, functions and responsibilities, operating apart from the Data Management and Steering Group Committees.

Both the Aspirin and Tranexamic Acid for Coronary Artery Surgery (ATACAS) and the Nitrous Oxide Anaesthesia and Cardiac Morbidity After Major Surgery Trial (ENIGMA II) have separate data safety and monitoring committees (DSMC) and data quality committees (DQC). All of these committees are coordinated by the ANZCA Trials Group at Monash University.

The Chair of ATACAS DSMC is Professor Andrew Tonkin, while the Chair of ENIGMA II DSMC is Professor Henry Krum. Both are eminent cardiologists with extensive experience in large randomised trials. Professor Krum replaces the late Professor Konrad Jamrozik, who contributed a great deal to multicentre research in anaesthesia.

A DSMC is responsible for safeguarding the interests of trial participants, assessing the safety and efficacy of the interventions during a trial, and for monitoring the overall conduct of a clinical trial. The DSMC provides recommendations about stopping or continuing a trial and meet at specified time points of a trial.

Both ATACAS and ENIGMA II are about to have their first interim analysis. Data quality committees are concerned with issues of data accuracy and data integrity. Both ENIGMA II and ATACAS have been set up for electronic data entry by participating sites. This system reduces data error, encourages timely data entry and allows analysis of data looking for evidence of data fraud or unusual data patterns as a trial progresses. In this environment, the need for time consuming and costly onsite data audit is reduced. Both trials continue to have onsite monitoring, but the process is much reduced in complexity and concerns itself with patient verification and end-point validation. This method of end-point validation uses a blinded methodology where the auditor is unaware of whether a participant has incurred any endpoints and seeks to confirm that endpoints have or have not occurred. This allows the audit team to access whether there has been any local site bias in recording outcomes.


The POISE – 2 Trial is the next large multicentre project to come to the ANZCA Trials Group from the McMaster Group at the Population Health Research Institute in Canada. This study follows on from the highly successful POISE – 1 Trial. Professor Kate Leslie is the national coordinator for Australia and New Zealand.

This research project is being run in Australia from the ANZCA-TG desk at Monash University’s Department of Epidemiology and Preventive Medicine based at the Alfred Health campus. The Royal Melbourne Hospital (RMC) is the start up site, using the new National Ethics Application Form (NEAF) to begin the research ethics process.

The POISE – 2 Trial, Professor Kate Leslie is the national coordinator for Australia and New Zealand.

This research project is being run at the Royal Melbourne Hospital (RMC) and a start-up site, using the new National Ethics Application Form (NEAF) to begin the research ethics process.

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The Anaesthesia and Pain Medicine Foundation
(Formerly the ANZCA Foundation)

Change of name for Foundation

The College Council at its August meeting approved a recommendation from the board of the ANZCA Foundation to change the Foundation’s name to the Anaesthesia and Pain Medicine Foundation.

The reason for this decision was very much driven by the fact that “the ANZCA Foundation” a low level of awareness in the wider community. Experience has shown us that in trying to introduce the ANZCA Foundation and its purpose to those not familiar with the organisation the initial response is invariably, “what is the ANZCA Foundation?”.

The College is not alone in having to address the issue of clarity and purpose. For example, the Royal Australasian College of Surgeons have established the “Foundation for Surgery”. The Royal Australian and New Zealand College of Ophthalmologists have established “The Eye Foundation”.

Apart from the change of name, the identity and look of the Foundation will remain much the same with the use of existing design, colours and the treatment of the College crest. There will be a progressive implementation of the new name to the wider community commencing in early 2011. It is proposed to run a parallel program (internal and external) whereby the existing name will be used internally among Fellows as we run down existing foundation material. The first piece of printed material featuring the new name will be the “Research Highlights for 2010”. This is a 32-page full colour publication that the College and Foundation will use to introduce ANZCA and the Foundation to a much wider audience, outlining medical research successes that have been made possible by ANZCA support and seeking new areas of support.

The global financial crisis and its impact on philanthropy and fundraising

When the College launched the ANZCA Foundation in September 2007, economic conditions were strong across much of the developed world. Virtually all the economic indicators were positive with strong corporate profits, record world trade, high employment and a high degree of consumer confidence.

The arrival of the global financial crisis (GFC) in 2008 ushered in a period of severe economic downturn. This has had a profound impact on philanthropy in the developed world. Companies have scaled back or eliminated much of their financial support. Trusts and foundations which rely heavily on dividend payments to fund their grants have been severely impacted.

To give Fellows a better understanding of how the GFC is affecting philanthropy the College and the Foundation, the Director of the Foundation, Ian Higgins, recently sought the views of two independent directors, Michael Gorton, AM, and Kieren Perkins, OAM. Both have considerable knowledge and experience of the philanthropic sector in Australia and New Zealand. Ian also spoke with Bruce Argyle at Philanthropy Australia, the national not-for-profit peak body for philanthropy, to seek his assessment.

The Foundation’s Patrons Program, which was established in 2009, has received strong support from Fellows. The program aims to build the funds of the Foundation to support ANZCA’s medical research and education programs. Past ANZCA president Dr Wally Thompson is the latest Fellow to join the program. The Director of the Foundation, Ian Higgins, recently had the opportunity to thank Dr Thompson for his continuing support of the College and the foundation and to welcome him to the Patrons Program.

Dr Leona Wilson joins the Foundation board

The former president of the College Dr Leona Wilson, ONZM, has taken up a three-year appointment to the board of the Anaesthesia and Pain Medicine Foundation effective from August 2010.

This appointment provides representation of another senior Fellow to the board as well as representation from New Zealand.

From left: Kieren Perkins, OAM; Michael Gorton, AM; Bruce Argyle from Philanthropy Australia.

Michael Gorton:

All charities and not-for-profit bodies have had a tough time trying to get corporate and public support in the middle of the GFC. We look forward to better times and opportunities ahead.

The best thing we can do is position the Foundation and its profile to take advantage of the recovery. I think we are doing that.

Bruce Argyle:

The GFC had an impact on the philanthropic sector but not to the same huge extent as in other countries. Corporates did cut back and trust and foundation incomes were reduced, in many cases by 20 per cent or more while at the same time the demands from the community increased. This was particularly evidenced in 2009 by the large increases in requests from charities for material aid and immediate assistance to help with those most impacted by the financial climate. In Victoria, the advent of the bushfires placed huge pressure on trusts and foundations to respond locally.

Kieren Perkins:

Those charities that have relied on corporate giving have been found wanting during the GFC. All companies have tightened their philanthropic spending, interestingly there hasn’t been too much fall in individual giving. Over the next period of time though individual giving will also come under pressure as average Australians struggle with the rising cost of living, and the precarious position many SME’s find themselves in.
There are so many “good causes” seeking support, how strong do you believe the “message” of the Foundation is?

Kieren Perkins: I believe the Foundation has two distinct advantages in the philanthropic landscape. Firstly, the commitment of our Fellows ensures we have a large group of informed advocates pushing the messages of the Foundation, helping provide sustainable income. Secondly, the work being achieved in the public domain regarding pain management provides a platform for community engagement we haven’t enjoyed previously.

Michael Gorton: The Foundation is the only voice for “safe anaesthesia” and “pain relief” among all the other worthy medical causes. We need to educate the public on the benefits of anaesthesia in the daily lives of Australians. The millions of people affected by pain in their daily lives. I believe that this is a key focus.

Looking to the future what is your assessment for the philanthropic sector here in Australia over the coming 12-18 months?

Kieren Perkins: The next 12-18 months will continue to be extremely difficult for the philanthropic sector. The economy is still on a knife edge and this lack of confidence in the economic environment will make it difficult to convince corporations and governments to increase their charitable spending. I also believe individual giving will require a much higher level of transparency and credibility to gain any market share in the public’s spending decisions.

Michael Gorton: I hope that, economically, we are in for better times. I expect that Fellows, the public and the corporate sector will be able to better support the Foundation and its important work.

Bruce Argyle: There is a growing interest in philanthropy in Australia – this is seen in the increased number of private ancillary funds established over the past five years (now over 800 in total) and by the growth in members at Philanthropy Australia (over 10 per cent for each of the past three years). In the next 12-18 months we will see additional new structures being set up to support philanthropic intent. The longer term outlook for the Australian philanthropic sector is optimistic – continuing increases in activity, greater awareness of “hands on” giving possibilities alongside a huge transfer of intergenerational wealth over the next 20 years.

To make a bequest, become a patron and for all other inquiries please contact: Ian Higgins, Director, the Anaesthesia and Pain Medicine Foundation

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ANZCA’s communications unit is always looking for good news or general interest stories that can be promoted in the media. If you have an idea or suggestions, please contact media manager, Clea Hincks, at ANZCA via e-mail chincks@anzca.edu.au or by phone +61 3 9310 6390 or 0418 583 276.
A Top End Experience

By Dr Raymond Nassar, Staff Specialist, Westmead Hospital

In May 2010 I was part of a team of healthcare providers from Westmead Hospital who visited Nhulunbuy in the Northern Territory. Nhulunbuy is the Yolngu name for the township in north east Arnhem Land. The traditional landholders in this area are the Yolngu people. Gove is the official name of the airport and harbour and is a commonly used name for the town. The Nhulunbuy township was built in the 1960s to service the bauxite mines of Rio Tinto. The population is currently 4,000. The Gove peninsula, an area of 500,000km² has been populated by the Yolngu people for 40,000 years and has an overall population of 13,000.

The Westmead healthcare team was brought to the Top End as part of the Australian Government’s “Closing the Gap” program for paediatric oral health care. Their aim was to provide dental care to paediatric Aboriginal patients in the east Arnhem Land area and it was the second time that a group of paediatric dentists and an anaesthetic team from Westmead had visited Nhulunbuy. It is only one of many trips that have been made by medical and dental teams since the Northern Territory Emergency Response (NTER), also referred to as “the intervention”, began.

In June 2007 the “Little Children Are Sacred” report led to the announcement of the NTER to protect Aboriginal children. Part of this intervention involved child health checks. Nine thousand children were assessed up to the age of 12 years, and dental neglect was identified as the most widespread health problem among Aboriginal children. It was estimated that 40 per cent having untreated dental decay. One third of those were referred for further treatment and it was estimated that 10 per cent would require their treatment to be completed under general anaesthesia. This workload could not be managed by local hospitals so the treatment of these patients has been brought to Nhulunbuy. The team has operated in Alice Springs, Katherine, Gove and Tennant Creek hospitals.

The reasons for the high rate of dental decay in the children are multifactorial. A diet with a high intake of carbonated drinks, poor oral hygiene and lack of availability of primary oral health care are major contributing factors. The team consisted of two dentists with paediatric sub-specialisation, a dental registrar, two dental assistants, Dr Jane McDonald (paediatric anaesthetist), Dr Raymond Nassar (anaesthetic Fellow), an anaesthetist (enrolled) nurse and a recovery (registered) nurse. Registration to practice in the Northern Territory and accreditation at Gove District Hospital were obtained. The township and surrounding area is owned by the local indigenous people and visitors require permits to travel to different sites. Dhimmurland Permits were obtained from the Land Council to enable us to visit some of the surrounding areas. Hospital Visitors Permit only enabled us to travel between the airport, hospital and our accommodation in the town.

As the anaesthetic trainee, it was a great opportunity to gain some intense exposure to paediatric anaesthesia, as well as an insight into indigenous health issues. During the week of operating we anaesthetised 30 Aboriginal children between the ages of two and 12 years, who underwent general anaesthesia for dental extractions and repairs. We were based at Gove District Hospital, a 32-bed hospital with two functioning operating theatres usually staffed by GP anaesthetists and local nursing staff. The hospital has a maternity and paediatric ward, as well as an emergency department and general wards. As a result of the geographic remoteness, any significant medical or surgical problems require evacuation to Darwin (600km away) which is only accessible by air. Children under the age of five are not normally allowed to undergo anaesthesia at the hospital.

