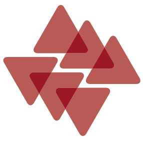

Australian and New Zealand College of Anaesthetists
Joint Faculty of Intensive Care Medicine
Faculty of Pain Medicine

THE ANZCA BULLETIN

June 2009

Feature:

THE FUTURE OF ANAESTHESIA

Plus:

PRIVATE PRACTICE
ASM CAIRNS COVERAGE
CanMEDS CURRICULUM
DIVING AND HYPERBARIC MEDICINE

Contents

The ANZCA Bulletin

The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional medical body in Australia and New Zealand that conducts education, training and continuing professional development of anaesthetists, intensive care medicine and pain medicine specialists. ANZCA represents more than 5000 Fellows and trainees across Australia and New Zealand and serves the community by ensuring the highest standards of patient safety.

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Photo: Joe Vittorio

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President's message

In this edition of the *Bulletin* we examine the future of anaesthesia. This follows the release in March of the Australian workforce study "Supply and Demand for Anaesthesia Services" which looked into factors that shape the supply of, and demand for, anaesthesia services and identified gaps in service provision over the next 20 years. A similar survey is planned for New Zealand. As I mentioned when the study was released, it is vitally important that ANZCA take a central role in not only assessing the demand for anaesthetic services and the number of anaesthetists required but that we also have a view about the proper scope of services and the appropriate model of care. In this edition we publish some views about the future of our specialty and we take a look at some interesting and exciting developments in some private practices in Australia which will hopefully stimulate debate about future directions. There are many challenges in front of us as we continue to fulfil our aim of serving the community by fostering safe and high quality patient care in anaesthesia, intensive care and pain medicine.

College of Intensive Care Medicine
Our colleagues in the Joint Faculty of Intensive Care Medicine have decided that their specialty is best served by establishing an independent college, and preparations for this are now well underway. I would like to thank Fellows who took the time to vote on the resolution to endorse Council's decision in respect of separation issues. In the JFICM vote, 1310 votes were counted, 1161 for (88.6%) and 149 against (11.4%). ANZCA's support for a new College has been gratefully received by JFICM and it provides a strong basis for excellent relations in the future.

Our training programs and standard setting processes have been separate for some time so for many people, the separation will have very little direct effect. The group who could be affected will be our Fellows who practice both anaesthesia and intensive care medicine but have FANZCA and not FJFICM. These Fellows are mainly working in smaller hospitals, and we (ANZCA and CICM) will be supporting their practice. We anticipate working very closely with the new College on this and other matters, as we do with other specialist medical Colleges. This is critical with our current advocacy for the retention of the role of medical colleges within specialist medical training and accreditation. Having multiple colleges is a strength of our system, as each specialty can develop its own standards in a way that is best suited to the specialty.

ANZCA Foundation
A great deal of work has been undertaken in recent months to complete the essential infrastructure for the ANZCA Foundation. This has included developing a suite of promotional materials, establishing a fund raising database, and consulting with regional committees to seek their input. Raising funds for medical research and raising awareness of anaesthesia, peri-operative medicine and pain medicine research and education is crucial. With ongoing research we can improve the quality of outcomes for patient comfort and can return many people to virtually normal lives in work, family enjoyment and community activities. The success of the Foundation will depend greatly on the participation and willingness of Fellows and trainees to support it, including communicating its existence and benefits more widely. To this end, in July you will receive some information and promotional material covering the Bequest program and the Patrons Program. By supporting the Foundation you will be making a vital contribution to promoting the role that our profession makes to the well-being of so many people and enable further crucial research to be undertaken.

ANZCA Strategic Plan
Work continues on developing a revised ANZCA Strategic Plan for the next three years. Our current plan has led to a range of important projects and improvements. Consultation continues with regional committees and other key stakeholders. Council will consider the plan further at its August Council meeting. It is envisaged that the key elements of the strategy will be communicated to Fellows and trainees in the months ahead.

Dr Leona Wilson
President

People & Events

Final Fellowship examination

The final oral examination was held on Thursday, May 29 and Friday, May 30 at the Melbourne Convention and Exhibition Centre. One hundred and fifty candidates successfully completed the final fellowship examination and three candidates successfully completed the IMGS Performance Assessment. The results were announced at 7pm on both Friday and Saturday nights at ANZCA House in Melbourne.

For the first time, candidates were able to receive their results using the SMS Results Service as well as attending the College to view the posted results, receiving a paper copy of the results or viewing them on the ANZCA website. Approximately 50 examiners were in Melbourne to participate at both the oral examination and the preceding meetings that were held at the College on Thursday, May 28.

Above: Dr Wat Chun Yin, Dr Wong Hoi Kay Tiffany, A/Prof Jacobus Ng (Final Fellowship Examiner), Dr Chan Lai Mel and Dr Chan On Yi; Dr Chris Butler (Final Fellowship Examiner), Dr Elizabeth Egan and Dr Margaret Knight.

New Fellows' Conference

The 2009 ANZCA New Fellows' Conference (NFC) was held over three days at the fabulous Thala Beach Resort, just south of Port Douglas and a little less than an hour north of Cairns, where the ANZCA ASM took place over the following five days. The NFC offers recent Fellows a few days away from work to discuss issues broadly related to professional and College matters.

This year the theme of the NFC was "Keeping Doctors Well". The facilitators were Dr Paul Carter, a GP with an interest in psychological medicine; Dr Allan Cyna, an anaesthetist with an interest in hypnotherapy; Trish Johnson, a psychologist who spoke about happiness; the 2009 NFC Councillor in Residence, Dr Genevieve Goulding; the FPM representative to the 2009 NFC, Dr Brendan Moore; and the representative from the 2008 NFC, Dr Sally Ure. The College President, Dr Leona Wilson, joined us for the second evening.

The program was eclectic and encouraged group participation. The formal sessions, whilst for the most part lecture-based, fostered lively dialogue. The great debates showcased oratory ranging from the ridiculous to the sublime and back again. Dr Carter also commented that the chicken dance at the end of the group hypnotherapy session on the final morning was the best he'd ever seen.

Having attended the 2008 NFC and organised this year's, I must say I regard the NFC's existence as being a reflection of a College in robust health. I'm grateful for the excellent logistic support afforded by College staff, especially Kate Briggs. The speakers and delegates formed a terrific group whose company and ideas I greatly enjoyed sharing.

The 2010 NFC will be held near Christchurch and will be run by Dr Karen Ryan. The theme is "Adventures in Anaesthesia". Fellows of up to eight years' standing are encouraged to apply.

Dr Chris Jackson
Convenor, 2009 NFC

Clockwise from top left: The New Fellows Conference delegates and facilitators; Dr Brendan Moore, Dr Bruce Hammonds, Dr Irina Kurowski, Dr Patricia Kan and Dr Diana Webster; Dr Tim Porter, Dr Allan Cyna, Dr Leona Wilson (ANZCA President), Dr Tomoko Hara, Dr Genevieve Goulding, Dr Shiva Hampasagar and Dr Bruce Hammonds.

Simulation-based sedation course for endoscopists

Nine senior New South Wales gastroenterologists participated in a pilot simulation-based sedation course for endoscopists conducted at the Hunter New England Skills and Simulation Centre in Newcastle from May 22-23, 2009. The course was developed to meet objectives delineated by the Tripartite Sedation Working Group by Hunter New England Simulation Director Dr Cate McIntosh and Faculty from the Centre. Also attending the resuscitation simulation sessions on the second day were five endoscopy nurses from participating gastroenterologists' hospitals.

Professor Barry Baker chaired the Sedation Working Group, with representation from ANZCA (A/Prof Kate Leslie and Drs Jo Sutherland and Tracey Tay), the Gastroenterological Society of Australia (Drs Brian Jones, Michael Burke, Phillip Craig and Andrew Thomson) and the Royal Australasian College of Surgeons (Drs Tony Eyers and Jon Gani). The Greater Metropolitan Clinical Taskforce, NSW Health, provided funding for the pilot course and secretariat support for the Tripartite Sedation Working Group (Ms Cassandra Smith).

Participants engaged enthusiastically in the two-day course which included tutorials on the pharmacology of sedation drugs, problem-based learning discussions on risk management, and medical assessment in the context of sedation, skills training and immersive simulation scenarios within the framework of PS9 2008 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical and Surgical Procedures. In order to assess the course pre-and post-testing of the participants' knowledge, skills and attitudes/behaviours relating to sedation were carried out.

Participants displayed great insight and willingness to learn. One participant highlighted that the course was not about propofol, but about delivering safe sedation.

Early written feedback from the participants has been praiseworthy: *"Congratulations! What a fabulous experience, it was clear that an enormous amount of time, planning and energy went into bringing this course to the humble GE consumer. It is clear to us that it needs to be part of the core training curriculum for GE trainees."*

A clear message from the gastroenterologists is that simulation offers great benefits for training in sedation and should be an essential component of training for both registrars and experienced clinicians. An invitation has been extended to Cate McIntosh to speak about the benefits of simulation-based training to the wider gastroenterology community.

Inquiries for places in the next course have already been received. A comprehensive evaluation of the course is being conducted and results will be disseminated. It is planned to extend this type of course to other states and New Zealand.

While participants have yet to complete the full sedation training process, which includes practical clinical sessions in their hospitals, this pilot Sedation Course for Endoscopists represents a significant step towards improving the safety of sedation for patients. The participants have clearly demonstrated an ability to reflect on their current practice with patient sedation and a desire to improve their knowledge and skills. Equally as important is the foundation that has been laid for a partnership in quality and safety that will result in ongoing gains for patients.

Dr Tracey Tay

Clockwise from top left: Back row: Judy Tighe, Warwick Selby and Barry Baker; Middle row: Michael Bourke, Joanne Shafer-Benhamu, Grace Chapman, Ian Norton, Philip Craig, Tracey Tay, Charles McDonald, David Abi-Hanna and Jo Sutherland; Front row: Brian Jones, Jeanette Valdivia, Kathleen O'Connor, Cameron Bell and Greg O'Sullivan; Teamwork during the simulation-based sedation course; Cardiac resuscitation during the simulation-based sedation course.

ANZCA Council Meeting report

Report following the Council Meeting of the Australian and New Zealand College of Anaesthetists held on April 18, 2009

Death of Fellows

Council noted with regret the death of the following Fellows:

Dr Sydney Dennis Giddy (Vic), OAM - FFARACS 1968, FANZCA 1992
Dr Rodney Hickey (NZ) – FFARACS 1974, FANZCA 1992

Honours and Awards

A/Prof Stephen Gatt (NSW) has been elected to Fellowship of the Royal College of Anaesthetists.

Education and Training Committee

Assessments

It has been agreed that new examiners will undergo a probationary appointment period of 12 months for the Primary Examination and 18 months for the Final Examination.

Advice to poorly performing candidates

A process has been adopted for both Primary and Final examination candidates and is available from the Training and Assessments Department.

Educational innovation funding

The Educational Innovation Grants have been renamed to reflect that they are not research grants, but tenders. The priority areas for the 2010 funding have been identified as follows:

- Workplace-based assessment of anaesthesia trainees
- Clinical teacher support and development

International Medical Graduate Specialists Committee

IMGS assessment process – workplace based assessments

Subsequent to approval of the IMGS assessment process and the supporting document titled *Workplace Based Assessments Process for IMGS* in February, it has been suggested that Council should defer the WBA for partially comparable IMGS to a date to be determined pending further discussion. Regulation 23 has been amended to reflect this decision.

Fellowship Affairs Committee

Annual Scientific Meeting – 2012 Perth

Drs Tanya Farrell and David Vyse have been appointed co-convenors for the 2012 ASM to be held in Perth.

Internal Affairs

Community representatives to College committees

The arrangements for community representatives are under review, and will include time-limited appointments and review of remuneration in line with the Australian Government Tribunal Guidelines. New sources for community representatives are to be investigated to expand the pool of available personnel.

Regulation 2.7.1 - Education and Training Committee

This Regulation was amended to include the following as ex-officio members: chairs of the Primary Examination, Final Examination, Assessments and Workplace Based Assessments subcommittees.

ANZCA support for developing countries

An ad hoc working party has been established to review the provision of assistance to developing countries, particularly in South East Asia.
The working party comprises:

A/Prof Kate Leslie (Chair)
Dr Michael Cooper
Dr Wayne Morriss
Dr Richard Morris
Prof Garry Phillips
Dr Peter Cook

Relationship between ANZCA, Fellows, trainees and the healthcare industry

A working group has been established to develop a consultation paper outlining relevant generic issues on the relationships between the healthcare industry and Fellows and Trainees. The working group comprises:

Dr Lindy Roberts (Chair)
Dr Michelle Mulligan
Dr Richard Waldron
Prof Alan Merry
Dr Rowan Thomas
Dr Kim Gray
A representative of the ANZCA Trainee Committee
Relevant members of staff

Fellows and Trainees will be given the opportunity to respond to issues raised in the consultation paper before a series of recommendations is made to Council later in 2009.

Strategic Workshop

The August 15, Council Meeting will be condensed to provide a half day dedicated to strategic planning.

Professional

Professional documents

PS51 – *Guidelines for the Safe Administration of Injectable Drugs in Anaesthesia* has been promulgated and is available for downloading from the College website.

A new document titled **"Process for review of College Professional Documents"** has been approved and is available for downloading from the College website.

ANZCA Representatives to external organisations

Prof Guy Ludbrook has been nominated as the ANZCA Representative to the Australian Drug Evaluation Committee.

Following a recommendation from the Obstetric Anaesthesia SIG, Dr Alicia Dennis has been confirmed as the College's representative to the steering committee for the Core Competencies and Educational Framework for Maternity Services in Australia Project.

Research

ANZCA Foundation

Council supported the request from the Foundation to raise funds in support of the publication of the hard copy of *Acute Pain Management: Scientific Evidence Third Edition 2010*.

New Programs Committee

Certificate in Diving and Hyperbaric Medicine – Post Nominal

It has been agreed that the post nominal for certificate holders in Diving and Hyperbaric Medicine will be "Cert DHM (ANZCA)". This may only be used by practitioners who are up-to-date with their annual certification fee.

Dr Leona Wilson
President

A/Prof Kate Leslie
Vice-President

Annual General Meeting minutes

Minutes recording the proceedings of the Annual General Meeting of the Australian and New Zealand College of Anaesthetists held in Hall B at the Cairns Convention Centre on Tuesday, 5th May 2009 at 5pm.

Present Dr Leona Wilson (President and Chair) and the following Fellows who indicated their attendance on the circulated register:

Dr Bruce Adendorff, ACT
Prof Barry Baker, NSW
Dr Jane Baker, NSW
Dr Phil Byth, NSW
Dr Peter Cook, QLD
Dr Martin Culwick, QLD
Dr Robert Edeson, WA
Mr Michael Gorton, VIC
Dr Genevieve Goulding, QLD
Dr Kerry Gunn, NZ
Dr Steuart Henderson, NZ
Dr Kevin Johnston, QLD
Dr David Jones, NZ
Dr Ross Kerridge, NSW
Dr Nathan Kershaw, NZ
A/Prof Kate Leslie, VIC
Dr Martin Lum, VIC
Dr Ruth Matters, TAS
Dr David McConnel , QLD
Dr Jane McDonald, NSW
Prof Alan Merry, NZ
Dr Frank Moloney, NSW
Dr Michelle Mulligan, NSW
Prof Paul Myles, VIC
Dr Timo Nyman, SA
Dr John O'Reilly, QLD
Dr Greg O'Sullivan, NSW
Hon. Brian Pezzutti, NSW
Dr Nicole Phillips, NSW
Dr Mark Priestley, NSW
Dr Ian Rechtman, VIC
Dr Richard Riley, WA
Dr Lindy Roberts, WA
Prof John Russell, SA
Dr James Sartian, QLD
Dr Joe Sherriff, NZ
Dr Richard Simmie, VIC
Dr Natalie Smith, NSW
Dr Renhard Steiner, SA
Dr Joanne Sutherland, NSW
Dr Sandra Taylor, NSW
Dr Annette Turley, QLD
Dr Richard Waldron, TAS
Dr Margaret Walker, TAS
Dr Andrew Warmington, NZ
Dr Robert Webb, QLD
Dr Richard Willis, SA

In Attendance Dr Mike Richards (CEO)

Ms Carolyn Handley (Director, Corporate)
Ms Jess McKay (Director, Finance and Business Administration)

The President welcomed all in attendance to the sixteenth Annual General Meeting of the Australian and New Zealand College of Anaesthetists.

Apologies
Apologies for non-attendance were received from:

Dr Kerry Brandis, Qld
Dr Penelope Briscoe, SA
Dr Vernon Cook, NZ
Dr Peter Duff, Qld
Dr Elizabeth Feeney, NSW
A/Prof Stephen Gatt, NSW
Dr Basil Hutchinson, NZ
Dr Gordon Kellerman, Qld
A/Prof Greg Knoblanche, NSW
Dr John Lauritz, Qld
Dr Bernard Lee, WA
Dr David McCuaig, Vic
Dr Desmond McQuillan, NZ
Dr George Merridew, Tas
Dr Taryn Naggs, Qld
Dr Edmond O'Loughlin, WA
Dr Harry Oxer, WA
Dr John Paull, Tas
A/Prof David Scott, Vic
Prof Hugo Van Aken, Ger
Dr Paul Wajon, NSW
Dr Brent Waldron, NZ
Dr Rod Westhorpe, Vic
Dr Michael Whitehead, Vic
Dr John Williamson, SA

Annual General Meeting minutes

Continued

1. **Confirmation of previous meeting held on May 6, 2008**

The President advised that the minutes of the last meeting held on May 6, 2008 had been previously circulated, and there being no amendment, moved that they be accepted.

Resolution From the Chair

That the minutes of the Annual General Meeting held on May 6, 2008 be accepted.

Carried

2. **Report of the Council**

The President highlighted the following items:

- A number of outstanding CME activities took place during 2008, with the Annual Scientific Meeting in Sydney a highly successful and well-received event.
- The introduction of the e-newsletter and revamp of the *Bulletin* have helped improve communication with Fellows and Trainees.
- Support for research continued in 2008 through ongoing input to the ANZCA Foundation.
- There was ongoing support for Fellows involved in training, including increased involvement with government in core areas of training and standard setting.
- There has been an increase in the number of Trainees registering with the College, and the largest examinations in the College's history were held during 2008.
- The review of the FANZCA curriculum was commenced in 2008, and input has been sought from a variety of sources as part of this process.
- The separation from ANZCA of the Joint Faculty of Intensive Care Medicine, and the establishment of a new College has been negotiated in an atmosphere of mutual respect. ANZCA was happy to support JFICM's view that the specialty of Intensive Care Medicine would be best served through an independent College. As many of the processes are separate for most Fellows and Trainees, it was anticipated that there would be minimum impact as a result of the final separation. The College has undertaken to work with the new College to try to ensure that no Fellows or Trainees are adversely affected.

In concluding her report, the President acknowledged the extensive pro bono work undertaken by Fellows as members of a variety of committees, supervisors of training, regional education officers, module supervisors, tutors, mentors, examiners and Councillors. She also thanked College solicitor, Mr Michael Gorton, and the CEO, Dr Mike Richards and the staff for their extensive contributions to the College.

There were no questions for the President.

3. **Annual Financial Reports and Auditor's Report**

The Honorary Treasurer was invited to present his first report on the College's financial affairs. He highlighted that the College maintains its sound financial position with no outstanding loans or debts. He reported an operating deficit of approximately $500,000 for 2008, which was a significant improvement on the 2007 deficit of close to $2 million. The more favourable result for 2008 related to a number of cost-reduction measures put in place by management.

A significant loss for 2008 was reported as a result of a decrease of 30% in the investment portfolio since June of that year. It was explained that this has been partially offset by an 8.3% investment return to date. It was highlighted that in recent years, the College relied on the investment portfolio to offset any losses incurred in operations. The investment portfolio encompasses the ANZCA Foundation and represents a source of funding for a variety of scholarships and professorships offered by the College, and in addition, provides a capital reserve.

The Treasurer reported that in December 2008, Council resolved that the 2009 management plan would be implemented in such a way that normal operations would no longer be reliant on income from the investment portfolio to balance the overall budget.

The College holds net assets of $18 million. Financial checks and balances were completed for 2008 and it was confirmed that the College has fully complied with the external auditors' recommendations. In addition to this, an internal auditor has been appointed for 2009.

In reiterating the sound financial position of the College, the Treasurer highlighted that this has resulted from the ongoing commitment of Councillors, committee members, staff and Fellows throughout Australia, New Zealand, Hong Kong and South East Asia.

There were no questions for the Treasurer.

The President moved that the balance sheet, income and expenditure account and auditor's report for the period ended December 31, 2008 be received and adopted.

Resolution From the Chair

That the balance sheet, income and expenditure account and auditor's report for the period ended December 31, 2008 be received and adopted.

Carried

4. Declaration of the Polls

Council Ballot

It was noted that there had been six nominations for the four vacancies on the Council. In addition to her re-election, the President congratulated Dr Michelle Mulligan on her election, and standing Councillors Dr Frank Moloney and Dr Richard Waldron on their re-election to Council for the period 2009 - 2012.

The following is the result of the Council ballot:

Position on Ballot	Votes Counted
1 WILSON, Leona Fay	814
2 MOLONEY, Francis Xavier	784
3 WALDRON, Richard John	731
4 MULLIGAN, Michelle Janice	696
5 FARRELL, Patrick Thomas	607
6 BRAZENOR, Stephen Thomas	436
Total Votes Counted	**4068**

Total Ballots Counted **Total Votes Counted ÷ 4**	**1017**
Envelopes Received	1039
Less Invalid Envelopes	20
Ballots Received	1019
Less Invalid Ballots	2
Total Ballots Counted	1017

JFICM Separation Ballot

The following is the result of the postal ballot regarding the resolution to endorse Council's decision in respect of separation issues between JFICM and ANZCA:

	Ballots Counted
For	1161
Against	149
Total Votes Counted	**1310**

Envelopes Received	1334
Less Invalid Envelopes	19
Ballots Received	1315
Less Invalid Ballots	5
Total Ballots Counted	1310

The President moved that the Declaration of the Polls be received, and put the motion which was carried.

Resolution From the Chair

That the Declaration of the Polls be received.

Carried

5. Appointment of an auditor

The Treasurer moved, seconded by K Leslie that RSM Bird Cameron & Partners be appointed the auditors for the College.

There being no further discussion the President put the motion which was carried.

Resolution R J Waldron/K Leslie

That RSM Bird Cameron & Partners be appointed the auditors for the College.

Carried

6. Other business of which due notice has been given to the CEO in accordance with the constitution of the College

No item had been received by the CEO.

The President thanked everyone for their attendance, and declared the meeting closed at 5.20pm.

Snapshot

- 1657 Full registrants
- 46 Exhibitor registrants
- 48 Problem Based Learning Discussions and Quality Assurance Sessions
- 152 Faculty registrants
- 61 Day registrants
- 66 Workshops

"We were delighted (and relieved!) with the overwhelmingly positive response to the scientific program. Many people commented on its relevance to practice, as well as the quality of speakers, both well-established and new. Key ideas in the 'Branching Out' theme were the responsibility of anaesthetists in organ protection, our potential extended roles in perioperative care, as well as improving skills and concepts to enable this to happen. While the brainstorming of ideas within our department in Cairns was fundamental in the formation of the program, when one considers the 132 invited speaker talks, 114 small group sessions, and 77 free papers or abstracts, the enormous contribution of the wider anaesthetic community to the success of the meeting is clearly apparent."

Dr James Sartain
Scientific Convenor ASM 2009

2009 Prize Winners:

Gilbert Brown Prize
Dr David Belavy

'Ultrasound guided transversus abdominis plane (TAP) block for analgesia after caesarean surgery'

Formal Project Prize
Dr Angela Palumbo

'Controversies in Anaesthesia Safety: Implications for the Teaching and Assessment of Trainees'

Regional Organising Committee:

Dr Sean McManus – Convenor & health care industry liaison officer

Dr Rob Grace – Deputy convenor & workshop/PBLD convenor

Dr James Sartain – Scientific program convenor

Dr Jason Ray – FPM convenor

Dr Rhonda Boyle – Treasurer

Dr Emile Kurukchi – Workshops

Dr Catherine Hellier – Social program convenor

Dr Chris Jackson – New Fellows' conference convenor

Dr Genevieve Goulding – ANZCA councillor

Dr Richard Waldron – ASM officer

2009 Named Lectures:

Ellis Gillespie Lecture
Dr Andrew Lumb from the UK (ANZCA ASM visitor)
Challenging dogma in medical science

Michael Cousins Lecture
Professor Andrew Rice from the UK (FPM ASM visitor)
Cannabinoid analgesia: Future friend or dead end?

Mary Burnell Lecture
Associate Professor Dan Raemer from the USA (ANZCA QLD visitor)
The anaesthetist's response to very challenging cases

QLD Pain Medicine Visitor's Lecture
Associate Professor Steven Passik from the USA (FPM QLD visitor)
Risk management in opioid therapy

Australasian Visitors Lecture
Professor Matthew Chan from Hong Kong (Australasian visitor)
Brain protection in the 21st century

The ASM Committee Lecture
Professor Tong J Gan from the USA (Special Guest) PONV and ambulatory anaesthesia: State of the art

From left: Health care industry tradeshow; Dr Leona Wilson, ANZCA President; Cocktail Reception at The Sebel Cairns; Performer, Lisa Hunt at the College Gala Event at Fogarty Park; A session during the Scientific Program; The College Gala Event at Fogarty Park; Dr David Belavy; Dinner at the College Gala Event at Fogarty Park; Prof Michael Cousins & Prof Stephan Schug; The College Ceremony; Prof Maree Smith & Dr Bronwyn Williams; ANZCA Annual General Meeting; Dr Amanda Smith, Dr Sarah Earnshaw, Dr Naomi Pearson, Dr Jarrod Ngan & Dr Tania Dutton (all from QLD Health); Dr Frank & Cate Moloney, Dr Dick Willis, Dr Jenny Carden, A/Prof Kate Leslie & Gretta Willis.

ANZCA ASM2009

ANZCA ASM2009

From left: Dr Vanessa Andean (Austin Hospital), Dr Gordon Wong (Hong Kong University) & Dr Liz Mackson (St George Hospital); Prof Michael Cousins is awarded the Robert Orton Medal at the College Ceremony by Dr Leona Wilson (ANZCA President); Dr Penelope Briscoe (Dean, FPM) presents Dr Charles Kim with the Barbara Walker Prize for Excellence in the Pain Medicine Examination; Dr Jason Ray, FPM Convenor; Dr Debbie Bettenay (Northern Hospital Melbourne) & Dr Hannah Parker (Austin Hospital);

The College Ceremony; Dr James Sartain (Scientific Program Convenor) & Prof T J Gan (Special Guest); Dr Peter Lane, Dr Alex Douglas (both from Royal Brisbane Womens Hospital) & Dr Wal Grimmett (Downs Anaesthetic Practice); Karen Bryant (C.R Kennedy) & Penny McDougall (Canterbury Anaesthetics Services Melbourne); Dr Rae Duffy, Dr Nan Crimmins & Dr Peta Lorraway (all from Brisbane); Dr Diana Webster (Redcliff – Caboolture Hospital), Dr Tomoko Hara (Auckland District Health) & Nick Stevens; Dr Geoff Crawford (QLD Health / Logan Hospital) Dr Anthony Sorensen & Dr Maree Meier (GABA Anaesthetics); Dr Miriam Scully, Dr Sue Anastasios, Dr Kim Rees & Dr Gail Aughterson; Dr Vanessa Beavis (Auckland) & Dr Sandy Garden (Wellington Hospital; Dr Sean McManus, Convenor & Health Care Industry Liaison Officer; Dr Gopi Raju (Royal Brisbane Hospital), S. Balan (Malaysia) & Dr Jahizah Hassan (Penang, Malaysia); Dr Forbes McGain; Dr Lisa Mohanlal, Dr Hamish Holland, Dr Nicole Fairweather & Dr Rod Van Twest; Prof Alan Merry; Health care industry tradeshow; Dr Atlas Ko, Dr Lisa Ku (both from Austin Health) & Dr Michelle Chia (St Vincents Hospital); Cairns Convention Centre; Dr Jason Thomas, Dr Brett McGuirk, Dr Andrew Middleton & Dr Simon Jones (all from St Vincents Hospital); Dr Erna Meyer (Whangarei Hospital), Dr Annette Turley (Rockhampton Hospital) & Dr Morne Terblanche (Bundaberg Hospital); Dr Kate Fry (Mater Childrens Hospital), Dr Nicola Acworth & Dr Jane Morris (both from Brisbane); Dr Andrew Winter (Narkos Partners), Dr Tony Bergin (Narkos Partners) & Dr Kristian Lundqvist (Greenslopes).

A delegate's perspective

From the pain management specialist point-of-view the ANZCA ASM actually started with the Faculty of Pain Medicine refresher course day. This was well attended and this year encompassed a variety of topics by an excellent range of speakers. To cap it off we had the annual faculty dinner and enjoyed Dr Jamie Seymour discussing his personal experiences of having the Irukandji syndrome so many times that he almost did an RCT on himself.

The conference proper started with the welcome reception I missed – always painful having to make choices about what to attend. This, of course, was an issue repeated throughout the meeting. Saturday started with the plenary session in which Dr Andrew Lumb gave a convincing and thought provoking dissertation on dogma. Apparently Laplaces law is irrelevant to the alveoli but you still have to say it in the exam and the examiner still has to pass you.

Also, there is no evidence to say you are wrong to put epidurals in asleep or give a muscle relaxant when you can't mask ventilate. Professor Andrew Rice spoke about Cannabinoids which as a pain doctor I enjoyed – the bottom line being they aren't much use at the moment. I attended an excellent simulation workshop at Cairns Base Hospital run by Kersi Taraporewella and team. This quality assurance activity aligned well with the thrust of the meeting which was the contrast between perceptions of how we practice and reality. A lot of misconceptions were broken down. The simulation theme continued on Sunday with Professor Dan Raemer's lecture. The Queensland FPM visitor, Steve Passik gave an entertaining talk on managing risk in opioid therapy, again another reality check for some. Hydrophyllic opioids tend to get lost down the toilet easily apparently.

The rest of the meeting proceeded in a similar high-quality fashion with excellent attendances at all the sessions I went to. The difficult airway session on Monday and listening to Steve Bolsin's experiences on Tuesday afternoon were highlights. A conference in Cairns wouldn't be complete without a debate about LMA's involving Joe Brimacombe and there was excellent insight into the increasing clinical and research experience with ultrasound guided blocks. A great deal of interesting research was presented including the FPM free papers, the Dean's prize session, the Gilbert Brown prize and the ANZCA trials group sessions. The College ceremony and the Gala Event were highlights amongst very enjoyable social events.