Paediatric patients were booked for theatres through community dental clinics. A locally based dental technician travelled to the more remote communities in the lead up to the Westmead team’s arrival and booked appropriate cases onto the GA waiting list. Patients were from remote Aboriginal communities such as Elcho Island, Sandy Beach, Ski Beach, Yirrkala, Biranybirany, Gapuwiyak and Milongimbi. Patients and their carers were flown to Nhulunbuy the day before their operation and accommodated in local hostels. In order to ensure compliance, patients from each particular community were brought in on the same day so that they could remain within their own cultural and family groups. A few patients could not be found on the day they were to be collected from the more remote communities. Their places on the theatre list were filled at short notice by local patients.

In addition to the referrals from the community-based dental clinics other cases were booked by the dental registrar on our team. She spent the entire week at a dental health clinic at Yirrkala, half an hour from Nhulunbuy. She treated simple cases on site, referring more complex cases to Gove hospital for general anaesthesia. In order to maximise attendance to this dental clinic, a local health worker drove through the community in a minibus, announcing in Yolngu language the presence of a children’s dentist through a megaphone!

For the hospital team, a typical day commenced with an eight o’clock start in theatres. The five minute drive to work from the Walkabout Lodge where we stayed was a pleasant change from the usual struggle through heavy Sydney traffic. Pre-anaesthetic assessments had been made the day before, and we would meet the children in a separate waiting room and escort them to the operating theatre accompanied by their carer. Pre-anaesthetic assessment was typically performed. The children were enticed to blow up the “Blow-out”, Not being aware if these children were used to blowing up balloons as we may be used to when celebrating birthday parties, we were pleased to find that some of them were familiar with this concept. The majority of them were very cooperative but a few were tentative and needed more persuasion for the induction.

Overall, the behaviours of the indigenous children were similar to those of children that we see in very multicultural western Sydney. In contrast, the responses of the carers during anaesthetic inductions were varied. Some carers showed the common emotional response of fearlessness on seeing their relative fall asleep under anaesthesia. Others simply walked out of the room mid-induction with no display of emotion.

Another major difference to my previous experiences in paediatric anaesthesia was that the carers that accompanied the patients were usually uncles, grandmothers or sisters. Occasionally mothers were present, whereas fathers were rarely so. One child was accompanied by another child, his 15 year-old sister! Often the same carer would accompany several children into the operating theatre for their anaesthetics.

Patients and their families seemed grateful for their treatment which must have made their mouths feel better and eating less uncomfortable. Some of the patients presented for follow-up. Their overall dental health had greatly improved as a result of intervention and education.

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Fasting instructions were to “not eat or drink after the sun comes up” for all patients and carers regardless of their scheduled operation time. This was necessary as eating is done together as a community and the message of separate fasting was hard to explain.

The patients and their carers did not like the cool, air-conditioned environment of the hospital and were keen to get outside as soon as possible after their procedure. Post-op we could find most of them sitting on the ground outside the hospital, enjoying the “healthy” snacks they had been given to both patient and carer to aid recovery.

Anaesthetic equipment at the hospital was well stocked and of high quality. The only equipment that we brought with us were some spare paediatric T-pieces, Cass needles which were resterilised by the local CSSD, and some ondansetron. We also brought some disposable laryngoscopes in case we had problems with having enough  

In early 2010 the Australian Indigenous Doctors’ Association (AIDA) launched an impact assessment of the Australian Government’s NTER. Many aspects of the NTER, such as imposition of external governance and control, compulsory income management, alcohol restriction and prohibition of substances, were found to be having a negative impact on psychological health, social health and well-being, and cultural integrity. However, interventions such as the child health checks and initiatives that increase access to specialist health services are seen as an area with potential positive impacts.

Ongoing positive impacts of the Northern Territory medical programs are largely provisional on community involvement, long-term recurrent funding and support of primary healthcare services.

For the Westmead anaesthetic training scheme, involvement in the dental team offers a valuable opportunity for registrars to have a concentrated experience in paediatric anaesthesia along with exposure to the challenges of providing anaesthesia in remote Indigenous communities.

Dr Raymond Nassar, Staff Specialist Westmead Hospital with contribution by Dr Jane McDonald, Visiting Medical Officer Westmead Hospital and Westmead Children’s Hospital and Elizabeth Todd.

Reference:

Photos are with permission of the patients and the Department of Health and Families Closing the Gap Child Oral Health program, which is funded by the Australian Government under the Northern Territory Emergency Response.
New Zealand roadshow
The Chair of the New Zealand National Committee, Vanessa Beavis, is about to embark on a major exercise that will help fulfil one of the key priorities in ANZCA’s 2010-12 strategy – that of increasing engagement with the College’s members. Over the next few months, she is planning to visit all 26 departments of anaesthesia in New Zealand’s hospitals for face-to-face meetings with Fellows, trainees and other anaesthetists.

The “roadshow”, as it is being termed, will build on ANZCA’s Fellowship survey carried out earlier this year and provide Dr Beavis with the opportunity to outline initiatives ANZCA is handling on behalf of Fellows and trainees, and international medical graduates (IMGs). More importantly, it will provide Fellows with the opportunity to let Dr Beavis know what issues they would like ANZCA’s New Zealand National Committee to address. Each meeting will see Dr Beavis give a presentation about College initiatives and activities, and then invite a discussion from the floor.

The concept has been warmly received by departments and the national office is now putting together an itinerary that will provide the opportunity for as many anaesthetists and trainees in each department to attend as possible. The first meetings are expected to be held in early October with the program extending into early 2011.

The New Zealand office has set up a dedicated e-mail address for those who want to contact its National Committee Chair – chair@anzca.org.nz.

President’s visit
NZNC members were delighted to welcome Professor Kate Leslie in her first visit as President of ANZCA. Kate attended both the joint meeting with the NZSA and the first session of the NZNC meeting. Her key message as President was for ANZCA Fellows and trainees to engage more and become more involved in the opportunities that the College offers them. At the NZNC meeting, she also spoke about the curriculum redevelopment and the new ANZCA merchandise available.

Workforce issues
At the NZNC meeting, HWNZ Board Chair Professor Des Gorman gave a brief overview of his background and then spoke about the work and future plans of HWNZ, a stand-alone business unit within the Ministry of Health. HWNZ aims to provide a single coordinated response to improving New Zealand’s ability to train, recruit and retain the health workforce. During a lengthy discussion with the committee, Professor Gorman said that one of ANZCA’s challenges would be how best to contribute to the changes being driven by HWNZ.

Since those meetings, the NZNC has been advised that HWNZ has established a workforce service reviews, which are to report by the end of the year. The NZNC is seeking further detail about what those reviews cover, who is conducting them and how ANZCA can contribute.

Clinical teachers courses
The New Zealand pilot of ANZCA’s foundation level teachers course will be held at the New Zealand national office from October 18-20. There was keen interest in the course, with about 30 applicants for the 12 places. This two and a half day course is designed to equip participants with the fundamental skills, knowledge and attitudes to teach ANZCA trainees effectively.

National Registrars’ Meeting
The NZNC’s July meeting was a busy time with the committee welcoming new committee members, ANZCA President Kate Leslie and other visitors to its meeting, farewelling outgoing members, electing officers for the next year and holding its annual joint meeting with the New Zealand Society of Anaesthetists.

The election saw Dr Vanessa Beavis (Auckland) appointed chair for a third year, with the previous deputy chair, Dr Paul Smeele (Christchurch), having chosen to step down from the committee. As well as Dr Beavis, the following officers were elected:

- Deputy chair and national education officer: Dr Geoff Long (Waikato).
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Quality and safety
Dr Joe Sherriff has been elected to the new role on the NZNC of quality and safety officer, a position being established in all ANZCA’s regions as well as at the national level for New Zealand. The main aims of the role are to:
• Act as a point of contact and as a conduit for relevant quality and safety information.
• Seek opinions for submissions relating to quality and safety reviews.
• Attend pertinent local quality and safety workshops/meetings where possible, and liaise with the quality assurance officers in accredited hospitals.

Recent publicity about claims under New Zealand’s accident compensation (ACC) scheme showed anaesthesia practice in a good light with claims having halved in the last four years. ACC’s figures showed that there were only 65 treatment injury claims in the anaesthesia category during the 2009-2010 year, continuing a steady reduction since 2006-2007, when there were 135 claims. Nearly all other categories showed considerable year-on-year improvements. Interviewed by The Press (Christchurch), ANZCA’s immediate past president Leona Wilson stressed ANZCA’s and the profession’s commitment to patient safety and quality practice.

Dr John Smithells, (above) who is based at Waikato Hospital, has secured a 12-month position as International Training Fellow in Cardiothoracic Anaesthesia at Derriford Hospital, Plymouth, UK. On August 24, New Zealand’s Health Minister Tony Ryall announced a new productivity program led by surgeons, anaesthetists and theatre nurses to improve quality and efficiency in public hospital operating theatres.

Dr Nina Civil, (above) has recently completed her ATY-year as an anaesthetic registrar at Rotorua Hospital and will undertake her provisional year at Derriford Hospital. Dr Civil’s Fellowship will be divided into two blocks: six months will be spent at the Regional Anaesthesia Fellow and six months as the Simulator Training and Medical Education Fellow, based at the Peninsula Simulation Centre. Dr Civil is looking forward to increasing her skills in regional block techniques and to developing skills and knowledge in her special interest of medical education, particularly with the use of simulation.

More productivity in operating theatres
On August 24, New Zealand’s Health Minister Tony Ryall launched a new productivity program led by surgeons, anaesthetists and theatre nurses to improve quality and efficiency in public hospital operating theatres. The program encourages frontline staff to identify problems with their operating procedures and find ways of solving them. “Theatre staff are often frustrated by delays in starting the day’s surgical list, and delays in preparing patients. These delays often mean less productivity with patients having their operations cancelled,” Dr Ryall said. He said results from the NHS program suggested productivity improvements could be made in a number of key areas:
• Improving start times, turnaround, session uptake and utilisation, and staff wellbeing.
• Reducing time wasted searching for equipment.
• Improving rates of pain control in recovery.
• More smoothly running surgical lists with fewer glitches and improved safety culture with the introduction of briefing and debriefing, along with the WHO checklist.

“Theatre staff report fewer cancelled operations, up to 25 per cent reduction in start time delays, up to 60 per cent faster turnaround between each operation, and significantly improved job satisfaction.”

“The public health service is making progress in doing things better, and making the most of our resources,” Mr Pigou said. It would also benefit patients by contributing to quality and safety in the health system. The MoU contains information in the guidelines to the relevant local and district health boards agreement.

NZ Pain Society abstracts
Abstracts are invited for oral or poster presentations for the New Zealand Pain Society’s Annual Scientific Meeting. To submit an abstract for consideration by the organising committee, you must also register to attend the conference. The theme is “Planning for Pain Management”. The closing date for abstract submissions is January 3, 2011. See www.worksafeconferences.co.nz/ Conference-Calendar/NZ-Pain-Society- Inc-Annual-Scientific-Meeting-2011.aspx for guidelines as to what is required for the abstracts, to submit an abstract or to register for the conference, which is being held in Christchurch, March 17-20, 2011. ANZCA’s Faculty of Pain Medicine is associated with this ASM.

The Medical Council and district health boards agreement
On August 31, New Zealand’s Medical Council and the country’s 20 district health boards (DHBs) signed a Memorandum of Understanding (MoU). The document was signed by ANZCA Fellow and former NZNC member Dr Don Mackie in his capacity as chair of the DHB chief medical officer group, and Mr Philip Pigou, the Medical Council’s chief executive. It enables DHBs and the council to work collaboratively, clarifying their respective roles and responsibilities on the regulation of doctors in New Zealand. Mr Pigou said that the MoU signing recognised the need for clinical governance and leadership between DHBs, the council and clinicians. “The MoU will help achieve our joint objective of ensuring the competence and quality of our medical workforce,” he said. It would also benefit patients by contributing to quality and safety in the health system.

Dr Mackie said that time and money would be saved because the roles and responsibilities were clearly set out.

“Medical Council research
New Zealand’s Medical Council has asked TNS New Zealand, a market research company, to replicate research it undertook for the council in 2007. The research is looking at perceptions for guidelines as to what is required for the abstracts, to submit an abstract or to register for the conference, which is being held in Christchurch, March 17-20, 2011. ANZCA’s Faculty of Pain Medicine is associated with this ASM.

The research is looking at perceptions of the Medical Council’s objectives and performance in various areas. The council wants the research to provide a better understanding of how it is perceived and recommendations on how communications with its different audiences can be improved. The research may also form the basis of social marketing or the development of consumer documents.
31st Annual Combined Continuing Medical Education meeting

More than 200 delegates attended the 31st Annual Combined Continuing Medical Education meeting at the Sofitel on Collins in Melbourne on Saturday, July 24. The theme was “Anaesthesia – tools of our trade”, and the sessions were devoted to discussions of drugs, monitoring, airway devices and quality and safety. It culminated in a fascinating insight into the recent separation of conjoined twins Trishna and Krishna.

Part 0 course for new trainees

On August 1, SA/NT held their Part 0 course for new trainees at the SA/NT regional college to assist them integrating into the SANTRATS training program. Dr Rowan Ousley, chair of the SA/NT Trainee Committee and Dr Rebecca Lewicki (ASA/GASACT representative), facilitated the course. Topics covered included the role of ANZCA, ASA and GASACT, trainee welfare, role of SOTR, ANZCA accredited hospitals, training modules, formal projects, examinations and in-training assessments. The course receives excellent feedback from new trainees and begins their relationship with ANZCA feeling supported and confident to proceed with their training.

SA/NT Scientific Registrars CME meeting

The SA/NT Scientific Registrars CME meeting was held in mid-August. Five registrars presented their formal projects and the winning presentation was awarded to Dr Min-Chi Lee for her presentation on “Providing written information about anaesthesia to patients having elective surgery: A review of practice”. Dr Simon Roberts, part Regional Committee chair, was the course convenor and there were 35 attendees. The meeting was also video-conferenced to Royal Darwin Hospital.

Regional news

Victoria

South Australia and Northern Territory

New South Wales

Port Macquarie ACEC – Future directions in anaesthesia

The NSW Anaesthetic Continuing Education Committee is venturing to Port Macquarie for its annual weekend meeting from November 20-21. Following a tumultuous federal election who knows what lies ahead for health care in Australia? Whatever the outcome, major health reform is coming to an operating theatre near you. This CME meeting, “Future Directions in Anaesthesia – where to next?” will explore some of the changes in health care that are likely to have an impact on your practice.

Professor Stephen Leeder will deliver the plenary address exploring the political aspects of health reform. There will be talks on anaesthesia as it occurs in remote and regional locations as well as some perennial favourite workshops such as the use of ultrasound in anaesthesia, failed intubation, use of the new “smart phones” and by popular demand a repeat of the “Harvey” simulator workshop demonstrating cardiac signs and symptoms in preoperative assessment.

For more information please contact the Sydney ANZCA office on +61 2 9966 9085 or visit www.nsw.anzca.edu.au/events.

NSW ACE Anatomical Workshop – Saturday, November 27 – University of Sydney

The NSW Anaesthetic Continuing Education Committee is pleased to present another full day of anatomy demonstrations using specimens especially dissected for anatomy relevant to nerve blocks. There is a strict limit on the number of registration (50), so please enroll early.

For more information please contact the Sydney ANZCA office on +61 2 9966 9085 or visit www.nsw.anzca.edu.au/events.

Advanced teacher course – delivering feedback

The ACT Regional Committee hosted an advanced teacher’s course on the topic “Delivering Feedback” on August 28. Local ACT and NSW Fellows were in attendance. The ACT Regional Committee and Australian Society of Anaesthetists ACT held a two-hour workshop on Friday, September 10, entitled “Ultrasound from A to Annaesthesia” providing an introduction to ultrasound with plenty of time for hands-on experience in small groups. This was followed on Saturday, September 11, by “Simple But Not Easy: Anaesthetic Management of Acute Trauma” – a combination of short lectures and hands-on stations focused on airway management, ultrasound and transfusion. The workshops were given ANZCA CPD program approval.

Australian Capital Territory
Kathmandu program
This year saw a continuation of the Royal Hobart Hospital’s involvement with anaesthetic training in Nepal. Doctors Simon Morphett, Simon Pitt, Bill Miles and Roger Wong presented a series of lectures and workshops in Kathmandu at the SAN (Society of Anaesthetists of Nepal) Refresher Course in April (among other local and international speakers). The educational theme this year was the cardiovascular system, and the lectures and workshops (on basic TTE evaluation, CPR and problem-based learning scenarios) were received enthusiastically by the Nepalese participants.

The hospital also took part in the scientific meeting at the SAN Congress. There were a number of very interesting audits presented by the Nepalese anaesthetists, including spinal anaesthesia for laparoscopic cholecystectomy and post dural puncture headaches with Quincke spinal needles. Dr Pitt reviewed the use of ECHO for haemodynamic assessment.

Dr Wong remained behind for a further two weeks working at the Kathmandu Medical Centre helping teach the Nepalese anaesthetic registrars. This was extremely valuable and helped give a better understanding of the very different working conditions in Nepal. It also provided feedback to our department on how one of the previous Nepalese anaesthetists the hospital had sponsored to stay in Hobart, was using the knowledge gained from his time with us.

The hospital will again sponsor a Nepalese anaesthetist to come to Hobart for a month this year, and plans to take part in next year’s SAN Refresher Course. It is encouraging to witness the enthusiasm with which the Nepalese anaesthetists learn and apply themselves, and we hope that our relationship will continue to expand over the coming years.

Hobart paediatric update
A meeting entitled “Hobart paediatric update for the occasional paediatric anaesthetist” was held this year at the University of Tasmania Clinical School. This event was organised by Dr Ben van der Griend, paediatric staff specialist anaesthetist at the Royal Hobart Hospital. The full-day meeting was well attended, with more than 120 registrants from around Tasmania and interstate. The topics ranged from difficult paediatric airways, fluid management, resuscitation to congenital heart disease, with speakers from Tasmania and the Royal Children’s Hospital, Melbourne. This meeting provided useful information and tips for non-paediatric anaesthetists.

Regional news continued

Tasmania

From top left: Nepalese anaesthetists Dr Babu Raja Shrestha and Dr Amrit Babu Shrestha on a ward of the Hospital for Disabled Children, Duhikel, Kathmandu. Dr Simon Morphett on the steps of Nyatapola temple, Nepal.

Western Australia

WA Winter Scientific Meeting
The Annual Winter Scientific Meeting was held on Saturday, July 31, at the Perth Convention and Exhibition Centre. The theme of the meeting was “Current Challenges in Anaesthesia”. The meeting was well supported with more than 150 anaesthetists and 34 trade representatives attending.

This scientific meeting is the first of the three-year WA lectureships named in honour of our esteemed colleague Dr Ian McGlew. Pain medicine specialist Dr Eric Visser gave the first in this series speaking on “What’s new in pain: Smoke and mirrors” (see page 92). The morning session included a lecture from endocrinologist Dr Emma Hamilton who discussed the recent advancements in diabetes including new medications and treatments.

Morning tea was followed by the free paper session and the ANZCA Western Australia Annual General Meeting. The Dr Nerida Dilworth Prize, which is given to a registrar in anaesthesia in Western Australia who contributes significantly to the ASA and/or ANZCA, was awarded to Dr Manuel Wenk. Dr Nerida Dilworth attended the meeting to present the prize.

The first session after lunch was presented by Dr Mark Krumrey, a consultant anaesthetist from Fremantle Hospital, on “Optimal management of a patient undergoing joint replacement”, followed by Dr Preeti Negi, previously an enhanced recovery anaesthetic Fellow at St Mark’s Hospital, Harrow, UK, now based at Fremantle Hospital, who spoke about enhanced recovery following colorectal surgery. Delegates also had a choice of a concurrent impaired-colleague workshop presented by specialist addiction medicine physicians Dr Moira Sim and Dr Eric Khong.

The final session consisted of a choice of three workshops including “Airway toys and tools” with Dr Alex Swann, “Management of double lumen tubes” presented by Dr Bill Waitegreen and “Practical fluid management” with Dr Michael Hwang. Thank you to those people who assisted with the workshops. There was also a case panel discussion chaired by ANZCA WA Chair Dr Jenny Stedmon and assisted by panel members Dr David Wright, Dr Brian Hemmings, Dr Craig Cox, Dr Luke Torres and Dr Malcolm Thompson in which a new electronic keypad voting system was trialled.

From top left: Delegates at the meeting Dr Sarah Wyatt and Monzer Sadek; Dr Eric Visser and Dr Peter McLoughlin; Dr Markus Scherff; Dr Stephen Hirs; Dr Prani Srisakala and Dr Andrew Miller.

Above from top left: Delegates at the meeting Dr Sarah Wyatt and Monzer Sadek; Dr Eric Visser and Dr Peter McLoughlin; Dr Markus Scherff; Dr Stephen Hirs; Dr Prani Srisakala and Dr Andrew Miller.
Regional news continued

Queensland

Primary exam preparation short course
The primary exam preparation short course was held in late June. The course was fully subscribed with 35 participants who heard from Dr Frances Ware, Dr Peter Moran, Dr Rebecca Finnis, Dr Genevieve Goulding, Dr David Trappett, Dr Mark Dilda, Dr Sue Lawrence, Dr Anna Mildeck, Dr Dean Hayden, Dr Paul Gray, Dr Victoria Eley, Dr Hau Tan, Dr Michael Fanthawe, Dr Simon Patullo, Dr Mark Lai, Dr Adrian Chin, Dr Pal Skvologang, Dr Peter Reid, Dr Victoria Eley, Dr Peter Waterhouse, Dr Steve Cook and Dr Helmut Schoeneng (convenor).

Primary Lecture Program
The Primary Lecture Program for semester two has commenced. The lectures are held monthly on a Saturday in the Queensland regional office and the convenor is Dr Gamini Wijerathne. Topics covered so far include fluid and electrolytes, neurophysiology, autonomic physiology and pharmacology, antihypertensive agents, physiology and pharmacology of pain, opioid and non-opioid anaesthetics and opioid antagonists. Thank you to speakers Dr Matt Kello, Dr Mark Lai, Dr Gamini Wijerathne, Dr Rebecca Ruberry and Dr Paul Franks and convenor Dr Gamini Wijerathne.

ANZCA Queensland Regional Committee AGM
The ANZCA Queensland Regional Committee AGM was held on July 21 and the guest speaker was Dr Tony O’Connell. Dr O’Connell is a Fellow of ANZCA and OCM and spent 28 years as an anaesthetist and an intensive care specialist. In 2009 Dr O’Connell was appointed CEO for the Centre for Healthcare Improvement in Queensland.

Final exam preparation course
The final exam preparation course was run in July. The course was fully subscribed with 31 participants, including participants from Perth and New Zealand who heard from Dr Dominique Hopkins, Dr Peter Moran, Dr Rebecca Finnis, Dr Genevieve Goulding, Dr David Trappett, Dr Mark Dilda, Dr Sue Lawrence, Dr Anna Mildeck, Dr Dean Hayden, Dr Paul Gray, Dr Victoria Eley, Dr Hau Tan, Dr Michael Fanthawe, Dr Simon Patullo, Dr Mark Lai, Dr Adrian Chin, Dr Pal Skvologang, Dr Peter Reid, Dr Victoria Eley, Dr Peter Waterhouse, Dr Steve Cook and Dr Helmut Schoeneng (convenor).