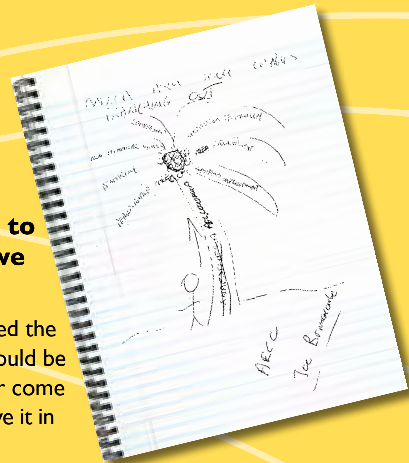
The industry turned up in force as usual and I found this a great opportunity to check out new equipment and catch up with old contacts. I am sure most anaesthetists came away with insights not only into how they can improve their practice but also into the amount of research and administrative activities their colleagues are involved in.

Dr Charles Brooker
Director
Chronic and Cancer Pain Program
Pain Clinic
Royal North Shore Hospital
Sydney

From left: Dr Leona Wilson (ANZCA President) and Prof Matthew Chan (Australasian Visitor); Cocktail Reception at The Sebel Cairns; Cairns Convention Centre; A/Prof Dan Raemer, ANZCA QLD Visitor; Dr Andrew Warmington (NZSA President) and Dr Elizabeth Feeney (ASA President); Dr Leona Wilson (ANZCA President) presents Dr Angela Palumbo with the Formal Project Prize; Dr Leona Wilson (ANZCA President) presents Dr David Belavy with the Gilbert Brown Prize.

ASM photo galleries and videos of the plenary sessions are available online at **www.anzca.edu.au**

Behind the scenes



Standing at the back of the Gala Event watching Lisa Hunt light up the crowd of 1200, I thought to myself: "I can't believe we actually pulled this off."

At the 2006 ASM it was suggested the Queensland meeting in 2009 should be held in Cairns "We would rather come up to Cairns for a break than have it in Brisbane again."

This made a lot of sense to me as Cairns is an internationally known conference and holiday destination. The Cairns Convention Centre is consistently rated in the top five in the world. I believed we could make it a memorable experience for delegates' families as well.

The early planning was sketchy; none of the committee members had much experience with conference organisation. Then on a flight from Cairns to Brisbane, I drew an iconic image (above). My thinking was unless we find areas of interest we can only enjoy the fruits of our specialist qualifications for so long before stagnation occurs. "Branching Out" is vital for professional development and satisfaction.

In the next two years we followed the ASM Handbook; choosing the professional conference organisers (ICMS Australia) nominating overseas speakers to invite and planning our program.

In September 2008 we had our first full site visit and round-table ROC meeting. We soon realised we were way behind where we needed to be. James Sartain became the scientific convenor and Robert Grace the deputy convenor/small group learning convenor.

November was frantic. Personal contacts and the telephone succeeded where emails had not. We reached out to Australia, New Zealand, Hong Kong, SE Asia, Europe and North America. Our meeting was beginning to come together.

A tight-knit triumvirate – Rob, James and I – worked furiously, bouncing ideas around every spare minute of the day - what topics would interest us? Ideas were modified or rejected immediately with little concern for niceties.

We discovered that conducting an ASM outside a capital city did pose logistical challenges; beds for US workshops, simulator mannequins, bikes for hire, wet weather contingency for the Gala Event and many others. The health care industry showed tremendous faith in our meeting, for which we are grateful.

When it came to abstract submissions we learnt that polite email deadlines worked for the minority. The majority needed diplomatic prodding from James. Reviewing the free paper submissions was exhausting, informative and rewarding – the range of quality was wide.

The final months were a blur; I slept very little. We argued the issues passionately and made decisions. Rob Grace was the marketing guru with phone calls, hand-written faxes and personalised emails sent everywhere anaesthesia occurs, including Africa, Asia, Europe and North America. The web page launch and the start of registrations allowed us to believe the meeting was actually going to happen.

All we could do then was hope enough people would come and that the weather would be kind. They did and it was.

Dr Sean McManus
Convenor

In the March 2009 edition of the Bulletin the findings of a joint ANZCA/ASA independent workforce study which examined the likely future demand and supply for Australian anaesthesia services raised a number of interesting issues about the possible future workforce requirements in Australia. But what is the future of anaesthesia? What lies ahead for the specialty as a vital component of modern medicine? What role should anaesthetists play in perioperative medicine? What sort of medical expertise and skills will be needed in Australia and New Zealand's health care systems? In part one of a two part series, Australian and New Zealand anaesthetists and pain medicine specialists provide their perspective.

THE FUTURE OF ANAESTHESIA

Leading the debate on the future of anaesthesia: the College's role

Dr Leona Wilson

It is timely to consider where the specialty of anaesthesia is heading and how the College can provide leadership or support. Recent events, such as the formation of the College of Intensive Care Medicine of Australia and New Zealand and the healthcare reforms being contemplated in both Australia and New Zealand have highlighted these questions for us.

What is anaesthesia? Does it start when the patient is attached to the monitors in theatre and end with extubation? If we consider the mortality reports and research on outcomes from anaesthesia, there is a significant contribution to outcome from pre-operative assessment and preparation, and post-operative management, as outlined by Alan Merry in this feature. Our patients expect more than "simple" technical expertise from their anaesthetists. They expect to be able to make a fully informed choice about their treatment after being provided with the necessary information in a way that supports their sense of their own autonomy. They expect to have a good outcome despite suffering significant illnesses. At the same time, those who fund healthcare are trying to contain costs, and one way is bringing our patients in to hospital "just in time" for their procedures. Garry Phillips outlines some of the government expectations of changes in healthcare delivery.

If we are to fulfil our commitment to the provision of safe and high quality anaesthesia, then we need to incorporate these aspects within our care, and anaesthesia become peri-operative medicine. If we don't, then in my opinion we run the risk of being sidelined. Vanessa Beavis has advocated for anaesthetists taking a full role in the peri-operative process. I know that peri-operative medicine is concerning to some because of the changes in work practices that may ensue, especially for those in private practice, and during the post-operative phase of peri-operative medicine. In this edition of the *Bulletin* there are four different examples of how the pre-anaesthesia phase is managed excellently in private practice and a description of an anaesthetist-led perioperative care unit by Paul Myles. Michael Cousins has outlined the important role of pain medicine, especially that of the acute pain teams, in peri-operative medicine. The College has supported research into how peri-operative medicine would work and await the results. It is important that we do this research because if we don't, others will and will make statements about anaesthesia that display a lack of understanding of our specialty. However, the final outcome of this challenge (is anaesthesia peri-operative medicine?) will be determined as much by how anaesthetists shape their work in the workplace as by the decisions that our College makes. I would like to acknowledge the excellent work of Su-Jen Yap in leading the Peri-Operative Medicine taskforce, which developed into the Peri-Operative Medicine Committee of the College.

And so, what is the College's role in determining the future of anaesthesia?

The College was founded in 1952 to serve the community by fostering safe and high-quality patient care in anaesthesia, intensive care and pain medicine, with the main areas of focus being education, standard setting and support for research. This should be our starting point in considering the future of anaesthesia. How do we go about meeting that aim? The constitution outlines in more detail the objects of the College; these include:

- promote and encourage the study, research and advancement of the science and practice of anaesthesia, intensive care medicine and pain medicine;
- promote excellence in healthcare services and cultivate and encourage high principles of practice, ethics and professional integrity in relation to medical practice, education, assessment, training and research;
- determine and maintain professional standards for the practice of anaesthesia, intensive care medicine and pain medicine in Australia and New Zealand;

But first, we need to consider how a new model of care is developed. Whose role is it? The College's, the hospital Departments of Anaesthesia, the individual anaesthetist's, the institutions in which anaesthetists work, governments or other stakeholders'? Or is it all of them, interacting in a fluid manner? How do we make sure we take advantage of new and innovative ideas from "outside the loop"?

Once such models of care are developed, the College's role in supporting research into the safety and quality of such care is obvious, and such work is already underway. For instance, a grant has been given in support of the REASON (research into elderly patient anaesthesia and surgery outcome numbers) study.

The College's role of standard setting is a core function: there are standards already developed in the pre-operative setting and the post-operative phase, and as the model of care changes, then these will need to be amended, and others developed as needed. Education, both of trainees and specialists is the third core function, and peri-operative medicine is an essential part of both the pre-Fellowship curriculum and assessment, and continuing professional development program.

The increasing focus on peri-operative medicine as part of the future of anaesthesia is an exciting direction for anaesthesia, and the College will be providing support for research, development of standards of practice, and education of trainees and continuing education of specialists in peri-operative medicine.

Dr Leona Wilson
ANZCA President

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PS7: Recommendations on The Pre-Anaesthesia Consultation Guidelines on Consent for Anaesthesia or Sedation
PS3: Guidelines for the Management of Major Regional Analgesia
PS4: Recommendations for the Post-Anaesthesia Recovery Room
PS15: Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery
PS41: Guidelines on Acute Pain Management

Safety and skills

Prof Alan Merry ONZM

"Healthcare is in transition from a relatively ineffective cottage industry characterised by generalists to a future in which specialised expertise in technologically sophisticated proceduralism will increasingly define acceptable standards of care."

It is generally accepted that the rate of mortality associated with anaesthesia is steadily decreasing, and most people believe that anaesthesia today is very safe indeed.[1]

However, there is legitimate debate about the validity of the data to support this contention.[2] The best data on anaesthesia mortality in the world has been collected under the auspices of ANZCA,[3] and the latest triennial report on "Safety of Anaesthesia" will complete 20 years of uninterrupted data from several states of Australia.

Unfortunately in some states, and in New Zealand, mortality committees have not been functioning well (or at all). Furthermore, even in those states that are, the data pertain primarily to the first 24 or 48 hours after anaesthesia, whereas most people would probably want to know their chances of being discharged from hospital in good health.

In the future more comprehensive mortality reporting will be essential. In combination with the ANZTAD Committee's initiatives to revitalise anaesthesia incident reporting in our region, this will allow us to identify continuing areas of major concern, to monitor progress in our continuing efforts to improve one of the safest anaesthesia services in the world today, and to provide the information needed for anaesthetists to partake in debating the wider issues in healthcare.

One of the most important contemporary initiatives in promoting safety in the operating room is the introduction of a three-phase Surgical Safety Checklist (the checklist) developed by the World Alliance for Patient Safety of the World Health Organisation (WHO) in the Safe Surgery Saves Lives initiative.[4]

Anaesthetists have contributed substantially to the development and evaluation of this checklist, and ANZCA is liaising with ASA, NZSA, RACS, and other organisations in Australia and New Zealand to endorse and promulgate the use of this safety tool, with its particular emphasis on teamwork and communication.

In addition, another important outcome from the Safe Surgery Saves Lives initiative has been the first estimate of the number of surgical procedures undertaken around the world every year – about 234 million, which substantially exceeds the number of births.[5] These procedures are very unevenly distributed, and it is clear that many patients around the world are failing to get essential surgery while others are having operations that are not justified.

The adequate provision of safe surgery around the world is a priority for the future, and this will clearly depend on the availability of safe anaesthesia. Unfortunately there are many areas where anaesthesia providers have no medical or nursing qualifications, relatively limited training, and hopelessly inadequate facilities.[6] Anaesthesia mortality rates in some of these regions are unacceptable.[7-9]

At an even more fundamental level, the pre-requisites for health and wellbeing are factors such as peace, adequate food, education, empowerment of women, and respect for human rights and equity.[10] Regular work is also very important, and the recession presently deepening in most parts of the world is likely to place an increased burden on healthcare systems everywhere.

Anaesthetists have built their reputation for promoting patient safety substantially through the development of anaesthesia as a respected branch of independent medical practice underpinned by an enviable track record of training, and because of their commitment to research. The role of anaesthesia organisations has also been of pivotal importance – in particular the development of ANZCA as an independent college. The birth of a new College in intensive care is another step along this road and the importance of a qualification from the Faculty of Pain Medicine will continue to increase in the future.

To a considerable extent, the formal move to demonstrated qualifications in specialised areas is a reflection of increasingly high expectations from patients, and these expectations apply not just in intensive care and pain management, but in anaesthesia as well. Expectations that skills and competence have been maintained since qualification will also increase. Healthcare is in transition from a relatively ineffective cottage industry characterised by generalists to a future in which specialised expertise in technologically sophisticated proceduralism will increasingly define acceptable standards of care. It will become increasingly unrealistic for generalist anaesthetists without relevant training and expertise to provide occasional intensive care services to critically ill patients. It will also become equally unrealistic for intensivists to maintain occasional anaesthesia practices.

The adoption of ultrasound by anaesthetists to eliminate their traditionally "blind" approach to invasive procedures is just one example of the pressure to improve the ways in which anaesthesia is provided. Similarly, skills in fibre-optic laryngoscopy will not be seen as optional in anaesthesia for much longer, and echocardiography is likely to become a requirement for the evaluation of patient's cardiac fitness for surgery.

Pressure on the specialty to conform to best practice protocols will increase, and practices deemed idiosyncratic will become less acceptable. The risk, feared by many, is that the well rounded medically qualified anaesthetist may come under threat from narrowly qualified practitioners with good technical skills and a willingness to standardise.

In my view, however, we will still need the broadly based medical expertise typical of anaesthetists in Australia and New Zealand today. A key principle of the checklist is teamwork, and broadly trained medically qualified anaesthetists will be ideally placed to broker teamwork in the perioperative environment. In particular, anaesthetists will need to continue to understand the needs for postoperative intensive care and sophisticated pain management and to ensure that these are met (albeit, not always by themselves).

The credibility of our claim on the field of perioperative medicine will depend on how well we adopt new technology, and on the overall care we provide for our patients (often through liaison with others), but it will also depend on how assiduously we contribute to the debate about wider issues in healthcare. We need to be advocates for adequate access to appropriate and safe surgery, not just in our region, but globally as well.

We also need to take part in the debate about health economics, not just globally, but also (with increasingly difficult times) in Australia and New Zealand. As we move into the future, all doctors will need to have a wider view of the appropriateness and cost-effectiveness of healthcare they are providing than they have in the past. Anaesthetists will have to take part in this debate, and to lead it, they will need the relevant data.

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Broadening roles

Dr Vanessa Beavis

Anaesthetists are going to have to get out of the operating room and into other places to practice medicine so they are not just being seen as technicians.

Many people do not realize that anaesthetists are highly trained medical physicians with vast skills and experience. In a way, anaesthetists are victims of their own success. It appears that anaesthesia is so safe nowadays "that anyone can do it", whereas we know that it is only safe because of the high standards and quality of care, and training involved.

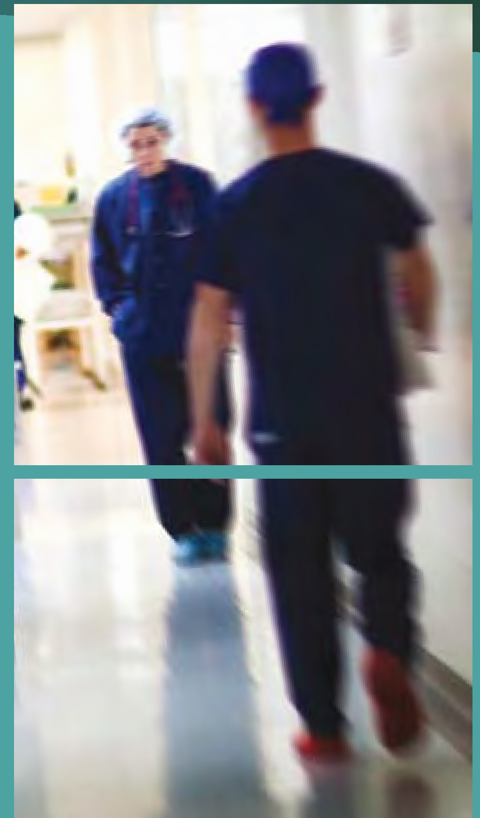
We have a marketing problem in the sense that we have a very short time to see a patient and usually on the day of surgery. Every pre-operative consultation is an opportunity for anaesthetists to demonstrate the fact we are highly skilled doctors.

In our hospital we do about 50,000 anaesthetics a year so that is 50,000 opportunities to convey some key messages. We have a role beyond the operating room managing physiology to managing pain and playing a preventative role with patients postoperatively.

Anaesthesia must go into perioperative medicine because unless the specialty expands it will contract and others will make decisions for us. There is going to be such a huge demand for patients to have anaesthetics and we need to examine ways to provide that level of service to the community in the future.

Anaesthetists are now more involved in systems of value management, organizational learning and clinical governance. We are quite good at taking a helicopter view of an organization as opposed to just caring for patients so that overall perspective in the pre-op and post-operative setting will become more important in the years ahead.

Dr Vanessa Beavis
Director of Anaesthesia and Operating Rooms
Auckland City Hospital



"It appears that anaesthesia is so safe nowadays 'that anyone can do it', whereas we know that it is only safe because of the high standards and quality of care, and training involved."

Government and workforce

Emeritus Professor Garry Phillips AM

The Government of Australia has been tracking the Colleges for many years, and first began publishing data provided by them, and obtained from other sources in 1996, when the first Medical Training Review Panel (MTRP) report was published[1], along with the first publication by the Australian Medical Workforce Advisory Committee (AMWAC) on supply, requirements and projections of the Anaesthetic Workforce in Australia cogently revised in 2001[2].

Since 2005, when the Productivity Commission's Research Report on Australia's Health Workforce hit the streets[3], the Council of Australian Governments (COAG) agreed to eight of its recommendations, modified eleven, and did not support two. As a result, AMWAC was abolished, and there has been a hiatus in reliable medical workforce data until some was included in the National Health Workforce Taskforce (NHWT) report by KPMG in April, 2009[4].

In a section entitled "Emerging Strategies", a brief and variable quality summary is made of trends in the UK, Canada and the USA with regard to "physician assistants", but it ignores the extent to which anaesthetists and intensivists have worked for decades with nursing teams in Australia in areas like pre-anaesthesia clinics, during anaesthesia, in the recovery room and in intensive care units.

A research paper published in March 2008 from the Social Policy section of the Australian Department of Parliamentary Services[5] repeats much of the information considered by, but interpreted quite differently, in a well-researched paper published by Thompson, Phillips and Cousins in 2007[6]. It is of more than passing interest that while the role of "nurse anaesthetists" in several countries was explored by the Royal College of Anaesthetists and the NHS in 2002, with a view to adoption in the UK of "nurse assistants", this had not progressed far by 2008[7-8].

One reason given for recommending continuation of training of nurse assistants in the UK is said to be "in the context of decreasing trainee numbers, hours of work and a higher expectation of training quality".

While nurses are in short supply in Australia, and likely to remain so for a long time, an ambitious program for expansion of medical student numbers in Australian medical schools is already in place. Commencing medical students are projected to reach 3074 by 2010 (from 1470 in 2002). This is a much higher percentage than the increase in commencing nursing students in the same period (from 8042 to 13,895). The flow-on effect of increased medical graduates to vocational training will result in a large increase in medical specialist anaesthetists.

In addition, anaesthesia in Australia is attracting increasing numbers of International Medical Graduate Specialists (IMGS). A paper published by the NHWT in September, 2008 sees no definite end to the need for IMGS[9]. Since 2002, the number of IMGS who have been accepted into the process agreed by the Australian Medical Council (AMC)/medical boards/councils and the medical colleges and have either achieved Fellowship of the Australian and New Zealand College of Anaesthetists

> "Commencing medical students are projected to reach 3074 by 2010 (from 1470 in 2002). This is a much higher percentage than the increase in commencing nursing students in the same period (from 8042 to 13,895). The flow-on effect of increased medical graduates to vocational training will result in a large increase in medical specialist anaesthetists."

(FANZCA) or are well on the way to doing so, has been increasing. For the past few years, FANZCAs by this route have averaged between 22 and 25 per annum.

But the rules are changing again – MTRP is re-inventing itself, and we now have the NHWT, the Health Workforce Principal Committee (HWPC), and a recent discussion paper raises important issues about clinical placement, governance and organization for all health professionals[10]. Source material included in this paper is taken from the Clinical Training Agency in New Zealand, and from the UK NHS Next Stage Review "A High Quality Workforce". As would be expected, the clinical training discussion paper concentrates on the increased numbers of health professionals about to enter the pre-vocational training workforce, and does not yet address the issue of specialist training, although putative models are canvassed.

Returning to ANZCA, after the Australian Competition and Consumer Commission (ACCC) completed its review of the Royal Australasian College of Surgeons (RACS), the ACCC and the Australian Health Workforce Officials Committee (AHWOC) reviewed the specialist medical Colleges, and published their report in 2005 [11]. ANZCA has done well in complying with all requirements, and has also participated in the program recommended by the Enhanced Medical Education Advisory Committee[12], supporting more applications for training in the private sector than were eventually funded by the government. With the projected increase in trainee numbers in a very few years time, it seems highly unlikely that "training in private" will provide an adequate solution, and increases in funding for trainees in public hospitals, and increases in specialist numbers to supervise and teach them will be required.

From ANZCA's perspective, all of the above movements, combined with national registration and national accreditation from 2010 will require serious planning to ensure that there are enough anaesthetists to keep providing the high quality patient care the community will continue to expect. It seems likely that the increasing number of Fellows in Australia, both by training and examinations, and via the IMGS pathways, and the program of the Joint Consultative Committee of ANZCA, the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine (the latter not available in the UK) ably assisted by nurses in their traditional, and perhaps expanded roles, will avoid the need for radical restructuring of the anaesthesia workforce here.

It is be hoped that when reviewed in another year or so, it will be seen that government and its new agencies have supported the Colleges, which produce medical specialists of high quality, a solid plank in our health system.

Emeritus Professor Garry Phillips AM
Former ANZCA President

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Perioperative and pain medicine

Prof Michael Cousins AM

"A crucial aspect of enhanced knowledge of pain is the very distinct possibility that we will be able to identify 'at risk' patients who are likely to progress from the acute pain situation to persistent pain."

Background

During the last 10-15 years I have had an opportunity to have broad ranging contact with Government and non Government organisations outside of ANZCA as a result of my appointment to a number of positions such as: NHMRC Councillor, Dean of the Faculty of Pain Medicine, Vice-President and President of the College, Chair of the Committee of Presidents of Medical Colleges and Councillor, The Australian Medical Council. Fellows will be pleased to hear that without exception I received strong feedback that ANZCA was viewed in an extremely positive light. This image had arisen from outside perceptions of our very strong training and examination process, our development of professional documents and other professional activities. Over the last decade ANZCA has attained status of equivalent level to the major colleges such as RACP and RACS. However we are about to have perhaps the greatest change in healthcare in our lifetime as a result of work by the Health Reform Commission and related bodies. Several Medical Colleges are moving rapidly to position themselves for these changes and ANZCA will need to do the same if it wishes to maintain or indeed enhance its key role in healthcare. I believe that there are some very major opportunities and even threats for ANZCA and my purpose in this brief article is to comment on a few of these.

Perioperative medicine

Fast tracking of surgical patients continues to evolve at a rapid pace, that in some respects has outstripped the science and practicalities of this approach. Undoubtedly anaesthetists have a great deal to offer in the field of perioperative care and this is why I appointed the taskforce on this area during my Presidency which evolved into an ANZCA Committee. However, physicians have an important and obvious role to play and it is my view that ANZCA should collaborate with RACP in the development of the science and practice of perioperative medicine. From time to time I talk to my friend and colleague Ron Miller in the USA about developments in America in this field and it is clear that perioperative medicine is evolving rapidly with many anaesthesiologists taking leadership roles. The ANZCA curriculum will need to evolve to include the key knowledge base of perioperative medicine and ANZCA research should encompass the effects and management of various disease states in the perioperative setting. Whether we like it or not, the perioperative medicine specialist will be in an unparalleled position to project a clear image of the knowledge and expertise of the specialist anaesthetist.

Pain medicine

Pain medicine is now an independent medical specialty, bringing the knowledge and expertise of five separate medical specialty bodies together. This is a unique professional body in the world at present and represents a very major asset to ANZCA in collaboration with RACP, RACS, RANZCP and AFRM. All ANZCA Fellows and Trainees should benefit from enhanced knowledge of the mechanisms and treatment of pain. Indeed this knowledge should be applied to the management of many patients in the perioperative phase. A crucial aspect of enhanced knowledge of pain is the very distinct possibility that we will be able to identify 'at risk' patients who are likely to progress from the acute pain situation to persistent pain. The implications of this will be that special techniques of acute pain management will be applied to provide a very cost effective intervention because of the reduction in the large disease burden that is currently represented by persistent (chronic) pain. Thus, there will need to be timely updating of the knowledge base of all anaesthetists with respect to pain mechanisms and treatment. It seems so simple, however cross fertilisation from one specialty body to another, even in the same college, has often been found to be lacking. A starting point may well be to ensure that the Faculty's role in the College is appropriate.

The name of the College

Another taskforce that I appointed during my Presidency was 'The Name of the Specialty". In retrospect this was not an optimum choice of title since the real issue for ANZCA is the name of the College. In my many interactions with people outside the College, I have rarely met an individual who could pronounce 'anaesthetists'. Certainly the media also have enormous problems with this word. This is not a good starting point for a College that is already in difficulty in projecting to the general community what it actually does. As noted above, it is much easier to project perioperative medicine, pain medicine and dare I say it intensive care medicine! In any case it is imperative that the word 'Medicine' appears in the name of the College, in my view. Thus keeping it simple, I would suggest that the College's name be changed to "Anaesthesia & Pain Medicine". At least anaesthesia is a term to describe the practice of our specialty and this matches the word pain medicine. Another advantage is that "Anaesthesia & Pain Medicine" appears to be a shorthand for Anaesthesia Medicine and Pain Medicine. I would much prefer anaesthesiology in the title since there are many medical specialties that are 'ologies'. The Australian Society of Anaesthetists could retain 'Anaesthetists' which I know is dear to the ASA. From the point of view of the Faculty of Pain Medicine, I think it is only fair that its role within the College be recognised by including pain medicine in the name of the College. ANZCA has to be very careful that a train of events similar to that surrounding the Faculty of Intensive Care Medicine, does not occur in the case of pain medicine.

Election of College Council

Much has been done within ANZCA to ensure that the College Council, and individual Councillors, act in accordance with the requirements of regulatory bodies. Councillors all now recognise that they are members of the Board of a medium sized company. However, the process of

election of College Councillors is in no way in keeping with the manner in which company boards are formed. Granted the College is not the same as a commercial operation, however there are many important similarities. It is my belief that the College must move ahead in developing a process for identifying individuals who will bring to the College Council the very wide range of skills that are now required on the board of any company. This has now been achieved by the College of Physicians with surprisingly little in the way of major problems. I strongly recommend that ANZCA examine the process that was utilised in moving towards what is now "the Board of RACP". Of course this must be done with very close consultation with all Fellows as was the case in RACP.

I should end by saying that all of the above represents my personal perspective and is intended to create discussion and debate in the interests of ANZCA. I am confident that the College has the people and resources needed to move forward with the same success in the next 20 years that has been achieved over the past two decades.

Prof Michael Cousins AM
Director, Department of Pain Management and Research, Royal North Shore Hospital

An anaesthetist-led Perioperative Care Unit (PCU)

Prof Paul Myles

Intensive care units (ICU) developed from the speciality of anaesthesia, as a logical extension of the operating theatre recovery room. Intensive (or critical) care medicine is now an independent and vibrant specialty.

Modifications to ICU include the step-down or high dependency unit (HDU), largely to improve cost-efficiencies because of flexible staffing and lower-level monitoring and therapy. In most countries ICU and HDU bed access have become increasingly limited because of reductions (in real terms) in funding and insufficient ICU-trained nursing staff.

This has been compounded by an ageing population and their concomitant comorbidity, often undergoing high-risk surgery. At the same time there are growing numbers of patients with morbid obesity and sleep apnoea. ICUs are unlikely to cope.

Some hospitals have created additional critical care beds within an extended recovery room environment; this is sometimes labelled a post-anaesthesia care unit (PACU). But in the majority of centres a PACU is no more than a standard recovery room by another name. This concept could be expanded further, as a true perioperative care unit (PCU), in order to improve the quality of ongoing postoperative care of high risk patient in a dedicated environment close to the operating theatre for say, 24 to 48 hours and perhaps incorporating preoperative optimisation.

An anaesthetist-led PCU could improve the safety of patients recovering from major surgery. Unlike a typical surgical ward, they can receive a higher level of monitoring and vasoactive therapy, using experienced nursing staff in a HDU-style environment, and easier access to senior anaesthetic and surgical staff in close proximity to theatres. This will provide a more reliable postoperative care environment and so can increase surgical throughput because of an improved ability to accept complex patients from the hospital waiting list. This should reduce hospital stay because of the opportunity to use sophisticated analgesic regimens and so facilitate earlier mobilisation and probably reduce postoperative complications. The latter would include a reduction in unplanned admission to ICU. A PCU should reduce staff stress and workforce requirements - why should interns be primarily responsible for such patients over the first night after major surgery? This is likely to reduce adverse events and need for medical emergency team (MET) calls. A PCU provides a ready environment to administer continuous positive airway pressure therapy in sleep apnoea and morbidly obese patients.

Most high-risk patients declare themselves on the first night after major surgery. Respiratory, fluid, and analgesic demands are typically at their highest and yet medical staffing levels overnight are at their lowest and most inexperienced. If a PCU patient deteriorates they will be detected earlier, managed better and can then be either stabilised or transferred to ICU. For the majority of patients who have an otherwise uneventful recovery from major surgery, they can be reviewed on the day after surgery and usually be discharged to a general surgical ward for ongoing care and recovery until hospital discharge.

Prof Paul Myles
Director, Department of Anaesthesia and Perioperative Medicine Alfred Hospital and Monash University

In part two of the *Bulletin*'s special feature on the future of anaesthesia, ANZCA will look at how technology and pharmacology will provide advances in anaesthesia and what some international commentators are saying about the future of the specialty. We would like to hear your views. Email: **bulletin@anzca.edu.au**

Private practice: improving patient care

Traditionally, private practitioners have seen their patients for the first time on the night before surgery; this has changed with day of surgery, staggered admissions making appropriate preoperative evaluation difficult. Four anaesthetists have outlined how different structures can be implemented in private practice to facilitate the perioperative care of patients. There are two group practices (ACT and Tasmania), a solo practitioner (metropolitan Sydney) and an informal group united by working with the same surgeon (metropolitan Sydney). Each has developed a structure in which to evaluate patients and facilitate communication between different team members.

St Vincent's Private Hospital, Sydney

The anaesthetists of St Vincent's Private Hospital in 1989 had the foresight to purchase rooms off the plan of the St Vincent's Clinic when it was built next to the hospital.