FPM CME dinner meeting
On Tuesday, July 27, the Faculty of Pain Medicine Queensland Regional Committee hosted their third continuing medical education dinner meeting for 2010. Dr Michael Gattas from Brisbane Genesics Private Clinic spoke on genetics and musculoskeletal medicine and the event was well attended by pain medicine Fellows.

2010 Queensland retired anaesthetists’ lunch
On Wednesday, August 25, the ANZCA Queensland office hosted a casual lunch for retired anaesthetists in Queensland. Thank you to Col Busby for initiating this lunch. It is a great social event for retired anaesthetists and a wonderful opportunity for those who have not visited our new premises in West End to see them.

Clinical training workshop
Friday, July 30 was the day of the clinical training workshop in Queensland facilitated by the Education Unit out of Melbourne. There were 15 attendees and the topic covered this year was delivering feedback.

34th Annual Combined ANZCA/ASA CME meeting
On July 10 the 34th Annual ANZCA/ASA Combined Continuing Medical Education meeting was held at Victoria Park Golf Complex. The theme for the day was acute pain, the ongoing challenge. The day was well received by 95 attendees, who heard speakers Professor Julia Fleming, Dr Bob Thomas, Dr Peter Goodyear and Dr Paul Frank. Following lunch, the afternoon contained problem-based learning discussions facilitated by Professor Fleming, Dr Tania Morris, Dr Kathleen Cooke, Dr Janice Stafford, Dr James Craig and Dr Nathan Goodrick along with a workshop held by Dr Mike Haines and Dr Frank on ultrasound guided techniques.

From top: Dr Mike Haines presents his workshop on ultrasound guided techniques; A problem-based learning discussion session.

Cost: $330 (Incl. GST) Includes: Arrival Morning Tea & Coffee; Lunch For information please contact NSWACE Ph: +61 2 9966 9085 Fax: +61 2 99669087 or email: nswevents@anzca.edu.au www.nsw.anzca.edu.au/events

Convenors: Dr Joe McGuinness and Dr Liz O’Hare

SA/NT COMBINED ANZCA/ASACME ASM 2010
The Burnell Jose anaesthesia update
Visiting Professor Steve Shafer
Guest Speakers
Professor Kate Leslie
Dr Erica Wood
Dr Andrew Davidson
Dr John Loadsman
Assos Prof David Story
Local Speakers
Assoc Prof Pam Macintyre
Dr David Costi
Dr Mark Boesch

Further information and a registration form is available from the ANZCA SANT Regional website www.sant.edu.au/events/CMEMeetings2010.html

The Burnell Jose anaesthesia update
‘Anaesthesia Fallout’
The longer term implications

Saturday 13 November 2010
Sunday 14 November 2010
at the Novotel, Barossa Valley, SA

Cost: $330 (Incl. GST) Includes:
Arrival Morning Tea & Coffee; Lunch
For information please contact NSWACE
Ph: +61 2 9966 9085 Fax: +61 2 99669087
or email: nswevents@anzca.edu.au
www.nsw.anzca.edu.au/events

Convenors: Dr Joe McGuinness and Dr Liz O’Hare
Dean’s Message

Those engaged in Faculty and College affairs have been well occupied with the future, only some of which will be mentioned here. First for mention is the appointment of Associate Professor Milton Cohen to the role of Director of Professional Affairs (DPA) for the Faculty. Although this is a part-time position, it is a role that has known how much input organisations like ours have to make to many of important processes, such as the Australian Medical Council’s request for input into their competence-based medical education proposals. The demand for input into this and similar submissions seems to be increasing. Engagement of DPs within ANZCA and the Faculty ensures quality responses beyond what pro bono participants alone can keep up with these days. We are fortunate to have the benefit of Milton’s extensive engagement with pain medicine over a long time, and as a former Dean of the Faculty, he is well versed in our activities and position on these subjects.

You may recall that a variety of opioid topics were referred to in my last message, cued by media items following our Christchurch ASM. We now have (a new) PM1 – Principles regarding the use of opioid analgesics in patients with chronic non-cancer pain, which was approved by the board at its August meeting. Some may recognise PM1 as the identification of a previous Faculty professional document, but on becoming obsolete it was vacated, freeing this easy to remember number for this purpose – somewhat poetic! It has been a long time coming, partly because of the controversy necessitating significant consultation, partly due to decisions in relation to waiting for some of the recent educational meeting expert visitor presenters, and the need to review a significant amount of the recent literature. Around the world this is a hot topic. One important factor in developing this set of principles, based on the best evidence available no matter how imperfect that might be, was that primary care has one of the greatest needs for guidance on a robust approach to opioid treatment for pain (across the board, not just long term non-cancer pain). What is evident to pain medicine specialists is that the dose is often already cast with opioid prescribing by the time we get to see cases. With that need in mind an easy to use single sheet guidance checklist for people such as GPs was included with other appendices as part of the package surrounding PM1. Patients on good, bad or ugly opioid prescribing are often surgical patients, so I urge anaesthetists to also read through PM1, even if they are not generally managing long term pain cases. Anaesthesia practice includes a high component of opioid prescribing, so being widely informed has to be a plus.

On the subject of primary care, it is pleasing to note that RACGP has set up a fundamentals day on pain in their forthcoming Cairns annual conference (“GP10”) in October. We live in times where the interest in managing pain better is on an exponential increase – and where the majority of pain is dealt with away from specialist facilities. So for the specialists – prepare yourselves to engage with helping them with that.

Another working group led by Associate Professor Leigh Atkinson is examining work on neuromodulation best practices and a document is nearly ready for publication for Australia and New Zealand; our DPA in parallel with this has made significant progress on a Faculty position statement based on that working group’s recommendations. Again, given the diversity of opinions, it has been a creditworthy exercise that the group is looking for that which captures the best evidence, and there are some other sets of recommendations from elsewhere in the world that have saved much renovation of the wheel. Without pre-empting their final deliberations, I can say that there is a list which has stratified conditions into those highly likely to respond, and a grey area in between those for which response is unlikely. This is highly relevant to minimisation of resource waste.

Highly connected with interventions such as referred to above, the board recently received a letter from a Fellow asking what was the definition of a pain medicine specialist. For the national registration body, it was earlier agreed that the term for such registered persons would be “specialist pain medicine practitioner”. You can imagine many heated discussions over that term! However, aside from the fact that a blueprint exercise on this very subject is underway, the board endorsed the underlying premise that such a person was one fully conversant with the full spectrum of the biopsychosocial components that make up pain and its impact, with knowledge enough to integrate and guide the patient through multiple modes of therapeutic help. This does not mean that any one person will be competent to engage in all of surgical, interventional or psychiatric help measures. Nor should surgical Fellows of our Faculty feel threatened that the specialised things they do to help those with complex pain (for example, hysterectomy as part of a wider package, not the sole means to an end in itself) mean they do fit from elsewhere in the world that have saved much reinvention of the wheel. Without pre-empting their final deliberations, I can say that there is a list which has stratified conditions into those highly likely to respond, and a grey area in between those for which response is unlikely. This is highly relevant to minimisation of resource waste.

Faculty of Pain Medicine

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Faculty of Pain Medicine

News

Fellowship training and examination dates for 2010

Examination dates November 24–26, 2010
Barbara Walker Centre for Pain Management at St Vincent’s Hospital, Melbourne, Victoria.
Closing date for registration: October 6, 2010.

Pre-exam short course October 13–15, 2010
Royal Adelaide Hospital, South Australia.
Closing date for registration: October 1, 2010.

Reviewer training A workshop for the Faculty of Pain Medicine’s Panel of Reviewers was held at ANZCA House on Saturday, August 7, and was facilitated by Mark O’Reen of the Cognitive Institute. The workshop attracted most reviewers who learned valuable interviewing skills and was viewed as a highly valuable exercise. One outcome from the workshop is to instigate pre-review teleconferences between the two reviewers to discuss potential issues and coordinate who will lead the review.

Professional documents The board approved a new professional document: PM1 The Use of Opioid Analgesics in Patients with Chronic Non-Cancer Pain. This has followed extensive review of the literature on both the goals of treatment and addiction medicine knowledge, which has been more available for ongoing research, together with similar consensus statements in Europe, US and UK. PM1 has been published in full in this issue of the ANZCA Bulletin and can be found on page 96.

Admission to Fellowship of the Faculty of Pain Medicine

Supervisors of training The supervisor of the supervisors of training (SoSoE), Dr Tim Sempel will be resigning from this position in October, and expressions of interest from colleagues are sought for his successor. The role of the SoSoE is to manage and coordinate the needs of the supervisors of training (SoEs). The SoSoE also oversees the two annual FPM SoEs workshops and the trainee lunch that is held at the Annual Scientific Meeting. The Faculty of Pain Medicine thanks Dr Sempel for his enthusiasm, dedication and hard work on formalising the SoE ratification process. For further information please contact the Faculty of Pain Medicine office.

Training unit accreditation Fremantle Hospital in Western Australia has recently been accredited, which takes the Faculty of Pain Medicine to 24 accredited units.
Discussion at the Summit focused on two areas: the desirable characteristics for national pain strategies and the Declaration of Montreal – an agreement that access to pain management is a fundamental human right. While the Summit agreed in principle that access to pain management is a fundamental human right, there was ongoing discussion about the wording of the Declaration. This will be finalised by a steering committee in the coming weeks and circulated to participants for their endorsement.

Held under the auspices of the International Association for the Study of Pain (IASP), the Summit was attended by a number of Australian pain management specialists including Professor Milton Cohen, Associate Professor Pam Macintyre and Dr Penny Briscoe.

On September 3, clinicians, health ministers, senior health administrators, the World Health Organization and other organisations representing healthcare, not-for-profit and human rights organisations, from 84 countries met in Montreal at the first global meeting about crucial aspects of pain management, with a focus on advocacy and assistance for all countries to develop national pain strategies.

The World Health Organization estimates that over five billion people live in countries with limited or no access to medicine or treatment for moderate to severe pain. The management of acute pain is suboptimal in more than 50 per cent of people in developed countries and 90 per cent of people living in developing countries.

The International Pain Summit was chaired by Professor Michael Cousins, who chaired the inaugural National Pain Summit in Canberra earlier this year that resulted in Australia’s National Pain Strategy, the first comprehensive national strategy with the largest and most consistent focus on a single healthcare issue in this era. The Australian summit was a catalyst for this global initiative and Australia’s National Pain Strategy was a key resource in the delegates’ deliberations at the international pain summit.

“Chronic non-cancer pain occurs in at least one in five people worldwide. It can be triggered by surgery, injury, diseases such as HIV/AIDS, multiple sclerosis, arthritis and shingles – and sometimes for no apparent cause. It is a disease entity that is inadequately managed in the majority of adults and patients worldwide,” Professor Cousins said.

“Of people with cancer, 70 per cent experience pain yet it is inadequately managed in more than 50 per cent of adults and 90 per cent of children in the developed world and more than 90 per cent in developing countries. The reality is that most pain conditions can be effectively treated, if current knowledge can be shared and put into practice. The International Pain Summit is a major step forward towards achieving this.”
Nociception is not the same as pain

John Cannon: Does it hurt when you get shot?

The Terminator: I sense injuries. The data could be called “pain.”


Although the definition of pain remains unchanged since 1979 (perhaps surprisingly given the massive strides in knowledge since that time), nociception was defined for the first time in a review of pain taxonomy in 2001.

Pain is still defined as, “an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.”

This is distinct from nociception which is, “the neural... encoding and processing of noxious (tissue-threatening) stimuli”; in other words, transducing the energy of tissue damage (mechanical, thermal, emotional, etc.) into neuro-electrical energy for processing in the nervous system. “Pain is a subjective phenomenon whereas nociception is the object of sensory physiology.”

Pain is a function of consciousness. There’s no ‘pain centre’ in the brain and, strictly speaking, there are no ‘pain pathways’; the spinothalamic tract transmits nociception and not pain. Pain doesn’t cause changes in the nervous system, although various processes such as cortical changes on fMRI are associated with pain.

Nociception is the process that usually (but not exclusively) triggers and drives the multidimensional experience of pain. However, pain can clearly occur in the absence of nociception (tissue damage) (e.g., phantom pain or algodystrophy). Thus is a key message for patients, healthcare professionals and even insurance providers, searching for that elusive ‘source’ of pain on an MRI for example; you can’t see ‘pain’ on an x-ray, and yes, it’s quite plausible to have pain without tissue damage!

Nociception is comparable to the process of sound energy being converted into nerve impulses in the inner ear and transmitted to the auditory cortex. Hearing is the conscious perception of these auditory stimuli, and pain is like ‘music’, the complex sensory and emotional experience. Like pain, you can also ‘experience’ music in the absence of a sensory stimulus (a tune playing in your head).

The ‘Yin and Yang’ of nociceptive processing

Central sensitization (CS) is defined as, “increased responsiveness of nociceptive neurons in the central nervous system to their normal or subthresholdafferent input”, or simply put, “increased output of a given input”, a true amplifier effect. Hyperalgesia and allodynia are the clinical signs of CS.

There is continuous modulation of nociceptive traffic in the nervous system, a “yin and yang” of signal amplification (peripheral and central sensitization), and signal dampening by processes collectively termed Diffuse Nociceptive Inhibitory Control (DNIC).

The balance is tipped in favour of DNIC which is tonically active, so we are not overwhelmed by a barrage of nociception (and pain); for example, the intense pressure (10 kg/cm²) on our ischiums whilst seated during this lecture!

Patients experiencing severe acute pain and chronic pain syndromes (e.g., fibromyalgia) may have dysfunctional DNIC as a root cause of their problem. A recent trial demonstrated that patients with poor DNIC (determined experimentally), were at higher risk of developing post-thoracotomy pain at six months. Such tests may become part of pain assessment in pre-anaesthesia clinics of the future.

Pain and the virtual body-self: smoke and mirrors?

Pain is a highly personalised sensory and emotional phenomenon which is experienced in our ‘internal world’ of the ‘self’ when our tissues are under threat, in turn motivating and conditioning us to take action to avoid tissue damage.

Neuroscientists believe that our sense of ‘self’ resides in a ‘virtual body’ (self) generated by a brain neuromatrix that is modulated or ‘nurtured’ by a constant stream of sensory (e.g., proprioceptive, visual, vestibular, nociceptive) and cognitive-affective inputs. In response, the neuromatrix ‘generates’ perceptions which we experience as ‘self’ (a sense of ‘what is me’ [e.g., my arm, our position in a 3-D space, the weight and volume of limbs], also experiences such as nausea, heat, itch and pain).

In all probability, the VBS operates ‘slowing down’ (more time to react?) at times of extreme threat (demonstrated experimentally by dropping psychology students into a net from a great height)!

With this in mind, our bodies might simply been seen as biological machines or ‘vessels’ that support and defend the viability of our ‘true’, experiential (virtual) self. Interestingly, this parallels descriptions of the ‘soul’ in some philosophies.

“Admiral Lord Nelson had a (painful) phantom hand, the presence of which convinced him of the immortality of the soul.” (Gooddy W, 1970).

Ronald Melzack proposed that pain is generated by a pain neuromatrix the brain (integrated within the VBS) in response to actual or perceived tissue threat. The data could be called “pain.”

The ‘Threat Matrix’ model

As an extension of Melzack’s pain neuromatrix model, Visser and Davies postulate the existence of a ‘black-box’ threat management super-system, integrated within the VBS of humans called the Threat Matrix (TM), which manages the entire spectrum of actual and potential threats to an individual’s tissue integrity and homeostasis.

Teleologically-speaking, various ‘noxious’ inputs such as cognitions, nociception, immuneception, chemoeception, thermoeception and conflicts in sensory or sensory-motor processing, are ‘interpreted’ as threats to the viability of the physical tissue substrate (and by extension the VBS) by the TM, which in turn generates a repertoire of defensive responses to deal with these threats. Such responses include the ‘experiences’ of fear (anxiety), pain, itch, noxious heat and cold, nausea, dyspnoea (suffocation) and fatigue. They also include motor and sensory responses (non-dermal sensory deficits and neglect; seen as ‘switching off’ an ‘at-risk’ body zone), pain behaviours (signalling tissue damage to others in the ‘tribe’, to obtain help or as a warning) and even dissociation and depersonalization (an out-of-body experience is the ultimate means of ‘escaping’ the VBS when it is over-whelmed by threat, as in PTSD).

These phenomena are often associated with significant biological and in particular psycho-social (‘yellow flags’)
What’s new in pain: smoke and mirrors? continued

As an threat management super-system, it is postulated that any threatening stimulus could conceivably trigger any—or all of the TM’s repertoire of defensive responses, especially in situations of ‘overload’ as in major trauma. A TM overwhelmed by nociception may produce not only pain (the congruous response), but also fear and nausea. A panic attack shows how a produces a sense of fear and doom, but also pain, nausea, dyspnoea and depersonalization.

The TM is a teleological model that may help conceptualize the often puzzling variety of threat-related phenomena seen in humans, including pain, fear, sensory-motor dysfunction, illness behaviours and suffering, especially in situations of extreme threat or stress loading. The ‘acute stress’ (‘fight or flight’) and ‘sickness’ responses (‘curl-up and conserve’) are integral to these phenomena.

The provisional program is headlined which they were exposed, perhaps reflecting the effects of stressor-loading.

Patho-physiological (‘wounding’), infection, inflammation, cancer) and psycho-social (‘yellow flag’) stressors act as ‘triggers’ or ‘drivers’ of this response. A recently published study showed the probability of a patient developing chronic low back pain after an acute injury increased cumulatively with the number of ‘yellow flags’ to which they were exposed, perhaps reflecting the effects of stressor-loading.

Many chronic pain patients and those with other systemic illnesses such as inflammatory bowel disease, clearly exhibit many of the features of the ‘stress/sickness response’, including widespread and chronic pain, fatigue, cognitive dysfunction, sensory sensitivity and behavioural withdrawal (very much like having a dose of the ‘flu that goes on forever), with sufferers becoming a kind of ‘walking-wounded’. Importantly, chronic pain is an effect of the sickness response, not a cause of it. This reflects complex changes in cellular, genetic, neurological (including psycho-cognitive and autonomic), endocrine, environmental and in particular immune (cytokines) systems, occurring in and around the sufferer.

Such patients may respond to modulation of these responses through ‘whole-person engagement’, using treatments as diverse as psychology (especially stress management), physical therapies, neural (drugs, ‘blocks’, mirrors, virtual reality etc) and immune modulation, even placebo techniques. Multidisciplinary educative pain programmes (‘knowledge is power’) are being investigated to help persons ‘modulate’ their own pain experience through information and self-efficacy.

The fear-pain continuum

The associations between fear (anxiety) and pain are numerous (neuro-anatomy, physiology, pharmacology, psychology, epidemiology); they might even be considered a ‘continuum’. To paraphrase the IASP definition of pain, fear may be considered, ‘an unpleasant physiological and emotional experience associated with actual or potential (‘total’) tissue damage’ (an existential threat!). The development of wounds widespread pain syndromes’ such as fibromyalgia may represent a ‘shift’ in this continuum towards fear (all the tissues are perceived ‘at risk’). It’s also possible that in higher organisms such as man, fear evolved from phylogenetically primitive nociceptive (pain) systems.

Conclusion

Pain is much more than the sensory perception of tissue injury. Pain is a complex and unpleasant multidimensional experience of the ‘self’, associated with perceived tissue threat. Pain is as difficult to understand as consciousness, love or anxiety and yet it pervades the existence of many living things on this planet and in particular the human condition.

Acknowledgement: Many thanks to Dr Stephanie Davies, Fremantle Hospital and Health Service for her shared ideas and concepts which are presented in this text.


Dr Eric J Visser MBBS FANZCA FFPMANZC

Pain medicine specialist and anaesthetist at Fremantle Hospital and Joondalup Health Campus, Western Australia.

Key References:

1. Introduction
This document outlines principles to guide the prescription of opioid analgesics in the management of patients with chronic (or persistent) pain of non-malignant origin, here referred to as chronic non-cancer pain (CNCP).

Two principles are acknowledged, as is the paucity of good quality evidence either in favour of or opposed to the efficacy of opioid analgesics in the management of patients with CNCP. However, the issue of underestimating the need for this document is that of effectiveness of pharmacotherapy in the individual patient. The scientific literature and clinical experience both attest that the responsiveness to opioid analgesic drugs of any patient with CNCP cannot be confidently predicted, so that the prescription of such agents must be regarded as an ongoing individual trial of therapy.

2.1 Comprehensive assessment
Pharmacotherapy for the patient in pain is only ever part of a multimodal plan. Such a plan does not imply necessarily that many health care personnel need to be involved, especially where resources are limited. Rather it refers to the importance of recognizing and, if possible, addressing non-somatic contributions to the patient’s predicament, especially the social environment, including work. This is not to ignore the somatic or biological contributions, where a confident diagnosis should be made if possible. Psychological assessment includes exploring beliefs regarding diagnosis and prognosis, expectations and mood. Social assessment embraces impact on activities of daily living including sleep, recreation and nutrition, effects on family and other relationships, and the influence of life events.

Non-steroidal anti-inflammatory drugs (NSAIDs) offer little advantage over paracetamol, especially in the most common situations when inflammation is not the relevant mechanism.

Addictive analgesics can be considered before opioids. These include tricyclic antidepressant drugs (amitriptyline, nortriptyline), serotonin-noradrenaline reuptake inhibitors (venlafaxine, duloxetine) and anticonvulsants (Gabapentin, pregabalin, sodium valproate). Invasive physical therapies (implants, injections, implants) are often considered in parallel with the above approaches. A trial of opioid pharmacotherapy can be considered independently of invasive techniques.

2.3 Agreement regarding an opioid trial
The aim of a trial of an opioid analgesic is to discover the individual’s responsiveness to this therapy in terms of improved quality of life. This requires frank articulation on the goals of the trial, including an agreement that if the goals are not met, then the trial will be discontinued. The goals are beyond pain relief alone and emphasise improvement in physical, emotional and mental functioning, including an increase in activity. These goals can be negotiated according to the individual’s wishes and capacity.

In this respect, a therapeutic contract is established, which can be made explicit verbally, through entries in notes or in a written written agreement. This contract reflects the seriousness of the undertaking between prescriber and patient. There should be only one prescriber of a patient’s opioids, with adequate back up provision should that prescriber be unavailable. Ideally, the one pharmacy should dispense the opioid. Once opioid responsiveness is established and side-effect profile addressed, the contract can be extended, with caution and no early repeats, no loss replacements and an option for random urine monitoring (where appropriate) until a stable dosage regime is established. The contract may include an option for a time limited maintenance period before staged withdrawal of opioid therapy.

2.4 Conduct of an opioid trial
Chronic pain should not be treated with short-acting drugs. Thus, long-acting or sustained-release oral or transdermal preparations are recommended. As the use of opioid analgesics in the management of pain is an ongoing individual trial of therapy, regular assessment addresses and documents:

- Analgesia.
- Activity.
- Adverse effects.
- Affect.
- Aberrant behaviour.

Titrating of dose according to this “AA” assessment need not be rapid: such a trial may take several weeks. An improvement in overall well being in the opioid-responsive patient may incur “incident” pain, which can be addressed by a modification of the long-acting opioid dose rather than by adding a short-acting agent. The question of a “ceiling dose” has not been settled. Doses above the equivalent of 120mg morphine per day require reassessment including specialist advice if possible. Once stability of dose and responsiveness has been achieved, regular review should be undertaken with repeat prescriptions contingent on ongoing satisfactory “AA” assessment. At least annual peer or specialist review is recommended.