These rooms were designed with space for four secretaries, two consulting rooms, a library/ lounge and a kitchen. The rooms have not only provided a departmental centre through which all lists are coordinated and after-hours rosters maintained but also enable the anaesthetists to run a pain clinic and a pre-anaesthesia consultation service plus, for those who wish, there is a billing service via an associateship.

In addition, St Vincent's Private Hospital three years ago opened a day of surgery admission ward that the anaesthetists helped design. It has five consultation rooms.

There is also a pre-admission nursing clinic that sees patients pre-operatively.

In my practice I have an afternoon nearly every week set aside to see patients. I aim to see all my patients having major surgery, or who have significant illnesses, in my rooms some days prior to their surgery. I dovetail this with their visit to the pre-admission nursing clinic. After seeing nurses where they are processed, weighed and have blood pressure, pulse, temperature and urinalysis taken, ECG done if indicated and nursing information provided about their admission, they then come to my rooms to see me.

I have their nursing information, admission information from their surgeon and their old notes. I not only have time for a thorough anaesthesia assessment but I can discuss with them their anaesthetic including the risks, provide them written information, an "Anaesthesia and You" brochure and a PCA brochure plus my secretaries provide them with a written estimate of the fees which I can also discuss with them. If needed, I can arrange further tests or consultations with other specialists.

After leaving, they have any required blood tests and radiology, the results of which I see prior to their anaesthesia. This enables even the most complicated patient having the most involved surgery to be admitted on the day of surgery with me confident that they are fully prepared for their anaesthesia.

For patients who are ASA 1 and 2 having reasonably straightforward surgery I see them in the Day of Surgery Admission ward before the morning or afternoon session commences. They are posted an estimate of the anaesthesia fee.

I endeavour to see my admitted patients post-operatively the next day to follow up particularly on pain and fluid management.

There are, I believe, many advantages to seeing patients in rooms some days prior to their anaesthesia.

First, I believe it is simply better medicine. In a non-rushed, efficient environment significant numbers of patients can be thoroughly worked up prior to their anaesthesia. There are, therefore, fewer cancellations and fewer tests are ordered, avoiding the shotgun approach of some surgeons when ordering tests. I believe also there are likely to be better outcomes due to better preparation.

Second, it enables the anaesthetist to develop a relationship with the patient. I am wearing a suit when they meet me in the consulting rooms. It is very professional and, I believe, far better for the image of anaesthetists than the cursory chat at the bedside while dressed in scrubs.

Third, it serves to greatly improve cash flow and reduce bad debts. The patients are fully informed about the costs well in advance of their anaesthesia.

Finally, it is far better for my lifestyle to be seeing patients efficiently in my rooms during the day than to be scouring the wards trying to find patients, notes, old notes, X rays and results of investigations after hours and on weekends.

Dr Gregory J Deacon
St Vincent's Private Hospital, Sydney

Hobart Anaesthesia Group

The Hobart Anaesthesia Group (HAG) is an organization of some 24 associate anaesthetists and three "locum" anaesthetists. It was formed in the early 1960s as a two-member group and has operated continuously since. HAG provides anaesthesia for approximately 80 proceduralists including all surgical disciplines except cardiac as well as anaesthesia for endoscopy, imaging and emergency procedures. As part of this service, we also provide emergency anaesthesia cover 24 hours a day, 365 days a year.

HAG employs 10 staff (seven FTE) at its operations base which is located independently of any hospital. The "rooms" have been expanded in the last 10 years and now include five consulting rooms, and office space for reception, account processing, debt collection, as well as co-ordination of lists and pre-operative visits. There is also a meeting room, library and practice manager's office. The number of staff has expanded dramatically in the last 10 years (corresponding with an increase in number of anaesthetists, plus the introduction of informed financial consent (IFC) processes and the growth in pre-hospital pre-anaesthesia assessments). We currently see some 120-150 patients per week in a pre-anaesthesia assessment setting in our rooms.

About 10 years ago, a decision was made by HAG anaesthetists that, due to the emergence and growth of day-of-surgery-admissions (DOSA) we would have to re-evaluate the way complex cases were being assessed prior to anaesthesia. In order to allow sufficient time for appropriate assessment, further specialist referral and investigation where necessary and to avoid late cancellations and disruptions to operating lists the decision was taken to organise pre-anaesthesia assessments in our rooms for all patients undergoing major surgery (eg. joint replacements, vascular surgery, bariatric surgery, LUSCSs, hysterectomy, etc) or those patients with major medical problems. This pre-hospital process also facilitated appropriate informed consent for patients (which also encompassed informed financial consent).

The process that now has been established is: all complex medical, surgical, or anaesthetic cases must be reviewed (wherever possible) by an anaesthetist as soon as practicable, usually 1-2 weeks prior to the planned procedure. This includes major joint surgery, LUSCS, laparoscopic gastric banding and complex bowel surgery, patients with complex medical conditions such as Type 1 or 2 IDDM, significant IHD and/or CCF, as well as known difficulties with previous anaesthesia.

Cooperation with both proceduralists' rooms and hospital "booking offices"/ operating theatre coordinators is essential and lines of communication need to remain open. All of our proceduralists are informed of our preferred system for pre-anaesthesia assessment. and a reminder letter is usually re-sent annually.

The proceduralist's rooms now liaise with our pre-anaesthesia co-ordinator and an appointment is made with a member of HAG. Our rooms then send out a confirmation letter which includes informed financial consent and an "anaesthesia brochure" prior to arriving for a pre-anaesthesia assessment. The patient, having filled in the health questionnaire, will have their personal details checked for the billing system and be asked to sign a privacy agreement (same as for any hospital) by the office staff. The consultation then takes place, generally lasting anywhere between 10 and 30 minutes, although the more complex cases often take up to an hour. Notes are made on hospital anaesthesia records, indicating the type of anaesthesia, what type of intra-operative monitoring may be likely, and the likely post-op destination of the patient. During the consultation, other specialists such as intensivists, cardiologists, or endocrinologists may be contacted to make appropriate arrangements. The patient is then given clear, consistent instructions.

At the end of the interview, the completed pre-anaesthesia record is scanned into our computerized database of patient records and "tagged" to the patient's file. It is also faxed to the hospital where the procedure will take place and is incorporated into the patient's hospital record. The original is kept by the anaesthetist so that it can be referred to as required and to ensure that it is not mislaid.

While this change in practice has been relatively costly to implement, the benefits of early pre-hospital pre-anaesthesia assessment have far outweighed the costs involved. All parties benefit with hospitals being less disrupted by late cancellations and delays in operating lists (awaiting the anaesthetist "seeing patients"), communication between our practice and both surgeons and hospitals has improved, allowing a greater degree of co-ordination and therefore better planning and allocation of resources. Finally, and most importantly, our patients have benefited allowing a very high rate of DOSA for major surgery and delivering an improved quality of anaesthesia care.

Dr Andrew Mulcahy,
Ms Elizabeth Stanick,
Dr Richard Waldron

Photos courtesy of Dr Michael Martyn

Above: The computerised management system and examples of patient information brochures; Patient reception at Hobart Anaesthetic Group consulting rooms.

Private practice: improving patient care

Continued

ACT Anaesthesia

ACT Anaesthesia Pty Ltd is based in Canberra and was established in 2003, the first private practice group in that city. Originally comprising four anaesthetists, the practice now has seven anaesthetists who work across all specialties. The business operates as a service company charging fees to the doctors on a per patient basis.

The main practice aims at establishment were:

1. The provision of high quality clinical care through good information collection and use. We were particularly mindful of the changing nature of our specialty and the increased emphasis on patient throughput. We were keen to mitigate where possible any adverse effects that this could have on patient care (and anaesthetist stress levels!)
2. To create a service that would handle billing and other administrative functions such as leave cover and list management. In particular, we wanted a systematic approach to pre-operative informed financial consent whenever possible.
3. To create a refuge away from the hospital environment. We hoped to create a physical place that would serve several purposes: to see our patients in a calm rooms environment; to facilitate and consolidate our educational endeavours and to have a forum to regularly discuss any relevant professional issues.

We specifically **did not want** to make our lives more complicated or to increase our non-clinical and out of hours workload.

At inception we agreed to employ both nursing and administrative staff and to run two separate but interlinked practice domains. The nursing staff collect preoperative clinical information from multiple sources including the patients (via telephone), the surgeon's rooms - who provide our patients with our practice information – and GPs and hospitals. One of our major challenges was to establish positive relationships and networks with all these groups unaccustomed to our more proactive approach.

Protocols have been developed to aid our staff in determining what information is collected and how it is presented and used. In general the information includes: a completed perioperative questionnaire, relevant specialist and past medical or anaesthetic information. The consolidated clinical information includes a summary of financial information, which has been provided to the patients by our administrative staff, and is available to the anaesthetist at all times via a secure web-based calendar system.

Patients identified by any means, including direct referral, as requiring additional preoperative input are seen in rooms consultation or managed by other means as necessary. The patients seen in the rooms vary according to doctor practice and preference. At least one consultant also sees selected patients as house calls. These patients are generally frail and elderly or have mobility problems. The majority of patients receive a post-operative review telephone call from the nursing staff.

While establishing the office we had to deal with issues such as practice indemnity, IT security and medical records management. Our communication flow was based on readily available Internet technologies to collect, manage and distribute information amongst staff and doctors. We also use this to employ staff working remotely using VOIP and Server based technologies. Some of the less technologically inclined doctors now appreciate the greater utility and real time provision of information this system allows.

Even if we could achieve a perfect web-based environment we acknowledge the need for a physical office. At the office the practice members attend one regular combined session per month for continuing education and addressing practice administrative issues. Attendance and active participation at this meeting is seen as a vital part of maintaining the integrity of the group. Clinical and administrative staff report to the meeting and provide relevant feedback or suggestions. We have run several clinical practice audits and generally include a journal discussion as part of the meeting. At the meeting we also receive our collated monthly post-operative reports. We view the completed information we receive for each clinical episode very positively both in terms of individual feedback and also for its value in risk management.

Six years on we feel we have progressed significantly towards our aims. We strive to ensure our practice is responsive to ever-changing demands. As a group we also pay tribute to our staff who strive to translate our mission into reality.

Dr John Ellingham
(ACT Anaesthesia: Dr J Ellingham, Dr T Lo, Dr D Lu, Dr P. Martin, Dr C McInerney, Dr P Morrissey, Dr M Wilson)

Mater Private Hospital, Sydney

Over the last 18 months we have developed and successfully implemented a Pre-anaesthetic Medical Assessment Clinic (PMAC) at a large metropolitan private hospital in Sydney which specializes in joint arthroplasty.

Previously, the majority of patients were assessed by a physician and admitted the night before surgery.

The retirement of a physician and a general sense that things could be "done better" encouraged us to develop an anaesthetic preoperative assessment clinic with an aim to improve and streamline perioperative care for our patients having knee arthroplasty.

Our team consists of seven VMO anaesthetists and two orthopaedic surgeons specialising solely in knee surgery. In the past 12 months 340 knee arthroplasties have been performed.

The anaesthetists come from different backgrounds of teaching hospitals and private group practices but with the common link of working with the same two surgeons.

When the patient has seen the surgeon a date for the procedure is booked, usually about six weeks later. The patient is given a pack consisting of a health questionnaire devised by ourselves, their signed consent form, admission assessment form and knee replacement clinical pathway documentation as well as comprehensive pamphlets on knee replacement, physiotherapy and rehabilitation. Information is also supplied about spinal anaesthesia and patient controlled analgesia.

The surgeon at the time of booking orders blood tests, ECG and CXR. The patient sends in the paperwork and then makes an appointment for the PMAC.

At the PMAC we see on average of six patients in one session spending on average 30 to 45 minutes with the patient. The patient health questionnaire, investigations and correspondence are all available to us.

We have formulated a hybrid anaesthetic assessment form which forms the basis of our paperwork. It is laid out in a way that allows our colleagues to easily assimilate our assessment including an anaesthetic plan, discussion of post- operative analgesia, discussion of risk, discussion of financial consent and if an intensive care bed has been pre-booked. As the patient has a date for the procedure we can usually tell the patient who the anaesthetist will be. This also gives an opportunity to contact and discuss the patient with them from the clinic.

We have addressed the issue of out-of-town patients by making a provision for them to be seen the day after seeing the surgeon. Their investigations are then reviewed at a later date in the clinic. The alternative is a phone interview but again with appropriate investigations available to us.

We have ready access to a number of medical specialists should we feel the patient warrants further investigation and this can usually be organized at short notice.

If the patient is deemed fit for surgery for that date a copy of our assessment is sent to the surgeon's rooms indicating we are happy to proceed and if day-of-surgery admission is appropriate. A copy is also sent to theatres where it is available for review prior to the date of surgery. The responsibility for following up all investigations and consultations rests with the PMAC anaesthetist who informs the surgeon's rooms once the patient is fit for surgery.This system has worked very well and almost 100% of patients are now admitted on the morning of surgery and at the same time reducing the cancellation rate from non orthopaedic factors.

Given the success of the PMAC during the hospital redevelopment program, plans have been altered to provide a larger area with two consultation rooms and a waiting room to accommodate the PMAC. We also have two nurses at the clinic, a physiotherapist and an occupational therapist.

Most importantly, the patients have conveyed their satisfaction to us. In general, they feel they are better prepared especially with the opportunity to have an informed discussion with an anaesthetist prior to their hospital admission.

Dr Paul Sinclair
Mater Private Hospital, Sydney

Sounds of Canada

by Dr Gavin Pattullo

From left: Dr Gavin Pattullo and his wife Venessa at Lake Louise; relaxing lakeside in Ontario; Dr Pattullo snowboarding the Rockies; Dr Pattullo waiting for patients in the block room; Dr Colin McCartney demonstrates to a Fellow.

Before starting this article I must first make a disclaimer. I have no misconceptions about my own lack of philosophical insight. This being the case, I do feel at liberty to make the following comment: life does take unexpected twists and turns, some bad and some good.

For my wife and me the "bad" was her diagnosis of acute leukaemia three weeks before our wedding. The "good" was her remission with chemotherapy and then the profound realisations that develop with such an experience. For some, these realisations may have already surfaced; for others, particularly when caught up in the world of training and career building, they may be otherwise suppressed. These realisations are the type that mean when your wife is offered an opportunity to undertake PhD research with a world leader – but in another country – you do not hesitate to drop everything and go.

So that is the background to how I found myself heading to Toronto for an 18-month fellowship in general and regional anaesthesia. Well, admittedly, that is not the full story. Having already completed a Pain Fellowship and worked as a staff specialist for a couple of years there was some reluctance to go "backwards", as it were. I toyed (very briefly) with the idea of employment as a barista in the summer and then spending the winters snowboarding. But if you have ever tried North American coffee you will know all too well that their coffee standards do not demand the services of a barista. But worse than that; there are no mountains within cooee of Toronto, so take snowboarding off the list of options.

I chose Sunnybrook Hospital for my fellowship because of its strength in ultrasound guided regional anaesthesia and its reputation as being a great place to work. The fact that its name made it sound like a retirement home was only a little disconcerting.

In Sunnybrook I found a dedicated and cohesive team of staff anaesthetists, numbering close to 40 and most working full-time. The ultrasound guided regional anaesthesia largely takes place at a dedicated upper and lower limb orthopaedic hospital situated in downtown Toronto. This location utilises a large block room where all patients are prepared for the four operating rooms. The benefit of this design is that it results in a

large number of anaesthetic colleagues being readily available within a small space, so making for a fertile learning environment. I am truly fortunate to have been able to interact in this way with Dr Colin McCartney, a humble Scotsman with inexhaustible patience who has established himself as an authority in the field of ultrasound guided regional anaesthesia.

Surgery at this location is almost exclusively performed under regional anaesthesia with sedation. The full range of upper and lower limb blocks, both single-shot and catheter techniques, are employed in achieving this. Needles are successfully placed in many unlikely places – and I thought my pain training had prepared me for most of the possibilities!

A few years back in an effort to improve efficiency, the anaesthesia department made a purposeful move to regional anaesthesia away from a strict GA practice. This move achieved efficiency gains, partly by eliminating the delays due to GA induction and emergence in the operating theatre. Regional anaesthesia also avoided recovery room backlogs through having patients practically ward-ready by the time they left the OR. Efficiency gains through early discharge are aimed for by optimising postoperative analgesia, with an impressive armamentarium of multimodal analgesics, and working this in with a comprehensive rehabilitation program.

The reality, as with any job, is that it is not all tea and scones. There is also the real work to be done. This being the other lists that need covering up at the main Sunnybrook campus. For these lists I needed brawn (no theatre orderlies to help transfer patients), brains to remember MAC values (as there is no TCI in North America) and a production-line-like efficiency (no anaesthetic nurse to assist in set up). Overtime regularly exposed me to gunshot wounds from gang-related violence (not something I regularly see on Sydney's North Shore) and far too much of that North American coffee I derided earlier.

The Canadian health care system is almost wholly publicly funded. Inevitably, though surprisingly only recently, this has led to the conflicts that occur when escalating costs meet a limited budget. Bed shortages and rotating list cancellations are a new experience for Canadian doctors while for a practitioner from NSW it is an all too familiar feeling.

For a smooth transition into Canadian life, an Australian needs to be aware of important cultural differences, the main one being that Canadians are incredibly polite. The latest James Bond movie, Quantum of Solace, even made a subtle reference to this fact. In one of the final scenes, Bond ambushes a Canadian double agent in her apartment, but after being forgiven she is released from gunpoint. Leaving the room and knowing the deadly fate of the partner she leaves behind, the agent turns to Bond and softly says in her Canadian accent "thank you".

After arriving in Toronto we stumbled upon a mini-boom of Australian and New Zealanders completing fellowships here. It seems that the closing down of the United Kingdom to Australian and New Zealand doctors by the European Union employment regulations has pushed more of us towards Canada. It is easy to spot your countrymen here – they are the ones despondently wandering around the supermarket looking for Tim Tams.

The benefits for those who do come are wide ranging. Specifically for those interested in ultrasound, coming to the city where a lot of it started offers the benefits of quality real world training. Otherwise back in your anaesthetic bay as you stand all alone and a million miles from the ultrasound courses with their buffed models, lays your reality; a patient who is aged, deconditioned and overweight – and an ultrasound machine that annoyingly keeps disappearing.

I encourage those interested and able to come to Toronto to enhance your ultrasound skills and take these new skills back home to build upon the base already established by a number of centres. Though for this New South Welshman, the talent pool currently seems to be alarmingly skewed toward those south of the border!

Anyone planning an overseas fellowship should carefully research the details and bear in mind that often the key information comes from those who have been before you.

I would like to thank Dr Gil Faclier and all the members of Sunnybrook Anaesthesia Department for their kindness and support during my fellowship.

Dr Gavin Pattullo completed medical school in Tasmania and then went on to undertake his training for FANZCA (2003) and FFPMANZCA (2004) at Royal North Shore Hospital, Sydney. He has taken leave from his role as Staff Specialist and Director of the Acute Pain Service at RNSH to undertake his fellowship in Toronto.

Diving and Hyperbaric Medicine: Roundtable discussion

Anaesthetists play an important role in diving and hyperbaric medicine. We caught up with three Fellows from Royal Hobart Hospital in a roundtable discussion.

Dr Margaret Walker is medical co-director of the Diving and Hyperbaric Medicine Unit at Royal Hobart Hospital, and a visiting specialist in anaesthesia. Dr David Cooper is a staff specialist in intensive care, and hyperbaric medicine trainee, who has competed his training time and is planning to sit the Hyperbaric Medicine Certificate examination this year. Dr Ian Maddox is an anaesthetic registrar in his fourth year of training, who is undertaking a six-month term in diving and hyperbaric medicine, and plans to sit his FANZCA part two exam this year.

How did you become interested in diving and hyperbaric medicine?

MW: I first developed an interest when I was an anaesthetic registrar. I was also a keen scuba diver and I was sponsored by the hospital to do some training because they were in the process of setting up a new hyperbaric unit.

DC: I was first interested in this field in about 1993 when I did an underwater medical officers course with the Royal Australian Navy. I have an interest in environmental medicine (as a pilot) and it seemed like an interesting sideline to that. Subsequently I developed that further when I became the registrar in hyperbaric medicine in Hobart in about 2001.

IM: Like Margaret my interest was stimulated by my scuba diving hobby. I was also pointed in this direction by a few cases I had while working as an emergency department registrar where we saw a couple of diving cases. I attended the Royal Adelaide Hospital diving medicine course a couple of years ago which further interested me and that's what drove me into finally trying to get a registrar position in diving and hyperbaric medicine.

What is the structure of training in diving and hyperbaric medicine?

MW: At the moment we have the ANZCA training scheme set up as a post-graduate qualification. We primarily aim it at senior registrars or people after they have achieved their fellowship, but it's actually open to anyone who has a specialist qualification and that includes general practitioners (who are also recognised as specialists by our College). In terms of training there are two two-week courses in diving and hyperbaric medicine. One is predominantly diving medicine, which is either at Royal Adelaide Hospital or at HMAS Penguin in Sydney, and the other one is predominantly non-diving hyperbaric medicine which is at the Prince of Wales Hospital in Sydney. Both courses are held annually. We require that trainees have done both of those courses at some stage. The formal training requirement is actually a total of 18 months full-time equivalent work in an accredited hyperbaric unit. We expect a lot of people will probably do six months full-time and then accumulate the other twelve months as a part-time commitment, as most people are already specialists when they're doing their training. There is a formal examination which is both written and oral, as well as a formal project. Once you have achieved all of those things, you are eligible for the certificate in diving and hyperbaric medicine awarded by the College. At the moment we are in the process of accrediting units around the country for training.

IM: My aim is working towards the Diploma in Diving and Hyperbaric Medicine that's run by the South Pacific Underwater Medicine Society. This requires six months full-time equivalent work in a diving and hyperbaric medicine unit, attendance at one of the courses Margaret mentioned and a formal research project as well.

DC: I'm in the process of preparing for the college examination in hyperbaric medicine. I did the South Pacific Underwater Medicine Society's diploma, the six month diploma with a formal project requirement, but then I decided to cross-credit that into the College's program and then continue to get the entire 18 months worth of clinical time that's required. I've been doing that on a 0.2 FTE basis for the last five years so I'm looking forward to the College quiz later this year!

Were there any difficulties in gaining a position for training?

IM: I had no particular difficulty getting a job here in Hobart. I had tentatively asked for jobs previously when I lived in Western Australia in Fremantle. As a junior registrar at that time, senior registrars were given priority and it was popular. Certainly in Western Australia and Hobart, I believe that if you wanted a job as a registrar in hyperbaric and diving medicine you would be able to get one.

DC: When I was initially looking for a registrar position back in about 2000, I looked in Sydney and Melbourne as part of the process. At that time there was a moderate amount of competition for positions there. Outside those two centres there seems to be an adequate number of positions for people who are interested.

MW: From the College point of view the following hospitals are accredited for training: Prince of Wales Hospital in Sydney, Royal Hobart Hospital and Fremantle Hospital, and both the Alfred Hospital and Townsville General Hospital are well advanced in the accreditation process. At Royal Hobart we have one full-time position for a registrar for a whole year

and we often split that into two six-month jobs so we can accommodate two people in a year. At Prince of Wales, they rotate anaesthetic registrars through their unit and in Townsville, which is about to apply for accreditation, they have six month positions. At the moment they're mostly emergency medicine trainees going through Townsville, but they can certainly accommodate anaesthetic trainees if there are any interested. Fremantle has a flexible arrangement for registrars to rotate through the unit. Royal Adelaide Hospital is planning to apply for accreditation in the near future, so there are a reasonable number of jobs around the country.

Are there any problems in fulfilling training requirements?

MW: The main issue is getting the 18 months full-time equivalent. It's fairly easy to get six months full-time experience in any of the units, but most people would do the other 12 months part-time so it will obviously take more than twelve months to complete. For example, David Cooper here has been doing his extra twelve months over a five-year period by working one day a week.

IM: I suppose another area is getting as much exposure to patients with different conditions for treatment. For example, intubated and ventilated patients are a rare commodity in this unit but it's something that trainees need to get experience in managing. Unfortunately I haven't had to deal with an intubated ventilated patient yet and apparently we only get about two to three a year in this facility. The number of injured divers seems to be reducing as well. At the recent South Pacific Underwater Medical Society meeting, a number of delegates presented their data and the general trend over the last few years is that there are fewer divers presenting with decompression sickness.

MW: Which is good because it means our diver education programme is getting through to them.

DC: But we're doing ourselves out of a job in the process.

MW: Although that's not all we do. Diving medicine is a very small amount of our work. The bulk of our work is hyperbaric medicine and that's actually increasing.

What types of patients are treated in the hyperbaric chamber?

MW: Aside from diving injuries, our patients are predominantly those with problem wounds. The largest patient group we treat at the moment would be patients who have had radiotherapy and have developed a radiation tissue injury as a result, ranging from skin ulceration through to radiation proctitis or cystitis. The next largest group would be diabetics with foot or lower limb ulceration, and in these two conditions we have considerable level one experimental evidence indicating that hyperbaric medicine is efficacious.

Aside from that we do treat other conditions including acute necrotising infections, cerebral arterial gas embolism, carbon monoxide poisoning, compromised flaps and grafts amongst other rarer conditions. We don't treat any conditions for which there is no evidence that there are benefits, so things like multiple sclerosis and cerebral palsy which are treated a great deal in the USA and parts of the UK we would not treat here because there's no evidence of efficacy. We are quite strongly evidence based in the way we carry out our practice which is necessary to maintain credibility and status within the medical community.

Diving and hyperbaric medicine as a specialty does seem quite different from anaesthesia. Can you describe the areas of similarity and comment on the areas of difference?

DC: The areas of similarity are not necessarily few and far between. They arise predominantly in the necessity for the practitioner to have a sound understanding of the behaviour of gases and vapours under various environmental conditions. There is no other specialty group which has the same fundamental understanding of physics and physiology which are necessary to the practice of diving and hyperbaric medicine other than the anaesthetist.

Above from left: Dr Ian Maddox, Dr Margaret Walker and Dr David Cooper; The Royal Hobart multiplace chamber.

Diving and Hyperbaric Medicine: Roundtable discussion

Continued

At a purely theoretical level, anaesthetists are best positioned to perform this job. With regard to the actual anaesthetic skills, the sort of general purpose anaesthetic skills like intubation and ventilation and the maintenance of anaesthesia during procedures are possibly of slightly less relevance. But again, an anaesthetist is a very useful individual to have around the chamber when you are dealing with critically-ill patients potentially coming down from the intensive care unit, ventilated with invasive lines and requiring for organ support during the hyperbaric treatment, so I would see those as areas of similarity.

IM: Diving and hyperbaric medicine itself is actually two rather different specialties. Diving medicine involves taking an acutely unwell, acutely injured patient and coming to a differential diagnosis and managing appropriate treatment. Hyperbaric medicine is more of an ongoing treatment in a very different type of population to the divers. Both areas are quite different to the practice of anaesthesia. One area of relevance to anaesthesia is in the acute management of divers, which may involve a complex retrieval process and often anaesthetists or critical care practitioners are well versed in retrieval issues.

MW: The bulk of our patients have chronic wounds or radiation injuries that we're treating, and a lot of them are medically quite unwell. Anaesthetists have the skill of being able to assess people's medial conditions and make sure that they are stable and everything's optimised as far as medical treatment is concerned, and we can then anticipate their response to increased atmospheric pressure and gas density. It's similar to a preoperative assessment. With respect to Ian's previous comment about intensive care patients, there are some units that treat a lot of intubated ventilated patients. For example, at the Alfred Hospital in Melbourne they are running some special trauma research projects where they actually have a lot of critically ill ICU patients treated in their chamber. Their chamber is located next door to the ICU, and they utilise their ICU and anaesthetic registrars quite significantly to run the hyperbaric unit.

DC: The Alfred would probably be an exception to that rule. Certainly here in Hobart I'm the only intensive care specialist in town with an interest in diving and hyperbaric medicine. There's a moderate amount of further education necessary for me to convince some of my ICU colleagues of the potential for benefit from hyperbaric oxygen treatment.

What opportunity is there for research or completing formal projects?

DC: There are loads of opportunities; the thing that we lack is the time and the money to do it. This is a field of medicine that lends itself to research. There are huge numbers of unanswered questions regarding everything from basic physiology to cellular behaviour under hyperbaric conditions. Unfortunately most hyperbaric units are running on very small numbers of FTEs so people have significant other calls on their time which prevent them from doing this sort of research. Also, because hyperbaric oxygen as a drug isn't patentable, there's very little industry sponsorship available to fund these big trials. Although there is lots of potential for research there are just a couple of small limiting factors that get in the way at the moment.

MW: Having said that, all of our registrars have easily been able to complete their formal projects in their six-month attachments. There are lots of opportunities for research. There are many international trials running at the moment which it is possible to join. There's a lot of theoretical physiological work also. One of our local respiratory physicians is very interested in using our chamber to look at cellular behaviour in cystic fibrosis, for example. There are lots of non-hyperbaric medicine applications available for research and certainly it's one of the big areas where a lot of research is currently being done.

IM: I would add there is a great opportunity for anaesthetic registrars to complete their formal project requirement for anaesthetic training. The *Diving and Hyperbaric Medicine* journal of the South Pacific Underwater Medical Society is hopefully going to be indexed on Medline very soon, so a publication in that journal could be considered for the anaesthetic formal project.

Has training in diving and hyperbaric medicine affected your progress in anaesthesia training?

IM: I suppose the main issue is time away from anaesthetics and practically giving anaesthetics. My experience is that one seems to deskill in anaesthesia as a trainee very, very quickly so I'm a bit worried about returning to anaesthetics. However, this unit is good in that we get time off to attend anaesthetic tutorials or to attend theatre during the week. So there may be a period of deskilling but I think the overall benefits outweigh that.

MW: It's probably no different to doing a term in emergency medicine or even going to ICU for a term as far as maintaining clinical anaesthesia skills goes.

DC: Likewise with pain medicine.

MW: You're still exposed to patients and you're still doing clinical work, you're just not actually in theatre putting people off to sleep and waking them up. Although it's a bit of a break away from anaesthesia, I don't think it impedes your progress in training. I think it's just another one of those optional rotational turns that can give you a bit of a broader education.

DC: I certainly think the majority of trainees in diving and hyperbaric medicine that I have seen come through this unit or have met elsewhere have been well advanced in their training programs. In many cases they're doing it post-part two examination and they work it into their training as an elective-type term in their fellowship. Certainly when I did my first registrar rotation here, which was six months, I already had both the intensive care fellowship and the anaesthetic part two examination and I think a lot of other trainees fit a similar pattern.

Has exposure to diving and hyperbaric medicine affected your future career pathway?