3. Response to difficulty in achieving or maintaining goals of an opioid trial

difficulty in achieving satisfactory “AA” assessments in the context of the individually tailored goals of an opioid trial may be attributable to pharmacodynamic, pharmacokinetic or behavioural factors. Pharmacodynamic factors, such as non-responsiveness of distress or development of insurable side effects, and pharmacokinetic factors, such as insufficient or excessive duration of effect, may respond to change in opioid preparation (“rotation”) or change in dosing regimen. Variations in stability of dose and responsiveness over time, including apparent increase in dose requirements (other than for “incident” pain), may reflect change in the underlying somatic (biological) contribution, development of tolerance (pharmacological, psychological or increased sensitivity to stimuli), change in mood, social circumstances or other stressors, or development of aberrant drug-taking behaviour. Such situations require comprehensive reassessment along the same principles as above.

Actions arising out of such reassessment may include recalibration of goals of therapy, tapering of opioid to withdrawal, reconsideration of other modes of therapy and consultation with colleague(s).

3.1 Key readings informing this document
Harnessing system plasticity to meet the need: A step in the right direction?

By Dr Stephanie Davies MBBS FANZCA FPMANZCA

Our aim was to empower patients to understand and use a range of evidence-based pain management strategies, as well as to restructure the public system so that they can contribute to “driving” their own health care in a time and resource efficient manner. The weekly eight-hour STEPS program provides attendees with evidence-based knowledge and skills to increase their use of active strategies, to improve their outcomes and reduce the unit cost, per new patient seen.

The STEPS intervention began life on October 2, 2007 as a pilot program. System changes at that stage included the introduction of a structured “Patient Triage Questionnaire” (PTQ). This valuable innovation enabled health professionals to better triage referrals, in terms of urgency, in line with the WA Clinical Priority Access Criteria and to appoint patients to pre-clinic STEPS when: (i) they were non-urgent; (ii) their prescribed opioid dose was less than 100mg per day morphine equivalents; and (iii) their clinical presentation was not dominant diabetic neuropathy or post-herpetic neuralgia.

The Fremantle Hospital Pain Medicine Unit has been involved in two research projects, both funded by the WA Department of Health, via the State Health Research Advisory Council grant scheme. The Royal Perth Hospital Pain Medicine Unit contributed to both projects.

The first project, known as “In-STEP”, is for people with persistent pain; the second is “gPEP”, which aims at health professionals. Development of both projects, from content construction through to implementation, involved physiotherapists, occupational therapists, clinical psychologists, and pain medicine physicians. A hybrid program, the "Spinal Pain Rural Roadshow", has recently been implemented as an initiative from the WA Spinal Pain Model of Care. It is exciting that these projects align with the WA Health Network’s Spinal Pain Model of Care as well the recently released National Pain Strategy.

Initiated Self Training Educative Process (In-STEP): “In-STEP” consists of pre-clinic inter-professional group education followed by patient-initiated outpatient clinic appointments. Self-Training Educative Pain Sessions (STEPS) is a two day eight-hour program that runs weekly. The system redesign for In-STEPS was placing the two-day group education program STEPS program ahead of initial individual consultations. This was a “system inversion” of the usual sequence of health care delivery within tertiary pain medicine units.

The remarkable team work from the many individuals and organisations involved in these three projects has shown how effective and important collaboration can be, both from an interprofessional perspective and partnerships with like-minded organisations. It has meant that the journey has been interesting, stimulating and educative for all (with just a “few” stressors). The question is “are we there yet?” or is this just one step in the right direction?

The Spinal Pain “Rural Roadshow” is jointly sponsored by the Health Networks Branch (WA Department of Health), Rural Health West and Arthritis WA, with the evaluation being conducted by Curtin University. The weekend forums introduce basic pain education and practical pain management skills to health professionals and consumers in WA’s regional and remote areas. gPEP is delivered to a wide range of health professionals on the Saturday, and STEPS to patients and carers on the Sunday. Its emphasis is on spinal pain, however, the principles of management are applicable to many of those with persistent pain. The forums start to address the inequity of access for those who live outside metropolitan Perth.

The three pilot locations are Kununurra (August 7-8, 2010), Albany (November 27-28, 2010) and Kalgoorlie (February 26-27, 2011).

References:
In Australia and New Zealand, pain often goes unrecognised and even when it is recognised it may be inadequately treated. In many developing countries, as in many Pacific Islands, as in many developing countries, is worse. Among the myriad barriers to overcome in improving pain management are problems with staff shortages, an unreliable supply of drugs, limited educational opportunities and cultural differences.

Fortunately, many effective pain management strategies are “low tech” and cheap and can offer significant improvements to an individual’s quality of life.

There is little good data about the prevalence of pain in developing countries. However, we know that trauma, especially from motor vehicles, is common and increasing, and postoperative and obstetric pain is prevalent, and the World Health Organization has indicated that 80 per cent of new cases of cancer occur in developing countries. It is estimated that PNG has about 15,000 new cancer cases per year with 10,000 cancer-related deaths. Extrapolating from Australian data, it is probable that at least 75 per cent of these patients will experience moderate to severe pain during the course of their illness. This adds up to a lot of patients with significant pain.

During 2009, Dr Roger Goucke collected some anecdotal pain data in Fiji and Vanuatu from nurses and doctors in an attempt to quantify the frequency of significant pain in Pacific Island hospitals. Cancer pain and acute pain were both commonly seen. One further outcome from this small survey was that pain in cancer patients following discharge from the hospital was thought to be poorly managed.

Our discussions with local health workers about types of pain confirm that cancer pain, post-surgery pain, trauma pain and even chronic non-cancer pain are common and often inadequately treated.

Barriers to pain treatment that were reported included:

- Cultural beliefs (staff and community) that pain is expected or normal.
- Limited knowledge about pain and its treatment.
- Concerns about opioid side effects and addiction.
- Unavailability of drugs, including immediate release morphine tablets or syrup.
- Shortage of health workers, for example, one nurse for 20 patients on a post-surgical ward.

There are persuasive humanitarian reasons to offer effective cancer pain management in a country where prevention is minimal, patients frequently present with late stage disease and treatment options are limited. There are also compelling reasons to treat other types of pain, as better postoperative and trauma pain management should decrease post-operative complications especially in high risk patients.

For a couple of years now we have been developing a short course called the Essential Pain Management (EPM) course. The main aim of the course is to upskill doctors, nurses and other health workers in developing countries on pain management. The course uses interactive techniques to teach a simple approach to recognise, assess and treat pain, now known by the acronym RAT!

We have also developed a short instructor workshop that can be run the day after the initial course for individuals who want to take the program back to their own hospitals/communities. This idea follows the highly successful Primary Trauma Care program of teaching the teachers" with the aim of getting some degree of sustainability.

To our knowledge, the Essential Pain Management course is the first pain management course of its type.

The morning session consists of a series of short interactive lectures and group discussions:

- What is pain?
- Classification of pain.
- Pain physiology.
- Pain pharmacology.
- Reasons to treat pain.
- Pain management barriers.

In the afternoon, participants use the RAT approach to guide small group discussions looking at a series of difficult pain problems (illustrating acute nociceptive, paediatric, cancer, and neuropathic pain).

Finally, the participants brainstorm possible solutions for overcoming barriers where they work. An appendix to the course material provides templates for acute and cancer pain management guidelines that can be modified to suit local situations. A feedback form and a number of multiple choice questions complete the day.

We wish to thank ANZCA for its ongoing support of the EPM program.
The Faculty will hold its ninth annual Refresher Course Day on May 13, 2011 in Hong Kong. The theme is “Pain Management: Getting Closer to the Dragon Pearl”. The provisional program is broadened by international guests, Professors Catherine Bushnell, You Wan and Spencer Liu, and complemented by national leaders in opioid management and outcomes in pain medicine.

Communications
Correspondence was exchanged with Good Health Publications with regard to their plans to develop a “Pain Management in General Practice” publication. Subsequently, a number of Faculty Fellows have agreed to participate on the editorial board with the aim of improving knowledge and practice at a primary-care level. While the publication will not carry the Faculty’s imprimatur, it is being driven at an editorial level by some of our Fellows.

Fellowship affairs portfolio
The following were admitted to Fellowship in June:

By training and examination:
- Assad Hussain, FANZCA (HK)
- Max Sarma, FRACGP (Tas)
- Kerryn Louise Thompson, FANZCA, (Vic)
- Garry Egger (Aus)

2011 ASM – Hong Kong
The Faculty will hold its ninth annual Refresh Course Day on May 13, 2011 in Hong Kong. The theme is ‘The Australian Pain Management Association, with the understanding and support of the Queensland Government and Queensland Health’. This significant boost to funding will make a tremendous difference to patients with persistent pain.

2011 Spring Meeting
Dr Geoff Spedewinde and Dr Guy Bennett will convene the 2011 Spring Meeting in Canberra. Dates have been confirmed as September 28-30, 2011.

2012 ASM – Perth
Dr Dan Bennett (USA) has been formally invited as the FPM ASM Visitor and Professor Henrik Kehlet as the FPM Perth Visitor. By accepting the invitation, Professor Kehlet would also have the opportunity to present for conferment of Honorary Fellowship of the Faculty, awarded in 2004.

FPM professional documents
Principles Regarding the Management in General Practice for Diagnostic and Interventional Medical or Surgical Procedures was endorsed subsequent to the last board meeting and ANZCA has been advised.

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Database upgrade
The OvidSP Medline and OvidSP Embase databases have undergone an upgrade and now have more flexibility and access options to support your online research activity. Major new features and changes include:
- My Projects allows you to manage a whole research project from a single interface. Create your own personal account and store citations, searches, full text articles, files from your computer, snippets and annotations.
- A toolbar application allows you to access My Projects from any external website.
- More citation styles and formats allows you to export and print using MS Word, PDF, EndNote, and more.
Contact the library if you are interested in learning more about managing a research project online or performing a literature search.
Login to the College website to access these journals articles.

Health and safety alerts – ECRI Institute notices
The ANZCA Library subscribes to ECRI publications on operating room risk management and health device alerts and information. Check this space regularly for updates on the latest information produced by ECRI.
Recent publications include:
- Health Devices, May 2010 – The Ins and Outs of Servicing Equipment In-House.
- Health Devices, July 2010.
Contact the library for more information on general anaesthesia for emergency situations.

Online textbooks
The ANZCA Library subscribes to a number of online textbooks including a package called Access Anesthesiology. This portal allows the user to search across all the textbooks in the package and even find images and videos – a great way to get an overview of a topic. Many books have been optimised for mobile device use.
The available online textbooks are:
- Anesthesiology: Examination & Board Review
- AusB – Australian Drug Information for the Health Care Professional
- Basic and Clinical Pharmacology
- Clinical Anesthesiology
- Clinical Manual and Review of Transesophageal Echocardiography
- Critical Care Ultrasonography
- Goodman and Gilman’s The Pharmacological Basis of Therapeutics
- Harrison’s Online
- Longnecker – Anesthesiology
- Pain Medicine
- Principles and Practice of Critical Care
- Principles and Practice of Mechanical Ventilation
- Principles and Practice of Pain Medicine
- Principles of Critical Care
- Procedures in Critical Care
- Review of Medical Pharmacology
- Stedman’s Medical Dictionary
- Syndromes: Rapid Recognition and Perioperative Implications
- Textbook of Regional Anesthesia and Acute Pain Management.
Login to the College website to access the online textbooks:
www.anzca.edu.au/resources/library/online-textbook-access.html

New research in anaesthesia and pain medicine
Log in to the ANZCA Library website to access these journal’s articles.

Clinical Guidelines

Practice advisory on anesthetic care for magnetic resonance imaging. A report by the American Society of Anesthesiologists Task Force on Anesthetic Care for Magnetic Resonance Imaging. An updated report by the American Society of Anesthesiologists Task Force on Anesthetic Care for Magnetic Resonance Imaging.