IM: Okay, well I'll start with that, being the most junior here. This exposure has given me further interest in the area and it may well be that I attempt to do some diving and hyperbaric medicine as a consultant.

DC: As someone who's slightly further along his career path, I would hope that it would give me the opportunity to move into diving and hyperbaric medicine on a more permanent sort of basis. The difficulty is, of course, that there's only a small number of chambers around the country, so full time positions in diving and hyperbaric medicine are a rare commodity indeed. Most of the time you are left with the difficulty of having a part-time commitment to hyperbaric medicine and also working part-time in another department. Working across a couple of departments can lead to potential conflict in terms of rostering and requirements between the departments. I would very much like to do more hyperbaric medicine.

MW: From my point of view, I've been doing hyperbaric medicine since 1989 when I started as a very junior registrar. I now work primarily in private anaesthetic practice and I come to the public hospital one day a week and do hyperbaric medicine. It's quite nice to have contact with the public sector – a change in pace and a chance to do some research, which is not really possible in private practice. From that point of view it's fitted quite well into my career path.

Most of the consultants who work part-time in our unit are working here one day a week or one day a fortnight. We have a number of people on our roster so we have a pool of people with expertise who come in on a rostered basis. That means that everyone keeps their skills up and keeps their interest level going, has an opportunity to be involved in research projects, and can cover for after hours emergencies so it works quite well.

How have you found the overall training, and do you have any suggestions for improvement in training in diving and hyperbaric medicine?

IM: So far I've enjoyed the training and I've got a great deal out of it. The research opportunity as mentioned has been very useful for me. I've also had the opportunity to go on courses and the recent South Pacific Underwater Medicine Society conference. So far, two-thirds of my way through, I've found it very interesting and very useful. I think it may be a little bit early for me to suggest improvements.

DC: As somebody that's still jumping through the hoops of the training program, I think the training itself is good fun – it's interesting, intellectually stimulating and offers a large range of opportunities for people to sort of grow and develop as either clinicians or researchers. The major downside that I have found, however, has been doing it part-time. I'm now nine years post-fellowship and I'm coming up to doing another college examination as a moderately experienced consultant and it's hard to get back into the mindset and grind of examination preparation. I think that the part-time training has the potential to be a disincentive to future trainees doing the College certificate. I would recommend that if people are intent upon doing the College certificate that they try and get it done in a much shorter period of time than I have taken over it. But that will, of course, depend on the availability of FTEs on the payroll of the various units.

MW: Although I received my certificate as a "grandfather", I did have to show that I had satisfied the requirements and it had also taken me about five years to get the required number of FTEs up doing it part-time. I think the major thing with any training program is the patient case load and depending on which unit you work in you may be exposed to a large number of patients with a certain condition but not so much of another. In our unit there's a lot of exposure to wound care and radiation injury and not so much exposure to diving injury because at the moment we seem to have our divers behaving themselves and not getting injured. On the other hand, in Townsville they treat a large number of scuba divers in their unit, due to the large number of divers on the reef. If you were to go to the Alfred you'd get to look after a lot of patients that are intubated and ventilated so it really depends on where you're doing your training as to what kind of exposure you get.

IM: A formal rotation around the different units may be of benefit.

MW: I would suggest an attachment to another unit which has a different kind of case load so you can get to see some different sorts of patients. At the moment that's all still evolving, and we're still accrediting units for the entire period of training, because it doesn't seem to be a practical problem at the moment.

Above: Dr Ian Maddox in the chamber.

Dr Vanessa Beavis: From South Africa to New Zealand

Dr Vanessa Beavis divides her time between being the director of Anaesthesia and Operating Rooms at Auckland City Hospital, the largest hospital in New Zealand, and her role as chair of the ANZCA New Zealand Committee. She has been a member of the committee for six years, the last as the chair. She is also a Part II examiner, was the founding chair of the Anaesthetists in Management special interest group and is a member of the Perioperative Medicine Committee. Recently, Dr Beavis was the chair of the ANZCA New Zealand panel for vocational registration for three years and in this capacity has also been a member of the College's International Medical Graduate Specialist (IMGS) Committee. In addition, she is also an honorary senior lecturer at the Department of Anaesthesiology at Auckland University.

It is a dramatic change from her early working life as a doctor in her native South Africa. "The first day I started work as a doctor was on New Year's Day at a very big hospital on the East Rand," she said. "As you can imagine it was enormously busy. On that first day I did not know how to put in an intercostal drain and by the end of the night I had put in 24."

There are many differences in the medical experiences and training between South Africa and her adopted home of New Zealand including that general practitioners are allowed to give anaesthetics. The East Rand hospital delivered more than 100 babies a day and Dr Beavis was taught how to perform an epidural by the obstetrician-gynaecologist. It was the first anaesthetic she administered.

Those experiences triggered a greater connection with the specialty. "With anaesthesia, you have very broad exposure to lots of different things. I like the basic science associated with anaesthesia, I love physics and the way machinery works – it is just so entirely logical."

In the South African system trainees are required to pay their own costs, including training fees. As a result, most doctors need to supplement their income. Dr Beavis became involved in medical evacuations.

"I worked for a private insurance company that ran a mobile intensive care system for people with insurance, such as diplomats," she said. Dr Beavis said she was involved in more than a dozen medical evacuations all over Africa.

"You learn to make do with very little and to use all your ingenuity," she said. "It was absolutely terrifying but it could also be great fun. There was always a doctor and one or two nurses, depending on who you were going to retrieve, as well as one or two pilots. We would carry American dollars in cash, depending on where we were going, so that, for example, you could bribe your way out of the airport in the middle of the night.

"One night we went to a central African country where there had been a near-death. The whole plane was full of beer as that was the currency. Another time we were flying in the middle of the night when a powerful politician was trying to move gold bullion to a Swiss bank. As we landed, the plane was surrounded by soldiers with guns. They thought we had arrived to steal the gold. Luckily, we managed to get ourselves and our patients out safely."

Dr Beavis finished anaesthesia training in South Africa in 1993 and arrived at the Department of Critical Care Medicine at Auckland Hospital in New Zealand in 1994. She said her family decided to migrate for personal safety reasons and because they did not want their children growing up in that environment.

There were some initial challenges for Dr Beavis, coming from an African health system with a mix of first world sophistication and third world pathology, to one where the ordinary run-of-the-mill public system provides the best care available.

In 1997, when New Zealand was setting up its liver transplant program, Dr Beavis spent three months at the Mayo Clinic in Rochester, Minnesota learning how to do liver transplants. "Lots of people have worked overseas but this was different," she said. "We were setting up a brand new national program deliberately targeted for livers and looking at systems and processes for that express purpose, as opposed to just gaining clinical experience."

Dr Beavis was appointed deputy clinical director at Auckland Hospital shortly after returning from the Mayo Clinic and then clinical director of the department two years after that. She was then appointed director of Anaesthesia and Operating Rooms and was responsible for integrating five anaesthetic departments into one in 2003 when the hospital relocated to its current premises.

Along the way, Dr Beavis started to take more and more interest in the professional side of anaesthesia: "I know it sounds trite but I felt I had been offered so many opportunities and had been given so much that I really did need to give something back. Fortunately in those days you were allowed to become a Fellow by election."

She was subsequently elected to the New Zealand national committee. As a member of the International Medical Graduate Committee she conducts IMG interviews and assessments in New Zealand and Australia. She is also involved with hospital inspections and was a member of the Perioperative Medicine Taskforce Committee and the working group that preceded it.

Dr Beavis said that part of the attraction of doing work with the College was that you worked with smart people who were very committed. "The College work is very satisfying professionally. Every large organisation has a certain amount of bureaucracy but you have to, or else you just have chaos. I am trying not to let anybody find out that I am really enjoying myself quite a lot."

Dr Tony Richards: Anaesthesia in the fast lane

Dr Tony Richards is a 47-year-old paediatric anaesthetist from Christchurch. He is New Zealand born, bred and trained, apart from stints in London and Melbourne. "I've spent most of my medical years, since my clinical years as a medical student, at Christchurch Hospital culminating in being head of paediatric anaesthesia. I've been privileged to have a career in paediatric anaesthesia and have always enjoyed and been humbled by the challenge of working with children and helping them through their time of need," he said.

Dr Richards said that anaesthesia is a wonderful career with many opportunities and he intends to explore a few more in the remainder of his career, including taking some more time off with his wife and family. "Eventually we would like to take our careers overseas, splitting time between travel, work and charity work. As keen skiers we'd expect to be fitting a whole lot of that in as well!" he said.

Ever since Dr Richards can remember he has wanted to be involved in motor racing: "I think back to my father taking me to race meetings at Levin and Manfield in the '70s and watching the cars that I was actually later to race against, and loving the whole spectacle. I'd always wanted to give it a go, but never did, or not until a recent major life crisis led me to revaluate, get off my backside and 'tick a few boxes'."

F5000 was introduced as a V8 stock-block class in the late '60s as an alternative to F1 and quickly swept the world. In New Zealand and Australia it became "The Tasman Series" and was contested by some of the world's best-known drivers. Dr Richards said: "I'm a committee member of the NZ F5000 Association and in the last few years we have been at the forefront of the re emergence of this historic class from my childhood. With a nucleus of more than 30 cars plus overseas support we regularly put together competitive international grids of 25-plus cars around Australasia in The Tasman Revival Series."

He said the experience of racing the 320kmph cars is difficult to describe: "With around 550bhp and no driver aids, these old beasts are raw but very rewarding to drive. The consummate race car. They are loud and brash and assault all of your senses. The crowds love them. It's simply the best thing I've ever done. The series is attracting a lot of attention and this finally led to an invitation to be a support race class at the F1GP in Melbourne, 2009. It was an honour to take these cars back to the Australian GP which they last raced at 30 years ago. I managed to finish second in our series, beat Craig Lowndes' new V8 Supercar lap record at Albert Park, to break our lap record, and spray French champagne from the top of the F1 podium in what, for me, was a great day. A boyhood dream come true."

Clockwise from top left: Dr Tony Richards getting ready to race; Dr Richards gets the chequered flag; Dr Richards, second from the right, celebrates on the podium.

The ANZCA Foundation

An initiative of the Australian and New Zealand College of Anaesthetists

Yvonne Kenny visits the Kolling Institute of Medical Research

Recently the chairman of the ANZCA Foundation, Professor Michael Cousins hosted a visit by Yvonne Kenny, one of Australia's great opera divas, to the Pain Management Research Institute at Royal North Shore Hospital, Sydney. Ms Kenny is a member of the ANZCA Foundation Board and this visit provided an excellent opportunity to view the new research facilities at the Kolling Institute of Medical Research.

This visit was also an opportunity to thank and present Ms Kenny with a copy of the Foundation's recently completed audio/visual presentation highlighting the role of Fellows and anaesthesia to a wider audience in Australia and New Zealand. Ms Kenny very kindly permitted a recording of her performance of "I dreamt I dwelt in marble halls" to be featured as the background to the presentation. There are plans for this presentation to also be shown on the ANZCA Foundation website in coming months.

Top, from left:

Professor Michael Cousins, ANZCA Foundation chairman with board member Yvonne Kenny;

New board members John Astbury and Geoffrey Linton;

Foundation board member Yvonne Kenny meets researchers at the Kolling Institute.

New appointments to The ANZCA Foundation Board

Two new appointments have been made to the Board.

John Astbury
Mr Astbury has a long history in senior banking and finance positions in the UK and Australia. He is a director of Woolworths Limited and a Fellow of the Australian Institute of Company Directors.

Geoffrey Linton
Mr Linton has wide business experience, being a former partner at Ernst & Young. He is presently the secretary of the Collier Charitable Trust in Victoria. Geoff is a Fellow of the Institute of Chartered Accountants in Australia.

The ANZCA Foundation Patrons Program

The ANZCA Foundation Patrons Program will be progressively introduced to Fellows and the wider community over the coming months. The Patrons Program has been established to encourage and recognize those people who wish to support medical research and education. All donations will be solely directed towards medical research and education with the Council of ANZCA determining the awarding of the grants. For further information concerning the Patrons Program, please contact Ian Higgins on +61 3 9093 4900 or via email ihiggins@anzca.edu.au

The ANZCA Foundation Bequest Program

A bequest to the ANZCA Foundation will greatly enhance ANZCA's ability to undertake important medical research that will significantly improve outcomes for the health of future generations.

You might consider a bequest to the ANZCA Foundation whether as a specific amount of money, a proportion of your estate, the residual of your estate or other specific property.

Your will and financial planning are intensely personal, and the Foundation respects your privacy. However, if you wish to allocate an amount to the Foundation, or to honour or commemorate a named individual, the staff at the Foundation are readily available to provide assistance. All discussions will, of course, be confidential.

We strongly recommend that you seek professional advice regarding your will. A solicitor will help you make a clear, concise will, which is easily located and causes no misunderstanding.

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Quality & Safety

Australian Commission on Safety and Quality in Health Care – Medical Devices Incidents Workshop

Meeting highlights

The aim of this workshop, held on March 29, 2009, was to improve the sharing of incident information nationally and to better understand medical device safety, both in design and technical compliance and in the evaluation of the role of human factors and training in minimising incidents with medical devices. Participants included government representatives of health services, clinicians, nurses, quality assurance managers and industry representatives. Among the clinicians, anaesthetists were well represented.

Need for better reporting

The keynote speaker was Dr Larry Kelly, head of Office of Devices, Therapeutic Goods Administration (TGA) who reported on the TGA Medical Device Incident Reporting Investigation Scheme (IRIS). The role of TGA is to regulate and monitor the supply and manufacturing controls of medical devices and drugs and to evaluate adverse events associated with the use or misuse of a medical device. It is mandatory for a manufacturer to forward any details of reports it has received on a device that did or could have resulted in an adverse event. TGA has considerable regulatory authority to investigate all such reports and if necessary to mandate a recall. *However, there is no such control on users as there is no obligation to report. Thus, an important issue is the under-reporting of problems either to TGA or the supplier.*

Dr Kelly presented figures for the 1317 reports considered in 2008. Suppliers issued 1090 reports whereas hospitals, clinicians and nurses contributed only 190. The responses by TGA to the 1317 reports received in 2008 indicated 20 recalls and 30 alerts while improvement in design and user education were a major outcome in a further 160 instances.

The take-home message was that there is urgent need for better reporting by users either through the suppliers or directly to TGA.

Need for better designs and systems

A biomedical approach to medical device incidents was presented by Mr Patrick O'Meley, Area Director, Biomedical Engineering, Sydney South West Area Health. He believes that incident management is poorly managed with inadequate documentation and that current practices are not solving problems.

While falls, drug errors and diagnostic errors in hospitals are now well documented, reports on equipment failure are "buried". There is an assumption amongst users that modern devices are safe, yet there is often a lack of experience, poor choice in selection and inadequate education or foresight. To date, the main focus has been on electrical safety and other factors overlooked are multiplicity of devices, a design which overlooks the usage environment, and the possibility of fatal configuration or user mistakes that are difficult to eliminate. Other problems include outmoded standards, poor service and support, while human factors are overwork, distraction, increased complexity of devices and overload of information.

Mr O'Meley's message was the need for better designs and systems along with the development of best practice guidelines for configuration and selection.

Pump infusion errors

In a paper on pump infusion errors, Dr John Lambert, FANZCA, FJFICM, Director of Critical Care, Orange Hospital NSW suggested there was an increasing awareness that TGA approval is not the only requirement for safe equipment choice as approval may not meet reasonable clinical standards or expectations.

With regard to infusion pumps there is a wide variety of designs on offer with dramatically different form factors and user interfaces and many designs are not immediately intuitive. In addition, there is considerable variety in technological awareness by what is a relatively small group of users, mainly nurses and doctors.

Examples of the ability of clinicians to "innovate" at the bedside include the ability to creatively bypass safety mechanisms and restrictions built into devices, the willingness to use devices with no understanding of how they work and the ability to justify the purchase of expensive equipment as mandatory with limited evidence of the benefit of such equipment.

In a search of international data for pump errors using free text, the reports were classified as medication incidents, medical devices and clinical management. The outstanding issue was pump setting errors with less frequent reports of syringe/drug/fluid mix-up, errors in the use of infusion devices or order error. Surprisingly, there were free running line errors despite a "forcing function". About 10-15% of incidents involved the use of the wrong channel on multi-channel devices, wrong pumps with multiple pumps in use and line mix-ups with lines swapped, mislabeled or not tracked correctly.

Of real concern was that the majority of these errors occurred in intensive care units. Suggestions for improvement included avoidance of multi-channel devices, standardisation of devices to minimize user interface difference errors, consideration of the use of unique devices for particularly dangerous infusions such as inotropes, epidurals, PCAs and possibly chemotherapy and the use of a forcing function for double check when changing settings or lines.

Case reports

Other case reports included the very full investigation by Queensland Health on adverse events with PICC lines (where the outcome of ongoing discussions with TGA and the manufacturers are pending), the safety of endoscopic vascular repair of aortic aneurysms and incidents with pleurocaths.

Of particular interest was a presentation from Stella Robinson of South Australia Health on hospital bed safety. Overseas data presented indicated that bed entrapment was a significant cause of mortality in the elderly. A state-wide audit of hospital beds in South Australia revealed that 84% of beds in that state presented a variety of entrapment hazards, importantly including undersized mattresses, presumably introduced for reasons of economy.

We now await initiatives that may follow this workshop.

Dr Patricia Mackay
Victoria

Trauma, surgery, obstetrics and bleeding disorders

Anaesthetists and intensivists usually have good access to blood and the blood products they most commonly use and to a ready source of advice from a haematologist or blood transfusion service when uncommon issues arise.

A previous article in the *Bulletin* (March 2009) summarized the National Blood Supply Contingency Plan 2008. Newly released is information relevant to the care of patients known, or suspected to have a bleeding disorder and who suffer trauma, require surgery or are pregnant.

The technical information comes with the authority of the National Blood Authority (NBA) Australia, the Australian Bleeding Disorders Registry (ABDR), the Australian Haemophilia Centre Directors' Organisation (AHCDO), the Haemophilia Foundation Australia and all Australian governments. Websites include www.nba.gov.au; www.haemophilia.org.au and www.ahcdo.org.au. At this last website, under "publications" are "Surgery guidelines" and "Guidelines for the Management of Pregnancy".

Information provided by the ABDR includes a list of the different types of bleeding disorders (36 in all), the usual "trigger" for diagnosis (including trauma and surgery), the treatment regimen (on demand, prophylaxis, tolerisation and secondary prophylaxis) and the products available, including suppliers.

Patient details registered with the ABDR will be entered into a database aimed at providing accurate information to the authorities tasked with ensuring that agents used for patient care are available in Australia in quantities sufficient for demand. This information is not currently accurate, which is why the registry is being revitalized.

While Fresh Frozen Plasma (FFP), cryoprecipitate, platelets, DDAVP and Tranexamic Acid are available generally, patients with specific bleeding disorders must be registered on the ABDR in order to be treated with the more specialised products.

As an aside, anyone wanting to use this article as a stimulus for a CPD project could investigate the latest information to be found on FFP, cryoprecipitate and platelets through to more exotic products and their use for an increasing variety of bleeding disorders, now including nine varieties of von Willebrand's disease. Just a thought.

Prof Garry Phillips
South Australia

Audible oximeter tones and alarms

In 2008 ANZCA revised Professional Standard 18, *Recommendations on Monitoring during Anaesthesia*[1]. This standard now requires having an audible variable pulse tone from the oximeter. It also requires an audible low limit alarm.

"...the variable pulse tone as well as the low threshold alarm shall be appropriately set and audible to the practitioner responsible for the anaesthesia."

Correctly used monitoring tones and alarms promote safety for our patients. Monitor settings need to be checked at the beginning of a list and whenever there is a change of anaesthetist. Inappropriate use of monitors puts patients at grave risk of undetected hypoxia.

The US Anesthesia Patient Safety Foundation has documented three cases of death and profound brain damage in healthy ASA1 patients due to lack of appropriate monitoring[2]. **These cases are recommended reading for all anaesthetists.**

Dr Rod Tayler
Editorial Advisory Board
Quality and Safety Committee
ANZCA

1. *www.anzca.edu.au/resources/professional-documents/professional-standards/ps18.html*
2. *www.apsf.org/resource_center/newsletter/2004/winter/03turn_on.htm*

Anaphylaxis to Chlorhexidine

In a recent edition of the *British Journal of Anaesthesia*, Parkes et al provide a report on three cases of anaphylaxis to chlorhexidine[1]. In all three reports the anaphylactic reaction followed the use of urethral lubricant in the operating theatre and the authors noted that there may be a delayed presentation of cardiovascular collapse and skin manifestations which in these cases occurred some time after admission to the recovery area.

A number of early reports of anaphylaxis to chlorhexidine were reported in urological journals and two reports in *Anaesthesia and Intensive Care* in 1994[2] and 1995[3] all related to the use of urethral lubricants.

Of interest is a case report which concerns a male undergoing a neck dissection and free flap who developed marked hypotension and tachycardia one hour after induction. A urinary catheter was being inserted at the time and latex allergy was considered but proved negative. The patient made an uneventful recovery and skin testing was unremarkable. The possibility of sensitivity to chlorhexidine was not considered at this time.

One year later the patient developed an erythematous rash over his entire body during the insertion of intra-arterial and central venous lines (PICC line). No anaesthetic drugs had been administered but the surgery did not proceed. Skin testing revealed strongly positive reactions to both the lignocaine-chlorhexidine lubricant used for the urinary catheter insertion and for the subsequent use of chlorhexidine skin preparation for the invasive monitoring.

Anaesthetists are reminded that when there is unexplained cardiovascular collapse, especially in the recovery area, the possibility of anaphylactic reactions to chlorhexidine should be considered as chlorhexidine is present in a wide variety of agents used in healthcare as well as in the community.

References

1. Parkes AW, Harper N, Herwadkar A, Pumphrey R Anaphylaxis to the chlorhexidine component of Instillagel: a case series. Br J Anaesth 2009; 102: 65-68
2. Russ BR, Maddem PJ. Anaphylactic reaction to chlorhexidine in urinary catheter lubricant. Anaesth Intensive Care 1994; 22611-2
3. Parker F, Foran S. Chlorhexidine catheter lubricant anaphylaxis. Anaesth Intensive Care 1995; 23:126

Dr Fred Rosewarne
Victoria

Quality and Safety Committee membership

The Quality and Safety Committee is just one of 12 committees of ANZCA that reports to the ANZCA Council. While both myself and Dr Elizabeth Feeney, President, ASA, are observers at the College Council, we are full members of the Quality and Safety Committee and therefore have an active role on this important group.

This means that opinions from outside a direct college framework that reflect the views of the respective societies' memberships can be expressed and particularly from the NZSA point of view there is an additional New Zealand voice on the committee. Not all practising anaesthetists are Fellows but via this forum it is possible for them to have a say in the College's activities.

The committee is responsible for advising and informing Council in matters of both quality assurance and safety and also report issues of concern directly to ANZCA fellows via the *Bulletin* or the website, giving all practising anaesthetists up-to-date and timely information that may seriously affect practice. The discussions of the committee are wide ranging and encompass all aspects of quality and safety in anaesthesia such as the Australia and New Zealand Tripartite Anaesthetic Data Committee process and the preparation of appropriate guidelines. It is an interesting and enjoyable committee to take part in, and its work is very important for the patients of New Zealand and Australia.

Dr Andrew Warmington, President,
New Zealand Society of Anaesthetists (NZSA)
Auckland, New Zealand

Changes to medical oxygen connections – re-visited

The March 2009 edition of the ANZCA *Bulletin* published an article by Professor John Russell regarding the recent amendment to AS2473.3 and the subsequent upcoming changes to medical oxygen connections which are to be converted by all suppliers on a state-by-state basis over the next two years.

The College has received correspondence from the Australia and New Zealand Industrial Gas Association (ANZIGA), regarding the schedule, and the information is outlined opposite.

Important changes to medical gas cylinders

ANZIGA recently wrote to you in regard to two important changes that are going to occur to medical gas cylinders in the near future:

- The changes to medical oxygen valve outlets as required by Australian Standard AS2473.3; and
- The requirement that all medical gas cylinders have a white body with the colour on the shoulder indicating the type of gas

This letter is to remind you that all large medical oxygen cylinders (D, E and G sizes including bundles/packs) will be supplied with a different valve outlet, called a pin indexed valve outlet, and will also be coloured white from the time indicated below:

Date	Location
September 2009	Northern Territory
February 2010	South Australia
May 2010	Western Australia
August 2010	Queensland
February 2011	New South Wales/ACT
June 2011	Victoria/Tasmania

This means that in your state or territory, from the date indicated above, large medical cylinders will be available only with pin index valves. For example in Northern Territory from September 2009, large medial cylinders will only be supplied with pin index valves.

Prior to the changeover time in your state or territory, you will need to arrange for a replacement medical oxygen regulator in order to be able to connect to the new valve outlet. It is recommended you contact your regulator supplier or medical gas supplier for assistance with your requirements. Users of medical oxygen with manifold systems will need to have their manifold connections and/or flexible connections changed prior to the change-over date.

Please contact ANZIGA or your medical gas suppler if you require further information, at:

ANZIGA
Level 1, Unit 7, Skipping Girl Place
651 Victoria St, Abbotsford, Vic 3067
Telephone: +61 3 9426 3812
Email: office@anziga.org

Successful candidates 2009

Primary Fellowship Examination

The written section of the examination was held on March 2 and the viva examination was held from April 27-29.

A total of 116 candidates successfully completed the **Primary Fellowship Examination** and are listed below:

Freya Emily Aaskov	QLD
Lahiru Nipun Amaratunge	VIC
Sophie Jane Anderson	TAS
Catherine Marie Ashes	NSW
Peter Joseph Bainbridge	VIC
Michael Lee Bassett	VIC
Miles Christopher Charles Beeny	VIC
Paul Joseph Bennett	QLD
Estibaliz Arantzazu Blazquez Basarrate	NZ
Daniel Edward Boyd	NZ
Jeremy Luke Brammer	QLD
Alastair Browne	NSW
Timothy James Byrne	VIC
Rodney James Cansdell	QLD
Geoffrey Paul Carden	NZ
Benjamin Cerutti	QLD
Rani Chahal	VIC
Kah Lynn Elene Chan	QLD
Ian Thomas Chao	VIC
Chong Yee Hui	NSW
Anne Wai Li Chew	VIC
Daniel Martin Clarke	QLD
Benjamin Andrew Crooke	QLD
Andrew Deacon	NSW
Edward Michael Debenham	WA
Rachel Dilernia	VIC
Andrew John Donohue	NSW
Trung Thien Du	VIC
Rosemary Kaye Duckett	NZ
Daniel William Ellyard	WA
Jeremy David Field	NSW
Stephanie Wei Yin Fong	NSW
Andrew Beresford Foster	SA
Michelle Diana Gerstman	VIC

Dr Yahya Shehabi (left), retiring Primary Examiner and Dr Craig Noonan, Chair, Primary Examination

Benjamin Thomas Hayes Greenwood	NZ
Alex Grosso	QLD
Arvinder Grover	VIC
Paul Christopher Hales	VIC
Michelle Harris	VIC
Daniel Alexander Hartwell	NZ
David Harvey	NZ
Paul Mark Healey	NSW
Nicholas Peter Heard	QLD
Marsha Kim Heus	NZ
Vui Kian Ho	SGP
Andrew Stewart Hunt	WA
Brendan Alexander Irvine	NSW
Veerendra Jagarlamudi	NSW
Dinuk Arshana Jayamanne	ACT
Melissa Johnston	NSW
George William Kennedy	QLD
Saejin Kim	VIC
Benn Morrie Lancman	NSW
Harvey Hsin-Fu Lee	VIC
Daniel Mattathiah Levine	NZ
Lim Guan Cheng Jimmy	SGP
Lim Wei Ming Wilfred	SGP
Ling Wai Yip	HKG
Jamahal Maeng-Ho Luxford	VIC
Hamish Stuart Mace	WA
Mak Wai Yin	HKG
Mak On Li Ann	HKG
Mak Nok Lei	SGP
Clare Bronwyn McArthur	TAS
Robert David Miskeljin	QLD
Steven James Mitchell	NZ
Nurul Shamsidar Mohamed Bakri	QLD
Wendy Julia Morris	QLD
Premala Nadarajah	QLD
Arjun Nagendra	NSW
Oriana Ng	SGP
Chong Seng Ong	VIC
Or Yin Ling	HKG
Samarasimha Pandhem	QLD
Anand Parameswaran	QLD
Pavithra Pasupathy	NSW
Sze Ying Pui	HKG
Joshua Simon Rath	NSW
Lloyd Antony Roberts	VIC
Emma Louise Rosenfeld	NSW
Elitza Vaneva Sardareva	NZ
Ryan George Savage	TAS
Brett Elliott Fabian Segal	QLD
Sukhpreet Singh Sihota	NZ
Sancha Claire Simpson-Davis	QLD
Alexander J Smirk	VIC
Jessica Natalie Smith	NSW
Scott Anthony Smith	QLD
Era Soukhin	NZ
Louise Mary Speedy	NZ
Dana Stanko	WA
Christopher Charles Stone	NSW
Jeremy Thomas Sutton	SA
Chandrashekhar Talekar	NSW
Angela Helen Tan	WA
Tan Pei Yu	SGP
Tze Ping Tan	VIC
Carradene Taylor	QLD
John Yuk Ching Ting	NSW
Clement Wei Ming Tiong	NSW
Tse King Yan Catherine	HKG
Michael Andrew Tsiripillis	VIC
Tsui Sin Yui Cindy	HKG
Christopher Andrew Turnbull	QLD
Neil Vanza	VIC
Hendrik Stephanus Viljoen	NZ

Wai Ka Ming	HKG
Laurent Anthony Wallace	NSW
Paul Christopher Williams	NSW
Donna Leanne Willmot	SA
Andrew Norman Richard Wing	NZ
Michael John Wirth	SA
Nicola Ellen Woollard	QLD
Jia Jia Ye	NSW
Yip Yu Yeung	HKG
Nusrat Zahan	NSW

Renton Prize

The Court of Examiners recommended that the Renton Prize for the half year ended June 30, 2009 be awarded to:

Dr Alexander Smirk	VIC

Merit Certificates

Merit Certificates were awarded to:

Dr Catherine Ashes	NSW
Dr Daniel Boyd	NZ
Dr Daniel Ellyard	WA
Dr Andrew Hunt	WA
Dr Benjamin Jones	NSW
Dr Daniel Levine	NZ
Dr Lloyd Roberts	VIC
Dr Angela Tan	WA
Dr Andrew Wing	NZ

Final Fellowship Examination (Anaesthesia)

The written and medical clinical section of the examination was held on April 3-4 and the viva examination was held from May 29-30.

A total of 150 candidates successfully completed the **Final Fellowship Examination** and are listed below:

Shalini Achuthan	VIC
Mahsa Adabi	VIC
Erik Steenfeldt Andersen	NZ
Trevor Robert Arnold	NSW
Simon Antony Astegno	VIC
Celine Baber	WA
Michael Babon	QLD
Liam Patrick Balkin	QLD
Ravi Bangia	VIC
Hannah Mary Barker	VIC
Anthony John Barnard	SA
Nicola Beauchamp	QLD
Michael Ryan Bishop	QLD
Dane Blackford	ACT
Mark Stephen Boesch	NSW
Christopher Joseph Thureau Breen	QLD
Deas Macdonald Brouwer	VIC
David James Burton	NZ
Brendon Eric Buzacott	QLD
Wayne Carstens	SA
Chan On Yi	HK
Chan Lai Mei	HK
June Mei Yee Chan	NSW
Janette Yuk Sau Chan	VIC
Giresh Chandran	SA
Arthur Yin Sau Cheung	VIC
Sue Cheng Chew	VIC
Tarragon MacLeod Chisholm	NZ
Chu Ka Lai	HKG
Matthew John Coady	NSW
Adriano Gino Cocciante	VIC
Erica Jane Dibb-Fuller	NZ
Gavin Doolan	VIC
Scott James Douglas	SA
Wayne Paul Edwards	QLD
Peter James Effeney	VIC
Catherine Elizabeth Egan	SA
David Geoffrey Fahey	QLD
Nasim Fahimian	WA
Jeremy Ranil Fernando	NZ
Peter Julian Flynn	ACT
Catherine Maree Fuller	WA
Tu Quyen Therese Fung	VIC
Alexander Hugh Degaris Gale	ACT
Alexander Gershenzon	VIC

Final Examination Court of Examiners

Successful candidates 2009

Continued

Jonathan Rael Golshevsky	VIC
Gregory Piers Timothy Hackman	NSW
Benjamin Hallett	VIC
Angelique Halliday	WA
James Anthony Halloway	NSW
Adam Francis Hastings	NSW
Dean Rowan Haydon	QLD
Geoffrey Healy	NSW
Sarah Louise Hedges	WA
Alexandre Stephane Henry	VIC
Bradley Michael Hindson	VIC
James Allen Hosking	QLD
Raymond Tiong Chin Hu	VIC
Romi Janovic	VIC
James Paul Jarman	VIC
Andrew David Jones	VIC
Jonathan Howard Kapul	QLD
Debbie Margaret Knight	SA
Steven Koh	NSW
James Michael Koziol	VIC
Oscar Kwon	NSW
David Lam	VIC
Andrew Kenneth Lansdown	NSW
Sidney S Y Lau	WA
David Guo Rong Law	WA
Rowena Anne Lawson	ACT
Yue Peik Leong	NZ
Li Lin	VIC
Ting-Ting Liu	NSW
Gordon Joseph Mar	VIC
Elmo Niroshan Mariampillai	VIC
Kate Ann Matthews	QLD
Paul Crossman McCallum	VIC
Sarah Grace McLeod	VIC
Hamish Douglas Devenish Meares	NSW
Agnes Katalin Molnar	NSW
Elizabeth Mary Louise Moran	NZ
Al Motavalli	VIC
Catherine Marie Muggeridge	ACT
Dominique Bayu Anthony Muller	WA
Luke John Murtagh	SA
Kirstin Larissa Naguit	NSW
Gary Newfield	NSW
Andrew Ng Wei Aun	MAL
Joseph Yeuk-Kei Ng	WA
She Yin Ng	NSW
Merlin Edward Nicholas	WA
Toby Troup Nichols	WA
Panya Nipatcharoen	NSW
Njo Kui Hung Anthony	HK
Kim Alexander Nuyen	VIC
Pallathu Kadavil Hasher	NZ
Andrew George Paterson	NSW
Margo Joan Peart	NSW
Andrew James Peart	NSW
Sabine Pecher	NZ
Adam David Perczuk	NSW
Jennifer Anne Plummer	VIC
Poon Ching Mei Clara	HK
Mark Vincent Porter	NSW
Andrew Douglas Powell	NSW
Arvind Raju Ganga Raju	NSW
Derek Michael Rosen	NSW
Paul Robert Rowe	NZ
Giles Victor Sampson	NSW
Bradley David Sartori	QLD
Shimon Scharf	VIC
Rajesh Sethi	SA
Andrew William Smith	NZ
Angela Ruth Stephen	NZ
Michael John Stone	NSW
Karl Peter Sturm	NSW
Sivanesan A/L T Subramaniam	MAL
Tamsin Melissa Supple	VIC
Wai Yin Tam	VIC
Roger Cheng Wah Tan	WA
Christine Ee Yean Tan	WA
Tang Mee Yee	MAL
Selene Tang Wei Lien	VIC
Melanie Elizabeth Thew	WA
Damon Nicholas Simon Thompson	NZ
Samantha Marie Tong	NSW
Joshua David Tooth	QLD
Amelia Traino	NSW
Sharon Lii-Anna Tsetong	NSW
Khai Tan Van	QLD
Paloma Gioia Van Zyl	NSW
Ramesh Vasoya	NZ
Stefan Waelde	VIC
Helen Marie Ward	NSW
Wat Chun Yin	HK
Edith Bodnar	VIC
Kim Yuh-Kuan Weng	NSW
Tiffany Jane Candida Wilkes	QLD
Luke Anthony Wilson	VIC
Chun Keat Wong	SA
Zarina Wai Bink Wong	NZ
Wong Sze Ming	HK
Wong Hoi Kay Tiffany	HK
Gin Leong Wong	WA
Christopher Kin-Bonn Wong	NSW
Jordan Gardiner Wood	NZ
David John Wright	ACT
Yeoh Hann Sean Brian	MAL
Alexander Michael Zoszak	NSW

The Court of Examiners recommended that the **Cecil Gray Prize** for the half year ended June 30, 2009 be awarded to:

James Paul Jarman	VIC

Merit Certificates were awarded to:

Jonathan Rael Golshevsky	NSW
James Michael Koziol	VIC
Dominique Bayu Anthony Muller	WA
Mark Vincent Porter	NSW
Helen Marie Ward	NSW

International Medical Graduate Specialist Performance Assessment

A total of three candidates successfully completed the International Medical Graduate Specialist Performance Assessment on Friday, May 29 and Saturday, May 30, 2009 and are listed below:

Dr Robert Brinkmann	QLD
Dr Alexander MacKinlay	TAS
Dr Anthony Parakkal	VIC

CanMEDS Curriculum Framework

The CanMEDS Curriculum Framework – How will it change your life?

Recently, I asked a group of anaesthetic teachers what the CanMEDS Framework meant to them. I wasn't trying to trick anyone or show off my own knowledge. I genuinely wanted to know. The response that greeted me was polite silence. After a while, one of them volunteered 'Isn't it that list of things in the introduction of the module book?' That Fellow was right, of course, but it is also the cornerstone of the ANZCA curriculum framework and I had an expectation that, as such, it should have an impact on the way in which our trainees and their teachers think about all their educational activities.

I have received very similar responses (indifference, bemusement, lack of familiarity) from other groups of trainees and anaesthetic teachers to whom I have talked about CanMEDS. Why should it be the case that so few people know about CanMEDS or feel that it has an impact on the ANZCA training program? CanMEDS was adopted in 2004 as the curriculum framework for the ANZCA training program. At this stage it was used in its generic format. At its inaugural meeting in August 2008, the Curriculum Review Working Group (CRWG) agreed to use the CanMEDS-2005 framework for the revised curriculum that will be developed. During this curriculum review the framework will be tailored specifically to contemporary Australasian anaesthetic practice. (see http://www.anzca.edu.au/edu/projects/curriculum-review for further details of the CRWG).

As a community, it is important that we develop a curriculum framework for our trainees that is widely understood and useful in practice. The following article, written by Dr Genevieve Goulding, helps to provide that understanding. She explains the background to the framework, how and why it was developed and how it can be used locally. When the CRWG has completed its work, I look forward to sharing with Fellows and Trainees the detail of our local CanMEDS framework. It is my sincere hope that, in the future, this will be helpful in shaping all teaching delivered by ANZCA Fellows and learning received by ANZCA Trainees. So, whilst the CanMEDS framework may not change your life, we do hope that it will have a positive impact on your educational practice and experience.

Mary Lawson
Director of Education

What is meant by "CanMEDS"?

"CanMEDS" is a curriculum framework developed for use in medical education. Its name is derived from "Canadian Medical Education Directives for Specialists".

The framework sets the standard for all domains of professional practice including the knowledge, skills and behaviours expected of specialists in Canada (and those countries that adopt it).

CanMEDS was an initiative by the Royal College of Physicians and Surgeons of Canada in the 1990s. At that time, the College recognised that the healthcare environment was undergoing rapid changes such as patient consumerism, an increasingly regulatory environment, budgetary constraints, access to medical information freely via the internet, higher rates of litigation, new drugs and technologies and the explosion of medical knowledge. These forces were changing the healthcare delivery environment, and it was felt that the roles and abilities of physicians (doctors) urgently needed to adapt to these changes.

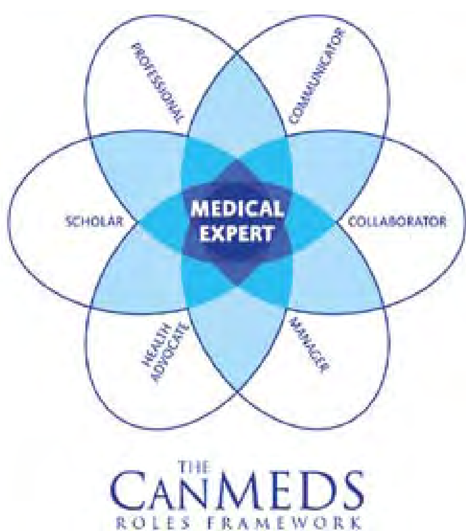
After many years of extensive consultative process involving doctors from many fields and educators and other stakeholders such as patient groups, seven "essential physician roles" were defined.[1]

The CanMEDS Roles: Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar, Professional

It was decided that training in these roles would provide the basis for medical education to prepare specialist doctors for practice that could meet patients' needs in the modern healthcare environment. Universities and specialist training programs in Canada adopted the principles into their curricula, and it was not long before many other countries followed suit at different levels across the spectrum of medical education.

Remembering the North American origins of the CanMEDS, "physician" would in our context equate to "medical specialist" and "medical expert" to expertise in the medical aspects of one's specialty rather than specifically to specialist medicine (what *we* would call physician specialist practice).

The CanMEDS Roles are typically represented by the diagram[2], the CanMEDS "daisy". It shows the centrality of the role of "Medical Expert" with all the other roles interconnected. Each CanMEDS role also has a list of "Elements", which explain the role more clearly. The "daisy" is a simplistic representation of this complex framework.



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www.rcpsc.medical.org

The CanMEDS Competencies

In 1995, the CanMEDS framework was revised[3] to be more than just a description of essential physician roles, and went on to describe essential competencies. (Competencies are important knowledge, skills and attitudes that can be taught, observed and assessed).

Competencies have now been organised around the physician roles. In the CanMEDS framework each of the seven Roles has "Key Competencies", and each key competency has been further outlined into multiple "Enabling Competencies". The enabling competencies specify the behaviours, skills and attitudes that must be displayed by the postgraduate learner.

As an example, here is the description of the key competencies for the Communicator Role:

"As Communicators, physicians effectively facilitate the doctor-patient relationship and the dynamic exchanges that occur before, during, and after the medical encounter."[3]

Key Competencies for the Communicator Role

1. Develop rapport, trust and ethical therapeutic relationships with patients and families
2. Accurately elicit and synthesize relevant information and perspectives of patients and families, colleagues and other professionals
3. Accurately convey relevant information and explanations to patients and families, colleagues and other professionals
4. Develop a common understanding on issues, problems and plans with patients and families, colleagues and other professionals to develop a shared plan of care
5. Convey effective oral and written information about a medical encounter

Each of the five key competencies listed above has enabling competencies which expand on exactly what is required (17 in total). For example, the enabling competencies for point 4 taken from the Communicator Role are listed below:

4. Develop a common understanding on issues, problems and plans with patients, families, and other professionals to develop a shared plan of care

4.1 Effectively identify and explore problems to be addressed from a patient encounter, including the patient's context, responses, concerns, and preferences

4.2 Respect diversity and difference, including but not limited to the impact of gender, religion and cultural beliefs on decision-making

4.3 Encourage discussion, questions, and interaction in the encounter

4.4 Engage patients, families, and relevant health professionals in shared decision-making to develop a plan of care

4.5 Effectively address challenging communication issues such as obtaining informed consent, delivering bad news, and addressing anger, confusion and misunderstanding

Many of the specialist medical colleges of Australia (including ANZCA) have incorporated the CanMEDS framework into their curricula, with some adaptations. The FANZCA program is undergoing an extensive review, and the revised program will more explicitly incorporate the framework, with Key and Enabling competencies as described above, pertinent to Australasian anaesthesia, included in the curriculum.

Trainees and IMGS undertaking the FANZCA Final Examination would benefit from reading the CanMEDS framework and ANZCA Code of Professional Conduct[4] for a clear idea of the standard and range of abilities that are expected to have been achieved by the end of training to deliver quality care as a specialist.

A full description of the CanMEDS framework can be found at: http://rcpsc.medical.org/canmeds/

Dr Genevieve Goulding
ANZCA Councillor
Chair IMGS Committee
Deputy Chair Education & Training Committee

References:

1. The Royal College of Physicians and Surgeons of Canada, RCPSC: The CanMEDS Project Overview (2005). http://rcpsc.medical.org/canmeds/CanMeds-summary_e.pdf
2. The Royal College of Physicians and Surgeons of Canada, RCPSC: Website. http://rcpsc.medical.org/canmeds/
3. Frank, JR. (Ed). 2005. The CanMEDS 2005 physician competency framework. Better standards. Better physicians. Better care. Ottawa: The Royal College of Physicians and Surgeons of Canada.
4. The ANZCA Code of Professional Conduct 2007. http://www.anzca.edu.au/resources guidelines/Code-of-Conduct.pdf

Continuing Professional Development: Planning for your future

Continuing Professional Development (CPD) concerns us all. As a profession, we are committed to providing the highest quality of safe and effective patient care. With the rate of change of knowledge in our discipline it is essential that we continue to learn, refine and develop our skills throughout our professional life.

The College, recognising the importance of CPD, mandated the new ANZCA CPD program in January, 2009. There are some inevitable problems associated with mandating an activity across a profession. Importantly, it has to be recognised that there are two roles of a CPD program and they may not sit entirely comfortably together but clearly the net position is a positive one for both the individual and the profession.

In designing the ANZCA CPD program, there have been two major considerations:

- How do we design a program that will support all specialist anaesthetists to maintain the highest possible standards of patient care over a lifetime of professional practice?
- How can we ensure that this program is both flexible in meeting the needs of a diverse workforce and rigorous in ensuring that standards are maintained?

Professor Phillips summarised that "the new CPD program caters for non-clinicians, including people in administration, research, teaching, overseas aid as well as clinicians. It can also be used by Fellows who are just plain retired". He found the completion of the program requirements to be relatively straightforward.

CPD is not (and should not) be limited to learning a relatively narrow range of skills and knowledge for your clinical practice. This is important but it fails to acknowledge the broad framework in which we practice our professional trade. The ANZCA curriculum framework adopts the CanMEDS framework and this may be a useful way to conceptualise the areas where we could focus for CPD. For example, it may include any activity that develops your skills to undertake the entire scope of your work commitments, for example:

- Knowledge (specific areas to update or new information to learn)
- Procedural skills (specific skills to update or new skills to learn)
- Developing your teaching and educational skills (this could include education research or leadership as well as more traditional delivery of teaching)
- Clinical problem solving
- Responding to clinical emergencies
- Communicating effectively with patients and colleagues
- Handling conflict in the workplace
- Management of work and time
- Organisation and teamwork skills
- Change management
- Engaging effectively in clinical quality assurance activities and audit

There has been growing support for the participation in a CPD program and this can be seen in the latest communiqué from the Australian Health Workforce Ministerial Council on May 8 (see www.nhwt.gov.au).

The new ANZCA CPD program is the way of the future. It is seen as one of the most intuitive and structurally sound programs, and 68% of the Fellowship have commenced their program and found it to be flexible to their needs and easy to achieve the required credits. As highlighted by one of the participating Fellows: "It looks good in that it is personalised learning with objectives and getting the individual to reflect on what has been done. The toolkits are crucial. We will now have to get out of our comfort zone and adjust to the new program."

Participation in the ANZCA CPD program involves the following components:

- CPD is a three-year program based on calendar years;
- Participation is via the online portfolio or offline portfolio;
- In the first year of the triennium you need to develop a CPD plan;
- Over the three years you need to obtain:
  - 30 credits in Category 1, Group Learning Activities;
  - 30 credits in Category 2, Self Learning Activities;
  - 30 credits in Category 3, Practice Assessment Activities;
  - An additional 30 credits from any of the above three Categories or Category 4, Educational Development Activities;
- In the last year of the triennium you need to evaluate your activities about the learning objectives you set out in your CPD plan.

There are a number of benefits to participants of the revised program. These include:

- You will be able to print out a Statement of Participation whenever you require one;
- Activities can be targeted to meet your specific learning needs;
- With the introduction of a three-year program, credits can be carried over between the years within the triennium,
- A broad range of activities can be included in the program.

ANZCA staff can provide assistance and answer any questions. This includes help in navigating the online program. They can talk you through what you need to record and how to record it. They can also assist with determining where the activities you undertake fit within the program. Please do not hesitate to contact the CPD Unit on +61 3 9510 6299 or by emailing cpd@anzca.edu.au.

Dr Michelle Mulligan
Chair, Fellowship Affairs Committee

Library update

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 notices include:

- Anesthesia Department Self-Assessment Questionnaire
- Anesthesia kit alerts
- Intensive Care Ventilators Evaluation – an evaluation of 7 models
- Overview of Anesthesia Safety
- Clinical Alarms
- High-Risk Health Technology Hazards
- Sharps Injury Prevention Training Program
- Hand Hygiene in the Healthcare Setting

Health Devices, Vol. 38, No. 4, April 2009 – Hazard Report – A lifesaving reminder: improper use of ventilator alarms places patients at risk.

Contact the ANZCA Library for further information.

New resources

Historia Medica – a collection of papers and lectures relating principally to the history of anaesthesia (mainly in New Zealand).

Donated by the author, Dr Basil R Hutchinson, 2009.

Australian and New Zealand Health Policy has recently been added to the ANZCA Library online journal list.

The journal is freely available at: *http://www.anzhealthpolicy.com/home*

Australian Resuscitation Council

Revised Guidelines:

Guideline 8.4 Shock

Guideline 8.8 Hypothermia: First Aid Management

Guideline 8.23 Anaphylaxis: First Aid Management

Available in hardcopy from the ANZCA Library or online at: *http://www.resus.org.au*

Donations

Many thanks to Dr Nick Jansen for donating recent issues of the *New England Journal of Medicine* and the *Medical Journal of Australia*.

Thank you to Professor W J Russell for converting a variety of audiovisual material to DVD and supplying them to the library.

New research resources

Having trouble understanding medical literature or submitting a report?

The journal, *Chest*, provides monthly medical writing tips such as:

- Abstracts for Professional Meetings: Small But Mighty
- Keep Attendees Awake: Writing Effective Presentations for International Conferences
- Development of International Standards for Medical Communications in English

http://www.chestjournal.org/cgi/collection/mwt

Becker Medical Library Model for Assessment of Research Impact

The Becker Medical Library Model for Assessment of Research Impact represents a practical, do-it-yourself tool for tracking the impact of biomedical research. The model includes guidance for quantifying and documenting research impact as well as resources for locating evidence of research impact.

http://becker.wustl.edu/impact/assessment/index.html

Database improvements

Two major medical databases OvidSP Medline and OvidSP Embase have recently undergone a number of enhancements. Improvements include:

- enhanced limit to publication year
- links to fulltext PDFs in the citation when available
- links to fulltext when exporting to a reference manager or emailing to a colleague.

The ANZCA Library subscribes to both these databases and tutorials have been added to the Database section of the Library website. While these are generic tutorials on using the database, the ANZCA Library staff are always available to assist with any further queries.

New titles

Anesthesiologist's manual of surgical procedures / Jaffe, Richard A [ed.]; Samuels, Stanley I [ed.]. -- 4th ed -- Philadelphia, PA: Wolters Kluwer/Lippincott Williams and Wilkins, 2009.

Clinical anesthesia / Barash, Paul G [ed]; Cullen, Bruce F [ed]; Stoelting, Robert K [ed]; Cahalan, Michael K [ed]; Stock, M Christine [ed]. -- 6th ed -- Philadelphia, PA: Lippincott Williams and Wilkins, 2009

Crisis management in acute care settings: Human factors and team psychology in a high stakes environment / St Pierre, Michael; Hofinger, Gesine; Buerschaper, Cornelius. -- Berlin: Springer, 2008.

Essential guide to generic skills / Cooper, Nicola; Forrest, Kirsty; Cramp, Paul. -- Malden, Mass.: BMJ Books, 2006.

Evidence-based practice of anesthesiology / Fleisher, Lee A [ed]. -- 2nd ed -- Philadelphia, PA: Saunders Elsevier, 2009.

Handbook for Stoelting's anesthesia and co-existing disease / Hines, Roberta L [ed]; Marschall, Katherine E [ed]. -- 3rd ed -- Philadelphia, PA: Saunders Elsevier, 2009.

Multiple choice questions in intensive care medicine / Benington, Steve; Nightingale, Peter; Shelly, Maire. -- Shrewsbury, UK: tfm Publishing, 2009.

The pocket guide to teaching for medical instructors / Bullock, Ian [ed]; Davis, Mike [ed]; Lockey, Andrew [ed]; Mackway-Jones, Kevin [ed]. / Advanced Life Support Group; Resuscitation Council (UK). -- 2nd ed -- Malden, MA: Blackwell Publishing, 2008.

Review of clinical anesthesia / Connelly, Neil R [ed]; Silverman, David G [ed]. -- 5th ed -- Philadelphia, PA: Lippincott Williams and Wilkins, 2009.

The structured oral examination in clinical anaesthesia: Practice examination papers / Mendonca, Cyprian; Hillermann, Carl; James, Josephine; Kumar, G S Anil. -- Shrewsbury, UK: tfm Publishing Limited, 2009.

Vander's renal physiology / Eaton, Douglas C; Pooler, John P. -- 7th ed -- New York: McGraw-Hill, 2009.

Most popular books

1. **Anaesthetic equipment** / Rosewarne F. -- Melbourne: F. Rosewarne

2. **Anatomy for anaesthetists** / Ellis, Harold; Feldman, Stanley. -- 8th ed -- Carlton, Vic.: Blackwell Publishing, 2004.

3. **Yao and Artusio's anesthesiology : problem-oriented patient management** / Yao, Fun-Sun F [ed]; Malhotra, Vinod [ed]; Fontes, Manuel L [ed]. -- 6th ed -- Philadelphia: Lippincott Williams and Wilkins, 2008.

4. **Anesthesia and co-existing disease** / Stoelting, Robert K; Dierdorf, Stephen F. -- 4th ed -- New York: Churchill Livingstone, 2002.

5. **Cardiovascular physiology** / Levy, Matthew N; Pappano, Achilles J. -- 9th ed -- Philadelphia: Mosby Elsevier, 2007.

6. **Management of the difficult and failed airway** / Hung, Orlando R [ed]; Murphy, Michael F [ed]. -- New York: McGraw-Hill Medical, 2008.

7. **Board stiff three: Preparing for the anesthesia orals** / Gallagher, Christopher J. -- 3rd ed -- Philadelphia, PA: Butterworth Heinemann Elsevier, 2009.

8. **Obstetric anaesthesia** / Clyburn, Paul [ed]; Collis, Rachel [ed]; Harries, Sarah [ed]; Davies, Stuart [ed]. -- New York: Oxford University Press, 2008.

9. **Crisis management in anesthesiology** / Gaba, David M; Fish, Kevin J; Howard, Steven K. -- New York ; Melbourne: Churchill Livingstone, 1994.

10. **Evidence-based anaesthesia and intensive care** / Moller, Ann [ed]; Pedersen, Tom [ed]. -- Cambridge: Cambridge University Press, 2006.

News Items

Intravenous or intramuscular parecoxib for acute postoperative pain in adults / Cochrane Database Syst Rev. 2009 Apr 15;(2) http://www.cochrane.org/reviews/en/ab004771.html

Systematic review of the clinical effectiveness and cost-effectiveness of oesophageal Doppler monitoring in critically ill and high-risk surgical patients / Health Technology Assessment 2009;13(7):1–118.

The study found that, although oesophageal Doppler monitoring is likely to be of both clinical and economic benefit in high-risk surgical patients, insufficient evidence is available to recommend its widespread use in critically ill patients.
http://www.hta.ac.uk/project/1633.asp

Guideline for the management of postoperative nausea and vomiting / Society of Obstetricians and Gynaecologists of Canada

The aim of these guidelines is to provide recommendations for the management of PONV in gynaecological patients.
http://www.sogc.org/guidelines/documents/gui209CPG0807.pdf

Conversion of epidural labour analgesia to anaesthesia for Caesarean section: a prospective study of the incidence and determinants of failure / Br J Anaesth 2009; 102(2): 240-3

Intraoperative conversion to GA may increase both maternal and foetal risks.

Available online via the ANZCA Journal List: *http://www.anzca.edu.au/resources/library/online-journals.html*

Open vs specific questioning during anaesthetic follow-up after Caesarean section / Anaesthesia 2009; 64(2): 156-60

Available online via the ANZCA Journal List: http://www.anzca.edu.au/resources/library/online-journals.html

Library update

Continued

Prediction and outcomes of impossible mask ventilation: a review of 50,000 anesthetics / Anesthesiology 2009; 110: 891-7

Impossible mask ventilation is an infrequent airway event that is associated with difficult intubation. Neck radiation changes represent the most significant clinical predictor of impossible mask ventilation in the patient dataset.

Available online via the ANZCA Journal List: *http://www.anzca.edu.au/resources/library/online-journals.html*

Haptic simulator for epidurals

Researchers at the University of Limerick in Ireland have created a spinal anaesthetic simulation program as a training tool.

"The 'haptic simulator' recreates the skin tension felt by the practitioner at the point the needle is inserted.

If the injection is not carried out correctly, the trainee receives immediate audio and visual feedback."

BBC report: *http://news.bbc.co.uk/2/hi/science/nature/7948300.stm*

Project website: *http://www.idc.ul.ie/dbmt/technology.html*

AAGBI safety guideline: pre-hospital anaesthesia

Pre-hospital anaesthesia is carried out regularly only by a small number of doctors in the UK. Although mostly predictable, pre-hospital conditions can be more difficult than those in hospital and, in addition, trained assistance and peer support is not usually available. It is therefore important that patient safety is paramount and systems are in place to ensure that the highest standards are achieved.

http://www.aagbi.org/publications/guidelines/docs/prehospital_glossy09.pdf

Long-term consequences of postoperative cognitive dysfunction / Anesthesiology. 2009 Mar;110(3):548-55.

Available online via the ANZCA Journal List: *http://www.anzca.edu.au/resources/library/online-journals.html*

A Healthier Future for All Australians / National Health and Hospitals Reform Commission

1. Taking Responsibility
2. Connecting Care
3. Facing Inequities
4. Driving Quality Performance

http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/interim-report-december-2008

Music during caesarean section under regional anaesthesia for improving maternal and infant outcomes / Cochrane Database Syst Rev. 2009 Apr 15;(2)

http://mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD006914/frame.html

WHO guidelines on hand hygiene in health care

These guidelines review the scientific data, state consensus recommendations and provide information on process and outcome measurement.

http://whqlibdoc.who.int publications/2009/9789241597906_eng.pdf

New 7th edition of *Miller's Anaesthesia* – special offer to ANZCA members

The ANZCA Library has arranged a special offer on the new edition of ***Miller's Anaesthesia, 7th edition 2009*** in conjunction with SPP Books.

The premium version of *Miller's Anaesthesia*, normally priced at $730, is on an **introductory offer of $599 net and free delivery within Australia.**

The expert consult version of *Miller's Anaesthesia*, normally priced at $550.00, is on an **introductory offer of $449.00 net and free delivery within Australia.**

In addition to these savings, announce yourself to SPP Books as a **ANZCA member** and receive with your purchase of *Miller's Anaesthesia* **a gift voucher to the value of $20** to be used against any purchase at SPP Books in the next 12 months.

This offer is valid until July 31, 2009.

Contact the Library OR SPP directly:

SPP Books, 688 Elizabeth Street, Melbourne, VIC 3000

Phone: **+61 3 9341 7000**
Fax: **+61 3 9341 7097**
Freecall: **1800 333 672**
www.sppbooks.com.au
Email: **info@sppbooks.com.au**

Contact the Library

www.anzca.edu.au/resources/library

Phone: **+61 3 8517 5305**
Fax: **+61 3 8517 5381**
Email: **library@anzca.edu.au**

Regions

Australian Capital Territory

The new Australian Capital Territory (ACT) office proved a suitable venue for a productive Continuing Professional Development (CPD) workshop on Saturday, May 23. Under the guidance of Vida Viliunas, Fellows were able to log on to the ANZCA website, set up and update their CPD portfolio.

On July 18, a Clinical Teaching Course (CTC) workshop will also be held. This will provide an opportunity for Fellows involved in supervision to structure their approach to teaching and learning in a clinical environment.

Planning continues for the popular Floriade Meeting to be held from September 19-20, with the theme "Anaesthesia for Renal and Vascular Surgery". A new venue is being planned and further details will be advertised on the ANZCA website shortly.

The Society for Paediatric Anaesthesia in New Zealand and Australia (SPANZA) Annual Scientific Meeting will be held at the Hyatt Hotel between October 29 and November 1. Professor Stephen Stayer is the international guest and the theme of the meeting is "New Frontiers in Paediatric Anaesthesia".

ACT Fellows are also looking forward to welcoming local and interstate guests to the official opening of the new offices on June 23, 2009.

New South Wales

Continuing Medical Education Meeting

Date: Saturday and Sunday, November 14-15, 2009

Where: Novotel Wollongong Hotel, Northbeach, Wollongong

Title: "Risky Business: The Art and Science of Preoperative Assessment"

This meeting will focus on a range of issues surrounding preoperative care. What are the risks for patients, how well do we assess this risk, what does testing tell us, how does it improve patients and is preoperative testing even necessary?

There will be numerous speakers from different specialties who will talk about current best practice and evidence-based testing.