Chronic pain

Articles

Interventions for preoperative smoking cessation.

Topical NSAIDs for acute pain in adults.

Scandinavian clinical practice guidelines on general anaesthesia for emergency situations.

Crisis resource management and teamwork training in anaesthesia.
Gaba D.M. BJ. British Journal of Anaesthesia. 2010 105: 3-6.

Rapid sequence induction and intubation: current controversy.

Anesthesia for bariatric surgery.


Predicting Postoperative Pain Based on Preoperative Pain Perception: Are We Doing Better Than the Weatherman?

New titles

ANZCA members are entitled to borrow a maximum of five books at one time from the College library. Loans are for three weeks and can be renewed on request. Members can also reserve items that are out on loan.
Melbourne-based members are encouraged to visit the ANZCA Library to collect requested books. Items will be sent to other library users within Australia. When requesting an item from the catalogue, please remember to include your name, ID number and postal address to ensure prompt delivery.
A core collection of the anaesthetic syllabus textbooks is available for loan from the New Zealand office of the College. A list of the New Zealand books can be accessed by selecting “New Zealand” from the “Location” drop-down box of the catalogue.
The ANZCA Collection

The ANZCA Collection features a range of beautiful products specially designed for the College. They are now available for purchase by Fellows. Nappa leather is full grain leather that is extremely soft and supple making it the most luxurious and desirable leather from which to craft high quality personal goods. The limited-edition pashmina is made from a blend of 75 per cent cashmere and 25 per cent silk woven in India by craftsmen who supply cloth to the very top European design houses. The luxurious tie and bow tie are custom made for the College from 100 per cent woven silk.

Any profits from the sale of the merchandise will go to support the College's medical research and education programs managed by the ANZCA Foundation.

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Delivery and Handling

Delivery and Handling Charges:
- Domestic (within Australia) $27.00
- New Zealand $27.50
- International $59.50

*Price includes GST.

**This form meets the requirements of a Tax Invoice. It is important that you keep a copy of the completed form and payment for your taxation needs in relation to GST.
“Most of our members have little knowledge of the practice and history of anaesthesia. We had even less knowledge of the importance of the College in the training, continuing education, safety and standards of our hospitals.”

The results of the recent College Fellows’ survey revealed that the role of the College as a voice of anaesthetists was considered among its seven most important services. It is an extremely effective way of raising the public profile of the specialty and the role of the College.

Dr Rod Westhorpe and Dr Chris Ball
Honorary curators, Geoffrey Kaye Museum of Anaesthetic History

With grateful acknowledgment to Maria Drossos, Museum Collections Officer, who organises the tours on behalf of the College. To inquire about tours of the museum contact Maria Drossos at: mdrossos@anzca.edu.au or visit www.anzca.edu.au/resources/museum

The living museum – using history to raise the profile of anaesthesia

The commonly held view of small museums is that they are collections of “old stuff” sitting on crowded shelves with dusty labels. It may seem unlikely that one can use museum collections to enhance knowledge and education about modern advances in technology. But that has been the focus of activity at the Geoffrey Kaye Museum of Anaesthetic History, at ANZCA House in Melbourne.

Over the last three years, an increasing number of tours have been hosted at the College, using the Museum and the heritage building “Ulimaroa” to educate members of the public about anaesthesia and the role of ANZCA.

Each tour lasts about two hours and is hosted by a small number of Fellows including two former councillors and one former President, who give their time voluntarily. Tours begin with a presentation on the role of the College in training and standards, followed by a question and answer session. A tour of “Ulimaroa” is followed by a visit to the Geoffrey Kaye Museum, where the story of anaesthesia is presented, using the exhibits to illustrate the remarkable development of the specialty. Particular emphasis is placed on the development of anaesthesia and pain management over the past 60 years.

Most of the tour groups so far have consisted of retirees, usually members of Probus groups, but we have also hosted historical groups, a vision impaired group, and one Year 10 school group. Each group comprises 10 to 25 people, and the growth of the program has been entirely by word of mouth. In 2009, there were 27 tours catering for 536 visitors. In 2010, as this article is written, we have hosted 26 tours with another 15 scheduled over the next few months.

The response of those taking part has been overwhelmingly positive. The age of those attending makes them high consumers of anaesthetic services yet very unfamiliar with the equipment and techniques in use today. Many describe their tour as an eye opener and a much greater appreciation of the role of the anaesthetist. To quote from one of many letters of thanks:

“Most of our members have little knowledge of the practice and history of anaesthesia. We had even less knowledge of the importance of the College in the training, continuing education, safety and standards of our hospitals.”

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Above left: Dr Rod Westhorpe (centre) conducts a tour of the museum.
2. That the number of curriculum authoring groups be reduced from 12 to 10 and that the number of Fellows in each curriculum authoring group be reduced from five to three.

3. That all Fellows working as consultants on the Curriculum Redesign Steering Group and curriculum authoring groups receive an hourly remuneration rate of $75 being the hourly rate paid to a Monash University associate professor with clinical loading.

4. That, given the imperative to start the project forthwith, a condensed process for recruitment and selection of Fellows to be involved in the project be approved, involving:
   4.1 Appointment of the Curriculum Redesign Steering Group without a further selection process.

5. That the following Fellows be appointed to the Curriculum Redesign Steering Group without a further selection process:
   - Dr Damien Castanelli (VIC)
   - Dr Peter Gibson (NSW)
   - Dr Sarah Nicolson (NZ)
   - Dr Brian Spain (NT)
   - Dr Jeneen Thatcher (QLD)

Examination Committee
Council has agreed to appoint a trainee representative to the Examination Committee. This representative will have passed both the ANZCA primary and final examinations.

Finance
Examination withdrawal fee
In order to reduce the significant administrative challenges created by late withdrawals from the College examinations, Regulation 14 has been amended to establish a fee for those who withdraw after the registration closing date. Medical or compassionate grounds will continue to be recognised as warranting full refund of the examination fee.

14.7.3.5 If the full fee is to be refunded on compassionate grounds, that amount will be accepted as a full application fee for the immediate subsequent examination at the candidate’s request.

National Pain Strategy
The College has agreed to provide in-kind support from the Communications, IT and Policy Units, to the Australian National Pain Strategy executive.

Fellowship affairs
2011 New Fellows Conference
Council has approved one additional delegate from each of Singapore and Malaysia to attend the 2011 New Fellows Conference in Hong Kong.

2013 Annual Scientific Meeting
Associate Professor David Scott has been appointed to the Regional Organising Committee of the 2013 Annual Scientific Meeting to be held in Melbourne.

Internal affairs
Community Representation Policy (Australia)
A copy of the approved policy and schedule of fees is Appendix 1 available at www.anzca.edu.au in the ‘News’ section under ‘Council reports’.

2011 Council calendar
A copy of the 2011 Council calendar is available at www.anzca.edu.au in the ‘News’ section under ‘Council reports’.

Revision of the ANZCA Constitution
Following establishment of the College of Intensive Care Medicine, Council has agreed that Dr Leona Wilson will lead a review of the ANZCA Constitution for a vote by the Fellowship.

Regulation changes
Regulation 2.1.0, Fellowship Affairs Committee has been amended to include the Director of Communications or his or her nominee and the Director of the Education Development Unit or his or her nominee as committee members.

Regulation 4 – Examination subcommittees and courts
In the past, two Council representatives have been included in the membership of the Primary and Final Examination Subcommittees. Regulation 4 has been changed so that the Chair of Examinations will be the only ex officio Council representative on the examination subcommittees.

Regulation 14 – Examinations in anaesthesia and Regulation 15 – Training in anaesthesia
To prepare for the revised in-training assessment (ITA) process commencing July 1, 2010, Regulations 14 (Examinations in Anaesthesia) and 15 (Training in Anaesthesia) have been amended with the new versions available on the ANZCA website.

Professional documents
Dr Peter Roessler, Director of Professional Affairs, will be responsible for input to professional document development and revision.

Trainees in Difficulty
A copy of the approved policy and schedule of fees is Appendix 1 available at www.anzca.edu.au in the ‘News’ section under ‘Council reports’.

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Regulation 4 – Examination subcommittees and courts
In the past, two Council representatives have been included in the membership of the Primary and Final Examination Subcommittees. Regulation 4 has been changed so that the Chair of Examinations will be the only ex officio Council representative on the examination subcommittees.

Regulation 14 – Examinations in anaesthesia and Regulation 15 – Training in anaesthesia
To prepare for the revised in-training assessment (ITA) process commencing July 1, 2010, Regulations 14 (Examinations in Anaesthesia) and 15 (Training in Anaesthesia) have been amended with the new versions available on the ANZCA website.

Professional documents
Dr Peter Roessler, Director of Professional Affairs, will be responsible for input to professional document development and revision.

Trainees in Difficulty
A copy of the approved policy and schedule of fees is Appendix 1 available at www.anzca.edu.au in the ‘News’ section under ‘Council reports’.

2011 New Fellows Conference
Council has approved one additional delegate from each of Singapore and Malaysia to attend the 2011 New Fellows Conference in Hong Kong.

2013 Annual Scientific Meeting
Associate Professor David Scott has been appointed to the Regional Organising Committee of the 2013 Annual Scientific Meeting to be held in Melbourne.

Internal affairs
Community Representation Policy (Australia)
A copy of the approved policy and schedule of fees is Appendix 1 available at www.anzca.edu.au in the ‘News’ section under ‘Council reports’.

2011 Council calendar
A copy of the 2011 Council calendar is available at www.anzca.edu.au in the ‘News’ section under ‘Council reports’.

Revision of the ANZCA Constitution
Following establishment of the College of Intensive Care Medicine, Council has agreed that Dr Leona Wilson will lead a review of the ANZCA Constitution for a vote by the Fellowship.

Regulation changes
Regulation 2.1.0, Fellowship Affairs Committee has been amended to include the Director of Communications or his or her nominee and the Director of the Education Development Unit or his or her nominee as committee members.
ANZCA Council meeting report

August 2010

Report following the Council Meeting of the Australian and New Zealand College of Anaesthetists held on August 21, 2010

Death of Fellow and trainees

Council noted with regret the death of the following Fellow:

- Dr Kishore Nanda Jayanthi (NSW)

Fellowship advising Disbandment of Rural Anaesthetic Recruitment Service (RARS)

With the introduction of GPALS and other professional locum services, and with the decline in the need for the RARS service, it was agreed that the service be disbanded.

Regional visit by ANZCA AsM Visitor and Australasian Visitor

In recent years it was recognised that attendance by Fellows and trainees at post-ASM regional visits by the ANZCA AsM Visitor and Australasian Visitor has decreased. With the increased access to presentations on the ANZCA and ASM websites, it was agreed that regional visits by the ANZCA AsM Visitor and Australasian Visitor will cease from the Perth 2012 ASM onwards.

Advanced life support capability at ANZCA House

Council approved the purchase of a defibrillator and self-inflating device for ANZCA House along with appropriate training for staff members.

ANZCA Foundation

Foundation change of name

In order to bring greater clarity and awareness to the wider community of the purpose of the foundation, it was agreed that the name for the ANZCA Foundation is to be changed to ‘The Anaesthesia and Pain Medicine Foundation’.

Foundation membership

Council approved the appointment of Dr Leona Wilson to the foundation board for a term of three years in accordance with the Regulation 34.

ANZCA Council meeting report

Intrafamilial

New Fellow Councillor

In August 2010, Dr Justin Burke was elected as the new Fellow Councillor.

Format of Council agenda and minutes

With the aim of producing shorter and more concise Council minutes, some changes will be made to the format of the Council agenda and minutes which are to take effect from the October 2010 Council meeting. Agenda items from the Council meeting which report directly to Council will no longer be listed by line in the Council agenda or minutes, and only unstrated resolutions that result from the committee minutes are to be listed. For any queries about this matter, please contact Anna Kleskovic (akleskovic@anzca.edu.au).