The meeting will also incorporate workshops, small group discussions and lectures, designed to stimulate thinking about what is best for patients.

This meeting is suitable for practicing anaesthetists and also has relevance to trainees preparing for their final examinations.

Primary Refresher Course in Anaesthesia

The Primary Refresher Course in Anaesthesia was held at the Royal Prince Alfred Hospital during May and was well attended. The NSW Regional Committee thanks the lecturers who put in a huge amount of time and effort in helping trainees prepare for their forthcoming examinations. Special thanks also goes to the convenor of the course, Professor Peter Kam. Professor Kam has overseen this course for more than two decades. The next Primary Refresher Course in Anaesthesia will be held at the Royal Prince Alfred Hospital from October 12 – 23, 2009.

Trial Vivas

To assist candidates presenting for their Final Anaesthetic Vivas in Melbourne on May 29-30, trial vivas were conducted at Liverpool, Westmead, Royal Prince Alfred and St George Hospitals. Once again, Fellows and trainees at each of the anaesthetic departments volunteered their time to assist in organising these successful trial viva evenings and we thank everyone involved. The next trial viva evenings will be held in September and October 2009.

Please also note that the Part Zero "Introduction to Anaesthesia" course scheduled for later in the year has been postponed until February 2010.

Clinical Teaching Course workshop

A Clinical Teaching Course (CTC) workshop was held at the Sydney ANZCA office on March 27. Conducted by Felicity Hutton (Education, Training and Development manager at ANZCA), the day workshop focused on "Teaching in Small Groups". Participants were encouraged to explore ways they could use small groups as a method of teaching anaesthesia. The activities and discussions were focused on developing understanding of small group dynamics and strategies to promote maximum participation of all group members. The workshop also provided a good opportunity for participants to plan, conduct and evaluate a small group teaching activity.

For updates and future meetings please visit the NSW regional website: **www.nsw.anzca.edu.au**

Top: Novotel Wollongong at Northbeach in New South Wales;
Above from left, back row: D. Wolfers, J.Poulos, A. Singh, H. Abouelnasr, J.Killen, S.Wharton, J.Prowse,T.Selak; front row: A.Playoust, N.Smith, T.Tay, F.Hutton, Y-L.Wan.

Queensland

The Faculty of Pain Medicine (FPM) Queensland Regional Committee (QRC) was fortunate to have Professor Andrew Rice from the United Kingdom speak at its recent Continuing Medical Education (CME) Dinner Meeting. The convenor was Dr Wilbur Chan and the meeting was held on Tuesday, May 5 in Brisbane at the ANZCA Queensland office.

Andrew Rice is Professor of Pain Research at the Imperial College London, where he is active in both laboratory research and clinical medicine.

Prof Rice is author of more than 75 scientific publications and sits on the editorial boards of Pain and Public Library of Science–Medicine. He conceived and is lead editor for the *Textbook of Clinical Pain Management*, now in its second edition. He was the Covino Lecturer at Harvard University in 2008, a plenary lecturer at the 10th World Congress of Pain in 2002 and was the Patrick D. Wall Professor at the Royal College of Anaesthetists in 1998.

Prof Rice is an honorary consultant in Pain Medicine at the Chelsea and Westminster Hospital, London, where he provides a clinical service for patients suffering from neuropathic pain, in particular post herpetic neuralgia and HIV neuropathy.

He spoke on pain and patients with HIV at the Queensland Dinner Meeting.

South Australia / Northern Territory

Accreditation Training workshop

Thirteen participants from around Australia and New Zealand attended an accreditation training workshop held at the Adelaide office on May 16.

Associate Professor Kate Leslie, Chair of the Training Accreditation Committee (TAC), and Dr Bronwyn Hartwig from the Cognitive Institute, facilitated the workshop.

A/Prof Leslie demonstrated the use of the TAC's new web-based hospital data sheet and accreditation report and guided participants through the accreditation handbook and the guidelines for writing recommendations, using examples from a de-identified hospital.

Dr Hartwig discussed the challenges and concerns that might be faced by both interviewer and interviewee. She also provided strategies for addressing these and how to maximise the benefit of the inspection process for both the College and the hospitals.

Participants used role-play to practice the tactics they learned during the workshop and are now eligible to participate in hospital inspections outside their own region.

South Australia Medical Careers Expo

The South Australia Medical Careers Expo was held on Sunday, May 24 at the Ridley Pavilion in the Adelaide Event & Exhibition Centre.

The expo was open to final-year students and early graduate trainees. Dr Richard Willis and Dr Thien Le Cong attended and provided information on anaesthesia as a career and ANZCA's training program. The event was also supported by Dr Suzy Szekely and Dr Neil Maycock.

Clockwise from above left: Prof Andrew Rice; Dr Bronwyn Hartwig (presenter), A/Prof Sandy Garden, Dr Lynne Rainey, Dr Charlie Clegg, Dr Jodi Graham; Dr Richard Willis and Dr Thien Le Cong at the Medical Careers Expo.

Regions
Continued

Victoria

Clockwise from top Left: Small group scenarios; Raje Rajasekaram, Dr Kushlani Stevenson, Dr Richard Horton (Victorian Regional Education Officer), Dr Adrian Grigo; Fibre-optic workshop.

Airway Refresher Workshop
A successful Airway Refresher Workshop was held on Saturday, May 16 at the College attended by 152 Victorian Fellows and trainees.

The program included presentations, small group discussions and a range of practical skills stations including: fibre-optic, video laryngoscopic and cricothyroid approaches to the airway.

Thank you to the convenor, Dr Rod Tayler, and all the presenters and participants.

Dr Rowan Thomas
Chair, Victorian Regional Committee

2009 Rural Careers Weekend
On behalf of the College, Dr Andrew Haughton attended the 2009 Rural Careers Weekend at Wangaratta on Saturday, March 28, 2009.

This was an ideal forum to highlight the College training programs in a rural context. Approximately 60 delegates attended from rural and metropolitan clinical schools and there was a lot of interest in rural training opportunities in becoming a Fellow of ANZCA.

One interesting observation Dr Haughton made from attending this event was that numerous medical students were already beginning to formulate career plans, but few had approached anaesthetists for this purpose.

Tasmania

A Clinical Teaching Workshop entitled "Teaching in the Operating Theatre" for consultants will be held at the Launceston General Hospital on Friday, June 26.

Another workshop entitled "Introduction to Ultrasound in Anaesthesia" will also be held in Launceston on July 11.

Dr Peter Hebbard will facilitate this hands-on workshop which will cover:
- Ultrasound physics and knobology,
- Nerve blocks and vascular access upper body
- Nerve blocks and vascular access lower body
- TAP (Transversus Abdominis Plane) block

This workshop is being sponsored by AstraZeneca and Sonosite.

Western Australia

The WA 2009 Autumn Scientific Meeting
The Annual Autumn Scientific Meeting was held on Saturday, March 21, 2009 at the University Club of Western Australia. The theme of the meeting was "Updates in Acute Pain". The meeting was again combined with the annual conference of the Western Australian Society of Anaesthesia Technicians (WASAT) and was well supported with more than 130 anaesthetists and 40 technicians in attendance.

Associate Professor David Scott was the Australian Society of Anaesthetists (ASA) 75th Anniversary Invited Speaker and he delivered a lecture on "The Progression of Acute to Chronic Pain". He also ran a problem-based learning discussion (PBLD) and registrars session. Dr Scott's contribution was greatly appreciated and made for an enjoyable and informative meeting.

Continuing with the theme of acute pain, Dr Priya Thalayasingam delivered a presentation on "Acute Pain Management in Children", A/Prof Scott ran a PBLD on "Polypharmacy in Acute Pain" and Dr Sai Fong ran a discussion session on the perioperative management of acute pain in complex patients and a PBLD on "A Practical Approach to CPD". Ms Pamela Malcolm from the Western Australia Medical Board also gave an update on the Medical Act.

The 2009 Nerida Dilworth Prize, awarded to an anaesthetic registrar in Western Australia who contributes significantly to the ASA and/or ANZCA, was awarded to Dr Angela Palumbo.

The 2008 D.R.C. Wilson Memorial Lecture "Standards, Status, Stress and Senescence" was delivered by Dr Geoff Mullins.

IMGS & WBA workshop
Professor Garry Phillips and Dr Michelle Joseph visited the Western Australia office on April 23 to conduct a Workplace Based Assessment (WBA) workshop. During the morning session, Professor Phillips explained the International Medical Graduate Specialist (IMGS) process that commenced on January 1, 2009 and then Dr Joseph explained the WBA process. The following Fellows were nominated by the Western Australia Regional Committee (WARC) to attend the workshop: Drs John Anderson, Jenny Stedmon, Peter Platt, Richard Riley, Alison Corbett, Aileen Donaghy, Simon Maclaurin, Mark Williams, Lars Wang and Jay Bruce.

CPD presentation
Professor Garry Phillips also delivered a Continuing Professional Development (CPD) presentation during his visit to Perth on April 23. The session was held at the St John of God Hospital, Subiaco Conference Centre and 25 Fellows attended.

Upcoming WA CME events for 2009
The Winter Scientific Meeting was held on June 13, 2009 at the Perth Convention and Exhibition Centre. The meeting was entitled "The Heart of the Matter". Topics included a paediatric refresher session (including congenital cardiac disease and off licence use of drugs) and an adult cardiovascular session including pacemakers and automatic implantable cardioverter defibrillators (AICDs) in anaesthesia. The meeting also included PBLDs and the ANZCA WA Annual General Meeting.

The Annual "Updates in Anaesthesia Meeting" will be held from November 6-8, 2009 again at the Quay West Resort, Bunker Bay near Dunsborough in the south west of Western Australia. The focus of this meeting will be trauma.

From top left: Chair Dr Paul Rodoreda and Nerida Dilworth prize winner Dr Angela Palumbo; Dr Prani Shrivastava and Dr Geoff Mullins; CPD presentation.

Annual Reports – National and Regional Committees

The Annual Reports from the National and Regional Committees for the period April 2008 – March 2009 are published in a separate booklet distributed with this issue of the ANZCA *Bulletin*.

New Zealand news

New Zealand Anaesthesia ASM 2009, Rotorua, November 4-7

The New Zealand Anaesthesia Annual Scientific Meeting (ASM) will be held in Rotorua from November 4-7 at the Novotel Lakeside. This is a joint venture between the New Zealand National Committee of the College and the New Zealand Society of Anaesthetists (NZSA), and its New Zealand Anaesthesia Education Committee. The ASM organising committee from the department at Waikato Hospital has organised a great program. Visit the website for further details: www.sixhats.co.nz/nza09

Call for abstracts

The call for abstracts for the free paper and poster sessions recently opened and the closing date is **5 pm on Friday, August 7**. Further details are available on the NZA ASM website listed above.

ANZCA New Zealand National Committee (NZNC)

Meetings

Three NZNC meetings were scheduled for 2009:

The first was held on Friday, March 27 at the ANZCA New Zealand office in Wellington. A wide range of issues were discussed and these are described in the NZNC Annual Report which has been distributed with this edition of the *Bulletin*. This report is also available on the NZNC website.

The next NZNC meeting will take place between July 24-25. Half a day is reserved for a joint meeting with NZSA. ANZCA CEO, Dr Mike Richards, and Director of Communications, Nigel Henham, will visit New Zealand during this time.

A cocktail function will be held at the New Zealand office to which the Minister of Health, other politicians, media and leaders of health organisations have been invited.

The final NZNC meeting for 2009 will be held on November 20. Committee members welcome your comments on College activities and issues that arise within the New Zealand health system. Please contact the New Zealand office to provide feedback.

Committee members

Committee members are elected by New Zealand Fellows every two years. Occasionally, there is a need to co-opt members if vacancies occur between elections.

Recently Alastair McGeorge resigned from NZNC due to other commitments. Alastair has served on the committee for seven years, the first two as the New Fellows' representative. Thank you to Alastair for his commitment to the committee.

Training and examinations

Clinical Teachers Course workshops

An invitation to attend these courses is open to all Fellows, especially those involved in training. The College covers the associated costs.

The topic for the next workshop on the September 4 is 'Assisting Trainees with Difficulties'. Registrations for this workshop are now open. Please contact Juliette Adlam at the ANZCA Wellington office if you are interested.

Admission to Fellowship

Council of the College resolved at its February and April meetings that the following New Zealanders be admitted to Fellowship by Examination:

February 2009

Emma Jane BLAIR	NZ
Annick Irene DEPUYDT	NZ
Nicholas James HUTTON	NZ

Above: View of Wellington harbour near the New Zealand national office.

April 2009

Stefan Andre LOMBAARD	NZ
Christopher George MUNNS	NZ
Thomas Michael Alexander O'ROURKE	NZ
David Matthew RUSK	NZ
Anita Lee-Ann SUMPTER	NZ
Craig Geoffrey SURTEES	NZ
Anthony Carl YOUNG	NZ

Workforce issues

DHBNZ HWIP and Ministry of Health Electives Initiative

The DHBNZ Health Workforce Information Project (HWIP) team has been contracted by the Clinical Training Agency (CTA) to provide workforce forecasts to help identify the projected medical trainee numbers required in New Zealand. NZNC and NZSA representatives met with the HWIP team on March 26. The methodology being used by HWIP is concerning as not all anaesthetists' work will be captured, resulting in an underestimate of the workforce and trainees needed. NZNC has conveyed this in writing to HWIP and referred the team members to the ANZCA/ASA workforce report that has recently been published.

The Ministry of Health is also seeking advice from ANZCA regarding additional anaesthetist numbers required for the twenty new elective surgical units announced recently by the Minister.

ANZCA workforce survey and report

ANZCA will be conducting a workforce survey and report in New Zealand in 2009 and this will provide data for workforce forecasts.

Rural issues

Training rotations

ANZCA is strengthening its training in smaller centres. Each New Zealand Training Rotation includes at least one rural/provincial training centre.

Division of Rural Hospital Medicine and anaesthesia training

NZNC has been asked by the Division of Rural Hospital Medicine (DRHM) to appoint a Fellow (Dr Tom Watson) to sit on the DRHM Board of Studies. The DRHM and ANZCA are developing a system for introducing anaesthesia training along the lines of the Australian JCCA training program.

For information on upcoming events, courses and CME activities, please visit the ANZCA NZNC website: www.anzca.org.nz

Dean's Message

I recently attended the ANZCA ASM in Cairns and presented the final Dean's report at the College ceremony. The quality of the meeting in terms of scientific content, organisation and collegiality was excellent. The ASM is a great showcase for the College and for the specialty. It was therefore with mixed feelings that I gave the last ever JFICM Dean's report – some sadness about losing the very close association our specialty has had with anaesthesia, but with ongoing excitement about the developments continuing to lead to the opening of the new College of Intensive Care Medicine in January 2010. It should also be noted that a stand-alone ASM for the JFICM has been a great catalyst for the development of a separate College and thanks are again due to Prof. John Myburgh for this great innovation some years ago.

JFICM ASM 2009

By the time you read this, the 5th JFICM ASM will have taken place in Brisbane. The theme of the meeting is "Energy Crises Large and Small: metabolism, microbiology and sepsis". We are looking forward to a great scientific program, including presentations by two excellent overseas speakers, Professors Annane and Kollef, together with a cast of local talent. Thirty seven new Fellows will be presenting for Fellowship and the second stand-alone JFICM New Fellows Conference will enhance the meeting. Over the past few years the oration has been, very ably, made by distinguished older Fellows. The theme, in general, has been one of surveying a great career, together with the history of the specialty, in a retrospective manner. This year we have broken with tradition and have invited Dr Carole Foot, one of our distinguished younger fellows to give the oration, looking forward from the start of a career in intensive care medicine (see page 79).

College of Intensive Care Medicine (CICM)

In addition to the developments reported on in the previous Dean's message, I am pleased to announce that, following a vote in the affirmative by ANZCA Council and then the entire Fellowship of ANZCA, a financial settlement has been reached between ANZCA and the CICM. ANZCA has generously gifted $1 million to the new College which will enhance its financial viability. Notwithstanding this gift, Fellows of the new College will be asked to contribute to the establishment and operation of the CICM. The various options to do so will be canvassed at the AGM to be held in June 2009. It is hoped that Fellows will support this aspect of an independent college with as much enthusiasm as they did last year when discussing and voting for the concept.

Two versions of a coat of arms for the CICM have been developed under the guidance of the CICM Board and with reference to heraldry specialists. These will be unveiled at the AGM later this month and Fellows will be invited to vote for their choice. A competition will then be held to find a suitable motto for the CICM. This will be open to Fellows and Trainees and will carry a substantial prize. It may also be timely to reconsider what we would like to be called as specialists – "intensivists" or "intensive care physicians"?

The separation working party continues to discuss matters of interest between ANZCA and the CICM as we work towards full and independent operation of CICM as from January 2010.

Clinical component of the final examination

Leading on from what we'd like to be known as, it is evident that what we do on a day to day basis is largely based on clinical acumen. We strive to be "bedside" specialists, rather than "end-of-the-bed" specialists. That is why there is a particular emphasis on clinical skills in the final fellowship examination. Despite widespread notification of this to trainees and supervisors of training, the performance of candidates in this section of the examination continues to be disappointing. The examination process has been in existence for decades now and examiners' performances are carefully calibrated in a rigorous process. Therefore the standard required is well-known and the assessment process is robust. This is not about an ivory tower mentality. This goes to the core of what we do and who we are as specialists. There must be some responsibility on the trainees and the trainers to address this matter. This will again be disseminated via JFICM/CICM communications with SOTs and trainees.

Annual report of activities

A detailed annual report of JFICM activities for 2008 will be distributed to Fellows at the Annual General Meeting and this will also be available for viewing on the JFICM (and CICM) websites.

I look forward to being able to report back on a successful ASM meeting in Brisbane in the next issue of the *Bulletin*.

Prof PV van Heerden
Dean, JFICM
President, CICM

News

JFICM Annual Scientific Meeting 2009

More than 300 registrants gathered in Brisbane recently for the fifth Annual Scientific Meeting of the Joint Faculty of Intensive Care Medicine. The meeting, based around the theme of 'Energy Crises Large or Small' ran from June 12-14 at the Brisbane Convention Centre.

The local organising committee, led by Prof Rob Boots (Convener) and Prof Bala Venkatesh (Chair, Scientific Program Committee) put together an interesting and stimulating program. Two renowned international speakers, Prof Djillali Annane from the Raymond Poincare University Hospital in France and Prof Marin Kollef from the Washington University School of Medicine, USA, were supported by an array of local experts in their field.

The Felicity Hawker Medal, for the best contribution by a trainee to the Formal Project Session, was this year won by Dr Balu Bhaskar for his presentation "The effect of blood transfusion on long-term survival after cardiac surgery".

The conference dinner and graduation ceremony was, as always, a highlight of the ASM. Thirty-seven graduands were presented at the ceremony, and an Honorary Fellowship was bestowed upon Professor 'Nip' Thomson for his contribution to intensive care medicine and the development of the Joint Faculty.

The Don Harrison Medal for the best performed candidate in each of the Fellowship Exams, were awarded to Dr Ed Litton for the May exam, and Dr Sara Jane Allen for the October exam. The Joint Faculty of Intensive Care Medal, which recognises an outstanding contribution to the specialty of intensive care medicine, was this year awarded to Dr Felicity Hawker, the first Dean of the Joint Faculty.

The ASM was well supported by the health care industry, with two major sponsors (Janssen-Cilag and Edwards Lifesciences) and 18 Trade Exhibitors.

A number of satellite meetings were held along with the ASM, including an ANZICS CTG Research Development Day, a two day workshop on simulation based training, a Supervisors of Training workshop and the second JFICM New Fellows Conference.

New Fellows Conference 2009

The New Fellows Conference was held from June 9-11 at the Hyatt Regency in Coolum three days immediately prior to the Annual Scientific Meeting.

The Conference was attended by 12 Fellows, each within three years of Fellowship, and an organising committee comprised of three Fellows from the previous year's Conference. Topics covered included leadership and negotiation skills, dealing with difficult colleagues, how to run an Intensive Care Unit, ANZICS and rural intensive care. A 20/20 style summit was also held and generated a lot of discussion and ideas on the future of intensive care.

From the positive feedback received it was evident that the Conference provided an opportunity for new Fellows to discuss common issues encountered, and to receive expert advice from those with many years of experience.

From top: 2009 Graduation Fellows; Professor Bala Venkatesh - Chairman of Examinations; Orator - Dr Carole Foot; International Speaker - Dr Djillali Annane.

News
Continued

JFICM Fellowship Exam May 2009

On Wednesday May 27, 2009 the general fellowship examination commenced at the Mercure Hotel in Brisbane. The Wednesday of exam week is dedicated to the examiners' workshop, aimed at analysing prepared questions to provide candidates with the best possible questions.

The Royal Brisbane and the Princess Alexandra Hospitals were selected for the "hot case" section of the examination. This section comprises two ICU cases of 20 minutes in duration and usually focuses on a clinical problem.

The examiner dinner was held at the River Canteen on Brisbane's picturesque Southbank, proving to be the perfect setting to farewell Professor John Myburgh from the Examiner's panel after 12 years of service. He was presented with a certificate of appreciation and a gift on behalf of the Joint Faculty for his wonderful service.

The examination concluded on Friday with the cross table viva section. Comprising eight active stations, this section is designed to test a large range of intensive care related topics with 10 minutes at each station. Again, the logistical requirements were testing and kept JFICM staff on their toes with a high number of candidates filtering through each station from 8am.

Following the exam, marks were checked and the Court of Examiners confirmed 18 of the 36 candidates had successfully completed the examination. The successful candidates were then presented to the Court of Examiners for celebratory drinks.

The focus now turns to Sydney for the October exam, where a higher number of candidates are expected to present. This, in conjunction with the Paediatric Fellowship Examination two days earlier, will make for another exciting week for examiners and staff.

Top: The JFICM Fellowship Court of Examiners.

Bottom from left: Professor Bala Venkatesh, Professor John Myburgh, and A/Prof Robert Young.

Joint Faculty of Intensive Care Medicine Board, June 2009

At the close of nominations for election to the JFICM Board, there were two nominations received for the two vacant places. Dr Bruce Lister was returned for a further three year term on the Board and Dr Amod Karnik was elected to the Board. The JFICM Board is now constituted as follows:

Dean
Peter Vernon van Heerden, Western Australia

Vice-Dean
John Alexander Myburgh, New South Wales

Education Officer
Peter Thomas Morley, Victoria

Censor
Ross Callum Freebairn, New Zealand

Chairman of Examinations
Balasubramanian Venkatesh, Queensland

Chairman, Hospital Accreditation Committee
Richard Priestley Lee, New South Wales

New Fellows Representative
Nicole Blackwell, Queensland

Elected Members
Charles Frederick Corke, Victoria
Bruce Gregory Lister, Queensland
Gavin Matthew Joynt, Hong Kong
Amod Karnik, Queensland

Appointed Member (from ANZCA)
Arthur Barry Baker, New South Wales

Co-opted Representatives
Allan Beswick, Tasmania
Michael O'Fathartaigh, South Australia

Honorary Fellowship: Prof Napier Maurice Thompson

Honorary Fellowship of the Joint Faculty of Intensive Care Medicine, conferred at the JFICM Annual Scientific Meeting on 13 June 2009 to Napier Maurice Thompson

Under the regulations of the Joint Faculty of Intensive Care Medicine, Australian and New Zealand College of Anaesthetists and Royal Australasian College of Physicians, the Board may confer Honorary Fellowship of the joint faculty on distinguished persons who are not practising intensive care medicine in Australia or New Zealand but have made a notable contribution to the advancement of the science and practice of the specialty. Professor Napier Maurice Thompson is such a man. His contribution has lasted for many years and has been integral to the growth of our specialty.

Professor Thompson, known as "Nip" by his friends and colleagues, was born in South Australia on the 8th June 1944. He graduated from the University of Adelaide medical school in 1966 and completed his physician training with the Royal Australasian College of Physicians in 1970. He completed his Doctor of Medicine at the University of Adelaide in 1976 after working as a research fellow in Paris and London from 1972-1975.

Thereafter, Nip began an illustrious career that encompasses the triad of clinical medicine, research and education that continues to this day.

His consultant clinical career in renal medicine spans nearly thirty years and commenced as an honorary consultant nephrologist at Geelong Hospital in 1981 to the present where he is Professor and head of the Department of Medicine of Monash University and director of Renal Services at the Alfred Hospital in Melbourne. He has made a considerable contribution to the clinical advancement of peritoneal dialysis and treatment of glomerulonephritis, organ donation and renal transplantation.

Nip's research career has mirrored his clinical one, focused on aspects of renal medicine and transplantation. He has published widely in aspects of laboratory and clinical research in three books, 26 book chapters and over 140 original journal articles. Aspects of his research include cellular and immune mechanisms of renal rejection, diabetic nephropathy, renal and pancreatic transplantation. He is the recipient of numerous research grants from bodies such as the National Health and Medical Research Council and Australian Kidney Foundation. He is a sought-after speaker at international and national scientific meetings including visiting lectureships across Australia and New Zealand, the United Kingdom, Malaysia, Singapore, Sri Lanka and China.

Nip has made a tremendous contribution to medical education at all levels including tutoring for basic and advanced physician trainees, co-ordination of training programs at hospital, state and national levels, supervision of doctoral and post-doctoral students and fellowship examinations. He has provided long and dedicated service to the Royal Australasian College of Physicians since 1980 and served as President from 2006-2008. In addition, he has held senior portfolios on the Medical Council of Victoria, Australians Donate, the Australian Kidney Foundation and the Centre for Clinical Studies.

In recognition of his contribution to renal medicine, Nip has received honorary fellowships from the colleges of physicians in London, Ireland, Singapore, Thailand and Ceylon.

But we honour him now for his great contribution to intensive care medicine, which has not only been through his clinical and academic career in renal and transplant medicine, where the two specialities intersect, but also in his activities relating to intensive care medicine within the Royal Australasian College of Physicians.

Nip served on the specialist advisory committees for intensive care medicine prior to and after the training programs of the Royal Australasian College of Physicians and Australian and New Zealand College of Anaesthetists were amalgamated. This major unifying step resulted in the establishment of the Joint Faculty of Intensive Care Medicine in 2002, following which Nip served as the Royal Australasian College of Physicians representative on the Board of the Joint Faculty of Intensive Care Medicine until 2008. During this period, Nip brought expert wisdom and knowledge borne of many years of service to medicine. Moreover, Nip provided balanced, but enthusiastic support as the Joint Faculty of Intensive Care Medicine moved inexorably towards independence and the formation of the new College of Intensive Care Medicine. His role in positively supporting the inaugural Annual Scientific Meeting of the Joint Faculty of Intensive Care Medicine in 2005 was an integral factor in the success of this meeting that is all too apparent tonight.

Nip is a true "all rounder": a dedicated family man and proud father, an excellent clinician, researcher and teacher and a dedicated physician to the science and art of Medicine. It is therefore most fitting that, at the last Annual Scientific Meeting of the Joint Faculty of Intensive Care Medicine before we meet in Sydney next year for the inaugural meeting of the new College of Intensive Care Medicine, we honour Nip for his tremendous contribution during this journey of transition towards independence.

Professor John Myburgh
Vice Dean
Joint Faculty of Intensive Care Medicine

JFICM Medal: Dr Felicity Helen Hawker

The award of the JFICM Medal to Felicity Helen Hawker, presented at the 2009 Annual Scientific Meeting.

The Joint Faculty of Intensive Care Medicine Medal was established in 2005 and was first presented at the inaugural JFICM Annual Scientific Meeting that year. The sole criterion for its award being that the recipient has made an outstanding and major contribution to the specialty. It is thus very fitting that Felicity Helen Hawker is to receive the JFICM Medal at the last ASM of JFICM. Fitting because of her enormous and continuing contribution, fitting because of the unique nature of that contribution and also that she was the first Dean of the Joint Faculty.

Like many famous Australians she was born in Tasmania and it was apparent from her university and school days that she was going to make a mark on the world. Our specialty is very fortunate that she chose intensive care medicine and she chose to lead and help guide the development of our specialty. She was dux of her school and first in her year at the University of Tasmania, and a champion horsewoman and winner of many academic and sports prizes.

After completing her university degree, she gained diverse anaesthesia and intensive care training in Hobart, Melbourne, Glasgow and Sydney, gaining English and Australian fellowships before taking up a position at Royal Prince Alfred Hospital in Sydney as an intensive care specialist. There she was known for her clinical skills, academic ability and consideration of patients, families and all members of the ICU team.

After 10 years as co-director of ICU at RPA, she moved to Melbourne in 1995 to become the director of ICU at Cabrini Hospital, perhaps somehow related to her blossoming relationship with a Melbourne surgeon, whom she later wed and whose career has many parallels with hers. They have a son Paul, an extended family and very full lives in and out of medicine.

It is difficult to do justice to Felicity's extensive career achievements, and 20-page CV, in several short paragraphs because Felicity has contributed at every level of intensive care education and training from supervisor of training, regional education officer; too many committees to list, boards and executives, the panel of examiners, education officer, Censor, Vice-Dean, Dean and now director of Professional Affairs. She was the last dean of the Faculty of Intensive Care and the first dean of the joint faculty, having been instrumental in bringing together the two intensive care training programs. In essence she has led and contributed to more than 15 different, major appointments over 20 years, not only in the section of intensive care, FICANZCA, JFICIM and ANZICS but also ANZCA and FRACP and the Committee of Presidents of Medical Colleges. For eight years she was a council member of the Western Pacific Association of Critical Care Medicine.

During her leisure time she has edited four publications, given more than 35 invited plenary lectures, written her own classic textbook and 21 chapters of other books as well as numerous original scientific articles, while following her love of horses and bringing up a family.

It is apparent that Felicity has not only affected the lives of many through her clinical skills and caring, but her intellect, wise counsel and capacious memory for detail have helped to guide our profession in its growth towards an independent college. She has done this with humanity and humility and her very humanness has been a beacon for trainees, particularly women.

A few years ago Sandy Peake quoted one of the pioneers of ICM, Matt Spence, when he said that the success of intensive care was dependent on a dedicated team of young doctors, who should be "young men, physically able to cope with emergencies at any time and for prolonged periods". Matt's model has proven to be outdated and it is such women as Felicity and Sandy who have helped our specialty into the 21st century. Hopefully work practices are becoming more balanced and opportunities are available for all to achieve leadership and academic success. This is no small part due to Felicity's advocacy for a flexible training scheme that gives fair opportunities for women.

Felicity has been a great role model and many a time I have used Felicity as an example to female trainees of the accomplishments, enjoyment and satisfaction that can be gained from ICU practice. She has devoted a large part of her very busy life to sustain and grow our specialty, its training program and presence in the region. She has been at the forefront, caring, transforming the profession and taking the lead. She is an inspiration to all and a very worthy recipient of the JFICM Medal.

Clinical A/Prof Richard Lee
Joint Faculty of Intensive Care Medicine Board Member

The future of intensive care medicine

This is an edited extract of the JFICM Graduation Ceremony Oration "The Future of Intensive Care Medicine in Australia and New Zealand" by Dr Carole Foot, staff intensive care specialist, Royal North Shore Hospital.

What does the future hold for intensive care medicine? I'm going to focus on what I see as the three most important and interlinked areas: technological developments that will influence how we practice, the nature of critically ill patients and the implications for the intensive care workforce.

Technology

ICU environment

What will our ICUs look like in the years to come? We are already seeing the results of exciting major design changes. For patients, more comfortable and pressure-easing beds that enable easy positional changes are entering the market. Access to natural light that facilitates restoration of circadian rhythms, a trend towards single rooms that offer greater privacy and reduced risks of cross-infection, noise-reducing and mood- enhancing decors, personal entertainment systems and more comfortable facilities for relatives are some of the staples of new ICUs.

Wireless technology is expanding and I think the spaghetti-like tangle of cables from patients monitoring systems will soon become a thing of the past. Advanced computer networking with more powerful platforms and improved user interfaces, offer the promise of more efficient monitoring and record keeping, decision support and availability of reference materials.

Research

I am hopeful that basic scientists will help us understand and potentially manipulate cellular systems that influence survival and assist in prognostication. It will become clearer why some patients appear remarkably resistant to critical illness and yet others equally fragile. We are already starting to understand some of the genetic polymorphisms that control the inflammatory response influencing the outcome of septic shock and ARDS.

New drugs and equipment will come and go. We must continue to ensure that they are evaluated in an ethical and scientifically robust manner that can be best achieved by being part of the process.

We must inspire, mentor and support a generation of ICU basic and clinical researchers who will push the envelope of our knowledge. This will not be easy as scarce resources are stretched, but creative ways of funding this must be pursued. Co-operative relationships that cross the borders of institutions, specialties and disciplines will foster synergism and efficiency that isolated silos cannot achieve.

Teaching

As multimedia technology changes our daily lives, the opportunity to blend new, sophisticated learning platforms with traditional medical educational pedagogy is truly electrifying.

Borrowing from aviation, medical simulation is here to stay. Its role is being increasingly defined as evidence mounts that it is a reliable and well-received method of teaching and assessing technical skills, as well as team crisis management. I feel extremely strongly that we must not underestimate our common sense when evaluating how to incorporate simulation into our ICU training programs. Practice can *make perfect*, patients should not be *guinea pigs* and doctors and nurses who work together every day should train together. In the future the insights and understanding that this will bring will make us more effective as well as cohesive.

Screen-based simulation is only in its infancy but is likely to come into its own over the coming years as computer power and bandwidth expands. Virtual worlds such as "Second Life" are being incorporated into university teaching for other disciplines and healthcare is catching up. Second Life is a 3D on-line environment where users can socialize, connect, explore, learn and create using voice and text chat.

There have never been so many methods available for communicating information to our trainees and with each other. Social networking sites such as *Facebook*, Podcasts, Blogs and Wikis are the preferred medium for exchanging information for an increasing number of people.

These new developments are a challenge for older clinicians who did not grow up with and become comfortable with these modalities. I am one of these. I am an adult of the email generation and student of the textbook and yet I feel strongly that failure to embrace these new technologies risks opening up a communication chasm and missed opportunities. Although there are many unanswered questions, including how to control the quality of information exploding in the virtual world, I feel strongly that we must not be *neo-luddites* - resistors of new technology!

Patients

The wave of obesity sweeping western countries is no small matter! Australia is now the fattest nation in the world. We are already seeing the consequences of this problem in our ICUs, with the need for bariatric equipment and increasing admissions of morbidly obese adults. This trend is predicted to increase over the coming years.

Competing for these beds is a wave of elderly patients. Like many countries, the Australian population is ageing as a result of unprecedented improvements in healthcare. The ANZICS database tells us that the number of intensive care days provided to patients over 70 has been increasing by around 14% per annum. This is not surprising as over the last decade papers reporting excellent ICU outcomes can be found for older patients with a range of admission diagnoses and organ failures.

Addressing the difficulties of ICU triage, particularly for chronically ill and elderly patients, is beyond the scope of this talk. I strongly believe, however, that regardless of clarifying the best candidates for our care, the pressure on hospital and ICU beds will only increase and resources are already stretched.

Our emergency medicine colleagues constantly struggle with *access block* and ambulance ramping on a daily basis and in the ICU I am starting to see *exit block*, where the hospital is so full that ICU patients no longer needing our care remain in our unit. As an example of this I recently worked with an endocrinologist in managing a young girl with her first diagnosis of DKA from admission right through to discharge home from our ICU. The situation is exacerbated

The future of intensive care medicine

Continued

by the need to isolate a growing number of patients colonized with multi-resistant organisms and a lack of isolation facilities on the wards.

Television and increasingly the Internet, also continue to set expectations that can be difficult to emulate in real-life, particularly when the realities of resource constraints are factored into the equation.

The demand for HDU care is booming where I work. I believe that this also reflects major resource constraints that those who practice on hospital wards are experiencing. Specifically, a lack of experienced nursing staff is threatening the capacity for sick patients to be cared for out of ICUs. We must therefore support our non-ICU colleagues in their quest for resources; doctors, nurses, social workers and therapists, as our goals are inexorably intertwined.

If we are to continue to meet the expectations of patients and their families then it seems inevitable that society will need to have its eyes opened to the limitations of resources that we face on a daily basis. It appears unavoidable that the opportunity costs of providing intensive care will need to be openly deliberated against infrastructure, education, defense and the environment and compete with other forms of healthcare for the budget.

Workforce

So how will we rise to meet these many challenges? In a nutshell, I believe that this rests on cultivating a committed workforce of intensivists with a diversity of complementary skills led by strong, inspirational leaders.

Management and Leadership training

So what skills am I talking about? There is a rapidly evolving body of evidence supporting the need for management and leadership training for healthcare professionals and recognition that this needs to be tailored to transition points in a doctor's career. I believe that this is absolutely true as I qualified as a consultant feeling well trained and yet in retrospect I had no idea of the traps and difficulties waiting for me as a new consultant. Thirsty for new survival skills, I recently completed a full-time MSc in international health management at the Imperial College Business School in London and found it an absolute revelation. I am constantly seeing the relevance in my daily work of subjects such as organisational culture, negotiation and conflict management, project and strategic management, change management and health policy and finance.

If we are to meet the challenges of the future we need to have additional skills that transcend patient care. We must understand *management speak* and be able to converse with and engage hospital managers to our cause. We need intensivists that aren't afraid of being political and have the skills to be eloquent and look beyond the needs of their individual patients to the needs of critically ill Australians and New Zealanders. We need intensivists who will engage in making the new college a successful and powerful body. We need Intensivists influencing government policy and being part of a strong international professional community.

Leadership

I am grateful to have worked and continue to work with a number of extraordinary leaders - competent clinicians, providers of vision, embracers of change and responsibility, humanistic, approachable and supportive people who can bring out the best in their teams - individuals who allocate resources fairly and inspire kudos such that teachers, researchers and those that perform the bulk of the administrative duties all feel equally valued and part of something special.

It is a tall order but absolutely necessary to have people such as this running ICUs.

In the future, leaders and team members with high levels of emotional intelligence will position themselves to recognize and manage their own and others' personal strengths and weaknesses. The most effective teams will be those who can unleash their combined skills on difficult clinical and political problems. These traits will help us to mitigate conflict and stress, foster innovation, career satisfaction and longevity, and position us for tackling the challenges of the future.

Work-life balance

For the first time in history there are four generations in the workforce. In the audience tonight I see so called *Traditionalists, Baby-boomers, Generation Xs* like myself and *Gen Ys*. Various attitudes to life and work have been attributed to each generation. My generation for example is described as skeptical of authority and valuers of work-life balance.

Perhaps it is therefore predictable that I believe that in the future, work-life balance needs to be given greater emphasis by our specialty if we are to consistently perform at our best and attract the best and brightest future intensivists. We must not ignore the fact that health professionals as a group are vulnerable people with well-known increased risks of divorce, substance abuse and suicide. We must monitor our own behaviour, observe and support our colleagues in achieving their own healthy habits and as a profession advocate for sustainable working practices and conditions.

Conclusion

I hope that I have convinced you that the future of intensive care medicine will no doubt be exciting as well as daunting. It is somehow fitting that the topic of this meeting is "Energy crises large and small". Meeting the many challenges facing our specialty will take great energy!

But on this account I am not worried. I believe that it is from our patients that we will find an unlimited source of inspiration and energy that will no doubt sustain our profession. I have also watched many talented and energetic young intensivists in their academic robes traverse this stage tonight. Over the last week I have engaged with a selection of the most motivated new fellows imaginable at the New Fellows Conference in Coolum. I see the future in their eyes, the eyes of my trainees and I see unlimited energy before me as I look out into this audience.

For we are the future – the future is us!

Dr Carole Foot
Staff Intensive Care Specialist
Royal North Shore Hospital

Dean's Message

This has been a busy period. In the last month I have attended the Australian Pain Society Annual Conference in Sydney and as part of this conference, Milton Cohen chaired a public forum on *"Health care services for people in pain: when there is a will there is a way"*, which was facilitated by John Quintner. A number of our Fellows were involved on the panel.

There was also the first face to face of the National Pain Summit (steering committee) chaired by Michael Cousins. A preliminary leaders meeting was held at ANZCA House on June 5 where a detailed framework for the summit was agreed.

At the beginning of May I travelled to Cairns where we had three visitors presenting at both the Refresher Course Day *("Unravelling the Chaos of Pain")* on May 1, then as plenary speakers in the main ANZCA ASM program. Professor Andrew Rice from London, our FPM ASM Visitor, was an incredibly dedicated visitor. He presented outcomes of his clinical research and also gave us clinical guidelines for managing peripheral neuropathies. He presented the Michael Cousins Lecture on the Saturday morning *"Cannabinoid Analgesia – Future Friend or Dead End?"* stressing that although cannabinoid receptors seem to have a very important role in pain management, because of the risk of mental illness including acute psychosis and long term risk of psychosis and schizophrenia, we cannot recommend their use clinically.

Andrew attended all the sessions over the two days of the Pain Medicine conference and was a great contributor, asking questions and participating. He and I then went on to Brisbane for the Royal Australasian College of Surgeons meeting where Leigh Atkinson had organised a three-day pain and neurosurgical program. Once again Andrew Rice and several of our Fellows were able to present to the surgeons our understandings of the risks and management of chronic pain problems.

Our second visitor, Associate Professor Steve Passik from New York, challenged his audience at both the Refresher Course Day and ASM, introducing the term *"The Chemical Coper"* to describe a patient who is on opioids but not benefiting from that prescription. He also presented the Queensland Pain Medicine Visitor's Lecture, talking about *"Risk Management in Opioid Therapy"*. This talk was particularly challenging to our anaesthetic colleagues as he pointed out that not all opioids are the same. Due possibly to their receptor properties, some opioids are much more likely to lead to dependency in "vulnerable" patients.

We once again welcomed Professor Rollin (Mac) Gallagher as our special guest and he presented to our Board meeting on the Thursday, and then again at our Refresher Course Day and as part of our ASM program on the weekend. Mac was also an active contributor in all parts of the program.

At the Faculty Dinner on the Friday night we farewelled Roger Goucke and Milton Cohen, who have now retired from the Faculty Board, and thanked them for their amazing contributions. We also acknowledged Professor Tess Cramond in her retirement.

On Sunday, May 3 we held our Annual General Meeting followed by the new Board meeting and were pleased to welcome Ray Garrick and Guy Bashford as new members of the Faculty Board.

Milton Cohen has taken up the challenge of being senior editor for our journal, *Pain Medicine*, and Professor Gallagher has encouraged the Faculty to put forward the names of other Fellows in Australasia who are prepared to work on the editorial board in different capacities.

I am pleased to say that more and more we are being asked as a Faculty to comment on many different issues, and I believe it is important for us to continue to strive to provide input so that we continue to raise the profile of Pain Medicine. To this end, occasionally I will ask the executive officer, Helen Morris, to approach Fellows to make comments on submissions I receive on behalf of the Faculty.

It was pleasing to welcome Professor Maree Smith and Associate Professor Michael Nicholas as Honorary Fellows of our Faculty at the College Ceremony in Cairns. Both of these individuals have contributed to the Faculty over many years.

Dr Michal Kluger FANZCA (New Zealand) was elected to Fellowship at the Board Meeting on April 30. We now number 265 Fellows (108 by examination). Three individuals have been directed towards the new summative assessment pathway to Fellowship without further training.

Once again I would like to thank the Board for their support and wisdom, Helen Morris and her staff, Angela Boolieris and Penny McNair for all their support and all the Fellows that contributed to the Faculty in so many ways.

Dr Penelope Briscoe
Dean

News

New Faculty Board

The new Board met on May 3 and welcomed new board members Dr Raymond Garrick FRACP and Dr Guy Bashford FAFRM (RACP), both from NSW. As Western Australia and Tasmania were not represented on the board following the recent board election, the Board resolved to co-opt the interim chair of the newly-formed WA Regional Committee, Dr Eric Visser, to the Board and to invite a Tasmanian Fellow to observe a Board meeting later in the year.

Establishment of the FPM WA Regional Committee

At a recent meeting of WA Fellows, it was unanimously agreed to form a Faculty of Pain Medicine Western Australia Regional Committee.

The interim committee comprises:

Chair:	Dr Eric Visser FANZCA
Secretary:	Dr Max Majedi, FANZCA
Treasurer:	Dr Philip Finch, FRCA
Members:	Dr Stephanie Davies, FANZCA
	Dr Jenni Morgan, FANZCA

Annual Scientific Meeting

The Faculty of Pain Medicine (FPM) Dean's Prize/Free Papers session was held on Sunday, May 3 at the ASM and included seven presentations. The Dean's Prize is awarded for original work judged to be the most significant contribution to pain medicine and/or pain research presented by a trainee, or a Fellow within eight years of Fellowship. The winner receives a grant of $1000 for educational or research papers and a certificate. Free paper presenters who are not eligible for the Dean's Prize are considered for a Best Free Paper Award and are awarded a certificate.

The 2009 winners were announced at the Faculty Annual General Meeting:

Dr Paul Wrigley (NSW): winner of the Dean's Prize for the research paper "Brain Anatomy Changes Associated with Chronic Neuropathic Pain Following Spinal Cord Injury".

Dr Jane Trinca (VIC): winner of the Best Free Paper Award 2009 for the research paper "Knowledge of Pain in Recent Medical Graduates in a Large Teaching Hospital 1998-2008. Have we Made a Difference?".

National Pain Summit

The National Pain Summit is a vitally important health policy initiative led by an alliance of pain specialists, primary healthcare professionals and consumer representatives. The proposal for the summit was initiated by the Pain Management Research Institute (PMRI) in collaboration with the MBF Foundation. The purpose is to elevate chronic pain as a significant issue on the political and healthcare agenda, leading to major benefits to consumers and ultimately, more cost-effective healthcare solutions. The summit is seen as a first step in progressing some of these recommendations.

FPM and the Australian Pain Society have also been approached to formally support the summit and contribute towards its organisation. It is proposed they will also assume leadership for taking proposals forward from the summit, in collaboration with the consumer group, Chronic Pain Australia.

Organisation
A Summit Steering Committee has been formed. It comprises representatives from all of the relevant pain management disciplines, GPs and other primary health care providers. The consumer group, Chronic Pain Australia, is also participating, as are representatives from Arthritis NSW and the Cancer Council. The steering committee has held three meetings and has agreed on a number of objectives.

Preliminary Leaders Meeting
In order to prepare for the summit and define the outcomes required, a Leaders Meeting was held at ANZCA House on June 5 to develop key proposals (policy recommendations) to be presented for validation to a wider audience during the summit. This meeting involved members of the steering committee and key stakeholder groups such as the Cancer Council, Palliative Care Australia and the bodies responsible for registration and education of relevant professional healthcare groups.

Fellowship training and examination dates for 2009

Examination dates
November 25-27, 2009
Royal North Shore Hospital, Sydney, NSW

Closing date for registration
October 9, 2009

Admission to Fellowship of the Faculty of Pain Medicine

By training and examination:

Dr Pamela Eccles	SA
Dr Charles Chul-Han KIm	VIC

By election:

Dr Michal Kluger	NZ

Photos from the ANZCA Annual Scientific Meeting, Cairns

Top row from left:

Dr Jane Trinca, winner of the Best Free Paper Award with Dean, Dr Penelope Briscoe;

A/Prof Steven Passik (FPM Queensland visitor), Prof Rollin M Gallagher (FPM special guest), Ms Helen Jones (Janssen Cilag), Prof Andrew Rice (FPM ASM Visitor and Dr Jason Ray (FPM Convenor);

Dr Jason Ray (FPM Convenor) with Dr Steven Passik (FPM Queensland Visitor);

FPM Dinner under the stars;

Retiring board member, Dr Roger Goucke at the unveiling of the Past Dean's portrait;

FPM refresher course at the Hilton.

Bottom row from left:

Dr Paul Wrigley, winner of the Dean's Prize with Dean, Dr Penelope Briscoe;

Retiring Board Member, A/Prof Milton Cohen and Mrs Pam Cohen;

Prof Tess Cramond (centre) receives a standing ovation at the FPM Dinner;

Dinner speaker A/Prof Jamie Seymour (centre) with Dr Penelope Briscoe and Dr David Jones;

Retiring board members Dr Roger Goucke and A/Prof Milton Cohen;

Prof Michael Cousins and Dr Penelope Briscoe present Prof Andrew Rice (FPM ASM Visitor) with the Michael Cousins Lecturer certificate.

Inaugural meeting of FPM Psychiatrists

When the Faculty of Pain Medicine (of the Australia and New Zealand College of Anaesthetists) was established in 1998, four psychiatrists were among the 30 Foundation Fellows. Now with about 250 Fellows, the number of psychiatrists within the FPM has risen to 14.

For the first time since the establishment of the FPM, a meeting of the psychiatrist Fellows was held in Sydney on April 6, 2009. Attendance of interstate colleagues was facilitated by the coincident annual scientific meeting of the Australian Pain Society. Impressively, 11 of the 14 Australian and New Zealand FPM psychiatrists attended a dinner during which a broad range of pertinent issues was discussed. It was a rare privilege to gather with such a group, to be able to put faces to people with whom one has liaised over the years and to meet afresh other colleagues working in this challenging field.

Against the splendid backdrop that is Darling Harbour's city light show, an array of significant issues pertaining to psychiatry and pain medicine was explored.

Several priorities were identified. These included raising the profile of psychiatry within the Faculty of Pain Medicine, and of the Faculty of Pain Medicine within the College of Psychiatry (RANZCP). Thought was also given to our relationships with allied groups such as addiction medicine and rehabilitation medicine.

At a more specific level the group considered it important that the knowledge base regarding pain management issues be raised in medical undergraduates, general psychiatry trainees, specialist CL trainees and the broader fellowship of the RANZCP. Ultimately, it would be hoped that more psychiatrists will be attracted to Fellowship of the Faculty of Pain Medicine and avenues for promoting this were discussed.

There was some discussion regarding the possibility that we establish a special interest group (SIG) within the RANZCP's section on consultation/liaison psychiatry. The same consideration was also given to forming a SIG in the Faculty of Pain Medicine. On a broader, global setting, the thought of establishing a SIG for psychiatry within the International Association (IASP) received a great deal of interest from the group.

Several decisions were made at the meeting. First, it was agreed that the group would meet informally whenever there were sufficient numbers at a conference of interest, but formally on an annual basis. There was some significant discussion as to whether the meeting should be attached to any specific conference, and if so which, without a clear decision having been determined. It was agreed that, as the next meeting of the Australian Pain Society will be conjoint with the New Zealand Pain Society, it would be an appropriate time to bring this trans-Tasman group together once again, a year or so hence. The agenda for that meeting will include the need to determine the timing of future meetings.

It was also agreed that the group would endeavour to coordinate a formal academic session at each and every future congress of the RANZCP, for our own academic development and of our colleagues.

A letter is to be written to the chairman of the board of education of the RANZCP to enquire about the prominence of pain medicine within the training curricula, and to offer involvement of the group in this regard. Members of the group indicated their acceptance that ideally, each of us should forge closer relationships with our CL colleagues; it was noted that many of us are employed by departments of anaesthesia/pain management rather than departments of psychiatry and that this might have facilitated some of us drifting a little from our colleagues.

At an even more practical level, much discussion was held about the potential for FPM psychiatrists to become more involved in undergraduate as well as Fellowship Examinations for both the FPM and the RANZCP. Fellows with ideas upon which they might develop model answers should contact Frank New or George Mendelson before putting too much effort into this, to ensure that they're not re-inventing something that is already on file.

The evening ended with a pervasive sense that this had been an important event, with a sense of satisfaction that a process had been set in train which will ultimately benefit ourselves as well as our professional and broader communities.

Dr Newman Harris
Convenor

HIV and Neuropathic Pain Seminar

Fellows of FPM in Melbourne and members of the Australian Pain Society, meeting as The Victorian Pain Management Group, were treated to a fascinating seminar on May 14, 2009 hosted by the Burnet Institute at the Alfred Hospital in Melbourne. The topic of discussion was HIV and neuropathic pain, with a seminar appropriately titled "Touching a Raw Nerve". Professor Andrew Rice, (FPM ASM visitor, 2009) from Imperial College London was joined by a local luminary on neuropathic pain in HIV, Dr Kate Cherry, who is head of Neuropathy and Drug Toxicity (HIV) Research at the Burnet Institute in Melbourne.

Many Fellows will have heard Prof Rice speak in Cairns and be aware of his vast clinical and scientific knowledge of neuropathic pain. In this instance his work on HIV neuropathy shed fascinating insights into this condition, which has features different to other forms of neuropathic pain. With an estimated incidence of 33 million HIV cases worldwide, the problem of pain is a major concern. Neuropathy can occur, typically a distal sensory neuropathy, both primary, and also secondary to antiretroviral therapies. Of great concern was the research showing poor response to typical analgesic therapies for neuropathic pain. The speakers highlighted new research including epidemiological insights, public health approaches, research into the results of phenotyping to select treatment and potential new drug developments for treatment.

Dr Carolyn Arnold

Australian Health and Medical Research Congress

Chronic pain and its treatment: from molecular to clinical

The Australian Health and Medical Research Congress (AH&MRC) is an initiative of the Australian Society for Medical Research and this fourth congress brought together 33 specialist societies and groups with the key aim of fostering cross-disciplinary collaboration and approaches to improving human health.

The symposium was proposed and financially supported by the Faculty of Pain Medicine (ANZCA), Australian Pain Society (APS) and ASCEPT (Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists) and was the only symposium that had more than two sponsors. It was held on Thursday morning November 20, 2008 to a packed audience (standing room only) of over 150 registrants and was chaired by Dr Amal Helou (APS President) and Prof Andrew Somogyi (ASCEPT Immediate Past President).

The four speakers were:

1. Prof Mac Christie (NHMRC Senior Principal Research Fellow, Brain & Mind Research Institute, University of Sydney): "Molecular Basis of Pain- New Targets". A large number of new drug targets was discussed including TRP channels, subtypes of sodium channels and GABAA receptors, new G-protein coupled receptors and cytokine receptors with the anticipated hope that we will see new pain-relieving drugs clinically available within the next four years.
2. Prof Maree Smith (Centre for Integrated Preclinical Drug Development and School of Pharmacy, University of Queensland): "Preclinical development of new drugs for pain treatment". Animal models with better predictive validity for targeted pain types were described including rodent models of painful diabetic neuropathy, mechanical nerve damage pain and post-herpetic neuralgia with the anticipated hope of accelerating the transition phase from preclinical to initial human studies.
3. Dr Luke Henderson (Department of Anatomy and Histology, University of Sydney): "Imaging as a tool for pain detection and assessment". Structural brain changes associated with neuropathic pain following spinal cord injury and in chronic orofacial pain were described with the anticipated hope of an improved diagnostic marker allowing for better assessment of treatment.
4. Prof Stephan Schug (Anesthesiology, School of Medicine and Pharmacology, University of Western Australia): "New Clinical Developments in Pain Therapy". Gabapentinoids, coxibs ("... an important improvement over non-selective NSAIDs, but regrettably not the harmless panacea on nonopioid analgesia"), ketamine and SNRIs were discussed in terms of advantages and disadvantages and highlighting that exciting new drugs are beginning to reach clinical practice and older ones establishing their place.

Overall, there was plenty of robust discussion and it was clear that pain has been a neglected area at these congresses. I would like to thank all the speakers and Amal Helou for making my job as co-ordinator quite easy. Perhaps we should consider participating in the 2010 Congress in Melbourne and including an international speaker as well.

Prof Andrew Somogyi
Symposium Co-ordinator

Report from the Board Meetings held on April 30 and May 3, 2009

Faculty Board

The Faculty Board met on April 30 and then the "new" board met on May 3 to appoint office-bearers and committees.

Strategic planning

At the April 30 board meeting, we reviewed the progress against the last strategic plan and good progress has been made with:

- Curriculums to medical schools PGY 1 & 2
- Increased number of training units
- Regional committees in three states
- MoUs signed off
- A budget of $7,000 each year for three years for a pain program at the RACS ASC
- Liaison with RACGP reorganising a curriculum for GPs
- National Pain Summit up and running
- Spring meetings established
- Teleconferences established with APS and NZPS

A half-day strategic workshop is proposed in conjunction with the August or October Board meetings to marry in with ANZCA's strategic review. Challenges ahead include:

- Educating the profession and public about pain medicine
- Education of GPs and supporting GPs to develop a curriculum
- Continuing to build the Faculty's profile
- Closer liaison with the AFRM and AChAM
- Attracting young psychiatrists into the Faculty
- Strengthening relationships with the APS and NZPS
- Changing nature of medical practice: Self management of chronic disease/illness

Regional representation

Following the recent Board election there was no representation from WA and Tasmania on the Faculty Board. The Board resolved to co-opt the interim chair of the newly-formed Western Australian Regional Committee to the Board. A Tasmanian representative will be invited to observe at a Board meeting later in the year and will be asked to bring ideas on how the Faculty can help raise the profile of pain medicine in that region.

Relationships portfolio

Liaisons with medical colleges

ANZCA

Dr Leona Wilson, ANZCA President, attended the April Board Meeting and will attend several board meetings a year to promote communication between ANZCA and the Faculty. Issues raised included the Faculty's desire for a strong sound relationship with the College, the reduction of FPM representation on ANZCA committees and concerns that the FPM Dean, as a co-opted representative is not a Director or included in the finance committee. Three Board members were invited to attend a council workshop in April with a facilitator from the Australian Institute of Company Directors and had found this to be very useful.

RANZCOG

A working group with multidisciplinary input from pain, obstetrics, psychology and physiotherapy, is developing a draft document on pelvic pain. It is anticipated this will take the form of a professional document or clinical update which may be considered for publication in the *Medical Journal of Australia*.

RANZCP

A group of psychiatry FPM Fellows met during the recent APS meeting. Several priorities were identified including raising the profile of psychiatry within the FPM and of the FPM within the RANZCP and coordination of a formal academic session at each future RANZCP congress. The group will next meet at the APS/NZPS meeting in 2010. A full report from Dr Newman Harris can be found in this edition of the *Bulletin*.

RACS

Faculty Fellows and the FPM ASM Visitor, Professor Andrew Rice, spoke at the two-day pain program of the 2009 RACS ASC following the ANZCA ASM. The 2010 RACS ASC will be held in Perth and the pain program is being organised by Dr David Holthouse.

Visitors to future Board Meetings

The President of the Australian Pain Society, Dr Stephen Gibson, will attend the August Board Meeting, and the President of the Australasian Chapter of Addiction Medicine, Dr Yvonne Bonomo, is to be invited to attend in October.

Liaison with pain societies

To further improve liaisons with the pain societies, Faculty regional committees will be asked to co-opt an APS member. Liaisons at a national level are to be pursued including the possibility of joint professional documents. A teleconference meeting of the Faculty, APS and NZPS is scheduled for June 3.

UK pain specialty

The Faculty of Pain Medicine of the Royal College of Anaesthetists (RCA) has sought advice on establishing a formal assessment process for the UK Faculty. They have accepted an invitation to send an observer to the 2009 examination in Sydney.

American Board Pain Medicine

Professor Rollin (Mac) Gallagher, president of the ABPM, met with the board and gave a presentation on developments with the *Pain Medicine* journal. At the new board meeting Prof Milton Cohen was appointed senior editor of *Pain Medicine*. Prof Gallagher also requested interested fellows to nominate as sub-editors.

Chronic Pain Australia

Chronic Pain Australia has organised conferences and held a well-attended consumer session before the APS meeting chaired by Milton Cohen, in which several Fellows participated. This organisation aims to offer a telephone advisory service in liaison with Arthritis NSW, a successful support group.

Fellowship Affairs portfolio

Fellowship

New admissions

Drs Pamela Eccles FANZCA (SA) and Charles Kim FANZCA (Vic) were admitted to fellowship by training and examination and Dr Michal Kluger FANZCA (New Zealand) was elected to Fellowship by election. Three applicants were offered the new summative assessment pathway to Fellowship which involves satisfactory completion of examination and case report requirements without further training.

Honours and appointments

The Board acknowledged and congratulated the following recipients:

Dr Bob Boas has been awarded life membership of the NZSA

Dr Carolyn Arnold, A/Prof Leigh Atkinson, A/Prof David Cherry, Prof Arthur Duggan, Dr David Gronow and Prof George Mendelson have been awarded Australian Pain Society Distinguished Members Awards.

Continuing education and quality assurance

Scientific meetings

The Faculty will request that a second plenary lecture on the Sunday morning of the ANZCA ASM be permanently allocated to a FPM Visitor and that an annual budget be allocated for a second speaker.

2009 Spring meeting – Melbourne

The registration brochure for *"Duelling with Pain"* at the Sofitel Melbourne from October 16-18 has been circulated and registrations have started. The visitor is Dr Roman D Jovey (Canada). The convenor, Dr Carolyn Arnold, and the local organising committee were congratulated on developing an excellent program.

2010 Spring Meeting

Dr Chris Hayes will convene this meeting and a theme of "Transitions in Pain" is proposed. A venue and date is yet to be confirmed.

2010 ASM – Christchurch

Plans are well advanced for a refresher course day and ASM program including Dr Jeffrey Mogil (Canada) as the FPM ASM visitor and Dr Richard Rosenquist (USA) as the FPM New Zealand Visitor.

2011 ASM – Hong Kong

Dr P Chen was confirmed as the FPM convenor for the 2011 meeting in Hong Kong. Professor Leigh Atkinson will be the deputy convenor.