Indigenous Health Working Group

Council approved the formation of an Indigenous Health Working Group, with the aim of promoting indigenous health in Australia and New Zealand. The Committee will comprise five members, four ANZCA and/or FPM Fellows from Australia and New Zealand, and a Councillor (Dr Rodmillie Howorth) to chair the committee.

CPD points

Council has agreed that the College will no longer progressively approve CPD points for CPD events. CPD participants will continue to self-acredit CPD events and the College will continue its routine audits of CPD participation.

Regulation changes

Regulation 2.2 Education and Training – Committees of Examination

In June 2010, Council agreed that the Examinations Committee should include a trainee representative nominated by the ANZCA Trainee Committee who has passed both College examinations.

Regulation 23 – Advice Regarding Recognition as a Specialist in Anaesthesia

The changes made to Regulation 23 are intended to improve the criteria for the assessment of DIMGs. However, the wording for “area of need assessments” is still being developed and is to be addressed at the October Council meeting. The implementation date for the revised Regulation 23 will take effect from January 1, 2013.

(Copies of the updated regulations can be found on the ANZCA website.)

Professional documents

T3 Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice

Due to a need to revise this document and the substantial lead in time required by hospital departments for changes to anaesthesia workstations, the deadline for compliance has been delayed until January 1, 2012.

PSIs recommendations on Essential Training for Rural General Practitioners in Australia

Provision to ANZCA to Administer to Professional documents

Revisions to the Professional documents have been approved and will be posted on the ANZCA website.

Professionals

Professor Kate Leslie

President

Dr Lindy Roberts

Vice President

ANZCA Bulletin

112

ANZCA Bulletin September 2010

113

Successful candidates

The list of successful candidates for the second sitting of the Primary and Final Fellowship Examinations in 2009 was inadvertently omitted from the ANZCA Bulletin. ANZCA apologizes to the successful candidates.

Primary Fellowship Examination – 2009 (second sitting)

The following candidates successfully completed the Primary Fellowship Examination:


Renton Prize

Dr Jon Christian Ying Queenie HEG

Merit Certificates

- Dr Jessica Dorman NSW, Dr Andrew Fah SA, Dr Rahul Garg NSW, Dr Delia Khangeta NSW, Dr Rachel Ruff NSW, Dr Chloe Tetlow NSW

Final Fellowship Examination – 2009 (second sitting)

The following candidates successfully completed the Final Fellowship Examination:


Regulation change

Regulation 2.7 Education and Training

ANZCA Foundation

Foundation change of name

In order to bring greater clarity and awareness to the wider community of the purpose of the foundation, it was agreed that the name for the ANZCA Foundation is to be changed to ‘The Anaesthesia and Pain Medicine Foundation’.

Foundation membership

Council approved the appointment of Dr Leona Wilson to the foundation board for a term of three years in accordance with the Regulation 34.
Future meetings
Australia and New Zealand
2010 – 2011

September 24-26 Port Douglas, QLD
Combined Simulation, Welfare & Management SIG Meeting
Theme: “Achieving our Best”
Contact: Hannah Bumell
Tel: +61 3 8337 5392
E-mail: hbumell@anzca.edu.au
Website: www.anzca.edu.au/fellows/sig/medical-education-sig

October 2-5 Melbourne, VIC
ASA National Scientific Congress 2010
Venue: Melbourne Convention and Exhibition Centre
Contact: Randell Portelli
Tel: 1800 806 654
E-mail: registration@asa2010.com
Website: www.asa2010.com

October 8-10 Newcastle, NSW
FPM Spring Meeting 2010
Venue: City Hall Convention Centre
Contact: Nina Lyon
Tel: +61 3 9510 6299
E-mail: nlyon@anzca.edu.au
Website: www.anzca.edu.au/events/events/fpm-spring-meeting-2010.ics

October 14 Brisbane, QLD
Combined Anaesthetic & Surgical Airway Workshop
Venue: Royal Brisbane and Women’s Hospital
Contact: Dr Linda Bedman
Tel: +61 7 3636 7154
E-mail: linda_bechmann@health.qld.gov.au

October 25-27 Canberra, ACT
National Forum on Safety & Quality in Health Care
Theme: Society, Regulators and Health Providers: a clash of expectations?
Contact: Annabel Holts
Tel: +61 3 8276 6050
E-mail: AChs2010@sapme.asn.au
Website: http://sapme.asn.au/conventions/forumshc2010

October 29-31 Dunsborough, WA
2010 Bunker Bay Anaesthesia Update
Venue: Quay West Resort Bunker Bay, Dunsborough
Contact: Sandra Box
Tel: +61 9 9386 2077
E-mail: dece@anzca.edu.au
Website: www.va.anzca.edu.au/events

November 9 Melbourne, VIC
Victorian Registrars’ Scientific Meeting
Venue: ANZCA House
Contact: Daphne Erler
Tel: +61 3 9026 3686
E-mail: anzca@fcmtravel.com.au
Website: www.vic.anzca.edu.au/events

November 20-21 Sydney, NSW
H.A.R.T. Scan
Contact: Jennifer Manion
Tel: +61 3 8344 5673
E-mail: echo-info@unimelb.edu.au
Website: www.heartweb.com.au

November 27 Sydney, NSW
NSW ACE Anatomical Workshop
Contact: Mia Bratsalis
Tel: +61 2 9966 9085
E-mail: rosevents@anzca.edu.au
Website: www.nsw.anzca.edu.au/events

December 6-10 Gold Coast, QLD
Ultrasound in Emergency Medicine
Contact: www.aiu.edu.au/contact.php
Tel: +61 7 5526 6655
Website: www.aiu.edu.au/ultrasoundinemergencymedicine.php

December 13 Auckland, New Zealand
Anaesthetic Crisis Resource Management
Venue: Advanced Clinical Skills Centre
Contact: Jane Torrie
Tel: +64 9 373 7599 ext89312
E-mail: j.torrie@auckland.ac.nz
Website: www.anzca.edu.au/events/events/acrm-december-2010.ics

March 5-6, 2011 Canberra, ACT
The Art of Anaesthesia Meeting
Contact: nswevents@anzca.edu.au
Tel: +61 2 9966 9085
Website: www.internal.anzca.edu.au/events/events/the-art-of-anaesthesia-meeting.ics

Please check with conference organisers to confirm dates before arranging travel.
Future meetings overseas 2010 - 2011

September 26-29  Philadelphia, USA
International Association of Medical Regulatory Authorities (IAMRA) - 9th Biennial Conference on Medical Regulation
Contact: Roxanne Huff, IAMRA Secretariat
E-mail: rhuff@fsmb.org
Website: www.iamra.com

October 15  San Diego, USA
American Society of Critical Care Anesthesiologists 23rd Annual Meeting
E-mail: ASCCA_announcement@asahq.org
Website: www.ascca.org

October 15  San Diego, USA
SPANZA & SPA Combined Meeting 2010
Contact: Lyndell Wills
Tel: +61 2 4973 6573
E-mail: spanza@willorganise.com.au
Website: www.spanza.org.au

November 7-10  Toronto, Ontario, Canada
Critical Care Canada Forum
Venue: Sheraton Centre Hotel & Conference Centre
Contact: Cass Bayley
Tel: +1 519 263 5950
E-mail: info@criticalcarecanada.com
Website: www.criticalcarecanada.com

November 12-14  Hong Kong, China
1st AMM-AMS-HKAM Tripartite Congress/44th Malaysia-Singapore Congress of Medicine
Theme: Benefits & Risks of Recent Medical Advances
Venue: HK Academy of Medicine, Hong Kong SAR
Contact: Justin Ng or Leonora Yung
Tel: +852 2871 8896 / 2871 8847
E-mail: tripartites@hkam.org.hk
Website: www.anzca.edu.au/events/events/1st-amm-ams-hkam-tripartite-congress-44th-malaysia-singapore-congress-of-medicine.ics

November 12-14  Hong Kong, China
Critical Care Canada Forum
Venue: Sheraton Centre Hotel & Conference Centre
Contact: Cass Bayley
Tel: +1 519 263 5950
E-mail: info@criticalcarecanada.com
Website: www.criticalcarecanada.com

February 13-18, 2011  Utah, USA
56th Annual Update in Anesthesia 2010
Venue: The Grand Summit Hotel & Conference Center, Park City
Contact: Chris Haber
Tel: +1 801 213 2870
E-mail: chris.haber@hsc.utah.edu
Website: www.anzca.edu.au/events/events/56th-annual-update-in-anesthesia-2010.ics

February 17-21, 2011  New Delhi, India
17th Annual Congress of the Indian Critical Care Medicine & International Critical Care Congress 2011
Theme: Reaching New Heights in Critical Care
Tel: +91 11 26925858, 26925801 Ext. 4162
E-mail: info@criticare2011.org
Website: www.anzca.edu.au/events/events/17th-annual-congress-of-the-indian-critical-care.ics

January 16-21, 2011  Hokkaido, Japan
5th International Hokkaido Trauma Conference
Theme: Trauma Conference
Venue: Rusutsu Ski Resort
Contact: Tina Cornell
Tel: +61 3 9342 7540
E-mail: tina.cornell@mh.org.au
Website: www.anzca.edu.au/events/events/hokkaido-trauma-conference.ics

May 14-17, 2011  Hong Kong, China
ANZCA/FPAH/KCA CSM 2011
Theme: Seeking the Dragon Pearl
Contact: CSM2011 Conference Secretariat
Tel: +852 2559 9973
E-mail: info@csmin011.com
Website: www.csm2011.com

Please check with conference organisers to confirm dates before arranging travel.
The Alfred Intensive Care
Upcoming Events Programme

Inaugural Alfred ICU Nutrition in the Critically Ill Symposium
A 2 day meeting covering basic and advanced aspects of providing optimal nutrition for Intensivists, ICU trainees, Surgeons & Physicians, Dietitians and ICU nurses.  www.alfredicunutrition.org.au
Keynote speaker: Prof Daren Heyland, Canada
5th & 6th November 2010.  Registration $550 - $750
Early Bird $450 - $600 by 05/10/10

2nd Alfred ICU Trauma Course
1 day meeting for Intensivists, trainees, nurses, allied health staff and other interested clinicians covering aspects of the optimal management of ICU trauma patients. This is a satellite meeting of Trauma 2010 (Nov 19-21st) a combined meeting by the NTRI and the Australasian Trauma Society.
18th November 2010.  Registration $300-$350

5th Alfred ICU Advanced Mechanical Ventilation Conference
Theme: New Approaches to Protective & Open Lung Ventilation in ALI & ARDS.
International Guest Speaker: Prof. Marcelo Amato.  www.alfredicumechanicalventilation.org.au
8th April 2011, Park Hyatt Hotel, Melbourne.
Registration: $390 - $490 Early Bird $350 - $450 by 16/02/2011

Alfred ICU ALS Courses
2 day Australian Resuscitation Council accredited adult life support provider training in advanced cardiac arrest and medical emergency management for doctors, nurses and paramedics.  www.alfredicuals.org.au
Inaugural Course Nov 30-01 Dec 2010
Six 2011 courses starting February

Alfred ICU Critical Care Echocardiography Course
2-day course covering problem orientated 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.  www.alfredicuecho.org.au
31st March - 1st April 2011, 6th - 7th October 2011

ICU & Perfusion Adult ECMO Course
For doctors, nurses & perfusionists seeking to provide ECMO support to patients with severe forms of cardiac and respiratory failure.
Optional 3rd day for cannulation training (Additional $1500).  www.alfredicuecmo.org.au
16 – 18th November 2010 and 11 – 13th April 2011.  Registration $900

Basic Assessment & Support in Intensive Care (basic|victoria)
2 day introduction course for medical staff new to intensive care and care of the critically ill.  www.alfredicubasic.org.au

Please note: Prices are subject to change without notice


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The Alfred  e: j.dyer@alfred.org.au
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