Research

Core outcomes database

A research proposal is about to go to the Hunter Ethics Committee for approval. Outcome measures have been agreed. Further information about the project, including opportunities for participation, will be included in *Synapse*.

Implant register

The board supported in principle the development of an implantable devices register for neurostimulation devices and implantable Intrathecal medication delivery devices. This register would be similar to ones used widely for implants in orthopaedic surgery. A sub-committee has been formed to prepare a proposal before seeking input from the Federal Government.

Regional committees

Queensland

The Board discussed the lack of funded pain places in Queensland public hospitals. A meeting will be convened with the ANZCA directors of communication and policy, quality and accreditation in conjunction with the August Board Meeting to brainstorm strategies for a federal and state level approach.

New South Wales

The NSW regional committee met in February and commenced circulation of an e-newsletter "The Algometer" http://*www.anzca.edu.au/fpm/news-and-reports/nsw-regional-committees-newsletter.* Three issues a year will be circulated to NSW fellows and trainees.

Western Australia

An interim Western Australian regional committee of the Faculty of Pain Medicine has been endorsed with the authority to work under the FPM Regional Committee regulations with elections to be held in the first quarter of 2010. The interim committee comprises:

Chair	Dr Eric Visser
Secretary	Dr Max Majedi
Treasurer	Fr Philip Finch
Members	Dr Jenni Morgan
	Dr Stephanie Davies

Professional

National Pain Summit

The Board believes a National Pain Summit is a vitally important health policy initiative. The proposal for the summit was initiated by the Pain Management Research Institute (PMRI) and the MBF Foundation (MBFF) and the purpose is to elevate pain management as a significant issue on the political and healthcare agenda, leading to major benefits for consumers and ultimately, more cost-effective healthcare solutions. The summit is seen as a first step in progressing some of these recommendations.

The faculty of pain medicine has been approached to formally support the summit and contribute towards its organisation. A summit steering committee has been convened. It comprises representatives of all pain management disciplines, GPs, other primary care providers. A number of consumer group, are also participating. In order to prepare adequately for the summit and define the outcomes required, a preliminary leaders meeting will be held at **ANZCA House on June 5**, to develop key proposals (policy recommendations), which will be presented to a wider audience at the summit, for validation.

Acute pain management: scientific evidence 3rd edition

In recognition of the significant amount of work put in by the editors of *APM:SE 3rd edition*, it was resolved that approval be given for the editors to be listed in this publication.

Pain physicians referral to allied health professionals

Following advice from the ASA with regard to complex pain consultations, referrals to allied health professionals and telemedicine items, the faculty will start dialogue with a view to making the appropriate submissions. It has been advised that a scheme providing access to allied health is under review and expansion to pain medicine specialists should be achievable.

Trainee Affairs portfolio

Assessor

As the Faculty moves toward tightening the amount of retrospectivity toward the "elective" year of training, more definition of the content and how it is assessed will be included in the regulations. The assessor is developing a guide for retrospective accreditation toward this elective period.

Education committee

A focused resources document for trainees and Fellows has now been completed and is available from the Faculty website. The ANZCA library will be asked to ensure that they have access to the books referred to in the document.

Report from the Board Meetings held on April 30 and May 3, 2009

Continued

Training unit accreditation
Following a paper review after one year, the Royal Prince Alfred Hospital in Sydney was accredited for the balance of the three year term.

Resources portfolio

Finance
Figures to March 31 showed the faculty to be doing well against budget.

Board and committee appointments

Board Members:

Dean	Penelope Briscoe
Vice Dean/assistant assessor	David Jones
Assessor	Frank New
Chair education committee	Ted Shipton
Chair examination committee	Ray Garrick
Chair training unit accreditation committee	Brendan Moore
Chair research committee	Chris Hayes
Chair continuing education & quality assurance committee/CPD officer	Guy Bashford
Treasurer/scientific meeting officer	Leigh Atkinson
	Carolyn Arnold
Co-opted member representing ANZCA	Kerry Brandis
Senior editor *Pain Medicine*	Milton Cohen (non-board member)

Executive committee/portfolio chairs:

Chair relationships portfolio	Penelope Briscoe
Chair trainee affairs portfolio	Brendan Moore
Chair fellowship affairs portfolio	David Jones
Chair resources portfolio	Leigh Atkinson

Examination committee:

Chair	Ray Garrick
Deputy chair	Meredith Craigie
Dean (ex officio)	Penelope Briscoe
Members:	
AFRM (RACP)	Carolyn Arnold
RACS	Leigh Atkinson
RANZCP	George Mendelson
	Frank New
ANZCA	Melissa Viney
New Fellow representative	Mark Tadros

Education committee:

Chair	Ted Shipton
Dean (ex officio)	Penelope Briscoe
Chair trainee affairs portfolio (ex officio)	Brendan Moore
Chair examinations committee (ex officio)	Ray Garrick
Members:	Michael Butler
Director of education, ANZCA	Mary Lawson
	Frank New
	Faizur Noore
Supervisor, SoTs	Tim Semple
	Stephan Schug
New Fellow representative	Mark Schutze
	Peter Teddy
	Jane Trinca
	Owen Williamson
	Paul Wrigley

Training unit accreditation committee:

Chair	Brendan Moore
Assessor (ex officio)	Frank New
Members	Carolyn Arnold
	Matthew Crawford
	David Gronow
	Diarmuid McCoy
Deputy SoTs	Melissa Viney
	Eric Visser
	Pauline Waites

Research committee:

Chair	Chris Hayes
Vice Dean (ex officio)	David Jones
Senior editor *Pain Medicine* (ex officio)	Milton Cohen
Section editor *Pain Medicine*	Colin Goodchild
Members	Carolyn Arnold
	Guy Bashford
	Julia Fleming
	Malcolm Hogg
	Tim Pavy
	Stephan Schug
	Philip Siddall
	Maree Smith
	Andrew Somogyi

Continuing education & quality assurance committee:

Chair	Guy Bashford
Vice Dean (ex officio)	David Jones
Scientific meeting officer (ex officio)	Leigh Atkinson
Immediate past ASM convenor	Jason Ray
ASM convenor	Ted Shipton
Spring meeting convenor	Carolyn Arnold
Future spring meeting convenor	Chris Hayes
Members	Milton Cohen
	Diarmuid McCoy
	Peter Rofe
	Michael Vagg

Representation on ANZCA committees:

Research committee	Chris Hayes
IMGS committee: assessor (ex officio)	Frank New
Regional committees:	
Queensland	Richard Pendleton
New South Wales	Kok Eng Khor
Victoria	David Scott
Tasmania	Gajinder Oberoi
South Australia	Pamela Macintyre
Western Australia	Eric Visser
New Zealand national committee	David Jones

External committees & organisations

Australasian anaesthesia	Robyn Campbell

Faculty working parties and task forces blueprinting sub-committee:

Chair	Frank New
Members	Wilbur Chan
	Tim Semple
	Jane Trinca
	Owen Williamson

Acute Pain Management: Scientific Evidence 3rd Edition:

Chair	Pamela Macintyre
Members	Stephan Schug
	David A Scott
	Suellen Walker
	Eric Visser

Dean's Report to the Annual General Meeting 2009

This is the tenth year of the Faculty and 47 Fellows were granted Foundation Fellowship at this ceremony in Adelaide in1999. We are now proud to now number 260 fellows, of whom 106 have been granted Fellowship by the examination process.

At the Annual General Meeting in May of 2008, the Faculty implemented a new Board structure, recognising its responsibilities not only to its trainees but also the Fellowship and to better provide support for the progression of strategic initiatives. Four portfolios were formed, each with a Board member as Chair - (Relationships myself the Dean, Fellowship Affairs Vice-Dean David Jones, Trainee Affairs Brendan Moore, and Resources, Leigh Atkinson). The Chair of these portfolios now makes up the Faculty Executive.

We also restructured the committees as we recognised that Ted Shipton, who had been Chair of the Education and Training Committee, had a massive workload, and Ted has continued to provide a fantastic service to the Fellowship, but now can focus on the Education Committee role. Brendan Moore, has taken over the role of Chair of the Training Unit Accreditation Committee, and in the last 12 months, five hospitals have been re-accredited for training and the Burwood Hospital Pain Management Centre in Christchurch New Zealand, and the Singapore General Hospital were also accredited. We congratulate Singapore in being the first unit outside of Australasia to be accredited by the Faculty for training in Pain Medicine. There are currently 23 accredited pain training unit throughout Australasia and now Singapore.

Milton Cohen has worked tirelessly as Chair of the Continuing Education and Quality Assurance Committee. The Faculty held a second Spring Meeting in September at Ayres Rock in association with the Acute Pain SIG of ANZCA, the ASA and the New Zealand SA and the Acute Pain SIG of the IASP. I thank Pam Macintyre the Convenor, Stephan Schug, the Scientific Convenor and Steve Jones the Co-Convenor for their tireless work for what we consider was an overwhelmingly successful meeting, both financially and politically. A great deal of good will and enthusiasm was generated between the acute and chronic pain practitioners, with recognition to improve outcome for all our patients good communication between the different speciality groups is essential. As a follow on from that, this year's Spring Meeting will be held in Melbourne in October with Carolyn Arnold as Convenor, and once again we have had very fruitful input from Jane Trinca and other members of the Acute Pain SIG.

The Faculty is also very grateful to Dr Jason Ray for his excellent work as the 2009 FPM Convenor in building an exciting and broad-ranging Refresher Day and Scientific Program.

Recognising the importance of cooperation between acute and chronic pain practitioners and the fact that not all pain practitioners can work within a multidisciplinary setting, the Board has now reintroduced the process where those who practice Pain Medicine, but who may not meet all the requirements for Fellowship can apply for election to the Faculty and be directed towards Fellowship without further training by completing the case report and examination requirements. I am hoping this will allow some of our acute pain colleagues who perhaps do not fulfil all the requirements to apply for fellowship.

We continue to receive applications to do our training from outside the five specialties that formed the Faculty originally. We now have Fellows who have backgrounds in Obstetrics and Gynaecology, ENT and Radiology, and we currently have three general practitioners undergoing our training programme. This leads us to ask the question, "What is a Pain Medicine Specialist?" Frank New is chairing a Blueprinting Sub-committee with support from Brian Jolly. This group is spending many hours debating this question. Once this process is complete then we will need to re-visit our curriculum to see that the two marry up and ensure that our trainees are comfortable in their roles after completing the training process.

In October the Board held a workshop looking at Board Members responsibilities and accountability, and this process was facilitated by the Australian Institute of Company Directors.

We are a small Fellowship, but our Fellows are enthusiastic and nationally we now have three Regional Committees; in Queensland chaired by Paul Gray, in New South Wales chaired by Kok Eng Khor, and, following a meeting in Western Australia in April, in Western Australia chaired by Eric Visser. We are hoping that other states will follow.

In New Zealand, David Jones, Ted Shipton and Steuart Henderson are working hard to get Pain Medicine recognised as a specialty within that country. Internationally our association with the American Academy of Pain Medicine continues to grow. Dr Michel Dubois the Chair of the American Board of Pain Medicine Examination Committee observed at our Faculty exam at St Vincent's in November. He was very impressed with the process and congratulations go to Dr Ray Garrick the Chair of the Exam Committee.

Seven Fellows attended the American Academy of Pain Medicine meeting in Hawaii where Roger Goucke was awarded a Presidential commendation and Nik Bogduk received a Founders Award for Outstanding Contributions to the Science or Practice of Pain Medicine.

We continue to try to raise the profile of Pain Medicine both across Australasia and also in our association with our other Colleges. Leigh Atkinson continues to work tirelessly improving the standing of Pain Medicine both with RACS and in Queensland and Andrew Rice our ASM visitor will be presenting at the RACS meeting in Brisbane later this week. Carolyn Arnold and Jane Trinca have been working with a group in Victoria looking at availability of Pain Medicine in that state. Newman Harris and Frank New have formed a group of interested psychiatrists to aim to improve our standing.

Dean's Report to the Annual General Meeting 2009

Continued

Chris Hayes as Chair of the Research Committee is looking at a multi-centre study with input from both the Hunter Integrated Pain Service and Caulfield Pain Management and Research Centre in Victoria looking at outcomes. Many of our Fellows contribute to the Faculty in so many ways and I would particularly like to acknowledge the tireless input of Tim Semple who is on a number of committees and is also the Supervisor of Supervisors of Training, Melissa Viney who is Deputy SSoT and also contributes to TUAC and Exams,Owen Williamson works on the Education Committee and Blueprinting Committee as does Jane Trinca. Paul Wrigley and Diarmuid Mc Coy are on several committees. To you all Thanks. To my Board – thank you all for your ongoing support, guidance and wisdom..

But of course the Faculty could not be possible without the support of our Executive Officer Helen Morris and her staff, Penny McNair and Angela Boolieris, and I particularly wish to thank them for their friendship, warmth and hard work.

In closing, I am very excited that this is the Faculty's 10th year and we will be acknowledging this at the Spring Meeting in Melbourne. The Faculty is well prepared to continue with its unique interdisciplinary model moving forward to provide what is considered internationally one of the leading Pain Medicine Faculties in the world, both with our organisational processes and certainly our training and examination.

Honorary Fellowship: Prof Maree Therese Smith

"The Board of the Faculty of Pain Medicine admits from time to time distinguished persons who have made a notable contribution to the advancement of the science and practice of pain medicine, who are not practicing pain medicine in Australia or New Zealand".

Professor Maree Therese Smith

After obtaining a B Pharm (Hons) degree from the University of Queensland, Maree Smith undertook research higher degree training in clinical pharmacokinetics, bioanalysis and drug metabolism under the supervision/mentorship of professors Wayne Hooper and Mervyn Eadie in the Department of Medicine, University of Queensland at Royal Brisbane Hospital, culminating in a PhD degree in medicine.

Following a period of postdoctoral training in the field of pain management with Professor Tess Cramond (director, Multidisciplinary Pain Centre at Royal Brisbane Hospital), Maree was appointed as a lecturer in the School of Pharmacy at UQ in mid-1989. Over the next 15 years, she was progressively promoted through the academic ranks at UQ culminating in her promotion to Professor of Pharmacy in 2004.

Prof Smith has specialist expertise in pre-clinical drug development including animal models of human disease, bioanalytical assays and pharmacokinetics and oversees research in a broad range of projects focussing on improving our understanding of the mechanistic basis of a range of pain states and their pharmacological management.

Prof Smith is the inaugural director of Australia's first Centre for Integrated Preclinical Drug Development (CIPDD) and is Professor of Pharmacy at the University of Queensland. In the past two decades, Prof Smith and her team have undertaken considerable research in the field of pain pharmacology with this research directed towards improving patient outcomes. Prof Smith has successfully supervised to completion 15 PhD students, two research Masters students and 30 Honours students and she is supervising four PhD students, three Master of Philosophy students and three Honours students now.

In 2001 and 2002, Prof Smith received "meritorious mentions" from the University of Queensland in recognition of sustained excellence in the supervision of research higher degree students. In 2003, Prof Smith was awarded a "Trailblazer Challenge" award by UniQuest, and in 2008 she received the Women in Technology Biotech Outstanding Achievement Award.

Prof Smith's contribution to improvements in clinical management of pain and to our own faculty of pain medicine is recognised today with the awarding of Honorary Fellowship of the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists.

Dr Brendan Moore

Honorary Fellowship: A/Prof Michael Kenneth Nicholas

Michael Kenneth Nicholas

Associate Professor Michael Nicholas was born in Christchurch in New Zealand, and grew up in Cheviot, North Canterbury before attending King's College in Auckland. Initially completing a BSc degree in Zoology at Otago University he switched to studies in psychology at Auckland University, graduating MSc with Honours in 1978. He completed his training in clinical psychology at the University of New South Wales in 1980, before going on to work in the multidisciplinary pain service at Westmead Hospital from 1980-87 and doing his PhD thesis on evaluating a cognitive behavioural therapy program for low back pain (Sydney University, 1988).

From then to now A/Prof Nicholas has been a prolific worker and international contributor as a clinical psychologist, researcher and educator. A/Prof Nicholas holds a conjoint hospital and university position at the Pain Management and Research Institute, University of Sydney (Faculty of Medicine) and Royal North Shore Hospital and is director of the ADAPT pain management program.

More than 80 journal and book chapter publications can be identified concerning psychological aspects of pain, its assessment and management. He has been principle investigator on a number of collaborative research projects, including a large NHMRC (Australian) funded RCT of physiotherapy for sub-acute low back pain, an Australian health minister's advisory council priority research grant to evaluate an intervention for self-management of chronic pain in elderly Australians, an Australian Research Council grant for attentional mechanisms in acute and chronic pain and an NHMRC project grant to evaluate psychological interventions aimed at reducing the distressing nature of chronic pain, and more. Very well-known in the professional and lay community is the self-management manual for people with chronic pain, *Manage Your Pain*.

Research on improving the return to work of injured workers has been a major interest, with contribution to development of guidelines (clinical framework) on psychological services for injured workers with the Victorian Workcover Authority, and similar for WorkCover (NSW) on the management of soft tissue injuries.

In 2008 A/Prof Nicholas was awarded a visiting research fellowship at the Centre for Health and Medical Psychology (CHAMP) in the psychology department at Orebro University (Sweden). He was a member of the scientific program committee of the IASP for the 2008 World Congress on Pain in Glasgow, and recently invited to the editorial board of *Pain*, a leading international pain journal. He is also a regular reviewer for 15 national/ international professional and scientific journals.

A/Prof Nicholas has pointed out that with a future ageing population and about a quarter of elderly people suffering some form of chronic pain, it will be essential to look at ways to help the elderly. His lecture topics include descriptions of common barriers that hinder rehabilitation, and ways to tackle challenging pain obstacles. Among what he considers his personal best achievements he lists helping in development of pain programs in South East Asia, London and throughout Australia. Personal traits of reflection, persistence and patience, with an interest in others and open discussion have carried him through the gigantic tasks that he has set himself, past and future.

By many direct and indirect means A/Prof Michael Nicholas has helped lessen the suffering of those in pain. The award of Honorary Fellowship of the Faculty of Pain Medicine is a fitting recognition of the substantial contributions A/Prof Nicholas has made in the broad field of our specialty.

Dr David Jones

OBITUARY

Dr Sydney Dennis Giddy

OAM 2008, FANZCA 1992, FFARACS 1968
1930 – 2009

Dr Sydney Dennis Giddy had a major role in the development of anaesthesia in Ballarat and served the community for many years as president of Sunways Retirement Home and as an active member of the Rotary Club of Wendouree.

Dr Giddy was born in Ilford, Essex in 1930. He undertook his medical training in the UK, graduating from Birmingham in 1954. After completing his internship and HMO year at Stoke-on-Trent and Bath, he spent two years with the Royal Army Medical Corp, and then returned to do his obstetric training at Swindon. He obtained his D.Obst.RCOG in 1958 and worked in general practice in Wiltshire before becoming an anaesthetic registrar at the Royal Victorian hospital at Swindon in 1960.

Dr Giddy migrated to Australia in 1961 coming to a general practice in Ballarat with an interest in anaesthesia and obstetrics and gynaecology. He was appointed as sessional anaesthetist at Ballarat Health Services and as an honorary anaesthetist at the Royal Melbourne Hospital from 1966-68.

With Dr Bill Dick, Dr Heather Lopert and Dr Peter Theobald, formed the Anaesthetic Group, Ballarat. He continued his study of anaesthesia while working full-time at Ballarat Health Services and became Ballarat's first formally trained specialist anaesthetist when he was awarded the Fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons in 1968.

He established the Department of Anaesthesia and set up the Intensive Care Unit. He was appointed as the first Director of Anaesthesia at Ballarat Health Services in 1968. Syd was especially proud of the development of the ICU, as this was only the second intensive care unit to be set up in Victoria, a remarkable achievement demonstrating enormous foresight.

He set up a training program, with anaesthetic registrars from the Royal Melbourne Hospital. Over the years he trained many specialist anaesthetists, many who are now training young anaesthetists themselves. At least twelve of these trainees have returned to Ballarat to work as specialist anaesthetic VMO's for Ballarat Health Services.

When he retired from the position of director of the Department of Anaesthesia and Intensive Care, he became a sessional anaesthetist. Dr Giddy continued in private practice until he retired in 2004. He had established the department on a very sound footing, with registrars and hospital medical officers in training, a level 2-3 intensive care unit supported by 12 specialist anaesthetists/intensivists. It was ideally positioned for further development, a remarkable achievement for a small regional hospital.

Dr Giddy also worked tirelessly for the hospital medical officers as a whole. He was chairman of the Professional Staff Group from 1974-1976, a very volatile time when we saw the replacement of the honorary system with paid medical officers. He found time to work on the medical advisory, medical standard and review, theatre and the library committees within the hospital.

He was a very active member of the Australian Society of Anaesthetists, serving on the state committee from 1983-1995. He was Victorian chairman from 1989-90, and also served on the federal committee.

Dr Giddy was the senior local convenor of the 1988 Australian Society of Anaesthetists' National Scientific Conference in Ballarat. He was awarded the Gilbert Troupe Prize by the society that year.

In later years he undertook training of anaesthetists in South East Asia as well as in Victoria, single-handedly running a course for second-part fellowship training in 1993.

Dr Giddy held several other appointments within the health industry. He was appointed to the Health CommissionCommittee on Anaesthetic Morbidity & Mortality in 1991 and served as the ASA representative on the Council of Hospital Standards.

He was also on the Medical Advisory Committee for the State Ambulance Service (1971).

He helped set up a study to assess the ability to theatre-train ambulance personnel for resuscitation at the roadside. It led to a continuing association with Ballarat Ambulance Services in training ambulance personnel in resuscitation, insertion of IV cannulas for fluid therapy and intubation. This study preceded MICA training in Melbourne, another demonstration of his foresight.

Dr Giddy was involved with other sundry community projects as well. He was an active member of Rotary International (the Rotary Club of Wendouree, D9780) for many years, serving on many committees, and as the president.

He had been on the council of Sunways Retirement Home in Ballarat from 1979 until they were absorbed into the Uniting Church program in 2007. He was the chairman from 1979.

Dr Giddy loved being fit, and continued skiing at Falls Creek until last year.

He was awarded the Medal of the Order of Australia in 2008 for his services to anaesthesia and to the community. He was very pleased to provide a copy of the medal to the Anaesthetic Group, Ballarat for their role in his recognition. The anaesthetic community of Ballarat was very proud to receive it.

Dr Giddy was awarded Emeritus Consultant status by Ballarat Health Services in 2005, and received a citation from the Post Graduate Foundation of St John of God Hospital in 2008, for his development of anaesthesia in the Ballarat Health system.

Dr Sydney Dennis Giddy was a source of inspiration to his trainees, to the people he worked with and to the patients he helped. He was devastated by the death of his younger daughter Joy in 2006. He is survived and sadly missed by his wife of 55 years, Sybil, by his three surviving children, Martin, Pam and Peter, by his 10 grandchildren and his many, many friends.

Dr John Oswald
Deputy Director of the
Department of Anaesthesia
Ballarat Health Services

Professional documents

Following the normal review process by Council, the following Professional Document has recently been approved:

PS51 – *Guidelines for the Safe Administration of Injectable Drugs in Anaesthesia*

Australian and New Zealand College of Anaesthetists

Professional documents

P = Professional
T = Technical
EX = Examinations
PS = Professional standards
TE = Training and Educational

TE1	(2005)	*Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia*
TE2	(2006)	*Policy on Vocational Training Modules and Module Supervision* (interim review)
TE3	(2006)	*Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia*
TE4	(2003)	*Policy on Duties of Regional Education Officers in Anaesthesia*
TE5	(2003)	*Policy for Supervisors of Training in Anaesthesia*
TE6	(2006)	*Guidelines on the Duties of an Anaesthetist*
TE7	(2005)	*Guidelines for Secretarial and Support Services to Departments of Anaesthesia*
TE8	(2003)	*Guidelines for the Learning Portfolio for Trainees in Anaesthesia*
TE9	(2005)	*Guidelines on Quality Assurance in Anaesthesia*
TE10	(2003)	*Recommendations for Vocational Training Programs*
TE11	(2008)	*Policy on the Formal Project* (interim review)
TE13	(2003)	*Guidelines for the Provisional Fellowship Program*
TE14	(2007)	*Policy for the In-Training Assessment of Trainees in Anaesthesia*
TE17	(2003)	*Policy on Advisors of Candidates for Anaesthesia Training*
TE18	(2005)	*Guidelines for Assisting Trainees with Difficulties*
EX1	(2006)	*Policy on Examination Candidates Suffering from Illness, Accident or Disability*
T1	(2008)	*Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations* (interim review)
T3	(2008)	*Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice*
PS1	(2002)	*Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia*
PS2	(2006)	*Statement on Credentialling and Defining the Scope of Clinical Practice in Anaesthesia*
PS3	(2003)	*Guidelines for the Management of Major Regional Analgesia*
PS4	(2006)	*Recommendations for the Post-Anaesthesia Recovery Room*
PS6	(2006)	*The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care*
PS7	(2008)	*Recommendations on the Pre-Anaesthesia Consultation*
PS8	(2008)	*Guidelines on the Assistant for the Anaesthetist*
PS9	(2008)	*Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures*

Professional documents

Continued

PS10 (2004) *Handover of Responsibility During an Anaesthetic*
PS12 (2007) *Statement on Smoking as Related to the Perioperative Period*
PS15 (2006) *Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery*
PS16 (2008) *Statement on the Standards of Practice of a Specialist Anaesthetist*
PS18 (2008) *Recommendations on Monitoring During Anaesthesia*
PS19 (2006) *Recommendations on Monitored Care by an Anaesthetist*
PS20 (2006) *Recommendations on Responsibilities of the Anaesthetist in the Post-Anaesthesia Period*
PS21 (2003) *Guidelines on Conscious Sedation for Dental Procedures*
PS26 (2005) *Guidelines on Consent for Anaesthesia or Sedation*
PS27 (2004) *Guidelines for Fellows who Practice Major Extracorporeal Perfusion*
PS28 (2005) *Guidelines on Infection Control in Anaesthesia*
PS29 (2008) *Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities* (reissue)
PS31 (2003) *Recommendations on Checking Anaesthesia Delivery Systems*
PS37 (2004) *Regional Anaesthesia and Allied Health Practitioners*
PS38 (2004) *Statement Relating to the Relief of Pain and Suffering and End of Life Decisions*
PS39 (2003) *Minimum Standards for Intrahospital Transport of Critically Ill Patients*
PS40 (2005) *Guidelines for the Relationship Between Fellows and the Healthcare Industry*
PS41 (2007) *Guidelines on Acute Pain Management*
PS42 (2006) *Recommendations for Staffing of Departments of Anaesthesia*
PS43 (2007) *Statement on Fatigue and the Anaesthetist*
PS44 (2006) *Guidelines to Fellows Acting on Appointments Committees for Senior Staff in Anaesthesia*
PS45 (2008) *Statement on Patients' Rights to Pain Management*
PS46 (2004) *Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults*
PS47 (2008) *Guidelines for Hospitals Seeking College Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine*
PS49 (2008) *Guidelines on the Health of Specialists and Trainees*
PS50 (2004) *Recommendations on Practice Re-entry for a Specialist Anaesthetist*
PS51 (2009) Guidelines for the Safe Administration of Injectable Drugs in Anaesthesia

Australian and New Zealand College of Anaesthetists

and

Joint Faculty of Intensive Care Medicine

Professional documents

IC-1 (2003) *Minimum Standards for Intensive Care Units*
IC-2 (2005) *Intensive Care Specialist Practice in Hospitals Accredited for Training in Intensive Care Medicine*
IC-3 (2008) *Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care Medicine*
IC-4 (2006) *The Supervision of Vocational Trainees in Intensive Care*
IC-6 (2002) *The Role of Supervisors of Training in Intensive Care Medicine Medicine*
IC-7 (2006) *Administrative Services to Intensive Care Units*
IC-8 (2008) *Quality Assurance*
IC-9 (2002) *Statement on the Ethical Practice of Intensive Care Medicine*
IC-10 (2003) *Minimum Standards for Transport of Critically Ill Patients*
IC-11 (2003) *Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine*
IC-12 (2001) *Examination Candidates Suffering from Illness, Accident or Disability*
IC-13 (2008) *Recommendations on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine*
IC-14 (2004) *Statement on Withholding and Withdrawing Treatment*
IC-15 (2004) *Recommendations of Practice Re-entry for an Intensive Care Specialist*

Australian and New Zealand College of Anaesthetists

and

Faculty of Pain Medicine

Professional documents

PM2	(2005)	*Guidelines for Units Offering Training in Multidisciplinary Pain Medicine*
PM3	(2002)	*Lumbar Epidural Administration of Corticosteroids*
PM4	(2005)	*Guidelines for Patient Assessment and Implantation of Intrathecal Catheters, Ports and Pumps for Intrathecal Therapy*
PM5	(2006)	*Policy for Supervisors of Training in Pain Medicine*
PM6	(2007)	*Guidelines for Longterm Intrathecal Infusions (Analgesics/Adjuvants/Antispasmodics)*
PS3	(2003)	*Guidelines for the Management of Major Regional Analgesia*
PS38	(2004)	*Statement Relating to the Relief of Pain and Suffering and End of Life Decisions*
PS39	(2003)	*Minimum Standards for Intrahospital Transport of Critically Ill Patients*
PS40	(2005)	*Guidelines for the Relationship Between Fellows and the Healthcare Industry*
PS41	(2007)	*Guidelines on Acute Pain Management*
PS45	(2008)	*Statement on Patients' Rights to Pain Management and Associated Responsibilities*
PS49	(2008)	*Guidelines on the Health of Specialists and Trainees*

College Professional Documents adopted by the Faculty:

PS4	(2006)	*Recommendations for the Post-Anaesthesia Recovery Room (Adopted February 2001)*
PS7	(2008)	*Recommendations for the Pre-Anaesthesia Consultation (Adopted November 2003)*
PS8	(2008)	*Guidelines on the Assistant for the Anaesthetist (Adopted November 2003)*
PS9	(2008)	*Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures (Adopted 2008)*
PS10	(2004)	*The Handover of Responsibility During an Anaesthetic (Adopted February 2001)*
PS15	(2006)	*Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery (Adopted February 2001)*
PS18	(2008)	*Recommendations on Monitoring During Anaesthesia (Adopted February 2001)*
PS20	(2006)	*Recommendations on Responsibilities of the Anaesthetist in the Post-Anaesthesia Period (Adopted February 2001)*
PS31	(2003)	*Recommendations on Checking Anaesthesia Delivery Systems (Adopted July 2003)*
T1	(2008)	*Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and other Anaesthetising Locations (Adopted May 2006)*